

**Stories of companionship and trust: Women's
narratives of their student midwife caseloading
experience**

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Abstract

It is national policy that midwifery students, as part of the undergraduate midwifery curriculum, gain experience of providing continuity of care for women throughout the childbearing continuum via caseload practice (NMC 2009). Student midwife caseloading has been cited as an example of best practice (DH 2003). However, whilst there is robust evidence of women's experiences of continuity from qualified midwives (Sandall et al. 2016), there is a lack of information regarding student's care. Although a small number of studies have been conducted in Australia and Norway, no formal research into women's experiences of this approach to student involvement in their care appears to have been undertaken in the United Kingdom.

This study focussed on hearing women's personal stories to develop an understanding of how being part of a student midwife's caseload may have impacted on their childbearing experience. Utilising qualitative methods, the study followed women's experiences of continuity of care provision from a student midwife, supervised by a qualified midwife, throughout pregnancy, birth and the early days of mothering. I was interested to hear women's stories of their relationships with students and how these were developed, how they described the care provided in relation to their holistic needs and how, and if, they linked the continuity of care by the student with the outcome of their experience.

Data were collected within a longitudinal model through story accounts from six women who had agreed to be part of a student's caseload. Participant stories were sought on three occasions: twice during pregnancy, and once in the postnatal period. The data gathered at these points in time were viewed as a continuing story that unfolded over the woman's childbearing event.

The story accounts were analysed through a narrative framework using a three phase re-storying model to uncover themes of significance to the individual women within the study, and the women as a group. Phase 1 involved the analysis of the three interview transcripts of the individual woman's unfolding story. Phase 2 included the construction of an interpretative story or personal experience narrative poem for each participant. Phase 3 provided a synthesis of the data to construct a collective story that encapsulated the emergent narratives themes of significance to the women as a group.

The three longitudinal narrative themes of significance to the women as a group were identified as: 'mutually supportive partnerships'; 'just like a midwife' and 'extra special care'. All women recognised the status of their caseloading student as that of learner, as someone working to become a qualified midwife, and described the reciprocal supportive relationships they developed with students through relational continuity within this context. While identifying the caseloading student as requiring supervision from a qualified midwife, women expressed high levels of trust and confidence in 'their' student's knowledge, clinical competence and caregiving abilities. Being with a student in a continuity relationship, and the extra support it engendered, was highly valued by women. The student's perceived 'constant' presence across the childbearing experience was welcomed and described as central to the women's comfort and contentment.

Study findings provide evidence that this group of women highly valued the student contribution via continuity to their care and this experience may be transferable to other women participating in student caseloading. This understanding adds weight to the Nursing and Midwifery Council expectations and reinforces the value of continuity educational schemes. The knowledge gained provides useful insights for curriculum developers nationally and internationally, educators and practitioners. Recommendations from the study are made for research, education and practice.

Glossary of terms

AIMS	Association for Improvements in the Maternity Services, consumer group.
Altruism	Selfless behaviour for the good of others.
Antenatal period	Period before birth from conception and pregnancy to the onset of labour.
ARM	Association of Radical Midwives.
Autonomy	'Self-government' – in the sense that people are autonomous to the extent to which they are able to control their own lives.
Biomedical approach	An approach to illness/events that excludes psychological and social factors and includes only biological factors.
Burnout	Stress-related occupational syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach and Jackson 1981, cited Yoshida and Sandall 2013, p.921).
Caseload midwifery	Organisational model of care in which an individual midwife provides all care-giving episodes for each woman in her/his caseload either as part of a partnership or group practice (Beake et al. 2013).
CMB	Central Midwives Board established following the 1902 Midwives Act, responsible for the regulation of midwives until its succession by the UKCC in 1979.
Continuity of care	Provision of care by a known midwife caregiver or small group of midwives across the childbirth continuum (Hundley et al. 1995).
DH	Department of Health.
Doula	Derived from the Greek word meaning 'woman who serves other women', is a woman who provides emotional and practical support throughout pregnancy and labour.

ENB	English National Board for Nursing, Midwifery and Health Visiting, one of four national boards working under the framework of the UKCC responsible for setting and monitoring standards for education and practice of registered practitioners in England from 1979-2002.
Feminism	The theory of the political, economic, and social equality of the sexes i.e. the belief that all people are entitled to the same civil rights and liberties and can be intellectual equals regardless of gender.
GP	General Practitioner.
HEI	Higher Education Institution.
ICM	International Confederation of Midwives.
Intrapartum period	Period of parturition, from the onset of labour to expulsion of the placenta.
NCA	National Childbirth Organisation, lay consumer group.
NCT	National Childbirth Trust, charitable organisation previously known as the National Childbirth Association.
NHS	National Health Service.
NMC	Nursing and Midwifery Council, the professional regulatory body for nursing, midwifery and health visiting since 2002.
Obstetric Nurse	A practitioner who, under the supervision of an obstetrician, helps to provide care for women throughout pregnancy, labour and childbirth.
Ontological	The study of being.
Postpartum period	Period immediately after birth until six weeks later.
Reflection	A mindful activity of 'sensing, perceiving, intuiting and thinking' (John 2005, p.2) about experience, which enables opportunity to observe or examine personal ways of doing.

Reflexivity	Concerned about thoughtful questions about self, described as 'thoughtful, conscious self-awareness' (Finlay 2002, p.532), involving a continuing, dynamic and subjective form of reflective self-awareness that is recursive (Finlay 2002; Hibbert et al. 2010).
Relational continuity	An on-going therapeutic relationship between a practitioner and the individual women within her/his care (Haggerty et al. 2003) across the childbirth continuum.
RCM	Royal College of Midwives, a trade union orientated organisation run by midwives.
RCOG	Royal College of Obstetricians and Gynaecologists, the professional body for medicine.
Sign-off mentor	A practitioner who has met the criteria set by the Nursing and Midwifery Council to be able to teach and assess students in relation to practice proficiency (NMC 2008).
Social model of birth	A model of care that views pregnancy and childbirth as normal and natural physiological life events.
Technocratic model	Is founded on a medical model in which pregnancy and birth are viewed as potentially pathological events that require medical control and monitoring.
Therapeutic relationship	Refers to the relationship between a midwife and woman that develops over time through engagement with each other, that is dynamic and uses cognitive and affective levels of interaction to effect beneficial change.
UK	United Kingdom.
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting replaced the CMB as national regulatory body in 1979 and was succeeded by the NMC in 2002.

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Chapter 1 Introduction

1.1 Introduction

As you the reader, and I the narrator, begin this story of discovery, I feel it important to contextualise the impetus for this work and share a little of my interests and myself.

As a mother, midwife and midwifery educator, I am passionate about midwifery, excellent maternity care for women, and the pursuit of normality in birth. I care about the primacy of holistic woman-centred approaches and the quality of women's experiences. Having worked extensively as a practising midwife in a stand-alone birth centre and the community setting, I enjoyed the opportunity to carry a small caseload of women in my last year of employment before my move into education. Qualifying as a midwife and raising a family during the 1980's, this experience contrasted somewhat from my midwifery education and training, early years of practice and personal childbirth experiences. Working in partnership with women, and the experience of relational continuity, which can be described as an on-going therapeutic relationship between myself and the women in my care (Haggerty et al. 2003), shaped and informed my vision and philosophy for midwifery and educational practice. I am an enthusiastic advocate for caseloading in practice and education and co-lead and coordinate the student midwife educational continuity initiative at Bournemouth University. My move into education was fuelled by a desire to promote excellence in practice in these respects. This is reflected in my research activities and area of scholarship in practice.

Because I care about student midwife caseloading and the quality of women's continuity experiences via this learning strategy, I sought to enhance the quality of student preparation and support for the experience via a collaborative action research project (Rawnsnson et al. 2009). My Master's research explored student midwives' perceptions of continuity and how they perceived this impacted on their learning journey to becoming midwives

(Rawnsdon 2011a). In recognition of the Nursing and Midwifery Council (NMC) requirements for Higher Education Institutions (HEI) to embed this learning strategy within midwifery undergraduate curricular (NMC 2009), this research provided enhanced insights to inform and develop continuity within professional education.

My interest in undertaking this doctoral study arose from a desire to enhance my knowledge and understanding of what it is like to be part of a student midwife's caseload, from women's perspectives. I was keen to enhance the quality of women's experiences via development of midwifery student education through bringing women's experiences into the classroom. Along with an appreciation of student midwife perspectives, I wanted to gain a more in depth understanding by hearing women's personal stories of experience. This knowledge can inform the collective evidence of understanding at a local and wider international level.

1.2 Midwifery education continuity directives

As the narrator of this thesis, I feel it is not only appropriate, but also important, to define the terms and context for this work. This preamble will focus on the nature and purpose of practice-based learning within United Kingdom (UK) pre-registration midwifery education. A central strand within this discussion is the concept of student midwife caseloading, and its role as a practiced-based educational strategy.

Given its importance, it seems wholly appropriate to initially reflect upon the fundamental requirement of pre-registration midwifery programmes to prepare and develop students who, at the completion of their education, are fit for practice, purpose and award. This means that educational programmes must be effective in developing competent, accountable, autonomous practitioners who at the point of registration are fully prepared to provide care for women in the real world of midwifery practice (NMC 2009). Historically this aim has remained unchanged, and since the introduction of formalised midwifery education, midwifery students have worked (under supervision of a qualified midwife) with women in real life contexts for significant periods to

develop knowledge of practice and skill achievement (Leap and Hunter 1993; NMC 2009; Towler and Bramall 1986; UKCC 1999).

In contemporary midwifery education, practice-based learning, where students are allocated to clinical placements across a broad range of health care settings encompassing the childbearing continuum, remains a core element of the curriculum (NMC 2009). As an experiential learning activity, practice-based learning places emphasis on 'learning by doing' to facilitate the application of theory-to-practice and knowledge generation through an active process of exploration and reflection upon experience (Jarvis and Gibson 1997; Rolfe et al. 2011). During this learning experience, students plan and provide care for women and their babies under the supervision of a qualified midwife who, as a 'sign-off mentor', confirms their progress in achieving the practice standards required for entry onto the register (NMC 2009), or where further support is needed, liaises with the university link tutor to facilitate this. A sign-off mentor is a practitioner who has met the criteria set by the NMC to be able to teach and assess students in relation to practice proficiency (NMC 2008).

New ideas and suggestions for how learning can be improved often come from the students themselves. This was how the inclusion of caseloading practice within the pre-registration undergraduate midwifery curriculum was first conceptualised. Two forward thinking student midwives approached their midwifery lecturers and the first student midwife caseloading was introduced at Bournemouth University (BU) in 1996 (Lewis et al. 2008). Students often experienced the practice-based learning curricular component as short clinical placements in many different care settings rather than reflecting the move towards woman-centred care and continuity within the National Health Service (NHS) in recent years. The students felt this provided a somewhat fragmented insight into women's experiences and maternity care (Lewis et al. 2008). To afford students an experience of providing continuity of care to women throughout their pregnancies and into the postnatal period, caseloading was initially developed as a voluntary curricular component (Lewis et al. 2008). The midwifery team at BU made the decision in 2001, to include student caseloading practice within midwifery education for all

students (Rawnsdon et al. 2008). This was recognised as an example of good practice in the report *Delivering the Best: Midwives contribution to the NHS Plan* (DH 2003).

These activities raised interest in the UK and abroad with other continuity initiatives being trialled or becoming an integral part of university's midwifery educational programmes across the world (Aune et al. 2011; Dawson et al. 2015; Yanti et al. 2015). In 2009, it became UK national policy that midwifery curricula include the opportunity for students to experience continuity of care. NMC guidance indicates this may be organised in the form of a personal caseload of women (NMC 2009). The NMC define a caseload as a group of women for whom the student (under mentor supervision) provides care and support throughout pregnancy, birth and the early days of parenting (NMC 2009).

Studies suggest that practice-based learning is highly valued by the student, as it is a learner-centred activity affording opportunities to develop confidence and competence in professional skills within meaningful real-life contexts, and the development of professional attributes through the generation of knowledge of practice (Morgan 2005; Papp et al. 2003; Spouse 2001). Learning occurs within a complex social context requiring students to combine psychosocial, psychophysical and cognitive skills in order to plan and deliver holistic woman-centred care. This engagement in the 'so called' real world of practice is reported to facilitate student clinical reasoning, problem solving and interpersonal communication skill development (Chan and Ip 2007; Parker and Freeth 2009). In an American study exploring baccalaureate nursing students' experiences of continuous versus block adult health placements, Adams (2002) disputed this reporting that students lacked depth where placement allocations are in fragmented random blocks. This is because students do not initially fully engage in new workplace environments, requiring time to settle in (Gilmour et al. 2013; Nolan 1998), and mentors need time to get to know individual students' learning needs (Hughes and Fraser 2011a; Shaw 2015), potentially limiting opportunities for independent working. This is compounded where clinical placements are of short duration, as they do not facilitate the active engagement of the student

in the clinical setting, or the opportunity to explore, assimilate and reflect on knowledge to develop understanding and meaning (Gilmour et al. 2013; Nolan 1998; Morgan 2005).

Student caseloading practice occurs outside of block clinical placements and facilitates close contact with a known group of women through continuous care provision throughout the woman's childbearing event. Caseloading practice may therefore mitigate the inhibiting effects of short clinical placements on learning, and is likely to attenuate the benefits of practice-based learning as students are provided with an opportunity to construct meaning from within individual social, cultural and professional contexts. This learning experience is therefore more likely to promote deep learning within clinical practice, as this takes time, requiring regular exposure to, and active participation in, women's care (Chan and Ip 2007; Lofmark and Wikblad 2001; Morgan 2005).

The very nature of caseload practice, where students work flexibly to provide individualised woman-centred care under the supervision of a known supervising mentor, is also likely to promote opportunities for independent working. This way of working could support student confidence development and is considered appropriate where clinical care can be safely delegated to senior students (NMC 2009). Having greater autonomy in the delivery of continuous care provision may enable students to build trusting and meaningful relationships with the individual women in their caseload. Establishing such close relationships with the woman and her family leads to a more in-depth learning process for the student. They are more present and consciously involved, and feel a greater sense of responsibility in ensuring care provision is tailored to the individual woman's need (Aune et al. 2011; Rawnsdon 2011a).

However, the NMC (2010) national survey reported variance in how HEIs had embedded mandated continuity practice component within the educational curriculum. Organisational differences appeared to stem from variances in interpretation as to what constitutes 'caseloading practice'. For example, some institutions incorporated a one-to-one continuity model,

others considered students organising care for a small group of women, who were part of their mentor's caseload each day, equated to caseload practice. Variance also existed in when the learning experience occurred within the curriculum, the size of caseload undertaken, and whether students negotiated their own personal caseload or assigned women. This lack of coherence in adherence to practice standards may have impact on student learning and on women's experiences of the educational continuity, as consumers of maternity care.

1.3 Theoretical models informing midwifery

The discussion within this section explores theoretical work informing midwifery pertinent to the impact of caseload practice. It provides context and will inform the discussions for the ensuing chapters within this thesis.

Midwifery is essentially about human relationships and the ability to work with women throughout the childbirth continuum and midwifery work is acknowledged as emotionally demanding (Hunter 2014). Pregnancy and childbirth are profoundly intimate and significant life events (Paradice 2002; Raphael-Leff 2005) that have an emotional impact not only on women and their families but also midwives and students involved in care provision (Hunter 2001; 2004a; 2005). Research evidence consistently demonstrates the high significance of the midwife in determining the quality of childbirth experiences, and the centrality of emotional support to this relationship (Allen et al. 2017; Corcoran et al. 2017; Dove and Muir-Cochrane 2014; Halldorsdottir and Karlsdottir 1996a; 1996b; Jepson et al. 2017a; Walsh 1999; Williams et al. 2010). Midwifery work not only involves caring for women experiencing joy, happiness and excitement but also the support of women experiencing anxiety, fear, pain and sometimes grief symptoms (Fenwick et al. 2015; Hunter 2014; Mollart et al. 2013). Working closely with women in these emotionally intense situations may contribute to a sense of emotional burden in midwives and students involved in care (Leinweber and Rowe 2010; Hunter and Warren 2014).

The journey to become a midwife includes opportunity for continuity of care experiences via caseload practice (NMC 2009) [1.2]. Caseload practice facilitates the ongoing midwifery relationship between the student and the woman from early in pregnancy, following initial contact, labour and birth, and the early days of mothering across the interface between community and hospital caring contexts (NMC 2009). Whilst establishing such close relationships with women can lead to a more in-depth learning process for the student (Aune et al. 2011; Browne et al. 2014; Dawson et al. 2015; Gray et al. 2013; Rawnsdon 2011a; Sidebotham et al. 2015; Sweet and Glover 2013). Working within a continuity of care model has the potential to intensify the 'emotion' aspects of student work (Hunter 2001) than that previously experienced during clinical placements allocations. Evidence suggests women have increased expectations of the quality of their relationship with their caseloading midwife (Walsh 1999; Williams et al. 2010) and there is possibility they may have similar expectations of their caseloading student. Students who caseload are reported as more present and consciously involved and feel a greater sense of responsibility in ensuring care provision is woman-centred and addresses the individual woman's needs (Aune et al. 2011; Rawnsdon 2011a). Furthermore, working with a mentor whose practice did not embrace a woman centric ideal was identified as a source of frustration for caseloading students that evoked feelings of inadequacy and remorse (Rawnsdon 2011a). In addition, the on-call commitment integral to the model, and the implications of this way of working on the student's personal life, alongside balancing academic demands are likely sources of emotional angst (Browne et al. 2014; Carter et al. 2015; Dawson et al. 2015; Gray et al. 2013; McLachlan et al. 2013; Rawnsdon 2011a).

Emotions are a daily experience in life, both inside and outside of work and are useful adaptations that help individuals interact with their environment (Zapf 2002). They are fundamental in determining what individuals attend to, what they store and recall from memory, and what behaviours they initiate, for example, approach versus avoidance behaviour (Schirmer 2015). They are therefore both a response to events and situations that we encounter and a cause of our responses (Zapf 2002). Whilst there is lack of consensus on

definition within scientific discourse, moods are typically theoretically differentiated from emotions in that they have no specific object (Schirmer 2015). However, a useful working definition is provided by Schirmer (2015), who describes emotions as “conscious or unconscious mental states elicited by events that we appraise as relevant for our needs and that motivate behaviours to fulfil these needs” (Schirmer 2015, p69). This suggests needs and their fulfilment are at the core of an emotion. Such needs may centre on concerns for personal safety, social belonging, self-esteem needs, and even needs of personal fulfilment (Schirmer 2015), which Maslow (1943) referred to as self-actualisation.

It has long been recognised that emotion management commonly described within the literature as ‘emotional labour’ (Bolton 2000; Hochschild 1983; Mann 2004; Zapf 2002) or ‘emotion work’ (Hunter 2004a; 2005), is an intrinsic but often invisible component of work within service sector ‘people’ work (Bolton 2000; Hochschild 1983; John and Parsons 2006; Mann 2004; Smith 1992; Smith and Cowie 2010). The term draws attention to the work expended in managing emotion in the workplace and is described by Hochschild (1983, p.7) as “the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place”. This indicates emotions are displayed to influence other people’s emotions, attitudes and behaviours and to contribute to the creation of the ‘correct’ organisational emotional climate (Bolton 2000; Zapf 2002). It is argued, that workers manage their emotions within the workplace in accordance with ‘feeling rules’ (Hochschild 1983), that is occupational and professional midwifery norms relating to feeling and emotion display (Hunter 2004a). The ability to manage emotions appropriately is being increasingly acknowledged within the literature as an essential skill for midwifery practice (Bolton 2000; John and Parsons 2006; Hunter 2004a; 2014; Hunter and Deery 2005; Smith and Cowie 2010). This is because the way in which midwives manage emotion will not only potentially affect midwives themselves, but also the women within their care (Hunter 2004a). However, the research literature indicates that it is this aspect of practice that students feel ill-prepared and find challenging (Allcock

and Standen 2001; Beaumont et al. 2016; Hunter and Deery 2005; Smith 1992).

In nursing, Smith (1992) explored the emotional aspects of the socialisation of student nurses and found that emotion work was often reported as stressful and demanding. An interesting finding was that this intrinsic aspect of nursing work was not formally acknowledged by the organisation as important, and emotion work skills were learnt 'on the job' by role modelling rather than formally taught. More recently, Allcock and Standen (2001) explored the experiences of students of caring for in-patients in pain during the first eighteen months of their nurse training. The study identified this aspect of work could be emotionally rewarding or difficult, and participants revealed strong emotions associated with the caring experience. When involved in the care of in-patients whose pain was, in the student's view, well controlled, students described feeling good or fulfilled by the experience. However, where the patients pain was perceived ill-controlled students experienced feelings of helplessness which quickly developed into feelings of frustration and anger if, in the student's view, the staff were perceived as not doing as much as they could to alleviate the patients pain. Resonating with the findings from the Smith (1992) study, Allcock and Standen (2001) found little evidence that students were given any assistance to develop emotion work skills or offered support or opportunity to discuss their feelings. These studies offer insights for midwifery and students who caseload, but while students will attend and provide support to women in pain, the focus is on ill-health settings, which limits their relevance.

In midwifery, John and Parsons (2006) in a UK ethnographic study, explored emotion work from the perspectives of women and the midwives (n=10) caring for them during labour and birth in a low risk obstetric unit. A key finding was the emotion work midwives undertook to establish a relationship with the labouring women in their care. Described as 'putting on a professional face', the midwives made a distinction between the biological emotions that they felt and the formal emotions they displayed as professionals (John and Parsons 2006, p.268). This suggests midwives in the study experienced emotional dissonance (Zapf 2002). Emotional

dissonance is associated with psychological strain and occurs in situations where an employee feels required to express emotions they do not genuinely feel (Zapf 2002). Complying with perceived professional and organisational 'feeling rules' (Hochschild 1983), in this situation was reported by midwives as emotionally draining and stressful, but necessary to provide the emotional care women needed (Johns and Parsons 2006). Furthermore, supporting findings from the nursing literature (Allcock and Standen 2001; Smith 1992), the findings from the John and Parsons (2006) study suggest that emotion work, and how it is managed by students in the workplace, is likely to be developed through role modelling midwife mentors and professional socialisation.

John and Parsons (2006) reported the women participating in the study did not acknowledge the emotion work undertaken by the midwives in providing their labour care. Rather, the women expressed an expectation that the midwife would have a caring nature and attitude, and that these attributes were a perquisite of the midwifery job role. This raises the possibility of negative emotional impact on women and a lack of satisfaction with care, if these anticipated attributes are perceived as absent or not well demonstrated by their midwife caregiver. Moreover, providing emotional support for women is recognised as a key aspect of midwifery work (Berg et al. 1996; Berg 2005; Halldrsdottir and Karlsdottir 2011; Nicholls and Webb 2006). Student midwives want to be valued and report high levels of self-judgement and a tendency to judge themselves unsympathetically (Beaumont et al. 2016). In the context of students who caseload, this lack of recognition by women has the potential to contribute to an increased sense of emotional burden in students.

Robust evidence indicates the emotional wellbeing of midwives may further be compromised by a range of workplace and personal stress factors. In a UK ethnographic study Hunter (2004a; 2005) explored how midwives, from a range of clinical locations, and student midwives in their first and final years of their 18-month (post nursing qualification) and three-year (direct entry) programmes experienced and managed emotion in their work. Study findings revealed the emotion work of midwives was strongly influenced by the

context of practice in which they worked. This was because community and hospital environments presented students and midwives with fundamentally different work settings that had diverse and conflicting values and perspectives (Hunter 2004a; 2005). Hospital midwifery appeared dominated by meeting the needs of the service via a medicalised approach to care in which a 'with institution' ideology was supported (Hunter 2004a). This was characterised by a focus on task completion and the significance of relationships with colleagues rather than women. Negotiating relationships with midwifery colleagues was thus reported as a major source of emotion work for staff, and students and junior midwives experienced many difficulties in their relationships with senior colleagues within the hospital environment (Hunter 2005). Conversely, community-based midwifery was underpinned by a 'with woman' ideology, where a social model of childbirth was endorsed and supported (Hunter 2004a). Community-based midwifery provided greater opportunity to work in ways that were 'with woman' and midwives experienced their work as emotionally rewarding when able to develop meaningful relationships with women and their families and work according to this ideal. When this was not possible, midwives experienced work as emotionally difficult, which involved emotion regulation and thus emotion work (Hunter 2004a; 2005).

In the Hunter (2004a) study, the students who participated were found to hold a stronger commitment to a 'with woman' ideology than midwifery colleagues who had been qualified for more than one-year. When not able to work to this ideal, the students described a greater degree of conflict and negative emotions than their more experienced midwifery colleagues. Given that caseload practice requires students to work across the interface between both community and hospital care contexts (NMC 2009), suggests the degree of emotional dissonance experienced during the initiative may be increased due to the reality of practice being mismatched to personal beliefs about care (Blomberg and Sahlberg-Blom 2007; Hunter 2004a; 2005). This may have significant impact on the student's emotional wellbeing (Zapf 2002), and their ability to learn from the caseloading initiative. This is an important aspect for consideration as evidence has shown that working in

stressful environments and care contexts can cause student midwives to overlook their own emotional and psychological needs (Beaumont et al. 2016).

However, it is important to acknowledge that emotion work has both positive and negative effects on wellbeing (Zapf 2002). As highlighted earlier, emotions centre around personal needs and their fulfilment (Schirmer 2015), fulfilment of personal needs, for example social belonging, and self-esteem needs, can result in a sense of self-actualisation (Schirmer 2015; Zapf 2002). This positive correlation with emotion work has been linked with job satisfaction (Zapf 2002) and demonstrated in the literature surrounding midwives' experiences of caseload practice. For example, the caseloading midwives in the McAra-Couper et al. (2014) study reported it was the 'joy' experienced in working in partnership with women and the reciprocal relationships developed that sustained their ability to work within the model and their passion for midwifery. Negative effects of emotion work have been linked to emotional dissonance and burnout (Zapf 2002). Burnout is a syndrome of physical and emotional exhaustion that occurs in practitioners as a result of chronic stress (Maslach et al. 2001). High levels of stress and burnout were reported in a recent UK survey of student midwives ($n=109$) (Beaumont et al. 2016). Moreover, burnout in midwives was found to be correlated with significant symptoms of depression, anxiety and stress (Creedy et al. 2017).

Calls have been made within the midwifery literature for the greater inclusion of emotion management skills within the university curriculum (Beaumont et al. 2016; John and Parsons 2006; Hunter 2004a; 2004b; 2005; Hunter and Deery 2005). However, given the context of midwifery education programmes where students are taught both within the academic environment and clinical practice [1.2]. Some debate exists as to the role of formal midwifery education within this, and whether the clinical setting is a more appropriate learning environment for developing these skills (Hunter 2010). This is an important issue for midwifery education, curriculum development and the midwife mentor role and wider consideration of the practice learning environment is needed. Whilst the intrinsic component of

emotion work within midwifery is discussed within the literature, evidence indicates its impact on the midwifery workforce continues to remain unrecognised and undervalued within midwifery practice (Deery and Fisher 2010; Hunter 2010; John and Parsons 2006). As Hunter (2010) pointed out, this raises challenges for mentors and their ability to support and teach students such skills within contemporary midwifery clinical environment contexts.

Social support is identified within the midwifery literature as an important mechanism in the moderation of job role related stressors that has a positive effect on emotional health and sense of wellbeing amongst midwives (Hunter 2014; McCourt and Sevens 2009; Sandall 1997; Stevens and McCourt 2002a; 2002b). Additionally, it is important to recognise women's emotional and support needs impact on health and the role of social support within this. Theories of social support centre on the belief that the impact of negative effects of stressful life events on wellbeing can be mitigated by interpersonal relationships (Shumaker and Brownell 1984). Lakey and Cohen (2000) discuss three important theoretical perspectives on the complex phenomenon of social support; the stress coping perspective, the social constructionist perspective, and the relationship perspective. Arguably, the most influential theory, the stress coping perspective proposes that social support buffers the negative health effects of stress by enhancing the recognition, quality and quantity of an individual's coping performance through the supportive actions of others (Lakey and Cohen 2000). For example, social support can influence an individual's appraisal of a life event, re-define the scale of a larger issue into a smaller, more controllable one or turn a stressor into a challenge (Brownell and Shumaker 1984). Regardless of the presence of stress, the social constructionist theoretical perspective predicts social support will promote self-esteem and self-regulation and thus have a direct influence on health and wellbeing. This premise is based on the belief that the experience of 'self' is primarily a reflection of how one is viewed by others and that the self, social world, and social support, are therefore inextricably linked (Lakey and Cohen 2000). The relationship perspective is based on the premise that the relationship processes that may

co-concur with support, for example, companionship, intimacy, low social conflict, cannot be separated from the health effects of social support (Lakey and Cohen 2000). This brief resume of social support theoretical perspectives provides insights to the complexities of the phenomenon and some of the social constructs embraced within the concept.

However, as Cohen et al. (2000) highlight, social support is often used as an umbrella term within the literature rather than linked to a particular theory or social construct. This generally appears to be the case in midwifery (see for example, Hunter 2014; Sandall 1997). While the meanings of social support are broad and diffuse (Lackey and Cohen 2000), drawing from a number of studies McCourt (2006) identified three aspects that appear central to societal understandings of what social support is; emotional support, informational support, and practical or tangible support. Emotional support is linked to relational presence, a caring relationship or companionship and a willingness to listen (McCourt 2006). Informational support refers to the resources offered such as advice and information and linked to promotion of an individual's confidence and sense of security. Whereas, practical support refers to a variety of tangible pragmatic support measures such as financial or physical support (McCourt 2006). In this broad sense, social support commonly refers to the nonprofessional and informal social resources midwives and women perceive available to them (Cohen et al. 2000), for example, family, friends, neighbours, co-workers and peers.

For the purposes of this thesis, the definition of social support provided by Shumaker and Brownell (1984) will be used throughout to underpin the ensuing discussions. Shumaker and Brownell (1984, p.13) describe social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the wellbeing of the recipient". This implies to be effective, social support is an exchange process that necessarily requires the involvement of at least two participants, and that for both participants, there are potential costs and benefits associated with the exchange (Shumaker and Brownell 1984).

1.4 Organisation of the thesis

My choice of convention for this study is inclusive of a reflective approach with embedded personal reflections and the use of poetry, to engage the reader and illuminate the construct of stories within stories – my story/journey amidst that of the women's (Anderson 2007; Bolton 2014; Fitzpatrick 2012). Reflection enables the opportunity to develop insights into self and experience through becoming observers of our own practice and ways of doing (Hibbert et al, 2010). It is described as a mindful activity of thinking about experience that is both subjective and specific to build understanding (Johns 2005). Given the reflective component, the first person is used throughout this thesis where appropriate (Bolton 2014; Ely et al. 1997).

'Reflection' and 'reflexivity' are terms that often appear used interchangeably within the literature. However, it is argued that while related to reflection, 'reflexivity' suggests a higher complexity of thinking about self and experience and is thus qualitatively different. 'Reflexivity' is concerned about thoughtful questions about self and can be described as 'thoughtful, conscious self-awareness' (Finlay 2002, p.532). It is more than reflection, in that it involves a more mature, immediate, continuing, dynamic and subjective form of reflective self-awareness that is recursive (Finlay 2002; Hibbert et al. 2010). This suggests it brings about change in the process of reflection and a returning to our ways of doing through questioning the bases of our interpretations (Hibbert et al. 2010). Both the concepts of reflection and reflexivity are acknowledged as important throughout the stages of this project and could be viewed as following a continuum. At one pole, reflection is concerned about thinking about my experiences in the light of existing knowledge to inform understanding. At the other pole, rather than a somewhat passive instrument of observation, reflexivity is concerned about my active participation in the process of meaning construction throughout each stage of the project and the research process itself (Finlay 2002).

This thesis consists of eight chapters that are divided into numbered sections. A glossary of terms is included on pages V-VI1, to guide the reader regarding specific terminology used. For ease of cross referencing, the

number in brackets will appear next to the text, e.g. [2.4], directing the reader to relevant sections where the points are further discussed. To protect participant anonymity, alias names and pseudonyms for potential identifiers of people, institutions or places referred to by the participants have been used throughout.

Chapter 2 illustrates the background and context to the study. I begin by exploring maternity care provision in the UK from the 1930s to the present identifying dominant discourses, political and societal factors that shaped and directed maternity service development and the resultant impact on women as consumers of maternity services, midwifery, midwifery education, and midwives as service providers [2.2]. I then evaluate caseload midwifery as organisational model of care from women's [2.3.1], midwives' [2.3.2], and student midwives' perspectives [2.3.3]. Finally, I discuss how this exploration of past paradigms and perspectives enables insights for future practice within education and midwifery [2.4].

In Chapter 3 I provide a review of the literature on women's/consumer experiences of engagement in health professional education in the UK and developed countries from 1990-2017. I discuss how the literature search was conducted [3.2] and then the findings, which are presented in two sections. Consumer engagement and contribution to student educational development [3.3] in curricular design and development [3.3.1], teaching and learning [3.3.2] and the conclusions drawn [3.3.3] forms the first section. Women's evaluation of student midwife rendered care forms the second section with the findings arranged in two themes [3.4]: 'wanting to connect' [3.4.1] and 'a valuing of student's presence and support' [3.4.2], followed by the conclusions drawn [3.4.3], before presenting my research aim [3.5.1] and objectives [3.5.2].

Chapter 4 is an in-depth discussion of the research methodology and methods and an outline of the study design [4.2] and philosophical framework [4.3]. Discussing the methods, I provide details of the research sample and recruitment process [4.4], data gathering process [4.5] my reflections on the methodology and data gathering methods [4.6] and ethical

considerations [4.7], with regard to procedural ethics [4.7.1] and relational ethics in practice [4.7.2].

Chapter 5 makes explicit the analytic strategy for the study discussing ontology within narrative accounts [5.2] and how understanding can be created from narratives through development of a pluralistic analytical model integrating both analysis of narratives and narrative analysis methods [5.3]. I then reflectively detail the analytical process and my initial creation of a robust scaffold to generate individual and collective stories of women's experiences [5.5], and how through listening to my inner disquiet [5.5], I repositioned and reframed the analytical scaffold to facilitate a more holistic way of re-telling [5.6]. Before discussing how the analytical outcomes, via creation of two interrelated formats of re-telling or 'stories within stories', will be shared [5.7].

In Chapter 6, I introduce [6.2], and then re-tell the six women's individual personal 'stories of experience', generated via application of a re-storying framework, in the form of poems [6.3].

In Chapter 7, I share the women's 'collective story' of experience, which captured the emergent longitudinal narrative themes of significance to the woman as a group. I explore the three story themes and subthemes as a chronology initially discussing the theme 'mutually supportive partnerships' [7.2]. All women acknowledged their caseloading student midwife's companion status as that of learner. This story theme describes women's perceptions of the reciprocal nature of the relationships developed with students within this context through relational continuity. The theme 'just like a midwife' illustrates how women felt about receiving care from their caseloading student, using their perceptions of what a registered midwife should do as benchmark [7.3]. The final story theme, 'extra special care', shows the meanings and significance to the women in this study of having a known student throughout their childbirth journey via student caseloading and how women perceived this as a 'win-win', a way of fulfilling their own needs as well as those of the student [7.4].

Chapter 8 is the final chapter and concludes the thesis by first discussing themes drawn from the study via the lens of women's knowledge for education and practice [8.2]. Original contributions to knowledge are then identified [8.3] and study limitations acknowledged and discussed [8.4]. Finally, the dissemination of study findings is discussed [8.5.1] and recommendations for education and practice and suggestions for further research identified [8.5.2].

Chapter 2 Context

2.1 Introduction

Pregnancy and birth are normal life events imbued with socio-cultural significance and meanings. The importance of birth and the continuum of life lies at the very heart of society, and as such, is often grounded in family through to societal superstitious practice, custom and ritual (Paradice 2002; Raphael-Leff 2005). The centrality of birth to society and life means childbearing is an aspect of a woman's life that is simultaneously intrinsically private and uniquely public, being an event that is not only significant to the woman and her family but to the wider society in its fullest sense (McIntosh 2012). Direct associations could therefore be said to exist between the way in which childbirth is managed, and women's position and status within society (Oakley 1993). Equally, the symbiotic nature of midwifery and childbirth suggest that the midwives' role, scope of practice, and position within society, are similarly constrained.

To contextualise the ensuing discussions within this thesis, this chapter traces maternity care provision from early in the 20th Century to the present, identifying political and societal factors that impinged upon, and directed service development. It explores the synergistic rise of dominant discourses and resultant impact on women as consumers of maternity services, midwifery, and midwives as service providers. It further documents the analogous changing nature of midwifery student education, exploring how external influences expanded or constrained learning and preparation for midwifery practice [2.2]. Caseload midwifery as an organisational model of care from women's [2.3.1], midwives' [2.3.2], and student midwives' perspectives [2.3.3] is then evaluated. The chapter concludes with consideration of how this exploration of past paradigms and perspectives enables insights for future practice within midwifery and education [2.4].

2.2 Reflecting on the past: Understanding the present

Before we can reflect on the past it is important to understand contemporary social context of birth, the dominant discourses underpinning maternity service delivery and present-day imperatives for pre-registration midwifery education.

Women residing in the UK today generally choose to birth their baby within an institutional setting (ONS 2016a), usually an NHS hospital with full obstetric facilities. Maternity service delivery within these institutions is generally held to be underpinned by two conflicting models of care (Garcia et al. 1990; Kitzinger 2000; Davis-Floyd 2001). Medical practitioners are presented as tending to adhere to what has been called the technocratic or medical model of childbirth, whereas it has generally held that the majority of midwives endorse a social model of birth. However, midwives and doctors are individuals with different beliefs and ideas and it must be recognised that there are doctors who are followers of the social model, and midwives who are technocratic.

The 'New Vision for Maternity Care' (ARM 2013) and recent National Maternity Review (NHS England 2016), place great emphasis on the importance of midwives in the minimisation of women's contact with the technocratic model, and the promotion of a social model of birth. Within this model, pregnancy and childbirth are considered within the context of the family and viewed as normal and natural physiological life events. The technocratic model was founded on a medical model, and I would argue the positivist position, in which pregnancy and childbirth are viewed as potentially pathological events that require medical control and monitoring. As Kirkham (1986) pointed out, this medical perspective indicates pregnancy could only be defined as normal in retrospect. Within contemporary service delivery, midwives are recognised as the lead maternity care provider for most women throughout pregnancy, labour, birth and the postnatal period. However, where a woman has or develops health, social or obstetric concerns, this care includes referral to, and liaison with, medical practitioners, and allied health and social care practitioners (ICM 2011). Quality care provision

therefore relies on mutual co-operation and effective negotiation and the education of practitioners in these respects.

UK Midwives today are educated to graduate level where learning for practice is underpinned with research-based evidence (NMC 2009). Entry onto midwifery educational programmes is open to men and women who can demonstrate they are of good health and character. Applicants do not require evidence of previous health education, training or experience but must meet stipulated academic attainment (NMC 2009). While a broad range of topics is embraced within midwifery curricula, a core construct embedded within teaching focus is the centrality of normality. Emphasis is also placed on the promotion of active birth, holism, partnership working and family-centred care (NMC 2009; ICM 2011). Whilst student midwives are developed in the acquisition of technical clinical skills, it could be suggested the promotion and continuation of the social model of birth is central to contemporary educational focus. Inclusion of inter-personal, communication, negotiation and leadership skills are thus essential requisites within midwifery curricula to engender effective multidisciplinary team working (NMC 2009). As Beddoe (1998, p.1) pointed out, “only history can begin to explain ‘why is it like this now?’ or if it has always been like this?”. We thus, need to reflect on our past to understand our present.

Because pregnancy, birth and maternity care are deeply embedded within the intersections of social, midwifery and medical discourse, its story cannot be told in isolation. Social constructs of family, motherhood and beliefs about the status of women and their role within society have changed significantly over time, impacting on midwifery practice and the role of the midwife. Changing economic and political climates, along with advances in medical technology, similarly impinged upon and directed the way in which maternity care has developed. My aim here is to present a range of perspectives to illuminate pertinent social, medical debate and policy decisions that informed and shaped contemporary landscape of service delivery. I explore the fascinating story of maternity care across time under the following headings:

- 1930s-1950s - Changing times: for women, midwives and the structure of maternity care
- 1960s-1980s - Medical institutionalisation and control
- 1990s-present - Family centred care and collaborative partnerships

2.2.1 1930s-1950s - Changing times: for women, midwives and the structure of maternity care

At the turn of the 20th Century, maternity care was delivered through a predominantly community-based maternal and child health system although annually, a few women birthed in hospital institutions such as poor law and charitable infirmaries. Socially home birth was the norm, the private domain of women conducted with known caregivers and female supporters (Hunt and Symonds 1995). Specialist obstetric services were available but in the main, women's choice of birth attendant was the midwife or medical practitioner, usually the woman's general practitioner (GP) (Towler and Bramall 1986). In reality however, this choice was limited according to financial constraints and the fee charged, with midwives being considerably cheaper than doctors (Donnison 1988). Midwives of the time were largely untrained, and women also patronised traditional or lay birth attendants of sorts as cheaper options as well, as those that attended birth, death and most things in-between. After 1910, legally only *bona fides*, untrained midwives or 'handywomen' deemed to be of acceptable local standing and expertise, and trained midwives could attend births (McIntosh 2012). Evidence suggests however, that handywomen continued to be engaged by women to attend births until well into the 1930s (Leap and Hunter 1993; McIntosh 2012). It is suggested this was because many handywomen were valued and respected within the local community (Leap and Hunter 1993), and unlike trained midwives, would undertake non-midwifery tasks to help sustain the household such as cooking and cleaning (McIntosh 2012).

Models of midwifery care were primarily concerned with care during labour and the puerperium. Availability of antenatal care was limited but could be accessed from some local authority clinics and GPs (Robinson 1990). Private midwifery practice continued but numbers were dwindling, and by the

early 1930s around 50 per cent of midwives were either subsidised through poor law provision or salaried by local government (Fox 1993).

The high maternal mortality rates first noted in the 1920s, continued to rise becoming a primary public health concern (McIntosh 2012; Topping 1936) and interest in antenatal care provision heightened (Tew 1998). Wide regional variations existed, with the industrial town of Rochdale near Manchester was recorded as having the highest rate of maternal mortality in the country at around 900-100 per 100,000 births (Topping 1936). By the mid-1930s the potential for fatality during childbirth for pregnant women in England remained high at around 400-500 maternal deaths per 100,000 births (Loudon 2000). In addition, accounts of high maternal morbidity were widespread, although these are difficult to quantify given the anecdotal nature of their reporting (McIntosh 2012). Parliamentary response was the 1936 Midwives Act, which it could be argued, instigated changes that have echoed down through the 20th Century regarding the shaping of midwives' employment, training and locus of care. The Act effectively established a national midwifery service, requiring local authorities to provide whole-time salaried community-based midwives and had significant impact on midwifery, and the quality of midwives working lives. Midwives were provided with equipment and uniforms (Towler and Bramall 1986) which, it could be suggested, for the first time gave midwifery a corporate image as a profession within society that persists to the present day. Midwives were also required to include antenatal care provision within their routine practice, and worked flexibly to provide continuity of care to women. Some midwives positively commented on the opportunity this afforded to develop relationships akin to friendships with women during pregnancy (McIntosh 2012). Provision varied and relied heavily on charitable help (Peretz 1990). Unlike those working in independent practice, midwives employed by the local authorities had financial security, off-duty and annual leave entitlement (Towler and Bramall 1986). However, as employees of the local authorities, they were also under greater state control. Thus, during the ensuing years, midwifery role and scope of practice was increasingly subject to scrutiny by

midwifery and medical supervisors, and gradual restrictions on midwives' occupational autonomy were incurred.

The Act also placed emphasis on improving midwifery education with the introduction of a Midwife Teacher's Diploma, and a mandate for regular five-yearly updating in the form of seven-day refresher programmes for qualified midwives (Towler and Bramall 1986). Focus was further directed on raising the standard, content and duration of pupil midwife training. The existing apprenticeship-style training undertaken in an approved hospital-based school was extended from twelve months to two years for direct entry, and from six months to one year for nurse entrants. Previously primarily community-based, the midwifery training programme was divided into two parts of equal lengths of community and hospital experience (Hunter 2012), with the requirement for pupil midwives to sit an examination after each part (Towler and Bramall 1986). As Hunter (2012) contends, the mandate to include more attention on medical complications, rather than greater focus on normalcy within midwifery training, signifies the beginnings of contemporary institution-based birth trajectory but must have aimed to contribute to better care.

In the period before the First World War, women had achieved significant legal emancipation regarding property, guardianship rights and grounds for divorce (Lewis 1992), as well as in politics with the granting of the vote after the war 1918 (Beddoe 1998). During the First World War, women responded to the call to take over men's jobs, and had gained greater financial independence, freedom and control over their lives. As Beddoe (1998) highlights, during wartime women went to dance halls and cinemas unaccompanied and ate in restaurants alone or with a female friend. Women's magazines of the era encouraged women to take-up the wider opportunities afforded them by the First World War, and female characters in popular fiction such as 'Tuppence' the female half of Agatha Christie's detective duo, 'Tommy and Tuppence' portrayed women as independent and successful. By contrast, following the end of the First World War and resultant mass unemployment amongst women, women were strongly encouraged that their place was in the home. Pre-the Second World War,

women's popular literature was characterised by the dominant stereotype of the housewife, and the stay-at home married woman (Beddoe 1998). However, while the birth rate remained high up until the early 1940s (Towler and Bramall 1986), there was growing trend towards smaller families amongst women of all classes (Lewis 1992). A growing quest for 'scientific' knowledge and belief in the need for greater supervision and surveillance during pregnancy amongst women was also espoused, and while not regular or frequent, attendance at antenatal clinics became popular (McIntosh 2012). Amid fears of fatality and morbidity, it could be suggested this indicates a shift in social attitudes towards childbirth and growing belief in the ability of medical science to improve outcomes.

Britain's entry into the Second World War in 1939 impacted significantly on prevailing cultural trends towards hospital birth, midwifery employment and women's experiences of maternity. Many pregnant women were evacuated from cities likely to be bombed to rural areas (Leap and Hunter 1993), and disruption to family life, as older women took on men's job-roles (Towler and Bramall 1986) left women without traditional home birth supporters. This arguably, reinforced social concepts of the use of hospital for normal birth amid beliefs of it being the safest option. However due to pressure on services and the high birth-rate, hospital maternity beds were not readily available (Towler and Bramall 1986), and 'maternity homes' were set up in requisitioned hotels, boarding houses and country estates (Hunter 2012). Many of these were run by midwives and despite the long hours and heavy workload (Towler and Bramall 1986), midwives report they enjoyed their job-role, especially "the sense of female camaraderie" (Hunter 2012, p.156) and increased occupational autonomy the work afforded (Leap and Hunter 1993). However, by 1944, 31 per cent of midwives worked in hospital institutions and the trend towards institutional birth gathered increasing pace, reaching 54 per cent in 1946 (Robinson 1990). This rise appeared integral to fundamental cultural shift in medical and social attitudes towards birth rather than a pragmatic response to social needs (Campbell and Macfarlane 1994). While midwives remained the primary care provider for the majority of women experiencing normal pregnancy and birth, the rise in hospital births

significantly impacted on midwifery employment, with an analogous shift from community to hospital-based practice (Robinson 1990).

Post the second World War, fewer women birthed at home, the previous decade seeing a gradual rise in the building of hospitals and the institutional birth rate went from 15 per cent in 1927 to 40 per cent in 1940 (Lewis 1980). This coupled with a national falling birth rate (Towler and Bramall 1986), meant midwives and GPs were 'competing' for work in a declining market. However, as Hunter (2012) highlights, economic rivalry was somewhat mitigated for salaried midwives but of significant impact to independent midwives and the continuation of this element within midwifery. According to Robinson (1990), this move towards institutional birth was triggered by three key factors: reduction in the stigma associated with poor law institutions following their placement under local government control in 1929, demand from working class women covered by national insurance who now had free access to these institutions, and obstetricians' recommendations advocated without evidence, of hospital birth as the safest option. However, it's important to recognise the extent of change within social construction of birth, where hospitals rather than home as the place for normal birth, was becoming more embedded within traditional birthing cultures (McIntosh 2012). As Lewis (1990) notes, persuasion from obstetricians was not always required and hospital birth was the preferred option for some, with women themselves calling for more beds to be available. Women from poorer socioeconomic groups often welcomed the privacy, rest and sanitary conditions hospital birth offered. Greater availability and access to analgesia in hospital was a further attraction, particularly for middle class women (Towler and Bramall 1986).

As Beddoe (1998) notes, since its inception as a compulsory experience for children in 1880, education has been key in perpetuating societal norms and values, particularly those around gendered roles and differing expectations of girls and boys. Educational reforms and the restructuring of secondary education introduced by the 1944 Education Act, embraced established ideology and maintained this dichotomy identifying the Secondary Modern School, with a curriculum grounded in the domestic sciences as the most

appropriate for girls. The Second World War and resultant social dislocation, had profound effects on marriage and family life while popularity of marriage as a social institution continued. Divorces reached an all-time high in 1947 (Marwick 2003). Accompanied by a rise in illegitimacy (Beddoe 1998; Lewis 1992) and juvenile delinquency (Lewis 1992), public and political concerns were expressed about the disintegration of family bonds (Lewis 1992; Marwick 2003). The falling birth rate, following the initial post-war baby boom, was of further concern and it was apparent that across all sections of society, deliberate policies of family limitation were being followed (Marwick 2003; Beddoe 1998).

The 'rebuilding of the family' (Lewis 1992, p.6) was central to post-war public and political conscious, debate and policy. Primacy was placed on the importance of children and the need to provide them with loving care (Lewis 1992; Marwick 2003). The 'adequacy' of mothering was a central concept within this, and renewed calls for the education of girls in mother craft and domestic subjects were made (Lewis 1992). Public and political attention refocussed on continuation of gendered roles within the family unit, with women's tasks clustering round functions as homemaker and child-rearer (Marwick 2003). The social context was such that women's work outside the home was frowned upon, and the concept of full-time motherhood espoused (Lewis 1992). At the highest peak of post-war birth rate in 1946, a critical shortage of midwives was of such concern that retired and non-working midwives were encouraged to return to practice (Hunter 2012). While there was no marriage bar within midwifery (McIntosh 2012), the majority of midwives were single, and many midwives ceased their employment following marriage (Towler and Bramall 1986). Prevailing shifts towards hospital birth, the rise in the number of GPs attending home births coupled with the falling birth rate was a further source of concern for the profession. Anxieties were particularly expressed about potential limiting effects on pupil midwife Part II training experience, which was primarily community-based. Several applications from training schools were made to the Central Midwives Board (CMB) for reduction of community allocation of pupils to three months of the curriculum (Towler and Bramall 1986). Arguably, these

calls for reduction in experiential learning reinforced the importance of acquisition of technical experience rather than the skills of normalcy.

The creation of the National Health Service (NHS) in 1948 instigated changes that according to Oakley (1986), “permanently altered the midwives’ [traditional] control over maternity care” (Oakley 1986, p143). It gave women access to free maternity care for the first time, effectively destroying the economic basis of independent midwifery practice. Most significantly, it gave women direct access to GP care, independent of the midwife (Tew 1998). The NHS paid GPs a separate fee for maternity services, giving them a strong inducement to develop antenatal care provision. The proportion of GPs offering antenatal services rose rapidly and increasingly rather than the midwife, the GP became the first point of contact for pregnant women (Robinson 1990). Rather than working in competition with GPs, midwives now waited for women to be referred to them by the GP and therein, held a more subordinate role. As Bates (2004, p.126) points out, this meant that GPs rather than midwives had ‘the opportunity to define normality’. Hospital birth was now free and available to all women, and consultant-led obstetric services expanded exponentially. By the early 1950s, home birth rates significantly reduced and around 65 per cent of births occurred in hospital (Campbell and Macfarlane 1994). The normalisation of GP engagement in normal midwifery, and the continuing trajectory of hospital birth, prompted anxiety within the midwifery profession. Concerns about potential impact on the education and practice of future midwives were expressed by the Central Midwives Board (CMB), with calls for home birth to remain the norm for women without need of hospitalisation (Towler and Bramall (1986).

Despite the continuing shift towards hospital birth, continuity of midwifery care continued to be the norm. Hospital-based midwives were ward-based and worked flexibly to facilitate antenatal clinics for hospital-booked women, intrapartum care in ward-based birthing rooms and postnatal care for the totality of the puerperium (Robinson 1990). Recent televising of Jennifer Worth’s trilogy reflecting on midwifery in the East End of London in the 1950s (Worth 2010), ‘Call the Midwife’, poignantly illustrates women’s and midwives lives of the time. The programme has brought women’s lives and

motherhood of the era into contemporary public consciousness, providing insight into the impact of class, marriage, family life and societal-cultural norms of the time on women's daily lives and expectations. It also highlights the prevailing public and professional focus on motherhood and the education of women, with the CMB requirement for the inclusion of mothercraft, infant care and principles of nutrition within the curriculum in 1955 (Towler and Bramall 1986). In addition, it could also be argued Call the Midwife visually reinforced the established corporate image of midwives and midwifery as a profession, via the use of the uniforms and equipment of the time.

In 1959, publication of the Cranbrook Committee Report (HMSO 1959) heralded a series of organisational change that would ultimately curtail midwives scope of practice, and result in a more fragmented model of care delivery. With increased GP involvement in normal birth, many of the community maternity homes established during the inter-war era evolved into 'GP units'. The establishment of these units offered women a place for birth that was local, free and medically supervised. The model of care was developed within hierarchical structures that persist today. An example of this is the naming of these GP or obstetric units where within their walls the primary provider of care, supervisor and facilitator of birth was the midwife (Campbell and Macfarlane 1994). The report recommended a 70 per cent hospital birth rate and a move towards centralisation of maternity services without evidence that this organisational structure would improve outcomes for mothers and babies. GP beds should be supervised by a consultant obstetrician and integrated within, or situated in close proximity to, a consultant-led unit. In addition, 20 per cent of beds within consultant-led units should also be made available for antenatal admissions. It could be questioned as to why these beds were necessary as evidenced-based practice was some three-four decades away, and the possibilities of care and treatment thus limited. Commentators have heavily criticised the report for its over-influence and bias towards the prejudices and assertions of the Royal College of Obstetricians and Gynaecologists (RCOG), the professional body for obstetric medicine (McIntosh 2012). This therefore begs the question

whether the recommendations made were linked to reinforcement of the medical model and Cartesian approach of Western medicine of splitting head and body (Davis-Floyd 2001; Gold 1985). It could be suggested that parallels can be drawn with the separation of the woman from her home context.

During the 1950s, women commonly remained in hospital for a postnatal stay of around ten days (McIntosh 2012). Almost inevitably, as institutional birth rates rose towards recommended target levels, hospitals struggled to meet this requirement, and early postnatal discharge schemes were introduced. These schemes required postnatal care to be completed by community midwives following discharge and were a source of dissatisfaction amongst both hospital and community midwives (Towler and Bramall 1986). Midwives were still required to provide maternal and neonatal supervision until the 14th postnatal day, and the increased workload significantly disrupted previously achieved patterns of continuity of care (Robinson 1990). As Towler and Bramall (1986) note, job-satisfaction was highest amongst those community midwives still attending home births and providing continuity throughout the continuum.

Additionally, resonating with present-day educational issues around postnatal care, the CMB expressed concerns about the limiting effects of reduced postnatal stay on pupil midwife hospital-based experiential learning (Towler and Bramall 1986). Furthermore, rather than work as professionals in their own right, recommendations from the Cranbrook Committee represented a major shift in professional roles and responsibilities, with an expectation that midwives should be subservient to medical knowledge and hierarchy. Midwives could no longer conduct antenatal examinations or facilitate births without a doctor in attendance. In addition, doctors rather than midwives were to be responsible for the planning and coordination of care provision for pregnant women (Robinson 1990). These recommendations inevitably led to erosion of the midwives' role, parameters of practice and occupational autonomy. Community work became primarily focussed on postnatal care, with little likelihood of attendance at births or intrapartum care. While hospital-based midwives provided care across the continuum, it was within an environment increasingly centred on embracing the medical

constructs of surveillance and management of childbirth (Hunter 2012). By the turn of the decade, midwives' role within the provision of maternity care was increasingly ill-defined.

2.2.2 1960-1980s - Medical institutionalisation and control

By the early 1960s, the use of hospital rather than home for birth was becoming more deeply entrenched within traditional birth cultures. Women, as well as doctors, championed the campaign for more availability of hospital beds. Women's attitudes to childbirth were changing, especially in regard to beliefs about the importance of 'valuing' the labour and birth experience (McIntosh 2012). Across all classes, the trend towards smaller families informed by the greater availability of reliable contraception seen in the post-war era had culminated in the average family comprising of no more than two children (Marwick 2003). Rather than the inevitable and successive sequelae to marriage seen in previous years, childbirth had become a more controllable event most likely to occur perhaps twice in a woman's life. While women wanted birth to be medically safe, there was growing recognition amongst women of their right to shape the experience. Birth was increasingly seen as "an achievement" (McIntosh 2012, p.99), and a growing belief amongst women of the importance of the experience being emotionally meaningful was developing. Technological advances, the development of new diagnostic screening tests, along with new understandings of embryology, genetics, biochemistry and paediatrics characterised the era (Towler and Bramall 1986). This new knowledge enhanced public beliefs in medical science, and its abilities to improve birth outcomes. NHS hospitals became epitomised within public perception, as "the bright new sanitised world of medical science triumphant" (Symonds and Hunt 1996, p.92).

Following the post-war austerity seen in the previous decade, the 1960s-witnessed the transition from embedded sociocultural controls imposed in the Victorian era to non-conformity (Marwick 2003) and self-indulgent psychedelia (Beddoe 2010). Characterised by the evolvement of a new "technological civilization" (Marwick 2003, p. 85), it was the 'age of the consumer' with visible growth in the acquisition of durable consumer goods

across all sectors of society. The average weekly wage rose exponentially (Marwick 2003) with full employment and economic growth (Hunt and Symonds 1995). The production of new modern conveniences impacted on women's working life, domestic chores and the pursuit of leisure. New 'convenience foods' became available through newly developed freezing and drying techniques. Smaller, more efficient electrical appliances (e.g. refrigerators, washing machines, spin-dryers, dishwashers and bigger and better television sets) flooded the market (Marwick 2003). Women's movements pushed for political reforms and public and educational policy began to recognise women as individuals with the right to equal opportunities. Culturally, one of the most unchanging aspects was the extent of women's unpaid work within the family and the continuation of women's gendered tasks as caregiver and housewife (Lewis 1992). At the same time, popular television programmes of the time (e.g. Dr Kildare and Emergency Ward 10) reinforced the dominance of male expertise, and the unquestionable authority of the medical profession within public conscious as "trustworthy miracle workers in a white coat" (Hunt and Symonds 1995, p. 15). Furthermore, NHS hospitals with their inherent values of hygiene and control and technological expertise, appeared synonymous with the modernising ethos of the era.

The transformation of the popular music scene, which erupted out of the separate youth culture was undoubtedly a central feature of what has been termed the 'swinging sixties'. An antithesis of Victorian convention, it expressed protest against established society and exuded a more cosmopolitan image, introducing the self-indulgent and 'jokey' use of psychedelic colours (Marwick 2003). Following the release of chart hits such as the Beatles' 'Lucy in the Sky with Diamonds' and Procul Harum's 'A Whiter Shade of Pale'. British music of the late 1960s, eluded to the growth and anti-establishment use of illegal recreational psychedelic drugs (e.g. Cannabis, Hashish and LSD) within popular youth culture, commonly seen as 'mind-expanding' drugs, and associated with transcendentalism and with 'flower power' (Marwick 2003). The psychedelic drug culture came to represent resistance to the Vietnam war, and the support of peace in

general. Central to this cultural revolution was the development of the oral contraceptive pill and the evolution of what has been termed the 'permissive society'. The pill, as it became known, gave women autonomy and control over their sexual reproduction but was initially only given to married women and access was by prescription only, and thus under medical control. However open access to contraceptive advice became the norm across medical practice following opening of the Brooks Clinic in the early 1960s, which offered access to all women, irrespective of age or marital status (Symonds and Hunt 1996). Mirroring social movements of the time, clothes changed dramatically breaking many fashion traditions. The bikini became widely popular in 1963, and Mary Quant popularised the mini skirt. Some women dressed in 'go-go' boots, box-shaped PVC dresses and psychedelic prints (Marwick 2003) and in contrast to Victorian principles of constraint, felt more able to freely and publicly voice and express their femininity and sexuality.

Women were also using their voice to question other elements of their lives. Consumer and lay professional groups came into focus and became a strong organisational force and influential voice in the shaping of maternity services in the coming decades. The growing medical dominance of childbirth seen in recent years, espoused the language and models of patriarchy reinforcing the prevailingly held view of women as 'patients' who were in receipt of care. Both the National Childbirth Trust (NCT) and the newly founded Association for Improvements in the Maternity Services (AIMS) argued the construct of women as 'consumers' of maternity services (McIntosh 2012). These organisations gave expression to their views and as public pressure for hospital maternity services grew, AIMS joined the campaign for more hospital beds (Towler and Bramall 1986). While the organisation's championing of this cause has elicited some debate within the literature, AIMS's decision appears in tune with contemporary public attitudes towards NHS hospital care and appetite for medical science (Hunter 2012). Analgesia for childbirth was also becoming more commonly requested by women. While inhalational analgesia was becoming more readily available for home birth, stronger analgesia could only be obtained within a hospital (Tew 1998).

It is further suggested that hospital care presented a more attractive proposition than the potential disruption and expense of home birth, particularly amongst working class women (Symonds and Hunt 1996). However, a central aspect within AIMS's campaign, and other pressure groups, was for women to receive better care within the increasingly larger and depersonalised NHS hospitals. The depersonalisation was intrinsically linked with the values of professionalism and the hierarchy of the service provision, that anticipated women would conform to medical instruction and practice. AIMS work led to fathers being allowed to be present during labour and birth and hospital care that was less regimented and more attuned to women's needs (Hunt and Symonds 1995), as well as the discontinuation of some routinized and depersonalising procedures, such as pubic shaves and enemas to purge the bowel (Towler and Bramall 1986).

The Cranbrook Committee advocated, with correct selection, that 30 per cent of women could safely birth at home. However, the medical community continued to debate this, as more pregnancies were being classified as 'high-risk' through the new obstetric knowledge and methods. With the development of ultrasound during the 1960s and early 1970s, along with other fetal surveillance techniques, much of the debate focused on the health of the fetus (McIntosh 2012). It could be argued that rather than the safety of the mother, the centrality of the fetus characterised the 'new' obstetrics. Widespread and increasingly indiscriminate use of the largely untested new technology, added to the pressure for NHS hospital beds as more and more pregnancies were classified as high-risk (Oakley 1986). By 1964, the recommended target institutional birth rate of 70 per cent was achieved and by 1970, just 12.4 per cent of births occurred in the home (Campbell and Macfarlane 1994). It could be suggested institutional birth, rather than home birth, had now become embedded within traditional birth cultures as the socio-cultural norm.

The 'baby boom' of the late 1950s early 1960s further compounded issues, requiring hospital services to modify existing models of care in order to meet the demands placed upon them (Towler and Bramall 1986). Within these changing contexts midwifery continuity of carer schemes became untenable

and it could be argued, were not held as essential, desirable or sustainable alongside technological surveillance within the medicalised model. Antenatal services for hospital-booked women became more fragmented, as institutions moved to models of shared-care provision with community practitioners (Robinson 1990). The development of bigger NHS hospitals and introduction of large centralised 'delivery suites' changed midwives working practices in what has been described as akin to a 'conveyor-belt' within an industrial model of service delivery (Oakley 1986; Towler and Bramall 1986, p.255). Care was fragmented, as women moved through the different hospital departments for the various aspects of their care with midwives they did not know. Midwives primarily worked in one domain becoming ward-based in the provision of either antenatal or postnatal care, or intra-partum care within the delivery unit (Tew 1998). Thus, rather than provide continuity to women across the continuum, midwives' role became contracted and compartmentalised, with midwives specialising in a particular aspect of midwifery practice (Robinson 1990).

To ameliorate pressure on hospital beds, early discharge schemes were introduced throughout the decade, with some mothers going home 36 hours post-birth in some areas. This greatly increased the workload of community midwives, who not only had to continue the postnatal care but also assess women in the antenatal period, as to their suitability for early discharge (Towler and Bramall 1986). Because of the limited opportunities to get to know women, a general lack of continuity and the increased workload midwifery dissatisfaction was more common and working in the new industrial hospital maternity model was cited as a source of lower job satisfaction amongst midwives (Towler and Bramall 1986). As well, concerns arose about midwives' ability to maintain the full-range of their expertise (Hunter 2012). However, for many hospital-based midwives the loss of continuity was compensated by the predictable working patterns and rostered off-duty that enabled hand-over of care and responsibility at the end of shift (Tew 1998). It could be suggested these practical attractions have echoed through the coming decades and have resonance for many midwives today.

The technological approach to obstetrics embraced the innovative medical and scientific advances that were rapidly becoming available. Midwives' workload increased exponentially during the 1960s, with proliferation of the new diagnostic screening tests, drugs, and routinized procedures and associated regimes that were rapidly incorporated into everyday practice. This is not to suggest these innovations were all based on what we would now call an effective evidence base, some were introduced using the hierarchical power base (Oakley 1986; Tew 1998). The new oxytocic drug, Syntometrine, was introduced to manage the third stage of labour and expulsion of the placenta, which midwives were able to use on their own responsibility (Towler and Bramall 1986). Following the introduction of Syntocinon, a uterine stimulant, induction and the acceleration of labour became increasingly routine and commonplace procedures (Oakley 1986). With the increasing management and medical involvement within childbirth, episiotomy, a surgical incision of the perineum at the time of birth became almost routine practice, especially in primigravida. In 1967, given the increasing frequency of the procedure, performing an episiotomy under local anaesthetic was also incorporated as a midwifery skill (Towler and Bramall 1986). However, it would be some twenty years till research evidence emerged to inform these areas of practice (Rogers et al. 1998; Sleep et al. 1984). Given prevailing medical dominance, Tew (1998) suggests midwives came to distrust their use of traditional conservative skills of perineal management. Acceptance of episiotomy as optimum management of choice, and uptake of its liberal and routine use amongst midwives, rose exponentially over the coming decade. This practice has been explicitly linked to the lack of control midwives had over the way in which they worked, and the primacy of obstetricians within the hospital environment (McIntosh 2012). While episiotomy remains a taught skill within the undergraduate curriculum, its liberal and routinized application is not advocated, and students are educated as to the appropriateness of its use in respect of clinical indications and the woman's consent (NMC 2009).

By the end of the decade, the roles and responsibilities of junior doctors and midwives had become increasingly blurred. By 1968, intubation of

the newborn and the obtaining of blood specimens from babies for the newly available diagnostic and screening tests were included within the midwives' scope of practice (Tew 1998). The midwife was increasingly required to initiate these diagnostic and screening tests on her own responsibility and interpret the test results and their implications. Amid the clerical work, non-midwifery tasks such as domestic cleaning, and midwifery care, which included bed baths and thrice daily vulval swabbings (Towler and Bramall 1986) continued. These additional duties or expanding list of tasks, impacted on midwives' workloads, leaving little time for provision of psychological support or meaningful contact with women in care-giving. The new technical responsibilities often challenged midwives' clinical skills and clinical knowledge, highlighting the importance of continuing post-qualification midwifery education (Towler and Bramall 1986). However rather than a process of upskilling, Tew (1998, p.66) argued that midwives were becoming little more than "competent obstetric nurses" working under the directions of obstetricians. The shift in traditional birth cultures across the era also significantly impacted on pupil midwife experiential community-based learning, especially intrapartum care as home birth became more of a rarity. In 1970, the statutory number of community births to be facilitated by pupils was reduced to six. However, as Towler and Bramall (1986) note, concessions had to be made as in some areas even this small number could not be achieved.

The 'swinging sixties' thus presents a paradox for women of the time who in everyday life had greater autonomy, choice and control and the ability to engage in and experience the social world differently than the past. Yet in maternity care, women's choices of birth place, caregivers and locus of control over their own birthing experiences were more restricted than in previous generations. Arguably, given the symbiotic nature of midwifery and childbirth, midwives had less autonomy and control over their professional practice and the training of midwives was similarly constrained. Furthermore, publication of the Peel Report (DHSS 1970) in 1970, according to Bates (2004, p.126) "enabled the medicalisation of childbirth to begin in earnest". The report advocated 100 per cent hospital birth on the grounds that this was

the safest option for all women and babies, though it was heavily criticised for a lack of evidence to support this and for a lack of consultation with women about their needs and experiences (Tew 1998). It endorsed the centralisation of maternity services advocated by the Cranbrook Committee Report and the closure of small isolated GP units in favour of larger combined GP and obstetric hospitals. Medical and midwifery care would be provided by obstetric teams of consultants, GPs and midwives and all women, irrespective of risk, should be reviewed by a consultant obstetrician at least twice during pregnancy (Tew 1998). The highly influential report contributed to the continuing shift from home to hospital birth. Rather than an integral part of life, home birth was now increasingly viewed as a “selfish indulgence” (McIntosh 2012, p.111) and birth had become cemented within traditional cultures as a public affair conducted with unknown caregivers. Over the coming decade, the nature and scope of midwifery practice fundamentally changed. Midwives now only played a minor role in antenatal care, and that care was often duplicated by doctors.

During the 1970s, obstetric services expanded substantially to address the increased workload with a corresponding up-surge in consultant obstetrician appointments (Tew 1998). The use of technology in the management of ‘normal’ labour and birth rose exponentially, with intervention as a routine feature. The induction and acceleration of labour became commonplace practices and surveillance of fetal wellbeing via application of an Electric Cardiotocograph machine, along with episiotomy almost routine aspects of every woman’s care (Oakley 1986; Tew 1998). Arguably the Introduction of partograms by obstetricians in the early 1970s, and their popular uptake, epitomised prevailing focus on controlling the birth process rather than on women’s experience. Partograms provided a means for midwives to document all physical data related to the woman’s ‘progress’ in labour and via this monitoring, have proven to be an excellent tool in developing countries in preventing complications. However, it is interesting information regarding the woman’s needs and psychological state was not required or recorded in the document (Towler and Bramall 1986). Increasingly, the acceptance of the medical construct of birth as only normal in retrospect was

becoming embedded within traditional birth cultures and midwifery practice. Indeed, so great was the change in hospital-based intrapartum practice, concerns were raised about midwifery training. In 1974, the CMB felt it necessary to issue a mandate stressing the importance of pupil midwives receiving instruction in the art of facilitating normal physiological birth as well as those of active management (Towler and Bramall 1986).

During the 1970s-mid 1980s, the mechanisation of birth became so endemic that midwifery practice became more focussed around technical tasks than the art and traditional skills of midwifery. Indeed, because of resultant erosion of the midwives' role, jurisdiction and locus of control. Towler and Bramall (1986, p. 259-260) assert pupil midwives undergoing training, were "conditioned to seeing their role as that of assistant to the doctor, a machine minder or technological handmaiden". Undoubtedly, the Short Report (HMSO 1980) published in 1980, did little to turn the tide and give women access to the artistry and traditional skills of the midwife available to women in earlier generations. Founded on the 'safety' premises' underpinning the Peel Report, it re-endorsed the earlier reports recommendations for all births to occur in NHS hospitals and advocated the maximum use of birth technology.

2.2.3 1990s-present - Family centred care and collaborative partnerships

Qualifying as a midwife in 1980, my reflections on my training and early years of practice are immersed within my socialised unquestioning acceptance of the predominant highly medicalised model of birth. Coming from a nursing background, I have reflected on whether this was because the medical model was commensurate with my previous practice or if via my nurse training and practice, I was more comfortable and perhaps socially conditioned to this way of working. Additionally, I had not yet had opportunity to witness childbirth within a social context or physiological labour and birth at this stage in my career, and this may have been a contributing factor [1.1]. Alongside my own personal experiences, multiple voices informed prevailing midwifery discourse and not all midwives were averse to the changes that

had occurred to their job-role over the last two decades. While some midwives reported a loss of job satisfaction, occupational autonomy and control and felt the profession was losing its status and identity (Towler and Bramall 1986), many were comfortable in their role, and embraced high technology birth as presenting opportunities to upskill and extend the midwife's domain of practice (Hunter 2012; Sandall 1996). Others chimed in accord with the dominantly held medical view that childbirth should and could be controlled. This was not necessarily on the grounds of safety but more about beliefs around the social notion, that women should not be held at the mercy of nature and the vagaries of biological birth (McIntosh 2012).

Women, as well as midwives, were also using their voice to express their views on their birth experience. It is important to recognise that women, as consumers of maternity services, cannot be considered a homogeneous group with identical aspirations, knowledge, expectations or needs. Perhaps because of my midwifery background and knowledge, my expectations were informed by my understandings and acceptance of fragmented care and high technology birth. Birthing my three children during the 1980s, I expected to give birth in the central obstetric-led NHS hospital and was happy with the arrangement to have my antenatal care shared between my GP and obstetric consultant. Reflecting on my experiences, I recall with some dismay and disbelief that I did not question why 'my' midwife was just present during my community antenatal clinic visits to assess my weight, blood pressure and urine or why my home postnatal care was often provided by midwives I did not know [1.1]. However, not all women were comfortable with such fragmented care or the prevailing routinized biomedical approach to birth. A growing number of women were dissatisfied with their experiences of technologically mediated birth (Hunter 2012). Some felt the emotional experience of birth was equally as important as the physical aspects, and wanted holistic alternatives while others drew on feminist discourses to argue their rights to have control over their own birth and bodies (McIntosh 2012). Medical dominance was questioned and amid vigorous public debate in medical journals, the press and television, a consumer-led challenge to

contemporary industrial model of birth began to gain momentum (Bates 2004; Hunter 2012).

The NCT, AIMS, along with consumer organizations grounded in contemporary feminist movements for social change, such as the Maternity Alliance and Active Birth Movement, joined the grass roots women's revolt (Sandall 1996). These childbirth activists were politically vocal in their support and played a key role in the growing lobby for change (McIntosh 2012). During the same period, economic assessments began to raise misgivings about the effectiveness of the policy for the centralisation of birth within NHS hospitals. Amid escalating costs, the contributions of technology to safer birth were also being questioned (Sandall 2000). Furthermore, accompanying these concerns were rising doubts about the effectiveness of obstetric-led services for all women and the lack of research informed care. Outcomes of contemporary research found infant and maternal mortality and women's satisfaction with their childbirth experience, was no worse in midwife-run continuity schemes than obstetric schemes and might be improved (Flint et al. 1989). Additionally, reviews of the evidence on place of birth indicated that planned home birth for women at low obstetric risk had similar (Campbell and Macfarlane 1994) or even better outcomes (Tew 1990). With research evidence legitimising these concerns, an alliance was formed between consumers, the Royal College of Midwives (RCM), Association of Radical Midwives (ARM) and the women's interest organizations identified above (Hunter 2012). This union escalated the debate momentum, pressure and opportunity for policy change.

Situated within feminist discourses, the core constructs of ARM's lobby for change centred on women's rights to have choice and control over the process of childbirth, as well as the aim to return to midwives' professional autonomy, full domain of practice and jurisdiction via continuity of care across the continuum (Sandall 1996). However, as previously noted, many midwives were happy with their existing job-role and level of occupational autonomy [2.2.2]. This re-shaping of midwifery to give continuity of care was thus not necessarily representative of the midwifery workforce in general (McIntosh 2012; Sandall 1996). Arguably, this ambivalence toward continuity

within service delivery could be said to have resonance for some midwives today. Amid this cultural climate of change was the resurgence of independent midwifery. This was promoted as a means of providing women with fundamental care via a continuity model, which would enhance the occupational autonomy and job-satisfaction (Hunter 2012). Although not large, this midwifery element has continued to offer alternative role models and care choices for women. However, it has been a legal requirement for all healthcare professionals, including midwives, to have an indemnity arrangement in place since 2014, and the indemnity scheme used by some independent midwives, who are members of the organisation Independent Midwives UK (IMUK), was deemed insufficient and inappropriate (NMC 2017a) and the continuation of this midwifery element seems uncertain.

At the same time, amid concerns that midwifery would lose its status as a 'profession' and be subsumed by nursing, attention was focused on midwifery training. This situation arose following the United Kingdom Central Council for Nursing, Midwifery and Health Visiting's (UKCC) succession from the CMB, as national regulatory body in 1979 (Hunter 2012). While 'direct-entry' to midwifery training had always been an option [2.2.1] by the mid-1980s, like myself, most midwives came from a nursing background (Benoit et al. 2001). It was argued that because of our nurse training our practice would be more pathology centric and imbued with the biomedical model whereas, by contrast, non-nurse midwives would be more focussed on normality (McIntosh 2012). Thus, attempts to delineate midwifery as distinct from nursing and medicine saw the investment in and resurgence of direct-entry programmes. It was held that midwives educated and trained via this route would be imbued with core midwifery constructs and stand up more determinedly for the profession (Benoit et al. 2001; Hunter 2012) and by the early 1990s, a substantial proportion of midwives came from a non-nursing background. However, this caused much unrest and rivalry within the profession, amid debate about the effectiveness and competence of non-nurse midwives (McIntosh 2012).

The introduction of direct-entry pre-registration midwifery diploma and degree programmes and the gradual move of schools of midwifery from NHS

hospitals to universities during the 1990s added to this debate. Over the ensuing years, the move to universities has led to widening participation linked to social inclusion of midwifery entrants via the direct entry route (Finnerty et al. 2013), and a refocusing on the academic level of professional preparatory programmes alongside the clinical skills and personal and professional qualities. Midwifery in 2008, progressed to become an all-graduate profession (NMC 2007) [2.2] with all programmes quality assured by the NMC (NMC 2009) and via internal university processes that meet the Quality Assurance Agency (QAA) standards. Amid the changing context of midwifery over the last two decades, it could be argued this has fuelled debate about the fitness for practice of midwifery graduates and led to rivalry and feelings of marginalisation by some.

The transition from student to qualified midwife is acknowledged as a difficult and stressful time (Avis et al. 2013; Hughes and Fraser 2011b). Many newly qualified midwives report feeling overwhelmed by the responsibilities of their new role (Hobbs and Green 2003; Reynolds et al. 2014) and a loss of confidence when they feel unsupported in the workplace (Avis et al. 2013; Fenwick et al. 2012; Hughes and Fraser 2011b; Reynolds et al. 2014). University-based pre-registration midwifery education was described as idealistic by new registrants (Reynolds et al. 2014; van der Putten 2008) and the midwives in the Reynold et al. (2014) study, felt their education and practice experiences had not fully equipped them for the real world of practice. Dissonance between expectations and the realities of midwifery practice have been reported by others (Begley 2002; Hughes et al. 2002; Hobbs 2012; Fenwick et al. 2012; van der Putten 2008). Midwives reported that they did not feel valued as part of the team or trusted in clinical decision-making and did not believe they were accountable or autonomous during their first-year post-registration rather, they expressed a perception that they were required to carry out preordained instructions from senior colleagues for the women in their care (Reynolds et al. 2014). Newly qualified midwives need to determine their place in an already established culture (Fraser 2006; Hobbs 2012; Avis et al. 2013) and the values and perspectives of the teams with whom they are working (Begley 2002; van der Putten 2008; Fenwick et

al. 2012). Negotiating these relationships was perceived as pivotal to their ability to 'survive' within the work environment and be accepted by colleagues (Hobbs 2012; Hunter 2004a; Reynolds et al. 2014). Newly qualified midwives wanted to 'belong' but felt they had to pass through a period of initiation and impress their senior colleagues before this would occur and they would become accepted as part of the team (Reynolds et al. 2014).

Due to changing political and social contexts, and in response to pressure from midwives, childbirth activists and women's organizations continued to campaign. By the early-1990s a significant change in policy rhetoric was witnessed. Underpinned by successive government policy directives, the ensuing years saw the move in education and healthcare towards a more consumerist ethos, in which consumer satisfaction was recognised as a key quality indicator. These directives placed increasing emphasis on the importance of consumer involvement in midwifery education (ENB 1996; DH 1999a; Ball 2006) and the planning and provision of people-centred health care services (DH 1998; 199b; 2000; 2001; 2006a), and NHS trusts now have a legal duty to actively consult the public (Local Government and Public Involvement in Health Act 2007). A core theme within these frameworks is the recognition of the public's right and responsibility to participate in health care decision-making at both an individual and organizational level. There is also focus on the primacy of individualised care and holism, and a move away from patriarchal and hierarchal relationships to partnership working and woman-centred approaches (DH 1993; 2000; 2004; 2006b).

The focus on consumer satisfaction led to radical change in the organization and delivery of maternity services following publication of the policy document *Changing Childbirth* (DH 1993). Underpinned by the key principles of choice, continuity and control, for the first time the report clearly placed women's needs as the focus of care. The report firmly established the philosophy of 'woman-centred' care and reasserted the role of the midwife as an autonomous practitioner able to practice independently and provide all midwifery care for women experiencing normal birth. Furthermore, it criticised doctors and midwives who unreflectively used the grounds of

'safety' to impose unwanted and unnecessary interventions on women. *Changing Childbirth* was published as part of the government's response to an earlier report in 1992 that revealed the extent of women's dissatisfaction with their lack of control over birthing choices, fragmented service delivery and the medicalisation of childbirth (House of Commons Health Committee 1992 known as the Winterton Report) and outlined a framework for service reform. Key within this was development of midwife-led models of care that would enable continuity of care and aimed to facilitate choice and control through partnership working. While this mandate was welcomed by local authorities (Sandall 2000), it required a radical shift in the context and content of midwives' work. To meet the continuity mandate, midwives were required to provide care across the continuum and work flexibly across community and hospital settings. Grounded within the emerging new culture of 'evidenced-based practice' within the NHS, effectiveness was expected to be demonstrated by research. *Changing Childbirth* also placed emphasis on the provision of research evidence on which to base practice decision-making. Thus, the new model required a highly educated consumer centric midwifery workforce, who would work flexibly, autonomously and facilitate an integral on-call commitment (Sandall 1996; 2000), presenting many practical challenges.

Following the publication of *Changing Childbirth*, midwifery continuity models were introduced in many maternity units. However, the report did not specify how these models should be organised and wide variation in the interpretation of the 'continuity of care' component was apparent (Green et al. 2000; Lee 1997). Some units considered this to be a shared philosophy of care amongst midwives i.e. 'continuity of caring', while others saw it as the provision of care by a known midwife caregiver or small group of midwives across the childbirth continuum i.e. 'continuity of carer' (Hundley et al. 1995; Morgan et al. 1998). Caseload midwifery falls within the latter category and is an approach where an individual midwife provides all care-giving episodes for each woman in her/his caseload either as part of a group practice or partnership (Beake et al. 2013). While the development of different models made interpretations of evaluations of early continuity schemes challenging

(Lee 1997), there is now robust evidence identifying the benefits of midwifery continuity of carer in terms of improved safety and outcomes for women and babies (Sandall et al. 2016) as well as positive experiences for women when compared with fragmented care (Forster et al. 2016; Homer et al. 2002; McCourt et al 1998; Sandall et al. 2016). Women's perceptions of the meanings of the experience are discussed in [2.3.1].

The evaluation of caseload midwifery in the UK showed benefits to women in terms of a high degree of continuity with known caregivers and reduced rates of episiotomy and the use of epidural anaesthesia (Page et al. 1999). A randomised controlled trial (North Staffordshire Changing Childbirth Research Team 2000) and a prospective non-randomised clinical trial (Benjamin et al. 2001), supported these outcomes and showed a reduction in induction rates (Benjamin et al. 2001; North Staffordshire Changing Childbirth Research Team 2000) as well as lower Caesarean birth rates and a higher home birth rate (Benjamin et al. 2001). A recent Cochrane systematic review provides strong evidence to support these claims as well as identifying links between a reduction in instrumental births and pre-term births (Sandall et al. 2016). Furthermore, randomised controlled trials conducted in Australia have shown caseload midwifery is cost effective (Tracey et al 2013; 2014), safe for women of any risk (Rayment-Jones et al. 2015; Tracey et al. 2013) and associated with a reduction in Caesarean section rates in low risk women (McLachlan et al. 2012). Midwifery continuity of care has also been shown to confer benefits and reduce potential harmful outcomes for women from vulnerable groups (Beake et al. 2013; McCourt and Pearce 2000; Rayment-Jones et al. 2015). Caseload midwifery is therefore clinically cost effective and promotes benefits for women and the NHS. While mixed feelings and some ambivalence toward the introduction of continuity models was reported amongst some midwives (Hunter 2012; Kirkham 1999), many midwives working in these models have reported high levels of job satisfaction (Haines et al. 2015; Sandall 1997; Walsh 1999), professional fulfilment and appreciation of the level of occupational autonomy afforded (Collins et al. 2010; McCourt 1998; Stevens and McCourt 2002c).

An in-depth discussion of midwives' experiences of this way of working is discussed in [2.3.2].

Following the publication of *Changing Childbirth*, subsequent policy directives continued to echo and reinforce the key concepts of choice, continuity and control embedded within the document. Published in 2004, The National Framework for children, young people and maternity services (DH 2004) set out a further agenda for change with the aim of promoting a cultural shift from maternity services designed around the needs of the organisation to family-centred services, individualised to the needs of each mother and baby. *Maternity Matters* (DH 2007), published in 2007, set out a framework for how these reforms were to be implemented, centring on four national choice guarantees for all women; choice of how to access maternity care; choice of type of antenatal care; choice of place of birth and choice of postnatal care. The concept of continuity was strongly endorsed within the document and *Maternity Matters* stressed the importance of women having a known and trusted carer throughout their childbearing experience.

More recently, *Midwifery 2020 Delivering expectations* (DH 2010) set out a vision of the contribution midwives will make to achieving quality maternity services for all women across the UK. It recognised the professional status of midwives and stated that midwives were to be the lead professional for all healthy women and the coordinator of care, as part of a highly skilled multidisciplinary team, for women with complex pregnancies. The report recognised the changing context of care within the UK and the need to reduce inequalities and improve maternal and family health, discussed below, and placed emphasis on the public health role of the midwife and the importance of safe, effective, evidenced-based, quality maternity care. Emphasis was placed on social and holistic models of care within the document, and the importance of continuity of known carer for women and their partners. The report saw partnership working as important and identified the need for midwifery to be firmly 'rooted' in the community rather than hospitals with the aim of enhancing visibility of the midwife, and access for women. Reciprocal relationships were central within this, and the importance of establishment of trusting relationship for women with the midwife who

coordinated her care and provided continuity across pregnancy and the postnatal period. Furthermore, *Midwifery 2020* placed focus on midwifery education and its role in the preparation and development of the future workforce. Pre-registration curricula were to be rooted in normality whilst, at the same time, preparing students to work across a range of care settings, and develop the required knowledge, attributes and skills to fulfil the lead practitioner role. However, despite the positive findings and successive government policy directives that have continued to endorse the concept of continuity and stress the importance of women having a known and trusted caregiver (DH 2004; 2007; 2010), the introduction of caseload practice is not widespread within the UK. It is suggested that this is because of perceptions that it is perceived to be an “unnecessary and unsustainable luxury” (Beake et al. 2013, p.997) with significant practical challenges in implementing such schemes (Homer et al. 2017). However, there is little research to ascertain if this is the case and with contemporary focus on continuity of carer, more research in this area is needed. The lack of continuity women experienced was highlighted in the recent 2016 National Maternity Review (NHS England 2016), particularly in care following birth. One in four women wanted to see the same midwife on all home postnatal visits but this was not their experience and 40% of women had not previously met any of the midwives who visited them at home (NPEU 2014). Moreover, whilst the majority of women reported their experience of maternity care in positive terms, it was evident that the national choice guarantees set out in *Maternity Matters*, had not been fully embraced across all trusts. The 2015 CQC Maternity Survey (CQC 2015) reported that 16% of respondents said that they had been offered no choices in regard to place of birth and 14% felt they were not enabled choice in where to have a baby because they were not provided with enough information to facilitate decision-making. Furthermore, the National Maternity Review (NHS England 2016) identified women want to receive personalised, friendly care and to be cared for by caregivers they know and have formed a trusting relationship with throughout the childbirth journey.

Informed by the findings from the review, publication of the Better Births (NHS England 2016) policy report in 2016, strongly endorsed the concepts

embedded in the earlier maternity directives discussed and sets out a five-year plan for change. Contextualised within the seven broad themes of: safer care, personalised care, continuity of carer, better postnatal and perinatal mental healthcare, multi-professional working, working across boundaries, and a payment system that adequately compensates service providers. This places focus on the importance of personalised care, centred on the woman and her family, and the core concepts of choice, continuity and control embedded within *Changing Childbirth*. NHS trusts are required to offer greater continuity of the healthcare professional supporting the woman, her baby and the family. The vision set out in *Better Births* identifies it is the midwife who will in the main, provide this continuity and that this should include having a midwife the woman knows at the birth. The National Maternity Review (NHS England 2016) thus provides a platform for innovation and the transformation of future maternity service provision within the UK in the coming years.

Amid the prevailing focus on woman-centred care, continuity of carer and consumer satisfaction and perceptions of quality within maternity services, notable changes have occurred within British society, obstetric practice and the midwives' role, which have significantly impacted on midwives working lives and workload. The period since the early-1990s has seen a significant rise in the proportion of obese women (NHS 2015), older mothers (RCM 2015) and, due to medical advances, women with pre-existing health issues and complex care needs accessing maternity services (Berg 2005). An increasing number of women from black and minority ethnic groups, along with women born outside the UK and refugee women, many with no or limited English, are also accessing maternity services (ONS 2016b). Over this period women's partners have also become progressively more engaged in pregnancy and childbirth (Redshaw and Henderson 2015) and rather than 'woman's work', childbirth has become a shared event. Personalised health care within a safe, equitable and accessible system is central to government policy. The primacy of choice is key within this, and women should have choice in when and where they access care and the place of birth. All of this has implications for women's experiences, expectations and satisfaction with

care in the context of NHS funding constraints, continuing shortage of midwives (RCM 2015) and rising Caesarean birth rates (Health and Social Care Information Centre 2015) as well as expectations of midwives' contributions to an increased public health role (DH 2000). It is argued rather than 'woman-centred', services in many units are often still akin to an "industrialised conveyor-belt model" without any relational continuity between the woman and midwife (Bryson and Deery 2010, p. 94). Working hours are described as intense and midwives today as stressed (Bryson and Deery 2010), unsupported (Kirkham 1999) and frustrated, due to not being able to provide the high quality and safe care they want to deliver (RCM 2015).

Historically, the role of doula as 'helpwoman', birth companion and supporter, has always existed (Berg and Terstad 2006; Goedkoop 2009). However, in recent years, the professionalisation of doula care has grown internationally (Steel et al. 2014), and a formal doula movement was founded in the UK in 2001 (Goedkoop 2009). Within this context, a doula provides physical, social and emotional support across the childbirth continuum (Steel et al. 2014). It is argued, this trend toward professionalisation of doula services is directly linked to women's desire for continuity of known care-giver, and the deficits of contemporary maternity care in this respect (Dahlen et al. 2011). Within the context of heavy workloads, this movement highlights broader issues around women's satisfaction, access to continuity, supportive care and the midwives' role as birth supporter.

In a critical review of the literature regarding women's experiences of different types of labour supporters, Rosen (2004) concluded that support early in labour and continued into the postnatal period from untrained female caregivers was the most beneficial. This is congruent with recent summarisations of research around doula care (Pascali-Bonaro and Kroeger 2004; Steel et al. 2014). It is argued that this is because via continuity, a trusting relationship is developed which enables a doula to gain understanding of women's concerns and expectations and facilitate a supportive dynamic during the birth process (Berg and Terstad 2006; Steel et al. 2014). In addition, for many women, one of the most important aspects of

labour support is the knowledge that they will not be left unattended and the labour supporter will be available as, and when, required (Pascali-Bonaro and Kroeger 2004; Rosen 2004). Given current professional educational context and mandated continuity component [1.2], parallels can perhaps be drawn with student midwives who carry a caseload. Whilst student midwives have attained some midwifery skills and knowledge, they are not yet qualified practitioners, but agree to be on-call and available to support the woman from early in labour under the supervision of a qualified practitioner.

Recent studies demonstrate that on entry to midwifery education, most students have strong 'with woman' values and a belief in women and physiological birth (Carolan 2011; Carolan and Kruger 2011). Students in the first year of the programme spoke of how respecting and supporting women's rights to make their own care choices was important to the role of the midwife (Carolan 2011). Two years later in a follow-up study, Carolan (2013) explored the views of third year students from the same cohort and it was evident their perceptions were becoming aligned with the views of qualified midwives. While the students still felt it important to facilitate and empower women to make decisions this was aligned within concepts of risk, accountability and safe practice. In fact, students spoke of 'guiding' women to make choices likely to result in a positive outcome and that women could be 'allowed' to make certain decisions (Carolan 2013, p. 119). This suggests the early transition and socialisation of students into the profession, and it is interesting to note how this includes language suggestive of control. Caseload midwifery is integral to the concept of holistic women-centred care (McCourt et al. 2006), the promotion of partnership working (Jepsen et al. 2016; Menke et al. 2014), and a 'with woman' approach (Corcoran et al 2017; McCourt et al. 2006; Walsh 1999). Practice-based learning within an educational continuity context may therefore hold potential to further shape and inform student development and transition to qualification as woman-centred practitioners able to practise safely and intelligently in collaboration with women.

2.3 Continuity of care

Continuity of care is designed to promote a humanistic consumer-centric approach to midwifery care; the inclusion of caseloading within education affords students opportunity to learn about the practicalities of organising, planning and providing woman-focussed care (NMC 2009; 2015a). The learning experience occurs within the tripartite professional relationship between the woman, midwife mentor and student. Models of maternity care that offer continuity of care are becoming increasingly popular, and many Western countries have implemented the caseloading model within service delivery. In this section, I explore women's evaluations of caseload midwifery, midwives' perceptions of working in the model, and student experiences of educational continuity to promote contextual understanding of student midwife caseloading within the curriculum. Exploration of women's experiences of student educational continuity forms the critical component of the literature review and is discussed in [3.4].

2.3.1 Women's evaluation as consumers of midwifery continuity

Irrespective of model of service accessed, a Cochrane Review of midwife-led continuity models (Sandall et al. 2016) indicated this form of care benefits women and their babies in regard of improved safety, clinical outcomes and positive childbirth experiences. Robust evidence identified continuity of care by midwives was associated with high levels of satisfaction (Forster et al. 2016; McLachlan et al. 2012; Sandall et al. 2013; Waldenstrom et al. 2000) and valued by women (Bulman and McCourt 2002; Corcoran et al. 2017; Homer et al. 2002; McCourt et al. 1998; Tinkler and Quinney 1998; Williams et al. 2010). Given the plethora of literature in this area, and earlier discussion [2.4], the focus of this section is on women's evaluations of caseload midwifery, drawing primarily on descriptive and qualitative studies to illuminate the meanings of the experience for women.

Caseload midwifery is integral to the concept of holistic women-centred care (McCourt et al. 2006) and the available evidence indicates women find the model attractive. Women generally perceived their caseloading midwives as enabling and altruistic (Allen et al. 2017; Walsh 1999), who demonstrated

interest in them (Leap et al. 2010) and genuinely cared about them (Allen et al. 2017; Williams et al. 2010). Women described how throughout their care they did not have to repeat information and re-tell their story because the midwife knew them and their history, which they appreciated (Beake et al. 2013; Corcoran et al. 2017; Huber and Sandall 2009; Jepsen et al. 2017a; Williams et al. 2010). Women reported the relational continuity enabled a trusting relationship to develop over time between themselves and their midwife (Allen et al. 2017; Corcoran et al. 2017; Leap et al. 2010; McCourt et al. 1998; McCourt and Pearce 2000; Walsh 1999). The trust generated was central to the model and facilitated a sense amongst women of being treated as an individual, and of receiving personalised care (Beake et al. 2013; Corcoran et al. 2017; Dove and Muir-Cochrane 2014; Huber and Sandall 2009; Jepsen et al. 2017a; Walsh 1999; Williams et al. 2010).

Women in Walsh's (1999) study described the trusting relationships developed within the woman-midwife dyad as 'friendships'. Outcomes from subsequent studies support this view, identifying the nature of the relational connections forged via continuity as reciprocal, personal and intimate (Allen et al. 2017; Beake et al. 2013; Corcoran et al. 2017; Huber and Sandall 2009; Jepsen et al. 2017a; Leap et al. 2010; McCourt and Stevens 2009; Williams et al. 2010). Women spoke of how this enabled them to connect with their midwife on both a professional and personal level (Jepsen et al. 2017a), and the close relational bonds this engendered (Allen et al. 2017). Being able to build personal relationships with midwives mattered and women identified lack of opportunity for this as a negative aspect of their caring experience (Williams et al. 2010). However, as discussed in [2.3.2] personal midwifery practice is not without challenge (Mccourt et al. 2006; Stevens 2009; Walsh 1999), particularly for midwives unaccustomed to engaging with women in this manner (Stevens and McCourt 2002a; Stevens 2009). Parallels with the midwifery literature can perhaps be drawn and from an educational perspective, it could be suggested women may wish to build similar relational bonds with students who caseload. Due to lack of exposure to continuity models and supernumerary status, this could pose a challenge

for students working within a continuity of care model and negatively impact on women's experiences of care. This aspect is explored further in [2.3.3]

While women recognised and welcomed the midwife's professional guidance, knowledge and expertise (Leap et al. 2010; Jepsen et al. 2017a), the professional friendships that developed (Pairman 2000; Walsh 1999), were perceived as characterised by equality and inclusiveness and based more on a partnership model and not on power differences (Allen et al. 2017; Corcoran et al. 2017; Jepsen et al. 2017a; McCourt et al. 2006; Walsh 1999). Women reported feeling more at ease, more informed (Allen et al. 2017; Beake et al. 2013; Leap et al. 2010; McCourt et al. 1998) and in control, and enabled to make their own decisions and choices in partnership with midwives through the relationship (Allen et al. 2017; Corcoran et al. 2017; de Jonge et al. 2014; Kemp and Sandall 2010; Jepsen et al. 2017a; Williams et al. 2010). Women spoke of how the relationships established, enabled feelings of empowerment both for themselves, their pregnancy and birth (Allen et al. 2017; Corcoran et al. 2017; Dove and Muir-Cochrane 2014; Kemp and Sandall 2010; Jepsen et al. 2017a; Williams et al. 2010). Feeling empowered during birth has been positively associated with women's increased satisfaction with care (Sandall et al. 2016; Walsh and Devane 2012).

Having relational continuity with a known midwife engendered a sense of comfort, confidence and ease amongst women (Allen et al. 2017; McCourt et al. 1998; McCourt and Pearce 2000; Walsh 1999; Williams et al. 2010). Women described how midwives shared information in a way they understood (Allen et al. 2017; Beake et al. 2013; Corcoran et al. 2017; Leap et al. 2010), took the time to ensure of their understanding (Allen et al. 2017; Beake et al. 2013) and how through continuity, they were less likely to receive conflicting advice (Huber and Sandall 2009). Women talked of how they felt supported by their caseload midwives (Beake et al. 2013; Corcoran et al. 2017; Williams et al. 2010), and of how their midwives were readily available to access when required to answer queries or offer reassurance (Williams et al. 2010). In the lead up to labour, women spoke of how knowing their midwife enabled them to feel calm, less anxious (Allen et

al. 2017; Huber and Sandall 2009; Leap et al. 2010), informed and well prepared for the birth (Allen et al. 2017; de Jonge et al. 2014; Kemp and Sandall 2010; McCourt et al. 1998). Women felt they would be able to make informed decisions during labour (Mccourt et al. 1998) as well as more confident in their ability to manage labour pain (Kemp and Sandall 2010; Leap et al. 2010).

Continuous presence by known midwives during labour and birth through the caseload model has been positively associated with women's perceptions of a better birth experience (Allen et al. 2017; Corcoran et al. 2017; Huber and Sandall 2009; Jepsen et al. 2017a; McCourt et al. 1998). Having a known midwife enabled women to feel safe, more at ease (Allen et al. 2017; de Jonge et al. 2014; Huber and Sandall 2009; Jepsen et al. 2017a) in control, and actively participate in decision-making during labour (Allen et al. 2017; Corcoran et al. 2017; Dove and Muir-Cochrane 2014; Walsh 1999). Women commented how the midwives working in this model, believed in them and their abilities to birth naturally (Allen et al. 2017; Leap et al. 2010). Some women felt this positively affected their self-belief and sense of empowerment. Conversely, other women viewed this as one of the few negative aspects of the continuity model, feeling the midwives' espoused philosophy reinforced a normal birth agenda inconsistent with their own approach (Allen et al. 2017) while little negative comment from women was evidenced in the literature. Having a known caregiver during labour mattered, and women reported feelings of disappointment when this was not possible (Jepsen et al. 2017a; Walsh 1999). Furthermore, following the birth women want contact with their known midwife (Beake et al. 2013; Jepsen et al. 2017a), and concerns have been raised about potential negative impact of termination of the relationship (Walsh 1999).

2.3.2 Midwives' experiences

A number of studies have explored the views and experiences of midwives who work in a caseloading midwifery model. Much of the literature on the midwives' perceptions of caseloading practice originated in the UK, from the work of Sandall (1997) and the research team of Stevens and McCourt

(2002). A growing body of international work in recent years adds to this evidence-base.

Qualified midwives working in these models reported high levels of job-satisfaction (Fereday et al. 2009; Haines et al. 2015; McAra-Couper et al. 2014; Sandall 1997; Walsh 1999), and found the role professionally fulfilling (Collins et al. 2010; McAra-Couper et al. 2014; McCourt 1998; Stevens and McCourt 2002c; Turnbull et al. 1995). Reluctance among the midwives who worked in this way to return to a more conventional way of working was reported (Stevens and McCourt 2002c). The potential to develop meaningful relationships with women (Sandall 1997; Walsh 1999) and the opportunity to provide quality of care through caseloading (Stevens and McCourt 2002b) are significant factors contributing to this satisfaction. Midwives in Hunter's (2006) study reported the most rewarding aspect of their job was the nature of the midwife-woman relationship established via midwifery caseload models. The outcomes of subsequent studies support this view (Collins et al. 2010; Crowther et al. 2016; Cummins et al. 2015; Fereday and Oster 2010; Freeman 2006; Gilkison et al. 2015; Jepsen et al. 2016; Kemp and Sandall 2010; Menke et al. 2014; Newton et al. 2016; Thorgen and Crang-Svalenius 2009) and it is the relationships they forge with women and their families that caseload midwives identified as sustaining their joy in midwifery practice (Gilkison et al. 2015; Hunter et al. 2016; McAra-Couper et al. 2014). The reciprocal relationships developed resulted in a feeling of commitment amongst midwives which was found to be central to the model (Edmondson and Walker 2014; Fleming 1998; Jepsen et al. 2016). Midwives personally invested time with women (Finlay and Sandall 2009; Stevens and McCourt 2002b), felt proud of their job and that they were doing high quality midwifery (Edmondson and Walker 2014; Jepsen et al. 2016; Menke et al. 2014; Thorgen and Crang-Svalenius 2009), and made a difference to women (Fleming 1998; Josif et al. 2014; Menke et al. 2014). Midwives described the caseloading model as returning to the 'roots' of midwifery (Jepsen et al. 2016), enabling them to embrace its true philosophy and do 'real' midwifery (Newton et al. 2016).

Midwives experienced caseload midwifery as working in partnership with women (Gilkison et al. 2015; Jepsen et al. 2016; McAra-Couper et al. 2014; Menke et al. 2014), described as a model of interdependence developed through relational reciprocity (Fleming 1998). Characterised by collaboration and shared decision-making, midwives spoke of how they worked across caring contexts to complement and supplement the women's identified existing knowledge and abilities and enhance her birthing experiences (Corcoran et al. 2017; Fleming 1998; McAra-Couper et al. 2014). It is reported this high level of engagement facilitated increased practitioner confidence in holistic care provision and clinical decision-making (Cummins et al. 2015; Sandal 1997; Stevens and McCourt 2002a; b), utilisation of midwifery skills and knowledge across the continuum (Cummins et al. 2015; Newton et al. 2014; Menke et al. 2014) and inter-professional communication and collaboration (Menke et al. 2014; Stevens and McCourt 2002b). Midwives claimed to take responsibility and worked in a self-governing way in order to provide safe practice (Dove and Muir-Cochrane 2014; Finlay and Sandall 2009; Gilkison et al. 2015; Jepsen et al. 2016; Newton et al. 2014) and were more likely to advocate for individual women within their care (Corcoran et al. 2017; Dove and Muir-Cochrane 2014; Finlay and Sandall 2009; Menke et al. 2014). From an educational perspective, it could be suggested caseload practice affords opportunity for midwifery students to consolidate skills, gain confidence in self-leadership and work to the full scope of their practice.

However, studies highlight concerns about aspects of caseload midwifery that may have negative impact on midwives. Leinweber and Rowe (2010) argued, that while autonomous working held potential to mitigate stress due to greater control over the birth environment, the intimate empathetic nature of the relationships developed with women might increase midwives risk of developing secondary traumatic stress. Studies further highlight a tendency for some midwives to over-commit themselves to the women within their caseload, resulting in emotional and physical exhaustion (Sandal 1997; Stevens and McCourt 2002b). Working in a geographical catchment area, where they are socially known and recognised, may increase midwives'

personal sense of commitment and obligation (Hain et al. 2015; Jepsen et al. 2016). Within the context of contemporary practice, evidence increasingly suggests midwives do not just caseload women with uncomplicated pregnancies and provide care to women at all obstetric, medical and social risks (Allen et al, 2015; Beake et al. 2013; Bulman and McCourt 2002; Corcoran et al. 2017; Finlay and Sandall 2009; Jepsen et al. 2016; Lewis et al. 2016; Menke et al. 2014; Rayment-Jones et al. 2015). It could be suggested this might heighten potential for midwives to over invest in women and experience emotional stress, particularly where there is poor maternal or neonatal outcome.

The potential of burnout within the context of caseload midwifery has been discussed. Triggers for burnout can include the 'giving of self' nature of midwifery work and the emotional demands of working closely in a caring role with women (Dixon et al. 2017; Young et al. 2015). Caseload practice is suggested to attract midwives with certain personalities or philosophies (Newton et al. 2014) and Allen et al. (2017) found midwives in a continuity relationship are more motivated to go 'above and beyond' than that required in a bid to meet the women's envisaged needs. The risk of burnout in this context is argued to occur where there is a 'selfless' passion that pushes some midwives beyond sensible limits into burnout (Young et al. 2015, p.162). It is further suggested burnout is more likely to occur where midwives lack peer and personal support, work in large groups, have high workloads or lack occupational autonomy (Sandall 1997; Sandall 1998; Stevens and McCourt 2002b). However, whilst caseloading midwives have described their job as challenging because of the impact on their personal lives (Forster et al. 2011; Newton et al. 2014), difficulty in achieving work-life balance due to excessive workloads (Wakelin and Skinner 2007; Wiegers 2007), on-call commitment (Collins et al. 2010; Newton et al. 2014; Sandall 1997; Stevens and McCourt 2002b; Wakelin and Skinner 2007) and working long hours (Newton et al. 2014; Yoshida and Sandall 2013). These concerns have not been substantiated in studies where burnout was measured (Dixon et al. 2017; Fenwick et al. 2018; Jepsen et al. 2017b; Newton et al. 2016; Sandall 1997; Sandall 1998; Yoshida and Sandall 2013).

Support to maintain a work-life balance (Yoshida and Sandall 2013), organisational support and sufficient resources, including enough time and opportunity to spend with women (Dixon et al. 2017) and autonomous midwifery practice (Yoshida and Sandall 2013) are elements identified as integral to the caseload model that may be protective against burnout. High occupational autonomy was identified as an essential component of caseloading practice that contributed to midwives' satisfaction (Collins et al. 2010; Dove and Muir-Cochrane 2014; Edmondson and Walker 2014; Haines et al. 2015; Jepsen et al. 2016; Menke et al. 2014; Newton et al. 2014). Arguably, within an educational continuity context, student midwives may lack autonomy and/or have limited abilities to control their job role. This is especially pertinent within a UK context where students are more likely to experience caseloading practice outside of primary care provision. This, along with the other factors identified as protectors against burnout raises issues for the curriculum in terms of educational support and preparation, and women's evaluation of midwifery care.

2.3.3 Midwifery students' experiences of educational continuity

Following publication of NMC (2009) standards for pre-registration midwifery education, there appeared a notable lack of evidence on which to base best practice and a paucity of information surrounding student midwives' views or experiences of educational continuity. Stevens (2002), in an English ethnographic study, explored the implementation of caseload midwifery within a medicalised inner-city NHS maternity service and the adaptations the midwives needed to make on moving from a fragmented model into caseload practice. Whilst the focus of Stevens (2002) work was on qualified midwives, some data was collected from students who were seconded into caseload practice for part of their clinical experience, via focus groups and individual interviews ($n=12$). My work in this area has focussed on students' experiences of their preparation for caseloading practice (Rawnsdon et al. 2009), and student perceptions of how the experience informed their learning for professional practice (Rawnsdon 2011a) [1.1]. Since this work was conducted, the literature has evidenced growth of interest in this area, most notably from Australia, where a significant body of work has been done, but

also pilot studies in Norway and Indonesia. These studies drew on different research methods and conducted in universities offering different models of student continuity. However, irrespective of approach, study focus or educational model, common themes surrounding student experience are apparent.

Students considered the educational continuity of care experience provided a learning opportunity that was unique and not possible in standard, more fragmented clinical placements (Gray et al. 2013; McLachlan et al. 2013; Yanti et al. 2015) and greatly appreciated the experiences of holistic care provision it afforded (Stevens 2002). Many students found it a positive (Dawson et al. 2015; McKellar et al. 2014; McLachlan et al. 2013; West et al. 2016), and highly beneficial learning experience (Gray et al. 2012; Rawnsdon 2011a; West et al. 2016) that taught them how to be 'with women' (McKellar et al. 2014) and assisted them in developing or confirming a woman-centred philosophy (Sweet and Glover 2013; Yanti et al. 2015). Many felt the student continuity was also a positive experience for women (Aune et al. 2011; McKellar et al. 2014; McLachlan et al. 2013), that was of great benefit to them, especially first-time mothers, those with additional needs or women more likely to receive a fragmented model of care (McKellar et al. 2014).

The continuity learning opportunity enabled students to observe midwifery care and service provision from the woman's perspective, and the impact of this on her life and caring experience (Browne et al. 2014; Gray et al. 2013; McLachlan et al. 2013; Rawnsdon 2011a; Sweet and Glover 2013; West et al. 2016). This enabled students to identify how service delivery could be improved for Australian indigenous women and their future role in this (West et al. 2016). Students reported they had gained enhanced appreciation of the importance of relationships and building a rapport with women and their families (Browne et al 2014; Dawson et al. 2015; Gray et al. 2012; Gray et al. 2013; Rawnsdon 2011a; Sidebotham et al. 2015; Sweet and Glover 2013; West et al. 2016). Students in the studies elicited, felt they had developed meaningful reciprocal relationships with women (Dawson et al. 2015; Gray et al. 2012; Gray et al. 2013; McLachlan et al. 2013; Rawnsdon 2011a; Sweet and Glover 2013), which increased their sense of satisfaction with the

continuity experience (Dawson et al. 2015; Yanti et al. 2015; West et al. 2016). Some felt they had not forged the same relational connection with every woman, which evoked feelings of disappointment and dissatisfaction (Gray et al. 2013; Rawnsdon 2011a). The Australian indigenous students in the West et al. (2016) study felt they had to work hard to earn the trust and respect of the Australian indigenous women in their care and many students found investing the time necessary to build and maintain such relationships demanding (McKellar et al. 2014) and a significant pressure, resulting in some limiting contact with women (Sweet and Glover 2013), and others reported missing university lectures and tutorials (McLachlan et al. 2013). Due to the close relationships developed, some students found it difficult to maintain appropriate professional boundaries with women (McKellar et al. 2014; Rawnsdon 2011a; West et al. 2016) and wanted more guidance around managing this aspect of the continuity experience (McKellar et al. 2014). This suggests being 'with woman', while maintaining professional relationships alongside academic commitments, can be stressful and place untenable demands on students. This will have an impact on student learning and could negatively affect women's experiences of midwifery care and the continuity experience.

Students spoke of how working in a continuity model enabled them to have greater autonomy and responsibility while under mentor supervision (Dawson et al. 2015; Rawnsdon 2011a; Stevens 2002) as well as a greater sense of purpose (Sidebotham et al. 2015; West et al. 2016), which for students in Yanti et al. (2015) study facilitated personal identity and philosophy development. Students described working across the entire scope of midwifery practice (Dawson et al. 2015) afforded insight into what it is like to be a midwife (Gray et al. 2013; Rawnsdon 2011a), and enhanced understanding of how other practitioners work (Gray et al. 2013). The experience facilitated student learning around skills of advocacy, collaboration and negotiation (Browne et al. 2014) and greatly enhanced student practice development and clinical skill acquisition (Carter et al. 2015; Gray et al. 2012; Gray et al. 2013; McLachlan et al. 2013; Rawnsdon 2011a; West et al. 2016; Yanti et al. 2015). Students both received and valued

constructive feedback on performance from women (Aune et al. 2011; Rawnsdon 2011a; Sweet and Glover 2013; West et al. 2016). This afforded valuable insight into personal learning needs (Aune et al. 2011; Rawnsdon 2011a), boosted student sense of confidence in clinical abilities (Aune et al. 2011; Carter et al. 2015; West et al. 2016; Yanti et al 2015) and for the students in the West et al. (2016) study, provided an affirmative learning experience that significantly enhanced their sense of self-belief and ability to succeed in their journey to becoming a midwife. Students described how 'being with woman' had enhanced the application of theory to practice (Sidebotham et al. 2015) and consolidated learning, through researching topics to facilitate woman's choices (Browne et al. 2014; Gray et al. 2013; Sweet and Glover 2013; Rawnsdon 2011a; West et al. 2016). This suggests educational continuity facilitated learning that was more meaningful and relevant because of its pertinence to the woman at the centre of care.

However, evidence demonstrates working in an educational continuity model was not without challenge as well as opportunity for students. Many students described difficulty in juggling the competing pressures of university and home life alongside the continuity experience (Gray et al. 2013; Dawson et al. 2015; Rawnsdon 2011a), especially the on-call commitment (Browne et al. 2014; Dawson et al. 2015). Students reported the level of time commitment required had negatively impacted on their personal and social lives (Carter et al. 2015; Dawson et al. 2015; McLachlan et al. 2013) and abilities to contribute to childcare and family responsibilities (Browne et al. 2014; Dawson et al. 2015; McLachlan et al. 2013). It also negatively affected student ability to continue paid employment (Browne et al. 2014; McLachlan et al. 2013), and some students quit their part-time jobs in order to complete the experience (McKellar et al. 2014). Travel costs incurred in order to meet women (Browne et al. 2014; McLachlan et al. 2013), as well as money spent on phone calls and parking (McKellar et al. 2014) further added to resultant financial strain experienced. These experiences often evoked feelings of stress and anxiety and students spoke of how they found it necessary to access support from family and friends (Carolan-Olah et al. 2015; Dawson et al. 2015; Rawnsdon 2011a) and each other (Gray et al. 2012).

Exposure to educational continuity enabled comparison of models of service delivery (McLachlan et al. 2013) and many students felt inspired by the caseloading model (Carter et al. 2015; West et al 2016). Following the educational continuity experience, students reported they felt more prepared to work in caseloading models (Dawson et al. 2015; McLachlan et al. 2013) and some spoke of aspirations to work in this way (Dawson et al. 2015). While this was a realistic ambition for some, students in Sweet and Glover's (2013) study questioned the relevance of continuity requirement within the midwifery programme, as little opportunity existed to work in this model on qualification. This study's findings resonate with contemporary UK context where opportunities for continuity within the NHS are limited and the majority of women receive a more fragmented model of midwifery care [2.2.3]. Given the significant demands, potential emotional toll and negative impact on family life caseloading may make, the students may feel less motivated to maximise the educational continuity experience to its full potential. This may in turn affect how women experience student caseloading practice and the midwifery care provided.

Students studying Australian accredited midwifery programmes must meet the education standards set by the Australian Nursing and Midwifery Accreditation Council [ANMAC]. The current standards require students to undertake ten continuity experiences and a time investment of an average of twenty hours with each woman (ANMAC 2014). This demonstrates a reduction in the number of mandated continuity experiences from twenty in the previous standards (ANMAC 2009). This change reflects the literature, which suggests that despite pre-course preparation, students felt unprepared for this additional commitment, engendering feelings of stress and anxiety (Carolan-Olah et al. 2014). Many students described how the continuity of care mandate made it harder to achieve other inherent programme theoretical and clinical requirements (Gray et al. 2013; McLachlan et al. 2013; Sweet and Glover 2013). Evidence indicates that because of this, some students' made-up or falsified records due to pressure to complete the continuity experience (Gray et al. 2013; McLachlan et al. 2013). Current NMC standards for UK midwifery education do not stipulate the size of

caseload students should undertake, or how much time students must invest in each woman (NMC 2009). However, the standards are currently under review, and it will be interesting to note how the continuity requirement will be progressed.

2.4 Contemporary landscape: insights for future practice

Exploration of past paradigms and perspectives shows the role of the midwife is integral to the improvement of maternity care and the 'humanising' of childbirth. While different countries have different agendas, this can be demonstrated within contemporary landscape of practice from an international perspective. While some countries have seen a revival of midwifery and midwife-led models in recent years, it could be argued similar struggles and focus on the professionalism of midwifery, hegemony of technology and the biomedical model is demonstrated (McIntosh 2012; Porter 2000). Like the UK, concerns have also been raised about the trajectory of hospital for 'normal' place for birth within traditional cultures in many developed countries (McIntosh 2012). Many nations have also seen significant changes, as well as debate, about the entry requirements, academic level and duration of midwifery education (Benoit et al. 2001; Porter 2000). High quality education, which balances knowledge, practice development alongside personal and professional standards has increasingly been central to the professionalism of midwifery and the promotion of a social model of birth. Recent years have witnessed significant growth of interest in educational continuity models and some countries, like the UK, Australia and New Zealand, have embedded this element within the midwifery curriculum.

Contemporary midwifery education in the UK is currently free from nursing and medical dominance, and the move of schools of midwifery from NHS hospitals to HEIs has promoted opportunities for students and staff to work with women to co-construct midwifery knowledge, theory and practice. At the same time, the clinical experience of students working in the hospital setting, particularly the labour ward, often occurs within an over-medicalised, 'industrial conveyor-belt model' of service provision (Bryson and Deery 2010)

rather than an environment supporting a 'with woman' philosophy (Hunter 2004b). Robust evidence identified provision of continuity of care via caseload practice is an attractive model for women, midwives and students. Characterised by the concepts of partnership, intimacy and reciprocity, the strong benefits of the model appear relationally mediated through the formation of what has been described as 'professional friendships'. The experience assisted students to understand the centrality of the importance of relationships, learn how to be 'with woman', and develop a 'with woman' philosophy. Moreover, the educational continuity facilitated the linking of theory to practice and learning that was more relevant because of its pertinence to the woman within care, and thus more meaningful. It could be suggested the continuation of this element within the midwifery curriculum will facilitate students to develop the requisite human attributes set out in Enabling professionalism (NMC 2017b) and the Code: Professional standards of practice and behaviour for nurses and midwives (NMC 2015b), as well as the ability to practice safely and effectively.

While continuity affords students many educational benefits and a unique learning experience that promotes the artistry of midwifery and social model of birth, it has been suggested for some midwives, adoption of approaches to birth more in tune with the biomedical model has increased though the physical and geographical separation of midwifery education from the clinical sites (Benoit et al. 2001). In these situations, it is difficult for university educators to influence the quality of clinical experience and mentorship a student receives. Working with mentors who are unwilling practice facilitators or whose practice does not transparently uphold the principles of professional practice (NMC 2015b; 2017b), will diminish the caseloading experience (Rawnsdon 2011a). The literature also indicates working in an educational continuity model can evoke significant emotional work and place untenable demands on students. In addition, some students reported difficulty in maintaining appropriate boundaries with women during the learning experience. Given contemporary focus on this element within practice and education and the importance of consumer satisfaction, this raises issues for the curriculum regarding educational preparation for the

experience, and initiation of supportive frameworks. To ensure best practice within this, women's experiences must be central to future educational development. The Professional Standards for UK midwifery education (NMC 2009) are currently under review and more research from a UK perspective is needed to inform how the continuity requirement will be progressed within the midwifery curriculum.

Chapter 3 Literature review

3.1 Introduction

This chapter provides a review of the literature on women's/consumer experiences of engagement in health and social care professional education in the UK and developed countries. Initially the literature relating to consumer contribution to student educational development, which underpins the context of student midwife caseloading within the midwifery curriculum, is discussed. Women's evaluation of student rendered care is then explored to give the reader an understanding of the importance of exploring women's experiences of being part of a student midwife's caseload.

3.2 Ascertaining relevant research

A literature review was conducted to provide a contextual overview of women's/consumer experiences of engagement in health professional education in the UK and developed countries. The search involved the following electronic databases: British Education Index, British Nursing Index, CINAHL, Maternity & Infant Care, Medline Complete, Scopus, and Google Scholar. As the search process was progressed different combinations of search terms and the use of Boolean operators 'AND', 'OR' were used to optimise search effectiveness surrounding literature on:

- Women/consumer engagement in student educational development
- Women's evaluation of student midwife rendered care provision

Relevant papers enabled the identification of further literature by following up on references and citations. The scope of excluded literature included papers comparing student gender and women's experiences, on the grounds that midwifery remains a female dominated profession. The papers identified were written in English and further examined for research location to elicit themes that may have resonance for this study. Literature was reviewed throughout the study process with historical limits set from 1990, when

consumer involvement in education gained momentum, up to thesis completion.

The literature review elicited fifty-seven papers reporting women's/consumer participation in health and social care education. Fifty-three papers reported on educational strategies in the UK, and four papers reported on one initiative in Australia, Belgium, Israel and United States of America (USA). Fourteen papers reported on curriculum development initiatives, with six using qualitative interviews, one a Delphi study, one a questionnaire survey and five, informal discussion groups to elicit women's/consumers views. Thirty-three papers reported on consumer involvement in teaching and learning activities and ten on consumer involvement in student assessment strategies. A randomised controlled trial was used in two studies to determine the effectiveness of consumer teaching on medical student learning and experience. One study used a non-randomised comparison method. A variety of methods were used in the other studies, encompassing qualitative, quantitative and mixed methods (Appendix 1, Tables 1-3).

In exploring the literature, one aspect noted was the use of language to represent women. Women were described using different vocabulary (e.g. 'patient', 'client', 'user', 'consumer') behind which it could be suggested lay an espoused, or unexamined, ideological position regarding women and healthcare. This position is informed by cultural and political contexts of women, within which social and cultural norms impact (Oakley 1993). This language can be used as a device for excluding and including people in the same way that medical language does, it classifies, labels, it dehumanises. It leaves the situation and context one of complexity regarding choice of nomenclature or language label used. Given its implications of illicit drug use and drug addiction, representing women as 'users' has close associations with negative stereotypes (McLaughlin 2009; Towle et al. 2010) and is thus emotive. Informed by historical cultural and professional contexts, the nomenclatures 'patient' and 'client' imply passivity, signifying a lack of agency or capacity to meet one's own needs (McLaughlin 2009), concepts juxtaposed to the midwifery philosophy of women as partners. Rather they relate to language associated with hegemony of the medical model (Tew

1998) and suggest power differential relationships where the greater power lies with educationalists.

Disagreement exists amongst recipients of care about how they wish to be represented (Lloyd et al. 2001; Speed 2006). However, people receiving care in a study by Lloyd et al (2001) identified 'consumer' as a preferred nomenclature. 'Consumer' can be defined as a responsible citizen who actively seeks participation (McLaughlin 2009; Speed 2006). Commensurate with the ethos of this work, the nomenclature 'women' or 'consumer' are used to describe the people identified in the papers as involved in student education.

3.3 Consumer engagement in student educational development

Over the last twenty-five years there has been changing focus on the importance of consumer involvement at both a national and local level within HEIs and practice. As highlighted in Chapter 2, emphasis has been placed on the primacy of individualised care and holism, and the need to humanise care delivery (DH 1993; 2012; HMSO 2013; NHS England 2016). This heralded a move from patriarchal and hierarchal relationships to partnership working and woman/consumer-centred approaches (DH 1993; 2000; 2004; 2006b; 2007; 2010a). Increasingly consumer experiences have become recognised as essential to inform high quality people-centred service provision, and consumer involvement is now a cornerstone of public service delivery.

Education is considered key to promoting a humanistic consumer-centric approach to care and development of practitioners with enhanced partnership working skill (Way and Scammell 2016). To ensure programmes are grounded in the experiences of women who use services, consumer input is now a lynchpin within the midwifery curriculum (NMC 2009) and quality assurance marker in the development of health professionals' fitness for practice for qualification and maintenance of registration (NMC 2015a). Student midwife caseloading practice occurs within the fusion of theory and practice and is grounded within the tripartite relationship between the

woman, midwife and student. It is about the application of theory to practice and women's evaluation of student care, and their readiness and competence for professional practice. The literature discussed in this section thus gives context to the study.

The focus of papers reviewed was on active consumer participation (i.e. in student selection, in teaching, in assessment of student work etc.) rather than those reporting initiatives eliciting women/consumer feedback on services (i.e. evaluating satisfaction, suitability or effectiveness). This was felt important as these forms of involvement align with the concept of a democratization approach, where the consumer is recognised as a citizen that has power to actively contribute to curricula decision-making and inform content (Hickey and Kipping 1998). A growing body of work surrounding the nature of consumer involvement within pre-and post-qualifying professional education was elicited, with the majority of papers coming from the fields of medicine and nursing. The papers evidenced a diverse array of activities in which consumers contributed to student education, although none reported experiences of participation in student selection (Table 3-1. P.71). In the following two sub-sections, consumer involvement in curricular design [3.3.1] and participation in teaching and learning initiatives [3.3.2] are discussed. The section concludes with review of themes drawn from the discussion that may have resonance for this study [3.3.3].

Table 3-1: Scope of papers elicited by professional group

	Midwifery	Nursing			Social Work	Medicine	Physiotherapy	Pharmacy	Podiatry	Inter-Professional education	Number of papers
		Adult	Mental health	Child health							
Curriculum Development	1	4	4	1	2	2	0	0	0	0	14
Teaching and Learning	0	4	9	0	3	11	2	1	0	3	33
Assessment	0	3	4	0	1	1	0	0	1	0	10
Number of Papers	1	11	17	1	7	14	2	1	1	3	57

3.3.1 Curricular design and development

A small body of work reported initiatives encouraging active consumer involvement in the design of health and social care professional curricula. These initiatives were generally reported once in the body of literature elicited, often following initial strategy implementation, and no published follow-up studies evaluating strategy effectiveness or impact were identified. Focus on description of consumer involvement appeared at the fore, and the papers did not evaluate or include how subsequent impact on students completing the programmes would be assessed (Appendix 1, Table 1). While agreement across the disciplines that consumer input was beneficial and gave new insights for learning was evident, the majority of papers elicited came from nursing. This may suggest greater focus on ill health experiences rather than life experiences and may lack translatability to midwifery and childbirth. Fraser (1999) used qualitative interviews to elicit women's views of content for inclusion within midwifery curricula however no other midwifery papers were elicited. If midwifery educational programmes are to meet women's needs, as well as students, it is imperative women who use maternity services actively contribute to their design (NMC 2015a), and this information is disseminated to inform a currently limited evidence-base. It is now national policy that midwifery students engage in caseloading as part of the undergraduate curriculum (NMC 2009). Thus, there is need to capture women's views and experiences of this learning strategy to inform curricula planning and development.

Women/consumer imperatives for student curricula placed emphasis on the centrality of the human dimensions of care including good communication and interpersonal skills (Alahafi and Burge 2005; Greenfield et al. 2001; Griffiths et al. 2012; Flanagan 1999; Fraser 1999; Sawley 2002; Whittaker and Taylor 2004) along with establishment of 'real' two-way interactional relationships between carer and care recipient (Fraser 1999; Rudman 1996; Scheyett and Diehl 2004). Human skills were identified as essential characteristics for midwives (Fraser 1999), nurses (Griffiths et al. 2012), the culturally sensitive doctor (Greenfield et al. 2001) and important criteria within student nurse assessments (Calman 2006). Emphasis was placed on

the need for professionals to see the person receiving care as a whole, rather than focus on diagnosis or illness condition (Forrest et al. 2000; Fraser 1999; Rudman 1996; Scheyett and Diehl 2004).

It was reported that consumer involvement grounded curricula in the reality of human experience (Flanagan 1999; Forrest et al 2000; Fraser 1999; Lathlean et al. 2006; Rudman 1996) and heralded a move from curricular philosophies espousing a medical model of care (Lathlean et al. 2006; Masters et al. 2002; Rudman 1996). Dissonance in opinion about curricular content was evidenced. Whittaker and Taylor (2004) reported disagreement regarding required nursing knowledge, skills and attitudes, and consumers did not like the child health programme ethos of 'family centred-care', identifying it as disempowering and poorly communicated (Sawley 2002). Consumers in a study by Jordan et al. (2000) felt there was too much focus on pharmacological interventions within mental health curriculum and wanted greater emphasis on knowledge of pharmacology and inclusion of non-pharmacological interventions. The ability of nursing curricula to promote the interpersonal and human qualities valued by consumers was questioned (Forrest et al. 2000). Many considered programmes were too academically orientated and students 'over educated' (Forrest et al. 2000; Griffiths et al. 2012; Whittaker and Taylor 2004). This suggests concerns exist amongst women/consumers that focus on equipping students with perceived essential specialist/technological knowledge for academic attainment and qualification has obscured the imperatives of humanised woman/person-centred care.

3.3.2 Teaching and learning

While the literature evidenced a significant body of work surrounding consumer involvement in teaching and learning activities across professional disciplines, no papers reporting midwifery initiatives were identified. A small number of papers reported on consumer involvement in student assessment strategies (Appendix 1, Table 2) with the majority centred on consumer contribution to teaching (Appendix 1, Table 3). Consumer contributions encompassed a range of classroom and practice-based teaching and learning activities. While the majority of papers reported engagement in one

particular activity, a wide variation in the extent of consumer involvement was evidenced. Variance also existed in frequency of involvement, ranging from consumer attendance at a one-off event to recurring contributions across different educational programme year levels. In the following sub-sections, consumer perceptions of their involvement and contributions are initially considered [3.3.2.1]. Student experiences of consumer involvement in teaching and learning [3.3.2.2] are then explored.

3.3.2.1 Consumer perceptions

Within the studies reviewed, consumers articulated a strong desire to contribute to health and social care professional education. Altruistic reasons appeared a primary motivator for many. A desire to enhance the practice of future healthcare professionals (Butterworth and Livingston 1999; Jones 2006; Shah et al. 2005; Speers 2008), to give something back for the care they had received (Agnew and Duffy 2010; Shah et al. 2005; Thomson and Hilton 2013) or improve services for future care recipients and staff (Coleman and Murray 2002; Jackson et al. 2003; McKeown et al. 2012) was expressed. Some consumers viewed themselves as experts in their own condition (Scheyett and Diehl 2004; Shah et al. 2005; Stacy and Spencer 1999) and wanted to challenge prevailing stereotypes, stigmas and assumptions surrounding the concept of disability or disease (Agnew and Duffy 2010; Thomson and Hilton 2013). Consumers felt positive about their involvement and the contribution they could make to student education (Debyser et al. 2011; Flanagan 1999; Jones 2006; McMahon-Parkes et al. 2016; Molyneux and Irvine 2004; Scheyett and Diehl 2004; Speers 2008).

Many consumers expressed the view that theoretical educational provision needed to be complemented by the consumer perspective (Cooper and Spencer-Dawe 2006; Thomson and Hilton 2013). A need to humanise care delivery and a curricular philosophy that supported a holistic rather than medical model was strongly espoused (Lathlean et al. 2006; Masters et al 2002; Rudman 1996). Offering students' insights into the lived reality of the insider experience, through sharing of experiential knowledge of illness and the healthcare system, was held to personify a consumer approach to care

(Agnew and Duffy 2010; McAndrew and Samociuk 2003; Thomson and Hilton 2013). This was felt important to enable students to link theory with practice (Cooper and Spencer Dawe 2006) embracing the human dimensions of care, as a 25-year-old man diagnosed with cancer at a young age, in the Agnew and Duffy (2010) study explains.

“By participating in the teaching, I was in effect ‘cancer with a human face’. By being in the classroom I helped remove any sense of detachment...I could emphasise that social workers need to remember they are dealing with a person and not a situation” (Agnew and Duffy 2010, p.755).

Mostly consumers felt their contributions were valued (Kelly and Wykurz 1998) and that they were taken seriously and of equal value in educating students (Debyser et al. 2011; Jones 2006; Masters et al. 2002). Many reported they enjoyed contributing to better inter-professional relationships (Brown and Macintosh 2006; Cooper and Spencer-Dawe 2006) and found students to be enthusiastic and non-judgemental (Walters et al. 2003). Some found the experience rewarding and enjoyable (Brown and Macintosh 2006; Shah et al. 2005) and gained satisfaction from helping students to learn (Stacy and Spencer 1999). The opportunity to mould, nurture and help develop future qualified staff was greatly appreciated (Agnew and Duffy 2010; Coleman and Murray 2002; Speers 2008).

Many consumers reported participation in student education as highly beneficial. For some, the involvement strategy led to new insights into their situation through the development of a coherent ‘illness narrative’ (Walters et al. 2003). Several described their knowledge of their prescribed medication (Shah et al. 2005), their condition (Haq et al. 2006; Kelly and Wykurz 1998) and the services available to them (Bailey 2005), as enhanced. As a result, some consumers became more questioning of health professionals (Shah et al. 2005), leading to a deeper understanding and appreciation of the doctor-consumer relationship (Walters et al. 2003). Specific therapeutic benefits were reported, many consumers enjoyed being able to use their illness in a positive way (Raj et al. 2006) and appreciated being listened to (Debyser et

al. 2011; Jackson et al. 2003). For some the experience was reported as cathartic (Costello and Horne 2001; Frisby 2001; Turner et al. 2000). Enhanced feelings of self-esteem, self-worth (McKeown et al. 2012; Raj et al. 2006; Walters et al. 2003), confidence (Haq et al. 2006; Jones 2006; Masters et al. 2002) and empowerment were reported (Frisby 2001; Kelly and Wykurz 1998). Learning new transferable skills through involvement appeared linked to this sense of changed power status (Masters et al. 2002). Additional benefits for many were the opportunities involvement provided to forge new friendships (Bailey 2005) with 'like-minded people' (Masters et al. 2002) and mitigate previously endured social isolation (Shah et al. 2005; Stacy and Spencer 1999).

Consumers reported few issues or concerns surrounding their involvement. Emotional feelings of ill health, triggered by repeated contact with doctors and medical students, were felt to be reinforced by some (Coleman and Murray 2002). It was also recognised consumers may require emotional support when involvement activities required re-visiting distressing experiences (Frisby 2001). Feelings of 'over consultation' by a spectrum of people and agencies was a further concern for some (Molyneux and Irvine 2004). Although Davies and Lunn (2009) argued that over preparation led to consumer responses becoming engineered or standardised, consumers considered specific and thorough training and preparation for the assessment task important (Muir and Laxton 2012). More preparatory guidance and support for the involvement activity was requested in a number of studies (Frisby 2001; Masters et al. 2002; Turner et al. 2000; Webster et al. 2012). The potential for organisational issues to engender anxiety (Flanagan 1999) or dissatisfaction amongst consumers (Masters et al. 2002) was also reported, and some would have welcomed more time to share their stories (Turner et al. 2000). Anxiety about medical students having access to personal medical records and concerns about confidentiality were also evidenced (Coleman and Murray 2002; Towle et al. 2010).

The opportunity to participate in student assessment was generally welcomed (McMahon-Parkes et al. 2016; Muir and Laxton 2012, Munro et al 2012; Speers 2008) but often reported as angst provoking and challenging.

Many consumers were preoccupied with demonstrating a positive attitude to the students (Debyser et al. 2011) and did not wish to cause them harm (Webster et al. 2012). Others were fearful that future care could be jeopardised if they gave negative feedback (Debyser et al. 2011). Thus, for many consumers, contributing to assessing nurse performance whilst being in receipt of nursing care engendered particular emotional turmoil (Calman 2006). While consumers in research by McMahon-Parkes et al. (2016) felt they were best placed to provide feedback and felt it important their voice was heard, giving critical feedback to students was found particularly difficult where pre-developed relationships existed (Stickley et al. 2011). Gaining women's evaluations of student educational relational continuity initiatives such as caseloading practice is important to inform student learning and future professional practice. This suggests careful consideration as to how women are prepared and supported in sharing their experience stories is imperative. This aspect of my study is considered in-depth in Chapter 4.

3.3.2.2 Student perceptions of consumer involvement in teaching

Students' perceptions of consumer involvement within teaching and learning strategies were primarily positive. In studies utilising satisfaction scales, high student satisfaction with consumer involvement in teaching was generally evident (Butterworth and Livingston 1999; Ikkos 2003; 2005; Khoo et al. 2004) and overall, sessions were positively rated (Costello and Horne 2001). Consumer generated learning materials were considered interesting and motivating (Brown and Macintosh 2006) and students in a study by Turner et al. (2000) felt honoured to hear consumers experience stories. However, accessing, recruiting and encouraging consumers to contribute can be challenging, and time consuming for staff (Forrest et al. 2000; Lathlean et al. 2006; Masters et al. 2002; Scheyett and Diehl 2004). Arguably, women's engagement in midwifery education may be particularly problematic, given the context of childbirth and the likelihood of family and work commitments. Gathering women's experience stories of caseloading practice for students to 'hear' could be an effective and less resource intensive strategy to 'have' women in the classroom.

Consensus amongst students of the beneficial and rewarding nature of consumer input into learning (Agnew and Duffy 2010; Cooper and Spencer-Dawe 2006; Debyser et al. 2011; Happell and Roper 2003; Ottewill et al. 2006; Rush and Barker 2006; Waterson and Morris 2005) was dominant within the studies. Students overwhelmingly agreed that the experience had engendered a more consumer-centric approach to care. Students spoke of gaining enhanced insight, knowledge and understanding of the consumer perspective (Agnew and Duffy 2010; Cooper and Spencer-Dawe 2006; Costello and Horne 2001; Debyser et al. 2011; Frisby 2001; Happell and Roper 2003; Ikkos 2003; 2005; Lathlean et al. 2006; Read and Spall 2005; Waterson and Morris 2005) as a student in Rush (2008) study reports.

“Having a story or a person’s face, it helps you to remember easily. In class when we talked about schizophrenia we were told about hallucinations, but the tutor can’t explain how that feels, whereas the service user might be able to give us some perception of that experience” (Student 15, cited Rush 2008, p.535).

Hearing consumer stories often challenged previously held student assumptions and attitudes, particularly surrounding disability, chronic illness and mental ill-health (Towle et al. 2010). The experience encouraged critical reflective appraisal of personal practice (Debyser et al. 2011; Happell and Roper 2003; Rush and Barker 2006), and for some, evoked emotive feelings of guilt and shame regarding previous actions (Rush 2008). Reflective insight promoted changed attitudes towards care. Some students felt they had become better practitioners (Happell and Roper 2003), whilst others felt motivated to change services (Khoo et al. 2004; Rush 2008). Consumer teaching was reported to reduce levels of uncertainty (Debyser et al. 2011), increase student confidence when talking to seriously ill recipients of care and have lasting impact on interpersonal skills (Agnew and Duffy 2010; Maughan et al. 2001). Long-term learning regarding the importance of empathetic understanding and a consumer-centric approach to care were further reported (Klein et al. 1999; Rush 2008; Wood and Wilson-Barnett 1999). It is unclear however, how these long-term benefits on learning were evaluated. The current minimal evidence-base limits understandings of

midwifery student's perspectives. Given the juxtaposition within conventional services of the medical and midwifery models of care discussed in Chapter 2, it may be that it is the tenacity, vision and action of the individual that retains this approach to care (Thomas 2007).

While students generally embraced consumer input into learning, some concerns about 'tokenism' were raised and some students challenged the representativeness of invited consumers (Khoo et al. 2004; Wood and Wilson-Barnett 1999). This was particularly evident in research by Gutman et al. (2012), where students questioned the ability of an invited consumer with severe learning disabilities to effectively contribute to their learning, suggesting this was tokenistic in nature. Consumer contributions were sometimes seen as antagonistic and confrontational, particularly when services were portrayed negatively (Happell and Roper 2003; Ikkos 2003; 2005). Some students expressed discomfort about consumer involvement, although this decreased with exposure over time (Ikkos 2005; Wood and Wilson-Barnett 1999); others expressed feelings of embarrassment (Costello and Horne 2001; Walters et al. 2003) or anxiety (Ottewill et al. 2006).

Students generally welcomed consumer involvement and participation in educational assessment activities (Davies and Lunn 2009; O'Donnell and Gormley 2013; McMahon-Parkes et al. 2016; Munro et al 2012). However, concerns and anxieties about consumer abilities to effectively contribute to the assessment task were commonly raised. Students in a study by McMahon-Parkes et al. (2016) were unsure about the usefulness of consumer feedback, raising concerns about its authenticity in terms of being an accurate representation of their true opinions. Students in Bailey's (2005) study felt consumer feedback on their assessed work would not motivate them to change their practice and similarly, feeling ambivalent about its helpfulness. Apprehension about the potential impact of 'unfair' feedback following transitory episodes of care (McMahon-Parkes et al. 2016), due to lack of consumer training or because of their mental state (Debyser et al. 2011), was also reported. Some students in research by Stickley et al. (2010) expressed similar opinions, dismissing critical consumer feedback as inaccurate and 'skewed' by their mental health. Interestingly, following

subsequent review of this student work by educationalists, student comments were upheld and the work re-graded. Further work in this area is needed to inform a currently absent midwifery evidence-base.

3.3.3 Conclusions drawn

The literature discussed in this section highlighted consumer concerns regarding the content of health and social care professional education. Resonating with contemporary policy directives, the need for greater focus on the humanisation of care (HMSO 2013; NHS England 2016), and curricula embracing holistic woman/consumer centric approach (NMC 2009; 2015a) was strongly espoused. Consumers welcomed the opportunity to contribute to student education and felt it important that theoretical provision was complemented by their perspectives, offering students insights into the lived reality of the consumer experience. However as little evidence was sourced with women playing a significant part, it is unclear how much or if women want to contribute or be involved in student midwife education.

Consumer input into teaching was reported as highly beneficial and rewarding for both consumers and students. Students enjoyed hearing the consumer experience stories and found it a powerful learning experience that had long-term impact on their practice. It promoted reflexivity, engendering a more holistic empathetic consumer-centric approach to care. Students reported enhanced interpersonal skills, self-awareness and greater confidence in working in partnership with consumers. These are all concepts associated with quality woman-centred maternity care (HMSO 2013; NHS England 2016). However, the current absent evidence-base limits understandings of midwifery student's perspectives and more work is needed. Although the literature elicited relatively little information about consumer involvement in the evaluation of student work [Table 3-1], this was recognised as a source of angst for both consumers and students. Giving critical feedback on performance whilst being in receipt of care, particularly where pre-developed relationships with students existed, engendered emotional work for consumers. No information however, was available as to

women's experiences of this type of involvement, and thus more work is needed in this area.

3.4 Women's evaluation of student midwife rendered care

UK midwifery educational programmes must be effective in developing competent practitioners who are fully prepared to provide care for women in the real world of midwifery practice (NMC 2009). Consistent with the international definition of a midwife, this requires curricula to prepare students to work within their full scope of practice (ICM 2011). Reflecting the move towards woman-centred care within the NHS in recent years, this includes the ability to work as the woman's primary care provider in a continuity of care model. Indeed, as highlighted in [1.2], curricula provision must now include the opportunity for student midwives to experience continuity of care through caseload practice (NMC 2009).

Student midwife caseload practice is embedded within a tripartite relationship between the woman, midwife and student and occurs within the fusion of theory and practice. It is about the application of theory to practice in an environment where the student is more likely to work independently with indirect rather than direct mentor supervision. Eliciting the meanings women attribute to receiving continuity from a known student via educational initiatives, and the significance this has on their childbearing experience, is important if students are to be effectively prepared for this learning strategy. This section is the in-depth analysis of literature that relates to my study.

The literature review elicited eight papers reporting women's experiences of student midwife involvement in their maternity care. Five studies used qualitative methods to elicit women's views, two a postal questionnaire, and one a Q-methodological approach. Two studies were conducted in the UK, four in Australia, and two in Norway (Appendix 2, Table 4).

While the two UK studies reported women's experiences of student midwife rendered care, the focus was on isolated episodes of care rather than continuity across the woman's childbearing event. In a phenomenological qualitative study, Snow (2010) explored women's experiences of receiving

care from student midwives during labour and birth. The timing of data collection is not provided, possibly due to journal article wordage constraints but it is likely women's experiences were elicited retrospectively. It is also not clear if the women experienced care from more than one student during their labour and birth. Finnerty et al. (2007) used qualitative telephone interviews to elicit women's views of clinical teaching following an episode of student care. Whilst data collection occurred across the childbirth continuum, the sample included women at varying stages of pregnancy and birth and timing was in relation to when student care had occurred. The studies provide insights into women's experiences of student midwife involvement within their care. However, this has limited value in terms of my study, as both studies focus was on isolated episodes of care from various students rather than continuity of care from one student midwife carer.

Six papers reported women's experiences of continuity of care from a known student midwife across the childbearing continuum. The two Norwegian studies specifically aimed to elicit understandings of how relational student continuity during the childbirth process may influence the woman's birth experience (Dahlberg and Aune 2013) and postnatal visit (Aune et al. 2012). The four Australian studies sought to explore women's experiences of relational student continuity across the childbearing continuum (Browne and Taylor 2014; Kelly et al. 2014; Rolls and McGuiness 2007; Tickle et al. 2016). However, data were not collected throughout the woman's childbirth experience. Women were questioned on one occasion either by qualitative interview or postal survey at some point following the birth. This approach may capture the type of relationships that developed within the student-woman dyad but not how they evolved or changed as pregnancy progressed. Issues of continuing significance rather than those of a more transient nature are also more likely to have been revealed (Cordon and Millar 2007; Miles et al. 2014). Furthermore, these studies were all conducted in retrospect which introduces an element of women's' experiences having been reworked creating meaning after the event (Simkin 1992; Waldenstrom, 2003). It is noteworthy that in Browne and Taylor's (2014) study, women's retrospective recall of experiences occurred up to three years after the birth.

The participants in the Australian and Norwegian studies varied but always included women who had experienced a continuity model via a midwifery educational initiative. One study elicited both men's and women's perspectives (Aune et al. 2012). Another explored the experiences of Australian Aboriginal women aged between 19-39 years (Kelly et al. 2014). Some studies did not seek to explore experiences from a specific group and included a broad range of participants in terms of parity, age and social demographics (Browne and Taylor 2014; Dahlberg and Aune 2013; Tickle et al. 2016). Aune et al. (2012) did not provide this information, possibly because the study was a pilot project. However, Dahlberg and Aune's (2013) retrospective Q-method study sample of 23 women aged between 23-44 years were drawn from the Aune et al. (2012) pilot cohort of 58 women and included primipara and multipara. While a proportion (42.7%, n=151) of the 354 respondents in Browne and Taylor's (2014) study received continuity from their primary maternity provider, it is of note that the majority (97.5%, n=230) of the 237 respondents in the study by Tickle et al. (2016) were clients of a midwifery continuity model. This over representation illustrates commendable growth in Australian women's access to provision of continuity but limit transferability of findings to a UK context, where currently the majority of women receive more fragmented care.

Although some studies reported women's experiences of midwifery educational continuity initiatives, variance existed in the organisation of these models. The two Norwegian studies reported on an initiative where six postgraduate students worked in a team continuity model. One of the six students provided care during birth and attended the one home postnatal visit (Aune et al. 2012; Dahlberg and Aune 2013). Current different educational programmes and expectations regarding organisation of continuity for UK student midwives (NMC 2009) and the different cultural context of Norway thus limits transferability to a UK context.

Four studies explored Australian women's experiences of one-to-one continuity models with undergraduate students. Kelly et al. (2014) explored the experiences of Aboriginal women who had experienced continuity with an Australian Aboriginal and/or Torres Strait Islander midwifery student. Given

the focus, study findings have limited transferability to a UK educational context. Two studies used postal surveys to elicit the experiences of women who had been paired with either a first or third year student (Browne and Taylor 2014) or student from any of the three educational year levels (Tickle et al. 2016). Both studies reported a low response rate 35% (n=354/1008) and 34% (n=237/698) respectively. Findings may not therefore be representative of all women who had agreed to student continuity via these initiatives. Thus, findings cannot be generalised in any way. It is also noteworthy that proportionally more responses in Browne and Taylor's (2014) study were from women matched with a first-year student (n=215) than with third year students (n=106). Rolls and McGuiness's (2007) qualitative study reported on the experiences of seven women paired with a student from any of the three undergraduate educational year levels. The role of students in this educational model was primarily observational, which contrasts with that of caseloading students in the UK (NMC 2009).

The majority of studies drew on qualitative methods to elicit women's views. One study used a Q-method (Dahlberg and Aune 2013) which can be understood as located within qualitative traditions, but is often contested as such given its methodological pluralism (Lazard et al. 2011). Pre-prepared statements drawn from women's experiences were ranked and analysed statistically (Dahlberg and Aune 2013). While this approach allowed comparability of experience, it restricted the true nature of qualitative inquiry in which women can offer subjective opinions and share experience stories. Stories describe life experiences, the meanings that have been attributed to them, and how these have been constructed within personal social contexts, and thus present a holistic representation of experience (Josselson 2011; Polkinghorne 1988). One study used focus group interviews to elicit women's views (Aune et al. 2012). While social dynamics amongst focus group participants may stimulate interaction, the dynamic engendered can also stifle individual story sharing through over-dominance of some group members (Holloway 2008). Although Kelly et al. (2014) used story sharing within the interview process, this occurred at some point following the birth and women were guided as to the story topic. Thus, there is need to capture

women's experiences and meaning making through the powerful medium of their unrestricted personal stories, in real-time, as they journey through pregnancy into motherhood.

Discerning themes of significance was somewhat challenging, given the limited body of available work and variety of caring contexts encompassed within the papers. However irrespective of approach, study focus or educational model, two major overarching themes appeared constant:

1. Wanting to connect
2. A valuing of students' presence and support

Women's perceptions of the value and benefits of these constructs appeared magnified in their reporting continuity of care by a known student midwife. The discerned themes are explored below in [3.4.1] and [3.4.2] respectively. The section concludes with summarisation of themes drawn from the discussion that may have resonance for this study [3.4.3].

3.4.1 Wanting to connect

Pregnancy and birth are unique normal life events imbued with socio-cultural significance and meanings. It is a time of transition that profoundly affects every aspect of a woman's life. The evidence considered in Chapter 2 highlighted how irrespective of model of service accessed, continuity of care by known midwives across the childbirth experience was highly valued by women. The significance and benefits to women of this type of care in terms of childbirth outcomes and satisfaction are dynamic and evident. Central to this satisfaction was the opportunity to develop mutually reciprocal relationships with midwifery caregivers. The evidence-base considered here is however in relation to women's experiences of student midwife rendered continuity. An emergent major theme centred on women's desire to connect and forge relationships with their student caregivers.

All eight studies evidenced a desire amongst women to form connective bonds with their student caregivers (Aune et al. 2012; Browne and Taylor 2014; Dahlberg and Aune 2013; Finnerty et al. 2007; Kelly et al. 2014; Rolls and McGuinness 2007; Snow 2010; Tickle et al. 2016). Gaining this sense of

connection was important for women irrespective of duration of the student's level of involvement. Snow (2010) reported women felt a sense of solidarity with the students caring for them during labour, a bond founded on both being novices, a 'mutual newness'. Women in the continuity of carer educational initiatives described the relationships they developed with their student as 'genuine', 'personalised' and 'trusting' (Aune et al. 2012; Browne and Taylor 2014; Kelly et al. 2014). Developing this type of relationship was an important need particularly for Australian Aboriginal women who felt their student addressed cultural needs often not met by the primary healthcare system (Kelly et al. 2014). Feelings of companionship and, for some women, friendships with students were reported (Browne and Taylor 2014). Building such positive relationships with students was also important to men, particularly during labour and birth (Aune et al. 2012). Forging this relational connection engendered a desire amongst some women to actively contribute to the student's education (Browne and Taylor 2014).

The majority of women felt they benefitted from relational continuity with their students. Some felt more comfortable to ask questions and seek information (Browne and Taylor 2014; Kelly et al. 2014) and many felt the student would act as an advocate on their behalf and ensure their wishes were communicated to the wider team/healthcare system (Browne and Taylor 2014; Kelly et al. 2014; Rolls and McGuiness 2007). The experience engendered feelings of empowerment and self-confidence amongst women and enhanced their satisfaction with childbearing and early parenting experiences (Aune et al. 2012; Rolls and McGuiness 2007; Tickle et al. 2016). However, some found it difficult to engage or develop the relationship they had envisaged with the student (Browne and Taylor 2014; Dahlberg and Aune 2013) and would not recommend it to others (Browne and Taylor 2014). For some, relational continuity evoked an added sense of burden of responsibility and anxiety about letting the student down if pregnancy complications developed or the student missed the birth (Browne and Taylor 2014).

3.4.2 A valuing of students' presence and support

Within contemporary practice, focus is placed on the primacy of humanised, woman-centred holistic care. The evidence considered in Chapter 2, highlighted how relational continuity facilitated this provision. The benefits of being able to connect with women via these models are dynamic and evident. Through knowing the woman, midwives are more able to meet women's emotional and physical support needs and empower them to exercise autonomy during their unique childbearing journey. The evidence-base presented here is, however, in relation to women's experiences of student midwife rendered continuity of care. An emergent major theme centred on women's valuing of the student's presence and support.

During care-giving, students were consistently reported as kind, supportive and helpful (Browne and Taylor 2014; Kelly et al. 2014; Rolls and McGuiness 2007; Snow 2010; Tickle et al. 2016) and student interpersonal and caring abilities were highly rated (Browne and Taylor 2014; Kelly et al. 2014; Snow 2010; Tickle et al. 2016). The women appreciated the students' presence and offers of physical and emotional support (Browne and Taylor 2015; Finnerty et al. 2007; Rolls and McGuiness) particularly during labour and birth (Aune et al. 2012; Dahlberg and Aune 2013; Kelly et al. 2014; Snow 2010). The student's continuous presence during the birth was equally valued by the women's partners (Aune et al. 2012). In studies reporting continuity of carer initiatives, women felt students intuitively knew what support they required, and exhibited perceptive knowledge about the care they wanted during labour (Kelly et al. 2014; Rolls and McGuiness 2007).

Having relational continuity evoked a sense amongst women that the student was 'for them', that they were the main focus of the student's attention (Aune et al. 2012; Browne and Taylor 2014; Rolls and McGuiness 2007). Being the main focus of student care was identified as important (Aune et al. 2012; Dahlberg and Aune 2013). Women reported that students would go the 'extra mile', and offer time, information or practical assistance to ensure identified support needs were met (Browne and Taylor 2014; Kelly et al. 2014). Having the opportunity to "talk about" their labour and birth experience with the student was particularly valued by women (Aune et al 2012; Browne and

Taylor 2014). It could be argued the benefit of this may have been embellished, given the limited opportunity to debrief for women in fragmented models of care.

Some women however, reported dissatisfaction with their educational continuity experience. Some had concerns about students they perceived as either overly or under confident (Tickle et al. 2016). Others felt it was not as good as they had anticipated and reported a lack of gratitude (Browne and Taylor 2014) or commitment from the student (Browne and Taylor 2014; Tickle et al. 2016). Women were particularly disappointed if the student missed the birth or failed to attend pre-arranged antenatal appointments (Tickle et al. 2016). A positive correlation was reported between women's satisfaction with their student continuity experience and number of student attended antenatal and postnatal visits. Where students attended more than seven antenatal and five postnatal visits, women reported higher levels of satisfaction (Tickle et al. 2016). This is a number that may fall outside the remit of UK national guidelines (NICE 2014) and educational programme stipulated requirements.

3.4.3 Conclusions drawn

The majority of the research exploring women's experiences of student midwife rendered care collected data retrospectively at some point after the woman's childbirth event. The reliability of findings in such studies is dependent on women's memory and ability to recall student caring abilities and their thoughts and feelings at the time, which Bowling (2014) argued is limited. Findings from the Simkin (1991; 1992) American longitudinal study exploring women's long-term memories of their first birth experiences do not support this argument. Women were recruited to the study in 1968 and 1974 (n=20). A mixed methods approach was used, and data were collected on three occasions; twice via a questionnaire, administered a few weeks after the birth and over 20 years later in 1988 and 1989, and individual interviews following return of the second questionnaire. The study reported women recalled vivid memories of childbirth events including how they felt and the way in which they were treated (Simkin 1991). Although women's memories

of the events of their births were reported as generally accurate years later, interestingly the significance they attached to negative events intensified and increased over time, whereas, the positive aspects remained consistently positive (Simkin 1992). However, a more recent Swedish longitudinal cohort study Waldenstrom (2003), did not support the Simkin (1991; 199) findings. Women were recruited to the study from all Swedish antenatal clinics (n=2,428) and data were collected by a questionnaire survey administered on three occasions; in early pregnancy, two months and one year following the birth. The study reported great variation in women's memories of their labour and birth and that woman's memories changed over time. While a small proportion of women (16%) reported their experience as more positive at one year compared with two months after birth, generally the overall birth experience became more negatively reported over the data collection period (Waldenstrom 2003). Moreover, in agreement with the findings of Simkin (1992), Waldenstrom (2003) reported women's memories of negative events increased in significance and intensity over the time of the data collection period. For some women in the research conducted by Tickle et al. (2016), the time interval between their experience of student continuity and reporting of experience was in excess of one year. Browne and Taylor (2014) reported a time gap of up to three years after the birth. This suggests subsequent events and experiences could colour women's memories providing a different and perhaps more negative perspective of their continuity experience from how it felt at the time and subtle nuances in the data may have been lost.

In the six studies reporting educational relational continuity initiatives, the vast majority of women described the relationships developed with their student in positive terms. Some women however, did not develop the relationship anticipated [3.4.1]. Data collection in these studies occurred on one occasion rather than contemporaneously across the women's childbearing journey. Critical subtleties and nuances surrounding the nature of the perceived relationships developed may not have been captured (Cordon and Millar 2007; Miles et al. 2014). Little understanding has been elicited as to why women agree to be paired with a student, how the

relationships within the student-woman dyad evolve or change over time or if these are perceived as reciprocal by women. Much of the work undertaken drew on qualitative methods to explore women's experiences. However, while a variety of approaches to eliciting women's views were taken, the opportunity for women to share their experience stories was limited. Kelly et al. (2014) used story sharing as a culturally appropriate way to elicit Australian Aboriginal women's experiences. However, the women were not invited to share a story of their choice but guided as to story topic. Thus, there is need to capture women's unrestricted stories in real-time as they move through pregnancy and motherhood, to gain holistic understandings of relational continuity with a student midwife.

Women's experience lies at the heart of student education and is central to quality practice provision. Understanding the meanings women attribute to receiving continuity of care from a known student is an important priority, as educationalists work to prepare students for the experience and future professional practice. The literature review elicited very little work exploring women's experiences of this educational strategy, suggesting this is an under explored area. While the studies reviewed in this chapter shed light on Australian and Norwegian women's experiences of relational continuity with students, no information is available as to UK women's views. Given it is national policy that students gain this experience (NMC 2009), more work is needed to inform a currently limited evidence-base for best practice.

3.5 Study aims and objectives

The literature review elicited very little work exploring women's experiences of receiving continuity from a known student via educational initiatives, with little known about why women agree to be paired with a student, how the relationships within the student-woman dyad evolve or change over time or if these are perceived as reciprocal by women. In response, my study aimed to address this lack of knowledge and these understandings informed the study research aims [3.5.1] and objectives [3.5.2].

3.5.1 Research aim:

To explore the experiences of women who have agreed to be part of a student midwife's caseload.

3.5.2 Research objectives:

To hear women's personal experience stories to identify:

- How the relationship within the student/woman dyad may evolve and/or change over the course of the childbearing continuum through provision of continuity of care and carer via student midwife caseloading.
- Women's perceptions of the significance of receiving care provision from a known student midwife via student caseloading, and how this may have impacted on their childbearing experience.
- How the women's experiences of student midwife caseloading informs midwifery education and practice development via the celebration of good practice and identification of areas requiring enhancement.

The next chapter, Chapter 4, discusses the methodology and methods that addressed the study research aims and objectives.

Chapter 4 Research methodology and methods

4.1 Introduction

The literature review revealed consumer interest and concerns regarding health and social care professional education. It exposed a rather limited body of work in which women played a significant part. The review also showed a paucity of information regarding women's experiences of midwifery student educational continuity initiatives and student midwife involvement in their childbearing experience *per se*. A gap in research was identified in that no one had captured women's unfolding experiences of being part of a student midwife's caseload in real-time as they moved through their childbearing event, and the meanings and significance of this for them.

Designing a way to hear women's experiences of receiving continuity from a known student midwife, and answer the study research objectives, was crucial. This chapter sets out the research design for my study and explores the philosophical framework within which it is based. It then discusses the methods of data collection employed along with my personal reflective experiential review of their application. Ethical issues relevant to the conduct of the study are then described and addressed. The chapter concludes with introduction preview to the study analytical framework found in Chapter 5.

4.2 Overview of the study design

To capture women's experiences of relational continuity from a student midwife, in-depth semi-structured interviews were used within a longitudinal framework. Data collection occurred on three occasions: twice during pregnancy, and once in the postnatal period. Rather than isolated accounts, the data gathered at these points in time were viewed as a continuing story that unfolded over the woman's childbearing event. Because the longitudinal design mirrored the woman's student caseloading journey, it enabled the interviews to capture episodes as her story of experience unfurled. As Miller (1998, p60) noted this gave 'a fluidity' to the data collection, which may not have been accomplished in a one-off interview.

All interviews were digitally audio-taped and transcribed verbatim prior to analysis. Contemporaneous field notes were retrospectively documented after each interview. A strategy, discussed in detail in Chapter 5, was developed using a 're-storying' framework comprising three phases to analyse the data. The first phase involved analysis of the three interview transcripts of the individual woman's unfolding story. The second phase involved the construction of an interpretative story or personal experience narrative for each participant. The final phase was a synthesis of the data to construct a collective story that encapsulated emergent narratives themes of significance to the women as a group. Through this framework, I sought to explore how women develop and maintain relationships with the student and their supervising midwife mentor, how they report the care provided in relation to their holistic needs and how and if they link the continuity of care by the student with their outcome experience.

4.3 Philosophical framework and methodology

As highlighted in Chapter 2, continuity of carer as a model for provision of maternity care has been vigorously promoted in the UK over the last twenty-five years. Its promotion has been based on the premise that continuity is one of the fundamental principles underpinning woman-centred care (DH 1993; DH 2007). Placing focus on the woman, partnership working, and a valuing of her experiences are central concepts within woman-centred approaches (DH 1993). To capture women's experiences of being part of a student midwife's caseload, it was felt necessary to choose a research method that had congruence with this ethos.

While it was recognised that in sharing experience stories women may express elements anywhere on a continuum of satisfaction with their care provision, it was not the intention of this study to measure or quantify this. It is generally recognised that effectively measuring women's satisfaction with their care experiences is fraught with difficulties as the concept of satisfaction is complex. There is lack of agreement on its definition (Avis et al. 1995), it is influenced by a number of factors such as personal values, previous experiences and expectations (Bramadat and Driedger 1993; Brown and

Lumley 1997), and is therefore difficult to deconstruct or measure as a definable outcome. Women also tend to value existing services over those of which they have no experience, further limiting lessons that can be learned from satisfaction surveys (Green 2012; van Teijlingen et al. 2003). The focus in this study was on individual women's perceptions, experiences and uncovering meanings of significance for them. With this in mind, the study did not seek to make attempts at inference or association but to listen to women's stories of care through the childbirth process to identify narrative themes of significance. A qualitative approach for the study was therefore selected as in harmony with a 'with woman' ethos, it would "enable the women's voices to be distinct and discernible" (Miller 1998, p.60).

4.3.1 Choosing an appropriate research method

Midwifery is essentially about human relationships and the ability to work with women throughout the childbirth continuum. Students new to educational continuity schemes often report a lack confidence (McKellar et al. 2014), and anxiety about how they might be received by women (Rawnsdon 2011a). Implementing clinical skills in the practice setting can be challenging for students, particularly when working in new models of care and new environments (Gilmour et al. 2013; Houghton et al. 2013). Confidence, along with a conducive learning environment and positive mentor support, are primary enabling factors that positively affect a student's ability to implement clinical skills (Gilmour et al 2013; Houghton et al. 2013). Student self-esteem and confidence have consistently been shown to be affected by a mentor's attitude and experience (Begley 2002; Currie 1999; Gilmour et al. 2013; Hughes and Fraser 2011a; Liquirish and Seibold 2008). Quality of student-mentor interaction and relationship within a supportive environment are therefore fundamental to student confidence, comfort, and ability to engage in the continuity experience (Gilmour et al. 2013). Choosing an observation approach did not seem appropriate, as my presence as researcher could easily disturb and constrain relational interactions within the student-woman-mentor triad. Given my background as a midwife and an educationalist, I was also mindful of the possibility for students to feel that by being present I would in some way be evaluating or assessing their practice,

and the potential negative impact of this on their confidence and relational interactions with the women in their caseload.

In recent years, gathering stories for use as narrative research has made a significant contribution to the development of knowledge and practice within healthcare research and education. Whilst grounded theory aims to generate a theory that is grounded in the data (Creswell 2013) the focus for phenomenological research, is on describing the lived experience of participants of a particular common phenomenon or object of human experience (Holloway and Wheeler 1996). Receiving continuity of known carer via student caseload practice could, arguably, be considered a particular human experience, or phenomenon. However, the aim of phenomenologists is to reduce individual participant experiences with a phenomenon to a description of the universal essence or collective meaning of the experience (Creswell 2013). My aim in this research was to uncover the meanings and significance of being part of a student midwife's caseload to both the individual women within the study, and the women as a group via generation of individual and collective stories of experience. Commensurate with the underpinning ethos of this study [4.3], this would enable the women's voices to be holistically visible (Etherington 2004; McCormack 2004). Moreover, I felt the stories generated could provide a valuable resource with which to inform midwifery education and practice. Congruent with the aim of this study, the focus of narrative research is on the individual stories of experiences of a small number of informants to uncover aspects that have meanings for them (Chase 2005; Creswell 2013). Defined as 'a way of understanding experience' (Clandinin and Connelly 2000, p20), narrative research is an inductive, humanistic and holistic approach (Josselson 2011; Squire 2008). Consistent with the 'with woman' philosophy underpinning this study, this method recognises the participant as an active collaborator within the research process, as it is their story that is the focus of investigation (Oakley 1993; Squire 2008).

Furthermore, Josselson (2011) considers communication through telling stories to be a 'natural' human impulse that transcends cultures. From an early age, our caregivers/ parents/ guardians furnish our world with stories,

fairy tales, myths and legends. As we develop during childhood, narrative schemes have a central role in how we learn to approach the world and gather information (Mateas and Senger 2003). As adults, narrative schemes enable us to make sense of and give meaning to our worlds. By telling stories we connect and assimilate our experiences often orientating, shaping and reforming life events to express the sense we have made of them (Polkinghorne 1988). Thus, stories told can convey a holistic representation of experience. They describe life experiences and the meanings people have attributed to them, and how these have been constructed and linked within personal social and relational contexts (Chase 2005; Cortazzi 1993). Because we understand ourselves through the stories we tell, narratives are considered integral to the process of constructing ourselves and our on-going adaptive identities (Frank 1997; Freeman 2006). Story-sharing is therefore recognised as an embodied (Charon 2006; Ramirez-Esparza and Pennebaker 2006) communicative practice (Peterson and Langelier 2006).

As stories are a primary way in which we communicate and express the sense made from experiences and life transitions such as childbirth, the narrative approach enables understandings of the impact of care on care recipients (Holloway and Freshwater 2007). Hearing women's experience stories in relation to student midwife relational continuity (through listening to women) appeared to fit this study. Indeed, given its suitability for researching experiences over time (Polkinghorne 1995), and participant-centred ethos, choosing a narrative approach appeared most appropriate for the study.

Narrative research does not originate from a single heritage or theory rather it is described as a 'cumulative discipline' (Polkinghorne 1988, p71). This diversity has led to development of a broad range of approaches often linked and defined according to discipline while differences exist in the way in which the narrative concept is defined and utilised. The aim is to identify and record aspects of a person's life story and experience in their context (Josselson 2011; Polkinghorne 1988). The breadth of contemporary narrative research can be considered as a continuum with psychology and sociology resting in the centre, social linguistics at one pole and anthropology and social history the other (Riessman 2008). Embodied within this spectrum are widely

divergent theoretical views as to how narrative is conceptualised and studied.

Sociolinguist William Labov's seminal work classically illustrates one of the most obvious differences (Patterson 2008; Riessman 2008). At this end of the continuum research is event-centredness, focussing on particular past events recounted by the narrator and their representation (Riessman 2008). Based on the assumption that the core purpose of narrative is the recapping or summarisation of events, research work is text-centred. Here structure or syntax embodies meaning rather than context, and personal narratives are considered as story-text or discrete units of dialogue (Patterson 2008). In contrast, moving along the continuum research is experience-centred. Here, rather than events, personal narratives are treated as stories of experiences based on phenomenological assumptions that through stories, experiences can 'become part of consciousness' (Squire 2008, p41). In this approach, narratives are studied in context rather than as text (Georgakopolou 2006; Phoenix 2008).

Given the aim of this research was to hear women's personal stories of care experiences, an experience-centred narrative framework was adopted. This method is based on the assumption that narrative gives expression to personal internal representations of events or phenomena (Chase 2005). It is recognised that rather than remaining constant, these representations evolve and change over time and in relation to life situations (Squire 2008). Because stories shared are embodied constructs (Charon 2006; Ramirez-Esparza and Pennebaker 2006), Polkinghorne (1995) suggests narratives of varying lengths including those that have evolved through a series of interviews over time are explored. To gather data rich in depth and breadth a longitudinal component, encompassing the woman's student continuity experience (from pregnancy to the early weeks of mothering), was developed [4.2].

4.3.2 My positioning as researcher

As a mother, midwife, educationalist and active supporter of student midwife educational continuity initiatives [1.1], I brought a body of personal and professional knowledge and understanding to this research. I recognised

early in the research the importance of maintaining a reflexive approach regarding my position within the research process throughout conduct of the study (Guillemin and Gillam 2004; Mauthner and Doucet 1998). Integral to this self-scrutiny, was reflexive consideration of how my personal values, attitudes and experiences may shape my approach to conducting the study and to analysing the findings (Bold 2012; Cresswell 2013). This facilitated increased reflexive mindfulness of how my sociocultural identity and experiences might influence both women participating in the study, and my own interpretations of their perspectives on student caseloading.

Being reflexive enabled me to recognise how working within a narrative construct acknowledged the inter-connectedness of researcher and participant. Indeed, in this method it is important that I see myself as being “in the middle of a nested set of stories”, mine and the participants (Clandinin and Connelly 2000, p.63). This is because my life worlds and stories and those of the participant are lived and move within different social landscapes and contexts (Clandinin and Connelly 2000; Mauthner and Doucet 1998). This facilitated an increased awareness that assumptions about my sociocultural identity, as midwife, educator and mother may be made by women participating in the study, and of women by me. As a result, participants may not wish to be viewed unfavourably and modify what they say, and how they say it. It is therefore recognised within narrative approaches that stories shared at interview are co-constructed, a product constructed within a social process of speaker and listener interaction (Finlay 2002; Josselson 2011; Squire 2013). As Rosenthal (1993, p.64) highlights “narrators do not simply reproduce prefabricated stories regardless of the interactional situation”, they are tailored to whom it is narrated (Squire 2008). This aspect is addressed in discussion of study limitations [8.4].

It was further recognised that narrative methods call for reciprocal interactive researcher/participant relationships at interview (Chase 2005; Clandinin and Connelly 2000; Leamon 2009). In hearing the women’s story, Leamon (2009) presents the view that the researcher/participant relationship is central to the way in which the researcher, as listener, engages in it. The researcher relates to the story and in how the woman communicates her thoughts and

feelings, and is therefore significant to the quality of information generated. The nature of this collaborative relationship in narrative research is described as being akin to a professional friendship (Oakley 1993). Congruent with contemporary philosophy, parallels with midwifery practice can be drawn highlighting the importance of reciprocity in the interview relationship. Indeed, Bold (2012) cautions researchers such as me, who interview participants over an extended timeframe, to acknowledge the relationship they develop with the interviewee, as stronger feelings about them and their story can develop. This challenge remained with me throughout the research project and is explored further in relation to research ethics [4.7.2], data analysis [Chapter 5] and personal reflective review of research methods [4.6].

Being reflexive enabled me to recognise that being a member of the group under exploration is advantageous when working within a narrative construct. This is because the people who participate within the research are viewed as embodiments of lived stories (Charon 2006; Clandinin and Connelly 2000; Ramirez-Esparza and Pennebaker 2006) and to understand their story, it is necessary to understand the people who construct it. As a woman and a mother, I was well placed to understand the guiding principles and language used by the women who participated in the study. However, it was important I developed strategies that facilitated constant scrutiny throughout each stage of the research project to ensure my ability to hear what women's stories were telling me was not clouded by my professional and personal knowledge (Creswell 2013; Mauthner and Doucet 1998). This was facilitated by my fervour to hear women's unadulterated experiences, feelings and opinions of what it is like to be part of a student midwife's caseload and the meanings of this for them. To aid this process I maintained a personal reflective journal as a means to compare and contrast my perspectives with the data collected and taking care to ensure compliance with professional standards re confidentiality (NMC 2015b), explored these with the women participating in the study at subsequent interview(s) [4.5.1]. During analysis of the data, I consulted with my research supervisors, they acted as 'sounding boards' to confirm those concepts truly generated by the data from those based on more personal perspectives. In addition, I have clearly

detailed the study analytic framework and made the connections constructed through the analytic processes undertaken explicit for readers of this work in Chapter 5.

4.4 Sample and recruitment

4.4.1 Choosing a research location

Given the variety of ways student midwife continuity initiatives have been integrated within contemporary UK undergraduate curricula generally (NMC 2010) and the longitudinal component of this particular project which called for three episodes of data collection, I needed to consider carefully the most appropriate research location for the study. Given the length of its experience in offering a curricular approach to student caseloading that paralleled midwifery one-to-one models of continuity of carer (Lewis et al. 2008), a university in the South of England appeared an effective choice. However, the decision to choose this location for the research project was not taken lightly given my job role. Although my role in the project is that of researcher, it is important to acknowledge that I am also employed as a full-time lecturer at the research university [1.1]. My reflective decision-making to discount HEIs where I was not known and that embraced a similar curricular approach was in part informed by the pragmatics of the research. I needed to be able to travel easily to each participant's home at a time of day suitable to the woman while meeting the needs of my full-time job role. Arguably, women's participation may be problematic given the context of childbirth and the likelihood of family and/or work commitments. I was mindful that a number of women wishing to participate in the study might prefer an interview time outside of office hours for example, during the evening or at the end of the working day.

Choosing this location for the research presented benefits in that I was well placed to understand contextual issues and so to comment. I was mindful however of the potential for students to feel that I would in some way be evaluating or assessing their practice by accessing and listening to women in their personal caseload. Because of this, I felt it important to recruit

participants who received caseloading care from students based in a different practice locality to my clinical link area although the study did not require midwifery students to participate or be directly involved in any way within the research process. I felt it important to inform students clinically placed in Sea Town hospital, the locality from which participant recruitment would occur, who were about to start caseloading practice of the study prior to initiation of participant recruitment. Each student was given a leaflet informing them of the research objectives and process (Appendix 3) by a senior lecturer based within the research locality, and therefore known to the students. This lecturer acted as a resource for students and responded to any questions that arose.

At the research university, students commence caseloading practice during the last eighteen months of their midwifery education. Students are expected to commit to be on-call for the woman's labour and birth (from 37 weeks gestation) and individually negotiate the timing of the experience and size of caseload undertaken (Fry et al. 2008). During the experience, students are both supported by a midwifery lecturer, who links to their clinical area, and are supervised by a community-based sign-off mentor, who is the woman's primary care provider. This practice supervision is initially direct but as the student matures in their caseloading experience and demonstrates professional understanding of their own and their accountable mentor's role and practice responsibilities, through individual negotiation may become increasingly indirect (Fry et al. 2008). With increasingly indirect supervision, the student is enabled to take on greater decision-making and personal responsibility while working within their scope of practice (NMC 2009). While students negotiate to attend women in their caseload for scans, during labour or urgent events arising antenatal/postnatal (Fry et al. 2008), the woman's safety is always paramount, and she would be guided by the supervising midwife to access relevant care pathways as appropriate (NMC 2015b). Non-urgent attendance is negotiated with the women around the student's university timetable and students negotiate flexible working patterns within their shift allocations to facilitate holistic care provision for the individual women in their caseload (Fry et al. 2008).

4.4.2 Identifying suitable participants: Inclusion and exclusion criteria

The study specifically sought to follow and capture women's experiences of continuity of care provision from a student midwife throughout pregnancy, labour and birth and the early days of parenting. Because the aim was to gather rich in-depth data from those best placed to share experience stories of this phenomenon (Creswell 2013), women in the first trimester of pregnancy who had agreed to be part of a student's caseload were invited to participate.

It was important women understood the study and the implications of participation (Corti et al. 2000) so that consent could be freely given, and women could participate in a meaningful way. This aspect is explored further in relation to participant recruitment process [4.4.3], and ethical considerations for the study [4.7.1]. Only women able to communicate in written and verbal English were invited to participate, as unfortunately no funding for interpreter services was available within this PhD study. Young women under the age of 18 years were also excluded from participation within the study, as they may be considered vulnerable. Likewise, women who experienced early pregnancy loss or had serious obstetric, medical, social or emotional complications were not included.

It was recognised that the self-selecting sampling method chosen [4.4.3] could result in several women who were part of a particular student midwife's caseload registering an interest to participate. Given the study did not seek to evaluate women's experiences of an individual student but gather a broader breadth of experiences from women, if this situation had arisen, no more than two respondents would have been accepted onto the study. These criteria are articulated in Table 4-1, p. 103.

Table 4-1: Inclusion and exclusion criteria

Inclusion	Exclusion
Part of a student midwife's personal caseload	Not involved in the caseloading initiative
In the first trimester of pregnancy	Gestation above 12 weeks
Aged 18 or above	Aged under 18
Communicates in English	Cannot communicate in English
Maternal and fetal wellbeing	Maternal ill-health, pregnancy complications, early pregnancy loss
Maternity care accessed from Sea Town hospital or Parson's Field hospital	Outside research locality practice areas

4.4.3 Inviting women to participate in the study

I identified target community areas for recruitment within Sea Town hospital catchment areas encompassing inner city as well as other areas within the conurbation. Having gained ethical support (South Central Research Ethics Service 2011) and access permission from relevant gatekeepers [4.7.1], participant recruitment began. I met with community midwives working in the target areas who were the woman's named midwife and the caseloading students' supervising mentor, to discuss the study. A leaflet giving an overview of the study and my contact details (Appendix 4) was also supplied. A number of these midwives agreed to act as local recruiters for the study and distribute 'invitation packs' to women who met the inclusion and exclusion criteria [4.4.2; Table 4-1], following their agreement to be part of a student midwife's caseload. The invitation pack comprised an invitation letter with reply slip (Appendix 5), comprehensive information leaflet (Appendix 6) and stamped addressed envelope.

Following receipt of the invitation pack women had a three week period on which to reflect upon the information provided and seek further information. If a woman felt she would like more information or wanted to discuss any aspect of the study she could contact me, or either of my supervisors, directly. Women wishing to participate in the study registered their interest by

returning the reply slip to me. This ensured that the women who agreed to participate would only be known to me to help maintain their anonymity. I received five responses from women over three student cohorts over successive years (October 2011-July 2013) one of whom subsequently withdrew her consent to participate, which was felt insufficient to generate meaning. The decision to extend recruitment to Parson's Field hospital (NHS Trust B) was taken following confirmation of NHS ethical support for this adaption from South Central Ethics Committee. Students clinically placed in the locality were informed of the study as previously discussed [4.4.1] and, as in Sea Town Trust, midwives working in Parson's Field Trust community areas agreed to act as recruiters for the study. A further two women receiving maternity care from the locality consented to participate within the study.

On receipt of a response from each prospective participant, I arranged to meet with them in their home at a time and date convenient to them. At this meeting, I discussed the research study in more detail and answered any questions the woman and her partner had. I re-iterated the information regarding maintaining anonymity of participants contained within the information leaflet and asked the woman to choose her own alias name. Cox and McDonald (2013, p.230) report researchers often misperceive participants understanding of 'the bargain struck' on agreement to enter research. Holding this preliminary meeting provided an opportunity to enable my understanding of the woman's comprehension of the research process to come, anticipated level of involvement, and what participation in the study would entail. This was important, given the longitudinal study component as engaging in social research inevitably constitutes an intrusion into people's lives (Guillemin and Gillam 2004).

The meeting provided an opportunity to introduce myself to the woman and her family and inform them that in accordance with university guidelines, interview audio-recordings would be stored for a two-year period and transcripts and analysis for a five-year period on completion of the study (Bournemouth University 2009) if following this discussion, the woman was willing to participate within the study. Before our meeting concluded, I gained

her written consent to be interviewed on three occasions; twice during pregnancy and once following the birth, and for these interviews to be audio-digitally recorded (Appendix 7). A date and time convenient to the woman was then arranged for the first interview story-sharing episode.

4.4.4 An introduction to the women who participated

A self-selecting purposeful sample of seven pregnant women, who met the study inclusion criteria [4.4.2] and had agreed to be part of a student midwife's caseload, was recruited to the study. Using this number of informants for the study was appropriate given the qualitative narrative framework of the study, which called for three in-depth interviews (Chase 2005; Creswell 2013; Squire 2008). The sample comprised primiparous (first pregnancy) and multiparous (second and subsequent pregnancy) women of differing ages and social backgrounds [Table 4-2, p.107]. Maternity care for each of the women recruited was provided by midwives employed in the research locations, either 'Sea Town hospital' (NHS Trust A) or 'Parson's Field hospital' (NHS Trust B). Of the seven women who agreed to participate, six were interviewed on three occasions. As previously discussed, one woman chose to terminate her engagement and withdrew from the study before the first antenatal interview.

In narrative work, the aim is not to produce data that can be generalised to the wider population but to elicit individual participant "experiences as expressed in lived and told stories" (Creswell 2013, p.70). The focus is on uncovering the meanings and sense-making of experiences participants communicate through stories-shared (Chase 2005). The individuality and uniqueness of each woman who participated within this study adds a 'richness', suggesting the possibility that multiple perspectives and diverse views on the experience of being part of a student's caseload could be gathered (Clandinin and Connelly 2000). Stories gathered are studied in context, as situated within personal socio-cultural and historical perspectives (Josselson 2011; Squire 2008). Understanding of the narrative context of the woman and her evolving story is therefore important.

The six women who participated in the study are represented here with their chosen alias names. On entry to the study, Erin, Anna and Ami were pregnant with their first child. Jody was expecting her second child, Emma her third and Kelly her fourth. Kelly had previous experience of being part of a student midwife's caseload with her second child. Three women were married and three were in long-term relationships, two of whom cohabited with the father of their child. Kelly lived alone with her children and Ami with her partner at her parent's house. Four of the women worked before the baby's birth. All of the women described themselves as white British.

Anna planned to birth her baby at home, the other five in hospital. Jody and Emma chose a co-located 'low risk' midwifery unit. Due to pre-existing medical condition, Ami planned to birth by elective caesarean section. Erin described herself as 'high risk' and planned to birth in a central maternity unit. Primary maternity care for five of the women was provided within a non-integrated model where midwives worked either in the community or hospital environments. Anna received a 'team approach' to care by the local homebirth midwifery team.

Table 4-2: Participant characteristics

Alias	*Age	*Parity	Partnership	Occupation	Partner occupation	Home
Jody	34	1	married	Claims advisor	Fire fighter	House
Erin	25	0	married	Hair dresser	N/A	Flat
Kelly	25	3	partner	House wife	N/A	House (social housing)
Emma	28	2	married	House wife	Asbestos technician	Flat (social housing)
Lydia	22	1	partner	Factory worker	Factory worker	House (living with parents)
Anna	38	0	partner	Retail assistant	Administrator	House
Ami	20	0	partner	Trainee optician assistant	Mechanic	House (living with parents)
*On entry to the study						

4.5 Data gathering process

4.5.1 Hearing the women's experience stories

In narrative research, data collection is primarily focussed on gathering participant oral stories, although other documentary sources can be used (Reissman 1993; Creswell 2013). In this study, the women's stories were gathered through the use of semi-structured interviews (Bold 2012; Squire 2008). Semi-structured narrative interviews can generate personal, open dialogue (Bold 2012). Within this approach the researcher does not take a neutral stance but is integral part of the research process (Squire 2008). Commensurate with the ethos of this study, the researcher/participant relationship is one of collaboration and interaction, where researcher involvement is not minimised within the interview conversation (Mauthner

and Doucet 1998). Documentary sources that articulated the woman's wishes, for example entries she had made in her hand-held maternity notes or birth plan, were used as a trigger for discussion when appropriate with the women's consent.

Data collection across the longitudinal component was designed to encompass and mirror the woman's student caseloading journey experience. It was anticipated that participants would receive continuity of care from the same student throughout pregnancy, labour and birth, and early postnatal period (NMC 2009). The first interview was conducted between 23-26 weeks of pregnancy, the rationale being that by this point in time it was anticipated the student would have provided care on at least two occasions (NICE 2008). The interview began with the opening question or story trigger (Appendix 8):

Can you tell me how (and why) you got involved in student caseloading?

This question placed student caseloading within the context of each woman's early pregnancy journey. Each woman talked about her first meeting with the student, her rationale for agreeing to be part of the student's caseload, and her care experiences and expectations.

Subsequent story sharing episodes were conducted using story triggers that encouraged the women to reconstruct their experiences of caseloading within the context of recent care and life events. The second interview was conducted pre-birth between 36-38 weeks, in anticipation that the student would have provided the majority of pregnancy care pre-labour (NICE 2008) and began with the opening story trigger (Appendix 8):

Can you tell me about the care you are receiving from your caseloading student (and how you feel about it)?

The third and final interview occurred between 5-9 weeks postpartum, following completion of midwifery care and conclusion of the student caseloading experience. The women instigated timing of this final interview; I had arranged that I would contact them to enquire as to their wellbeing and arrange a date for the interview four weeks after their estimated delivery

date. In recognition of the challenges of determining the best time to interview postnatal women during the early weeks of mothering (Wickham 2006), this appeared a pragmatic approach. In this interview, I encouraged each woman to reflect on the contemporary aspect of her student caseloading journey, and the meanings and significance of this within the context of her holistic childbearing experience. This conversation also looked to elicit future pregnancy maternity caregiver expectations, choices and recommendations and began with the opening story trigger (Appendix 8):

Can you tell me about your labour and birth (and what the student did and how you feel about it)?

The interviews began as the women were recruited to the study. The first initial antenatal interview was conducted in November 2011, and the third and final story-sharing episode for the last woman recruited, in December 2014. Prior to each interview the purpose of the study was re-explained, confidentiality issues discussed, aliases re-agreed, and informed consent to participate re-confirmed with each participant (Holloway and Wheeler 1996). The women were also reminded of their right to terminate the interview or withdraw from the study at any time (Corti et al. 2000). Mindful of the importance of an interview environment that facilitates a conducive and congenial atmosphere (Creswell 2013; Holloway and Freshwater 2007), I encouraged each woman to nominate a meeting venue where she felt most comfortable. All interviews were conducted in the woman's home apart from on one occasion for one participant, where the first interview was held in a quiet café of the woman's choosing. I was therefore most often a guest of the woman and I hope, as Oakley (1990) suggested, helped facilitate a more level relational power balance within the interview conversation.

Riessman (1993) asserted the aim of data collection within narrative research is to generate whole stories whose sequence and form are not shortened by researcher interruption. Contemporary authors however, recognise the value of a more varied format within experience-centred narrative interviewing (Bold 2012; Creswell 2013; Squire 2008). Within this context, the researcher's contribution can be minimal or extend to a co-

constructed account, almost conversational in style (Squire 2008). Ultimately, however, the approach taken needs to be commensurate with the research context and aim (Bold 2012; Squire 2008) and what was ethically supported. As in midwifery practice, my approach was to tailor the format to the individual woman, often moving along the continuum described by Squire (2008) in an interview. The prepared interview aide-memoire (Appendix 8) was thus used as a reflective resource rather than a structure to follow (Bold 2012). The prompt questions were used to facilitate greater exploration and clarification of issues, thoughts and feelings shared by the woman. This clarification enabled the woman's story to become more context specific, in that what I heard as story-receiver, I also understood (Silverman 2013).

The nature of conversation within the interview context is an artificial construct, a "pseudo-conversation" (Oakley 1993, p.222), a conversation shaped around a particular topic focus and instigated for a certain purpose. It is a social process of speaker and listener interaction in which both parties talk but only one is encouraged to share information about their experiences, thoughts or perceptions (Holloway and Wheeler 1996), a conversation moulded by choices. Choices were made by the woman in what to tell and how, as well as what not to tell, plus I made choices in how I heard and responded to what was shared. During the interviews, I was actively listening to the women's stories, alert to any subtle change in the story accounts, asking questions and seeking clarification. Inevitably, my nods, sounds of encouragement, facial expressions or prompts may have informed the woman in how she responded (Clandinin and Connelly 2000). The interview conversations are thus recognised as co-constructed and interpretative accounts, accounts shaped by the interpretative processes of researcher and participant and our relationship.

The interviews conducted varied from 35-60 minutes in length and were digitally audio-recorded. Following each interview, field notes were made of both participant and my behaviour/interactions (Miles et al. 2014). Integral within this record was a reflective account of the interview process. I reflexively appraised the way in which I interjected, how I asked questions and prompts, and my thoughts and feelings during the interview

conversation. This recursive, subjective form of self-awareness enabled me to question the bases for my interpretations and participation in the process of meaning construction [1.3]. Via this reflexivity, possible questions/queries to clarify with the woman at subsequent interview were formulated and documented (Appendix 9). Holistic reading of interview transcripts along with review of the field notes prior to subsequent interview, enabled identification of any particular topics/aspects to include within the conversation. Thus, data analysis began as the transcripts became available, as those things learnt at each interview were taken up in subsequent interviews.

4.5.2 Audio-recording and transcribing

The first step in working with interview data is to turn it into an 'intelligible product' (Miles et al, 2014, p.71) in preparation for analysis. This was achieved by the digital audio-taping of each woman's interview story sharing episode, and the fixing of that conversation in a written text through transcription. While commonly used methods amongst qualitative researchers (Silverman 2013), it was recognised that these are interpretative and constructive practices. This is because they are re-presentations of the woman's re-telling of her original experience that was shaped through the nature of our interaction and relationship as researcher and participant as well as by the woman's experience of any previous re-telling of her story and sense making of her childbirth experience to date.

Fixing the interview conversation in written text converts the raw oral data gathered into a new form. This re-presentation of the interview conversation is shaped by the researcher's decisions regarding what to transcribe and how to transcribe it (Riessman 2008). The same interview can be transcribed in a number of different ways, depending on the theoretical and methodological orientations of the research and the motivations and interests of the researcher (Riessman 2008; Silverman 2013). My decision-making regarding the study recording and transcription practices centred around two issues: how best to record and preserve the interview data gathered, and the format of the interview transcript. Weighing up the balance of the benefits and limitations associated with these methods informed the choices made.

Making these decisions transparent is important to facilitate understanding of what is influencing the analysis (Riessman 2008).

Within the interview context, audio-recording enabled me to be free to actively listen to the woman, and thus more able to pick up and respond to her cues. I felt this engendered a more reciprocal conversational interview style that gave time and space for her to story share. However as noted by Miller (1998), the presence of the digital recorder, though small and discretely placed, did at times appear to impede the flow of some women's talk and interaction. A further limitation of audio-recording is its inability to record and preserve visual and physical aspects of the interview context (Kvale 1996). This information, along with non-verbal facial expressions and bodily gestures made by participants, was documented retrospectively within contemporaneous field notes [4.5.1]. In accordance with Miles et al. (2014) guidance, these were later written-up in a more legible format to facilitate analysis of the interview transcripts.

I chose to transcribe all of the interviews myself. Via this time consuming process, I increased my theoretical sensitivity and immersion in the data (Holloway and Freshwater 2007). This engagement with the data engendered greater depth of reflexivity, stimulating identification of questions that could be taken up in subsequent interviews. Gaining this deeper understanding of the stories shared was important and every effort was made to complete transcription as soon as possible after the interview. All participants were sent a copy of their three interview transcripts prior to their further analysis.

Choosing to digitally audio-tape the participant interviews provided a means by which the conversations could be permanently preserved (Silverman 2013). This enabled repeated listening, an aspect central to the data analysis framework [Chapter 5]. Preserving the raw data in this way also proved an invaluable resource in facilitating an as accurate as possible transcription. To provide the fullest and richest data for analysis, I transcribed all audio-recordings of the interview conversations verbatim. By returning to the data again and again I was able to elicit previously un-noted or miss-heard

features, especially in regard to nuances in tone of voice and use of colloquialisms (Holloway and Freshwater 2007; Kvale 1996). This ensured detail such as pauses, non-lexical expressions and speakers interruptions and overlaps were annotated within the text (Silverman 2013). These characteristics together with the sequencing and organisation of talk engender greater depth within the analysis (Silverman 2013), and reveal the nature of our conversational interaction as researcher and participant. However, transcription as a way of re-presenting stories shared at interview cannot fully exemplify the interactional process of conversation in which those words arose (Kvale 1996). They do however, provide a representation that can be re-read and reflected upon (Silverman 2013), and provide a resource for both researcher and participant. It is also important to acknowledge that the audio-recordings and transcripts of the women's interview conversations are most likely partial representations, as there can be no true objective conversion from the spoken to the written mode (Kvale 1996).

4.6 Reflections on methodology and methods of data gathering

In this section, I provide an experiential reflective review of my personal learning and development through conducting this research. The accounts chosen to be included here are those aspects that have resonance for me as cornerstones in my professional growth as midwife, educationalist and researcher. My immersion in the participant data gathered facilitated and supported reflection in a mindful way. This approach to reflective practice places emphasis on reflection that is intuitive and holistic (Johns 2005) and is associated with less traditional forms of academic expression such as storytelling (Leamon 2004; Moon and Fowler 2008) and poetry (Anderson 2007; Bolton 2014). Writing poetry enables understanding through exploration of experiences, thoughts, feelings and insights (Bolton 2013). For this reason, I present my reflections on the methodology and data gathering process in the form of poems and extracts drawn from my reflective journal and interview field notes. As it can be seen in the mindful reflection below,

the focus of my writing moved between times of excitement, challenge, disappointment, frustration and more.

Following receipt of ethical support, I looked forward with some excitement to initiating participant recruitment and immersing myself in the research. Although I had taken time to work with local midwife recruiters [4.4.3], recruitment to the study was disappointingly slow, a factor I had not considered and found frustrating and at times demoralising, as recorded within my research journal below.

*As I sit, the digital audio-recorder catches my eye.
It sits, shrouded in its protective case, battery compartment empty,
waiting, gathering dust upon the shelf.*

*It stares at me sullenly, it's front panel dark and silent.
A constant reminder of the data yet to come, the stories waiting to be
collected.*

How much longer will it wait, I muse....

*I pick it up and look at it again. I press 'play'
It comes to life, it's lights flashing brightly
The voices resonate in the silence, sharing stories told
A reminder of the rich data already gathered
and those yet to come*

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Being able to articulate my thoughts and feelings about aspects in this way increased my awareness of my personal responses to challenges encountered within the research, and the impact of this. As Etherington (2004) asserts, this was an important tool in my learning journey to becoming a reflexive researcher.

It was with a somewhat heady mix of excitement and nervous apprehension that I began to gather participant stories for analysis. While I was confident in

my approach, I wondered how the women would respond to my invitation to share their story. Each of the interview conversations with the women took its own direction. Some women appeared initially nervous but as the cycles of data collection progressed and our relationship developed, the degree of nervousness the women exhibited varied. Erin for example, as I was settling on the sofa for our second interview conversation, placed a cup of coffee in front of me with the words *"I've just got so much to tell you, I don't know where to begin!"* (Erin2, p.1) before launching into her story. Whereas others, although appearing more visibly relaxed, seemed more able to share their story if a conversational approach was used initially [4.5.1].

While some women chose to respond to my sometimes inexpertly posed, somewhat closed question with a story (Riessman 1993), others responded with silence. In the poem 'Uninvited voices' p.116, I reflect on my interview interactions with Emma and about my perceptions of the power differential within our relationship.

Uninvited voices

It's cold, no lift
I trudge up the stairs to the third-floor flat
Smiling she welcomes me.
Dog whining, barking
I smile, I like dogs I say
I say hello to the dog
I've got a dog I say
but in the kitchen, he stays.

The tape is on
her voice is soft,
quietly spoken.
Loudly the dog whines and mews.
She answers my opening question with brevity
I try again but the voice of silence
along with that of the dog,
has joined our conversation.

Frustrated, horror struck
our conversation moves
as a short question and answer session.
I panic, I smile, I try a new tack
but silence's voice is strong.
Dog whines,
I say goodbye
Perhaps we will interact better next time?

As highlighted earlier [4.3], the ethos underpinning this research was commensurate with the concept of a woman-centred approach through placing focus on the woman, partnership working and a valuing of her experiences. Unlike the interview conversations I had facilitated with other women recruited, during my conversations with Emma to my dismay I found myself conducting rather than facilitating, more traditional stimuli/response sessions. It is purported perceptions of the role and status of the researcher

may influence participant interaction and response at interview (Taylor 2005). As previously discussed, Emma was aware of my professional roles and this may have been a factor. While I felt Emma and I enjoyed a positive, relaxed and mutually reciprocal relationship that seemed to enable us to share insights into our personal lives, our interview conversations remained hesitant, punctuated by the voice of silence. However, as her story unfolded across the cycles of data gathering, our conversations progressed from question and answer sessions to short conversations. As Oakley (1993) points out, the skill of interviewing is not easy to master, and I have reflected on my interview 'technique' particularly when listening to the audiotaped recordings, as exhorted by Taylor (2005). Reflecting on my experience of the data gathering process, I have come to understand interviewing as an interactive process reliant on shifting relational dynamics within a particular situated context (Leamon 2009).

As I discuss in [4.7.2], the women's stories shared at interview were often evocative and poignant with pregnancy hopes, dreams and aspirations expressed. The poem 'Where is the midwife within?', p.118 reflects on my learning as midwife and educationalist through journeying with Anna, a 38yrs old woman pregnant with her first child [4.4.4], through our three interview conversations.

Where is the midwife within?

She shares her vision of pregnancy and birth.
A strong belief in the centrality of normality shapes her view
a vision, at odds with the prevailing medical model
a blatant mismatch of view.
I feel a niggling sense of concern
Where is the midwife within?

She constructs herself as an older mother,
a thirty-eight-year-old primigravida.
She shares her aspirations of homebirth
no concept of risk is spoken.
She talks of homeopathy and natural birthing
I feel a niggling sense of concern
Where is the midwife within?

I listen with joy and happiness,
I smile a smile strong with emotion.
Her aspirations are met,
why did I feel a niggling sense of concern?
Is there a duality within?
How does that translate in action?
Do I speak with forked tongues?
Where is the midwife within?

As a midwife, I hold strong belief in the centrality of normality, of woman's ability to birth physiologically without intervention. This led me to reflectively question the sense of concern I felt when, during our first interview conversation, Anna shared her plans for homebirth. Why had I added a 'risk' label each time I heard her story unfold? Was it because contemporary obstetric opinion views primiparity above the age of thirty years of age as 'risky', a pregnancy that requires close monitoring and management (Carolan 2003; Herstad et al. 2014)? As an educator, I have researched the literature, and debated the topic of primiparity with students. Could this be an influencing factor? Reflecting on my negativity has proven challenging. It has struck at the very heart of my core midwifery beliefs and practice, and I have

struggled with the concept of how these tensions and roles merge within my professional practice as midwife and educator. Hearing and reflecting on Anna's story, while challenging, has enabled insight and transformative learning (Chase 2005) for my future professional practice.

Reflecting on the experience of gathering the women's stories across the longitudinal component of the study, I was mindful of the sense of continuity it engendered as I, like the student, journeyed with each woman as she moved through her childbearing event. As Oakley (1993) and Mauthner and Doucet (1998) identified, being able to embed myself in this way within the process and become a member of the group interviewed proved advantageous in developing reciprocal relationships with the women [4.3.2]. I was mindful however, of Bold's (2012) advice that as a woman, mother and midwife I may become over-involved and emotionally attached to the women who participated within the study through this continuity. However, I do not feel this has been an issue. While I recognise potential for a blurring of relationships with participants to occur, I feel my midwifery experience helped me negotiate relationships in an appropriate manner with each of the women recruited. This aspect, along with consideration of the emotion work of hearing the women's stories of experience, is explored further in regard to relational ethics in practice in [4.7.2].

4.7 Ethical considerations

If, as Frank (1995) contends, creating, telling and re-telling stories enables us to think differently about our lives, re-design its future shaping and re-align ourselves with our worlds, then it is a transformative process. This implies stories "teach us" how to live good and better lives, how to manage adverse situations and how to act appropriately (Adams 2008). It is my belief by advancing the women's experience stories/study outcomes it is more likely that their voices, feelings, and meanings as service users and recipients of care from caseloading students are heard. It is also hoped it provided an empowering experience and brought insights to the women who participated (Elliott 2005). Dissemination of this work further advances the potential for 'doing good' through change initiation to enhance midwifery education,

service provision and women's care experience. My responsibility as the researcher was to balance ethical concerns, to ensure the rights of the women who participated within the study were upheld (Elliott 2005; Miles et al. 2014). Making explicit how these considerations informed and shaped the research process is thus important.

Considerations of the ethical dimensions of the research were central within development of the study design, its conduct and management. Conducting research involves working with others, and as Adams (2008) and Ellis (2007) pointed out, we do not know how those involved will interpret or respond to our work. It is therefore imperative ethical concerns are never "far from the heart of our inquiries no matter where we are in the inquiry process" (Clandinin and Connelly 2000, p.170). The challenge for me, particularly as the study progressed, was to maintain an ethical stance whilst balancing the needs of the research with minimisation of any potential risks to participants (Elliot 2005; Guillemin and Gillam 2004). This was in part due to choosing a qualitative framework, which engenders a more fluid and inductive approach (Birch et al, 2002; Guillemin and Gillam 2004). Narrative methods further call for reciprocal interactive researcher/participant relationships (Chase 2005; Clandinin and Connelly 2000; Leamon 2009), a specific focus on interpretation and re-telling of stories told (Cortazzi 1993; Creswell 2013; Polkinghorne 1988) and acceptance of different ways of knowing (Chase 2005; Squire 2008). Concerns that ethics and narrative research can become something of a contradiction in terms have therefore been expressed (Ellis 2007; Callary 2013; Rice 2009). To enable a full discussion of the issues, the procedural ethics and relational ethics in practice framework was adopted, as it appeared commensurate with the demands of the study.

4.7.1 Procedural ethics

Procedural ethics are governance processes that regulate and monitor research undertaken involving human subjects (Guillemin and Gillam 2004). Governed by the Helsinki Declaration (2013), these codes and guidelines oblige medical researchers to work within ethical frameworks (WMA 2015).

As researcher, my primary consideration from the outset was to uphold the central tenet of humane conduct underpinning these agendas “*First do no harm*” (Miles et al. 2014, p.56). Formal rigorous scrutiny, review and approval for the research was sought, and subsequently given, from a number of agencies. Support and sponsorship for the study was initially gained from the Post-graduate Research Committee of the School of Health and Social Care, Bournemouth University on 23rd December 2010.

Subsequently, the South Central NHS Regional Ethics Committee reviewed my application for ethical support on 20th May 2011. My application particularly highlighted ethical issues relating to data protection, limits of confidentiality in regard to child protection, risks, burdens and benefits to women participating, and to myself as researcher. I attended the committee meeting, accompanied by one research supervisor, Dr Jen Leamon, and received a positive review. Clarification was required as to who else would review the themes I identified from the interview data to support rigour in the analysis and my response was that this would be my research supervisors. Minor revisions to the patient information leaflet were requested to enhance readability and ensure it was clear to women that if they did not wish to participate or chose to withdraw, their own care and that of the baby would not be affected (Appendix 10). Following submission of the revised documentation and requested information, a favourable ethical opinion was confirmed for the study on 4th July 2011 (Appendix 11). Subsequently, Trust A (Sea Town hospital) NHS organisational permission was granted on 25th August 2011, and Trust B (Parson’s Field hospital) 15th October 2013.

As a practicing midwife, I adhere to a professional code of ethical practice underpinned by the guiding principles of: respect for autonomy; beneficence; non-maleficence; human dignity and justice (NMC 2015b; 2017). This bioethical framework meets Bournemouth University Research Ethics Policy and Procedures Code (2009), and Research Governance Framework for Health and Social Care (DH 2005). By virtue of this ethical framework, I have a duty of care regarding the safeguarding of the health and wellbeing of those involved with the research (Corti et al. 2000) and a number of steps were taken to minimise potential for harm.

Student midwives and their supervising midwife mentors were not part of the study. I was mindful however, given the potential that in sharing their stories women might report negative as well as positive aspects of their care experiences. Caregivers could perceive that their practice was being judged or assessed. To mitigate potential harmful effects, students and their supervising mentors were advised of the study aims, objectives and processes and given an information leaflet about the study prior to participant recruitment [4.4.1; 4.4.3]. The information leaflet made it clear that study findings would be reported sensitively and that as researcher, I would not make judgements about the information women disclosed at interview. My contact details, as well as those of my research supervisors and the senior midwifery lecturer co-opted to act as a supportive resource, were included within the information leaflets.

A central ethical responsibility of researchers is to assure participation in the research is freely given and consenting (Miles et al. 2014: Smythe and Murray 2000). Before consent can be given, participants must be made fully aware of the purpose of the research, the nature of expected contribution, their rights of engagement and how findings will be disseminated (Corti et al. 2000; Miller and Bell 2002). However, as Miller and Bell (2002) point out, when using qualitative methods, clearly delineating the exact course of the research process can prove challenging given its inherent fluid and dynamic nature. Using narrative methods adds to this challenge as the design is often more emergent, with research processes and analysis shaped by participant's narratives shared (Bold 2012). Hence Bold (2012) suggests, when entering a narrative study, a high proportion of participants do not really comprehend the implications. Given these ethical challenges, I felt it important women had an opportunity to reflect on the information contained within the invitation pack (given to them by their named community midwife), and seek additional information before engaging in the study [4.4.3]. It was further recognised that the woman's signature on the consent form represented a formal acknowledgement of her engagement in the research, providing the required procedural ethics documentation, rather than constituting informed consent (Guillemin and Gillam 2004).

As researcher, I had an ethical duty to uphold participant's rights to anonymity and confidentiality (Corti et al. 2000). However, as Elliott (2005) points out, this can prove problematic for narrative researchers due to the holistic and contextual nature of the work. Choosing a longitudinal design, where data gathered was conceptualised and written-up as individual personal experience narratives further complicated the issue. Each woman's narrative was unique to her, grounded within a specific socio-cultural context it was characterised by an array of personal attributes that hold greater potential for anonymity to be compromised by those who know her (Ellis 2007; Elliott 2005). The research framework attempted to mitigate risks of identification by asking women wishing to participate to contact me directly [4.4.3]. All data collected was coded using alias names and pseudonyms for potential identifiers of individuals, institutions or places referred to by participants. Care was also taken to exclude any unusual or very specific examples of the data in discussion and dissemination of study findings.

However, it is acknowledged that the right to privacy and anonymity of the women who participated could not be guaranteed (Smythe and Murray 2000). By virtue of working within my professional ethical framework, my duty of care would have rendered this impossible if issues of child protection had arisen or if in sharing her story, a woman revealed poor professional standards of care and unacceptable practice (NMC 2015b). If this situation had arisen, I would initially discuss this with one of my research supervisors. Together the woman's story would have been reviewed and where further investigation regarding the student's or supervising midwife's practice was felt necessary, contact to relevant personnel at the research University/NHS Trust would have been made to uphold the woman's and any unborn/child's safety. If a woman/participant had an issue with an aspect of practice, I would have advised her to contact the relevant midwifery manager or matron e.g. community manager, in-services matron to discuss the issue and/or the local Patient and Customer Services Team (incorporating PALS) who are an independent contact point for consumers of NHS Trust services. Whilst this situation did not arise, Bell and Nutt (2002) highlight the challenging ethical and moral conundrums this can present practitioner-researchers like me.

Limits to maintenance of confidentiality and privacy were therefore included within the participant information leaflet and discussed at the preliminary meeting prior to seeking consent to participate (Elliott 2005). The woman's signature on the consent form was viewed as recognition and understanding of confidentiality limitations (Appendix 7).

The in-depth narrative interviews encouraged participants to reflect on their maternity care experiences and explore aspects of significance for them. The stories shared were not just descriptive but "constitutive of the self" (Elliott 2005, p.140), and thus embodied accounts (Charon 2006; Peterson and Langelier 2006; Ramirez-Esparza and Pennebaker 2006). It is recognised pregnancy and the transition to motherhood is a time of great adjustment physically, socially and psychologically and profoundly impacts every aspect of a woman's life (Paradice 2002; Wilkins 2012). Having an opportunity for time and space to share one's story and talk through personal sense-making of life experiences such as childbirth at interview can therefore be anywhere on a continuum of transformative through to therapeutic (Elliott 2005; Holloway and Freshwater 2007). It is hoped being heard and listened to, and having experiences acknowledged and validated at interview, was beneficial for the women who participated.

It is important to recognise however, that self-disclosure can evoke uncomfortable or disturbing memories (Hunter 2007; Kvale 1996; Guillemin and Gillam 2004). The emergent nature of narrative interviews is recognised within procedural ethical frameworks (Ellis 2007; Smythe and Murray 2000), and participants were provided with information on how they could seek further support from appropriate professionals if required. As Ellis (2007) noted, this anticipatory framework does not extend to the "relational ethics" of the interview situation, or the "ethics in practice" encountered in the actual realities of hearing stories shared (Guillemin and Gillam 2004). These interlinked dimensions are discussed below in [4.7.2].

4.7.2 Relational ethics in practice

Relational ethics required recognition of the personal and moral relationships I developed with participants through the research framework (Elliott 2005).

Described as being akin to “an ethics of care” (Ellis 2007, p.4), it required me to reflect upon and acknowledge how I connected, related and mitigated my relationships with the women who participated. I had to consider how my relationships with the women informed the analysis, how I re-constructed their experience stories and represented them within the text and in dissemination of study findings (Adams 2008; Elliott 2005; Ellis 2007; Mauthner and Doucet 1998). Congruent with midwifery practice and philosophical approach, it required me to facilitate the study in a manner that valued, respected and upheld the dignity of those involved (DH 2010a; 2010b; NHS 2016).

As Ellis (2007, p.5) noted, procedural ethical codes and frameworks are based on the assumption that “research is being done on strangers with whom we have no prior relationships and plan no future interaction”. Due to the recruitment strategy, on entry to the study the women who participated were unknown to me. However, as discussed earlier [4.6], once data collection began, I became very aware of the longitudinal design of the study and the sense of continuity it engendered. The concept of journey was a central construct within this, a construct that united us, the woman journeying through her childbearing event, the student journeying alongside her and through her own educational programme and my journey with each participant and personal study as a doctoral student. My research journal recorded the difficulties I experienced to articulate in words my thoughts and concerns around this. Creating a poster presentation for the Narrative Research Symposium Huddersfield June 2012 (Appendix 12) helped crystallise this concept and helped inform my reading around the nature of researcher/participant roles within narrative research and my reflections on this with my research supervisors.

As researcher, I found my relationships with each of the participants developed as the cycles of data collection progressed. As indicated in [4.6], gradually interpersonal bonds formed and a sense of connectedness engendered. I felt this generated relationships akin to the professional relationships I developed with women in midwifery practice. Like Hunter (2007), I learnt to “drink tea”, pat the dog, and play with toddlers and, as in

midwifery practice, felt the need to share a little about myself. I felt welcomed as a friend into the women's homes and families and was often invited to view scan photos, new items for the nursery or give an opinion on possible baby names. As noted by others, gaining the woman's trust through the nature of our reciprocal relationships was advantageous to the rich quality of data gathered (Bold 2012; Leamon 2009; Mauthner and Doucet 1998). However, while the situation did not appear to arise, I was mindful how this could lead to greater depth of disclosure that could leave the woman feeling vulnerable or discomforted by a response given (Guillemin and Gillam 2004). The questions posed were therefore of an open and general nature to ensure women felt able to exercise choice and control over topics discussed during the interview conversation.

The woman's stories shared at interview were often evocative and poignant. Hopes, dreams and pregnancy aspirations were shared, re-shared and then shared again with joy when realised and at times, sadness and emotion when lost. Frank (1995, p.25) considered listening to such stories "hard, but also a fundamental moral act". It is through generation of such valuable material that we learn how women view their pregnancy care experiences and the significance of this upon their childbearing event. Relational ethics in practice recognises the emotional context in which these experiences are shared and heard. As Carter and Delamont (1996) and Kiesinger (1998) report, hearing, listening and being present during emotional moments at interview can deepen understanding of the meanings shared but are also challenging for researchers. As noted by others, reflexivity in these challenging situations was essential (Guillemin and Gillam 2004; Kiesinger 1998). Documenting my thoughts and feelings in my research journal was cathartic and together with supervision, a mechanism that supported my development of a reflexive stand throughout the interview process.

While the continuity engendered through the cycles of data collection evoked a sense of connectedness and development of interpersonal bonds, I did not find it difficult to end or extract myself from the relationships forged with the women. Having previously worked in a midwifery continuity model [1.1], from the outset I understood the importance of establishing clear professional and

personal boundaries (Leap 1997; McCourt et al. 2006). This enabled me to recognise the importance of maintaining a reflexive approach regarding the relationships I formed with women who participated throughout conduct of the research (Guillemin and Gillam 2004; Kiesinger 1998). This was facilitated through documenting my thoughts and feelings in my research journal and reflecting on this with my research supervisors [4.3.2]. While the situation did not appear to arise, this facilitated increased reflexive mindfulness of the potential for women who participated to become over dependent on me and find termination of our relationship difficult. Concluding the researcher/participant relationship at the end of the final story-sharing interview conducted postnatally with each woman appeared to have parallels with midwifery practice in that it represented a natural conclusion of involvement. If participants had appeared discomforted or had sought to maintain contact with me following termination of our relationship, I would have informed my research supervisors and information on how they could seek support from appropriate professionals would have been provided.

The next chapter presents the data analytic strategy adopted for the study, discussing the rationale for choices made in developing the analytical framework and experiential review of its application.

Chapter 5 Stories within stories

5.1 Introduction

Analysis, Miles et al. (2014) argue, is the most crucial aspect of any study. The use and development of the narrative approach is associated with an organic development across disciplines that have informed a diversity of approaches (Creswell 2013). Whilst narrative methods have increased in their usage over the last decade, there remains a sense that they are still a “field in the making” that provides a “rich but diffuse tradition” (Chase 2005, p.651) regarding the options of how to interpret story-texts. This, coupled with few analytical frameworks, leave novice researchers with the difficult question of what to do with their data (Bold 2012; Chase 2005; McCormack 2004). Choosing, justifying and applying an analytical strategy is therefore not without opportunity and challenge.

As I progressed through the research, I was mindful that the data-analytic methods and techniques adopted for this study need to be shared and made transparent in order to demonstrate rigour and validity (Miles et al. 2014). To achieve this, I will make explicit the analytic strategy adopted for the study in this chapter. My process and choices made in developing the analytical framework is discussed along with personal reflective experiential review of its application. The chapter concludes with introduction preview to the women’s stories re-told via the analysis in Chapters 6 and 7.

5.2 Ontology within narrative accounts

In this study, the women’s stories gathered through the research process were those aspects that formed the basis for interpretation. From an ontological perspective, narrative strategies for the analysis of stories tend to configure around two approaches: the analysis of narratives and narrative analysis (Polkinghorne 1995). Methods employed in the analysis of narratives seek to analyse stories for the knowledge they contain (based on a representation of an individual’s reality) by eliciting themes that hold across stories and the relationships between them (Creswell 2013; Polkinghorne

1995). In this approach, the stories gathered are considered as the raw data for interpretation rather than the end point of the analysis or resultant product. Qualitative analytic strategies that can be applied to elicit story-themes comprise methods such as a thematic analysis (Creswell 2013; Riessman 2008), content analysis (Lieblich et al. 1998; Polkinghorne 1995) or discourse analysis (Cortazzi 1993; Josselson 2011).

Conversely, engendering a move away from theme-orientated approaches, narrative analysis is associated with more holistic and contextual portrayals of individuals, storytellers or study participants that are constructed and reconstructed through the telling and re-telling of stories (Chase 2005; Frank 1997; Lieblich et al. 1998; Polkinghorne 1988). It is recognised that in hearing the woman's story, it is her constructed truth that is shared rather than a formal or factually accurate account of events or experience (Josselson 2011; Lieblich et al. 1998). In this approach, the stories themselves are treated as knowledge rather than as holding the raw material of inquiry (Polkinghorne 1995). Analytic strategies tend to draw on methods reminiscent of conventional fictional texts (Creswell 2013; Riessman 2008) and seek to understand lived experiences (Clandinin and Connelly 2000) and the meanings attributed to them by 're-storying' stories from the original data. Re-storying is an active interpretative process involving a series of analytic steps in which stories are shaped around a plotline to give meaning to the data (Bold 2012; Polkinghorne 1995). The culmination of the analysis (or resultant product) is the re-telling of the story via the construction of a resonant and coherent story of the lived experience (Cortazzi 1993; Creswell 2013). The format of these narrative analysis stories draws on and from multiple narrative forms including composite narratives, poems, letters and diaries (Plummer 2001; Richardson 1990).

5.3 Understanding created from narratives

My aim in this research was to uncover the meanings and significance of being part of a student midwife's caseload to the individual women within the study, and the women as a group. Neither of the narrative approaches to analysis appeared fully able to meet both study objectives entirely. In

grappling with this conundrum, my readings of the work of Etherington (2004), Frost (2009) and Riessman (2008) proved influential. They enabled me to see the possibility of meeting study aims and objectives through creation of a pluralistic analytical model that integrated both analysis of narratives and narrative analysis methods to interpret the women's story texts. Of further influence was the poem 'Stories as mirrors and windows' by McCormack (2001, p46-47) [Figure 5-1, p.131]. This powerfully portrayed to me how application of more than one narrative analysis can enable the multiple storied voices and perspectives within the data to be heard and made visible.

Figure 5-1: Stories as Mirrors and Windows by McCormack (2001, p.46-47)

Stories as mirrors

In mirrors we see what we want to see
What we see depends on our angle of repose
The type of glass composing the mirror
It changes each time we look
As the place we view from changes.
In a mirror we do not see a reflection of the self
In a mirror we see into our selves

When we look into a story mirror
We see a story that is less than the actual life
Because it has been selectively reconstructed
From parts of the whole
Chosen from the past in the present
But missing the future
The life is not yet over.

Stories are windows
Through windows we see multiple vistas
Depending on where we are looking from
And where we are looking to
And what we focus on in between
The size of the window
The material of its construction
And who constructed it
All affect what we see.

When we look through a story window
We can see more than a single life
Because we see the possibility of commonality and difference
Across the lives of others
We can write collective stories
And in seeing, the possibility of knowing
Different possibilities. Alternative futures.

The resulting two-stage process is a creative and pragmatic analytical model supporting the analysis of narratives and narrative analysis. This created the possibility of the resultant qualitative analysis being a portrayal of both the experience story and the emergent themes that arise from it (Creswell 2013), via the generation of individual and collective stories of experience.

My vision in using this approach was its ability to generate individual and collective stories of the women's experiences. I felt this gave meaning to the data (Polkinghorne 1995), and aligned harmoniously with the 'with woman' ethos of the study, midwifery practice and educational philosophy, as it enabled the women's voices to be holistically visible (Etherington 2004; McCormack 2004). This holistic approach to data analysis considers the structure and form of the story as well as its content (Lieblich et al. 1998) and is coherent with the experience-centred narrative framework informing the whole study (Squire 2008).

In addition, I felt the stories generated via the analysis held strong potential as a valuable resource for midwifery education. As highlighted in Chapter 4, irrespective of culture, storytelling is a primary medium through which knowledge of lived experience is passed across the generations (Josselson 2011; Mateas and Sengers 2003). Indeed, sharing professional knowledge in the form of stories has a long midwifery tradition (Leap and Hunter 1993). Such practice can be a rich and powerful educational tool promoting reflective insight, and personal and professional development (Leamon 2004; Moon and Fowler 2008). Rather than traditional cognitive approaches to reflection, this method places emphasis on reflection that is mindful, intuitive and holistic (Johns 2005). As the students in the study by Leamon et al. (2009) reported, this provides a lens through which to view self, personal emotions, feelings and perceptions within the unfolding moment. Utilising creative approaches such as story sharing within education that encourage mindful reflective practice, is purported to nurture and facilitate woman-centred compassionate care via this way of personal knowing (Johns 2005).

5.4 Analytical process: My initial creation of a robust scaffold

Inspired by the work of McCormack (2004), I began the analysis by first re-storying each woman's personal experience story of being cared for by a student midwife during her childbearing process through the student caseloading initiative. To enable this active interpretative process, I drew on the work of Chase (2005), Cortazzi (1993), Rosenthal (1993), Polkinghorne (1995) and Riessman (1993; 2008) to develop a series of analytic steps. The

methods and techniques I employed and how these were applied to the interview story data are discussed below in [5.4.1]. To construct a collective story that encapsulated the emergent longitudinal narrative themes of significance to the women as a group, I conducted a synthesis across the collective story data through application of a thematic analysis. This drew on the women's individual stories of lived experience generated via the interpretative processes of the re-storying framework.

Thematic analysis focusses on identifying, analysing and reporting themes and patterns of articulated participant experience across an entire data set (Aronson 1995; Braun and Clarke 2006). Rather than a specific qualitative method, it is a generic approach to "thematizing meanings" (Holloway and Todres 2003, p.347) across different qualitative theoretical frameworks (Braun and Clarke 2006). Given its "theoretical freedom" (Braun and Clarke 2006, p.78), and ability to illuminate commonalities and differences across a data set (Attride-Stirling 2001; Braun and Clarke 2006), thematic analysis appeared an appropriate method to discern the collective narratives of significance to the women in the study.

Thematic analysis is, arguably, one of the most widely used qualitative analytic methods (Braun and Clarke 2006; Roulston 2001), yet there appears a lack of clarity within the literature regarding the pragmatics of performing the method. A number of published works detail techniques for conducting thematic analysis but there is lack of consistency regarding the process, particularly in regard to terminology, number of analytic steps and the representation of meanings discerned (see for example, Aronson 1994; Attride-Stirling 2001; Braun and Clarke 2006; Tuckett 2005). For this study, Braun and Clarke's (2006) 6-phase thematic analysis method was utilised. The 6 phases offer a structured approach, in the sense that they enable the complexity of the six women's narratives to be revisited in what appears at the outset, a series of six simple phases, with space for creative or inductive thinking to reveal and develop themes across the collective and time. In Table 5-1. p.134, Braun and Clarke's work has been integrated into this study by the adaptation of phrasing linked to the analytical activity of the six phases. This strategy was employed to ensure the narrative approach of the

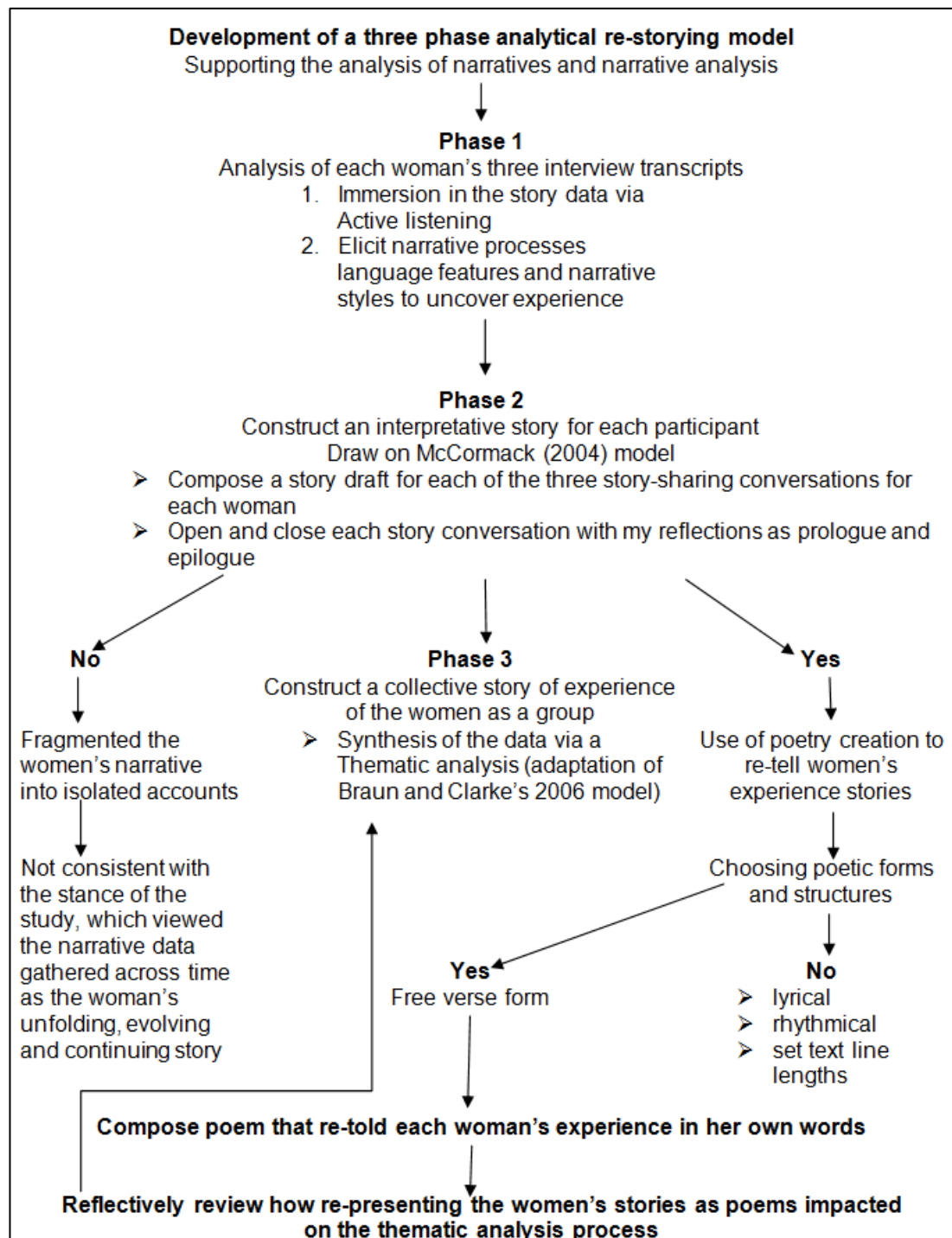
study remained evident in the thematic analysis process, something that is possible as the thematic process is recognised to have flexibility.

Table 5-1: Application of Braun and Clark (2006) 6-phase model

Phase	Woman's childbearing journey →	23-26 weeks preg	36-38 weeks preg	5-9 weeks post birth
	Analytical activity			
1	Re-read the women's narratives to be immersed in their stories			
2	Identify stories of interest, code the selected extracts			
3	Inductively note possible themes within and across the stories			
4	Review the emergent themes and the stories they tell			
5	Revisit the themes and the "overall story the analysis tells" (Braun and Clarke 2006, p.84)			
6	Select individual story extract to illustrate the overall collective story across time			

Application of these analytic processes enabled the creation of two interrelated formats of holistic re-telling or stories within stories. In the sections below, I discuss my reflective story of the data analysis through application of a re-storying framework and thematic analysis. Figure 5-2, p.135 provides a visual representation of my decision-making throughout the analytical process.

Figure 5-2: My analytical decision-making flowchart



5.4.1 My story of analysis

5.4.1.1 Active listening

I began the analytic processes by first immersing myself in the story data gathered at interview. This was important in the analysis, as often some time

had elapsed. I listened to the audiotaped narratives several times. Hearing the women's voice and reviewing the documented interview field notes [4.5.3] facilitated reflection as the "emotional heat" of the moment was linked to my memory of that account (Holloway and Freshwater 2007, p.45). This enabled me to reconnect with the storyteller, her story and my reactions to both of these (Mauthner and Doucet 1998) as I began the process of composing each woman's personal experience story. By first listening to the woman's voice, I re-engaged with her story, discerning main story characters (the woman, myself and other people), story events, actions, situations and plots. An understanding of the women's personal social contexts also developed as her story unfolded over the three story-sharing conversations.

On starting phase 1 and 2 of the 6-phase thematic analysis process, I once again read the interview narratives gathered. I had by this stage read and re-read them a number of times and was familiar with who said what where. That said, I always found something new, and the process deepened my appreciation of how or what something told was shared.

Through this phase of active reading, potential patterns, ideas and meanings were discerned. I created a document to record the data extracts each with its narrator, interview number and page number recorded. These extracts acted as memos, which collectively and reflectively were added to. The inductive reflective activity was associated with the emergence of patterns and ideas through the developing memo-ing lists (Creswell 2013). This involved noting shared or collective features of the narrative data. Capturing a portion or short phrase of articulated talk from within the interview text was associated with attributing a label that assigned "symbolic meaning" to it (Miles et al. 2014, p.17). Via this process, the thematic analysis was progressed to the third phase.

5.4.1.2 Uncovering experience

Following reflective re-immersion in the women's transcripts, I began to compose the individual personal experience stories by constructing a story line or plot. This was achieved by abstracting those aspects of story data that configured around the theme of student caseloading, and thus spoke to the

plot (McCormack 2004). These story pieces were selected to create a scaffold or framework with which to shape the unique experience context of each woman's story, on the basis that these aspects represented the woman's evaluation of her experience (Cortazzi 1993; Riessman 1993).

Storytelling is an active process that requires the storyteller to select and sequence past events in an effort to clarify meaning (Polkinghorne 1995). It is recognised that in hearing the woman's truth, her story may not be shared in a logical sequential way or chronological order (Josselson 2011; Lieblich et al. 1998; Squire 2008). To enable sense making and provide a coherent account, I re-organised the abstracted story data via temporal ordering into a chronological sequence (Chase 2005; Cortazzi 1993; Polkinghorne 1988; 1995). The resultant storyline chronology re-presented each woman's narrated story in relation to the points in time her story was shared at interview (i.e. abstracted story pieces from the first interview text followed by those from the second and then the third). This characterised the narrated story chronology with a particular structure: a beginning, middle and end (Cortazzi 1993; Polkinghorne 1995; Riessman 1993).

Having created the storyline, I began to develop the personal experience stories by eliciting the narrative processes the women employed to enrich or communicate the point of her story. To aid this process, I used coloured highlighters to identify the three styles of narrative presentation identified by Rosenthal (1993): theorising, augmentation, and description (discussed below). As Polkinghorne (1995) discussed, this required recursive movement between the story data text and the story plot as I reflectively re-read and re-examined the interview transcripts several times. I selected these narrative aspects on the basis that they were the mechanisms used to explain why the stories were told, and worth the telling (McCormack 2004). The narrative presentations elicited formed the building blocks with which to compose the women's stories.

Stories shared at interview are constructed and organised from a tumult of internal experience (Josselson 2011; Lieblich et al. 1998). It is suggested storytellers often become reflective, expressing personal interpretations and

thoughts in an attempt to theorise their experience (Chase 2005; Rosenthal 1993), as Jody illustrates when explaining why she agreed to be part of a student midwife's caseload:

"The thing for me is everybody needs to learn and you've got to start somewhere and if people like myself don't give people the opportunity to do the studies, then how they going to get their experience or knowledge up if people aren't giving them the chance? So I thought I'm quite easy going, I thought yeah I'm okay with it. I get two midwives instead of one [laugh] which is a bonus". [1:1]

As the interview progresses a process of augmentation often occurs, as participants recall additional information to enrich previously shared accounts (Rosenthal 1993). It was interesting how for some women these words or phrases became almost a refrain, a chorus, as Jody illustrates when talking about Pippa, her caseloading student:

"If I've ever got an issue or anything um I can text Pippa and within, I don't know an hour, I've heard back from Pippa" [1:2:line 9-10]

"Literally if I've got any concerns I just text Pippa and she gets back to me" [1:2:line 18-19]

"If I've got any issues any time of the day I can text Pippa or ring her and she literally comes back to me straight away [2:3]

"I could ring Pippa at any time...I even rung her a few days after he was born" [3:6]

To aid listener understanding, participants often give detailed descriptions of story characters, places and situations to provide story context (Chase 2005; Rosenthal 1993). As previously discussed [4.3.1], stories shared are the storytellers' constructed truth, her version of self, reality and experience (Josselson 2011; Lieblich et al. 1998). Stories are therefore studied in context, as situated within personal socio-cultural and historical perspectives (Creswell 2013; Josselson 2011; Squire 2008). The descriptions shared add

detail to this understanding as Kelly illustrates when talking about her relationship with the father of her children:

"We're not really together, sometimes we are sometimes we're not so my sister's my next of kin...yeah he don't, I don't live with him he lives in XXX [place name] with his two children". [1:4]

Inclusion of such details shared by participants are important to enable reader understanding, but also to highlight the centrality of individualised woman-centred care to midwifery practice and for students to see and understand this imperative.

Having clothed the story line scaffold with a foundation of building blocks, via eliciting the narrative processes employed, I reflectively re-examined the story text data to elicit what other styles of narrative text were present. Again, using coloured highlighters, I looked at the language features within the text in terms of what was said, how it was said and what remained unsaid but was implied for example, presentation features such as hesitations, periods of silence (Creswell 2013; Riessman 2008). Denzin (1994, p510) suggested stories may contain 'radical' moments such as 'epiphanies' or 'turning points'. These moments may indicate specific tensions or challenges that have changed and shaped decision-making and life choices (Creswell 2013). Participants may also structure their stories using performance features such as speech functions, an active or passive voice, metaphors or similes to give emphasis to particular story aspects emotions and feelings (Lieblich et al. 1998). Non-verbal characteristics such as gestures or facial expressions may accompany such descriptions and thus field notes created at interview were central to the analysis as they illuminated these aspects.

I carefully examined choice of words or phraseology employed by the women as this may indicate uncontested knowledge (Phoenix 2008), the relationship of self and society or cultural identity, for example words common to a particular community or group (Squire 2008). As Kiesinger (1998) reported, I found there was often an assumption of shared common understanding. For example, phrases such as "you know" or "do you know what I mean?" assume an expectation that I actually do know what was meant. As

previously discussed, stories shared at interview are co-constructed, a product constructed within a social process of speaker and listener interaction (Josselson 2011; Squire 2008). Canonical perspectives (i.e. what was understood to be a socially acceptable view or cultural norm) (Phoenix 2008) of how the women built their story, facilitated insight into how assumptions about my sociocultural identity as midwife, educator and mother may have been made and how the women may have modified what they said, and how they said it, as Anna and Kelly illustrate:

“Without me saying I like things to be a little more natural they’ve picked up on that and they’ve said things like ‘oh 37 weeks, are you going to start your raspberry leaf tea?’...obviously they did say this is not a midwifery thing but we’ve heard that raspberry leaf is good”.
[Anna: 2:5]

“My sisters boy he was breastfed for nearly a year of his life and he’s asthmatic, he’s got to have Epi-pen, he’s allergic he’s got, I’ve not got anything against breastfeeding do you know what I mean? I likes to have a bit of breastfeeds for a few weeks but I just think he’s got everything”. [Kelly: 2:4]

Uncovering these aspects illuminated the nature and texture of the interview conversation, emotions and feelings evoked by the experience, and specific tensions within stories shared (Chase 2005; Lieblich et al. 1998). The narrative styles elicited were used to craft and shape the building block foundation already laid, to enrich and nuance the women’s re-storied account.

Through application of these interpretative processes and techniques, an initial draft of each woman’s re-storied personal experience story was composed. The analytic steps discussed facilitated consistency in the way I approached the interpretation of each woman’s interview transcripts and re-storied her story. However as noted by others (Creswell 2013; Mauthner and Doucet 1998; McCormack 2004), the resultant analysis for each woman was unique to her in terms of which aspects of story data I abstracted to form and

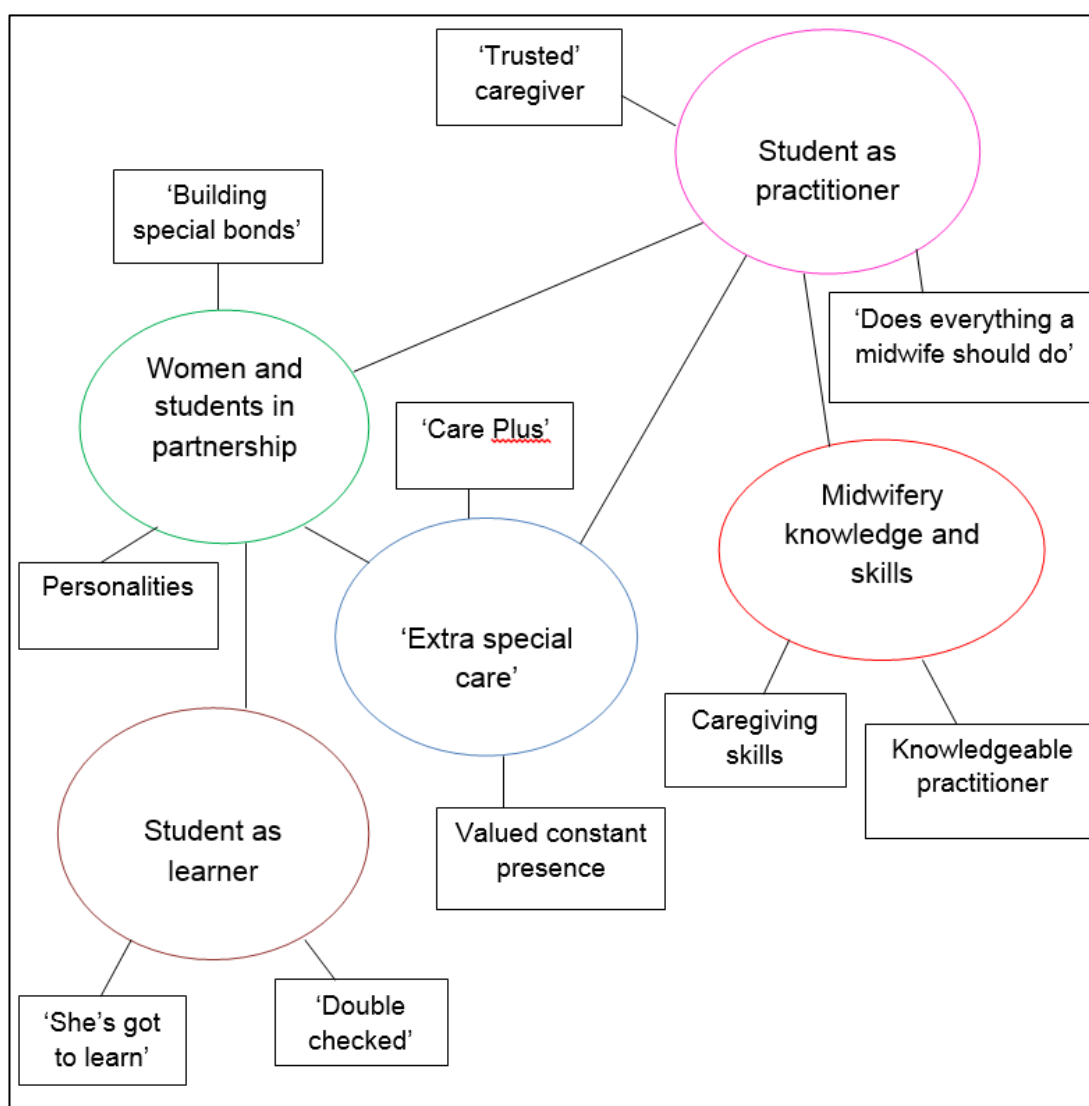
embellish the story plot, how these features were subsequently interwoven within the analysis, and how they contributed to the composition of her story.

Having discerned potential patterns, ideas and meanings via active reading and re-immersion in the interview story texts, I progressed the thematic analysis to inductively note themes within and across stories. My use of an inductive approach during this third phase of the model was associated with trusting I would find the title themes from the interview data. This could be described as in-vivo coding, as the title themes derived were from within the data set. This was congruent with the ambition to capture the socio-cultural meanings (Miles et al. 2014) of what it's like to be part of a student midwife's caseload.

The process of inductively organising the selected data extracts was completed across all interview story-texts. All of the story-talk that related to the individual codes was then aggregated to form clusters or categories of information (Creswell 2013). To draw collective longitudinal narrative threads of experience, data extracts that demonstrated the code were organised according to the relevant story-sharing time point.

Having collated and organised the data into information categories or codes, the third phase of the thematic analysis moved the process to a higher analytic level, as potential relationships between the various codes were elicited (Braun and Clarke 2006). This process enabled the various different codes to be organised into themes configured around a common idea (Creswell 2013). What emerged were not neat themes that could be easily presented in a sequential and coherent manner. The emergent themes showed interconnection, inter-subjectivity and interdependence as illustrated in Figure 5-3, p.142.

Table 5-3: Emergent themes of phase 3



Each theme was classified by a statement descriptor that expounded its meaning (Miles et al. 2014), and demonstrated the relationship of the collated coded data extracts configured within it. Through this analytic process five themes were identified:

1. 'student as practitioner';
2. 'woman and student in partnership';
3. 'extra special care';
4. 'student as learner';
5. 'midwifery knowledge and skills'.

The need to reduce the volume of information generated without losing the essence within emergent themes was challenging. Formation of subthemes

to describe segments of data within each of the five themes (Creswell 2013) was necessary. The creation of a thematic network [Figure 5-3, p142] enabled visual presentation of this phase of the thematic analysis (Attride-Stirling 2001), and illustrated the interconnected relationships between emergent themes and subthemes.

5.4.2 My expectations of how I would re-tell the stories

Different literary devices can be used to configure meaning from the data and present the different voices that have informed its shape (Ely et al. 1997; Plummer 2001). In writing 'Abbie's life', Kiesinger (1995) aimed to convey the lived experiences of women with anorexia and bulimia in bodily and emotional ways. Rather than re-presenting the data in participants' own words, Kiesinger chose an expressive style where some aspects of data were embellished, and others suppressed. In agreement with Anderson (2007) and congruent with the ethos of this study, I felt it important to remain faithful to the women's voices and re-present their stories using their own words and colloquialisms. Keeping the woman's voices distinct I felt the real power of her unique experience was captured.

As I worked through the analytic process, I was plagued by the dilemma of how best to present the women's re-storied personal narratives as meaningful stories that captured the essence of their embodied experiences. My vision was to find a way of presenting the stories, so they were narrated by the women themselves without interruption or signposting from me. My aspiration in this was for the women themselves to draw the reader into their lived world of experience and invite them to make their own interpretations. Kiesingers' (1995) approach of weaving her story through the participant's narrated experience, to make transparent her reactions and reflections, appeared incongruent with these aims. Etherington (2004) incorporated her voice alongside the participants as dialogue script. However, this interrupted the flow and rhythm of the narrated story making it appear rather disjointed.

Returning to the literature, the McCormack (2004) approach appeared a method with which to meet my aspirations. As discussed in [5.4.1.1], the women's story chronologies were organised in relation to the points in time

her story was shared at interview. Following the McCormack (2004) model, I reflected on the initial draft composition of the women's re-storied story of each story-sharing conversation to develop its format. I opened and closed each of the re-presented story-sharing episodes with my personal reflections (drawn from my personal journal and field notes [4.5.1]), as prologue and epilogue. I also included my words in short extracts within the text to bring together story contexts and enhance coherence as illustrated in 'Anna's story' (Appendix 13). The resulting re-storied account for each story-sharing episode was thus presented as the story 'middle' with the reflective prologue as introduction and epilogue as conclusion (McCormack 2004).

Following its composition, I returned the story 'middle' to the participants for review and comment as this was the aspect that re-presented their experience story. Although care was taken to use a format hoped to be conducive to participant understanding and ease of reading (Holloway and Freshwater 2007), no participant feedback on the composed stories was returned. Others (Mauthner and Doucet 1998; McCormack 2004) have reported eliciting participant response in returning or commenting on work shared as a challenge. This may be because active contribution to the research process inevitably constitutes an intrusion into people's lives (Guillemin and Gillam 2004) particularly during the early months of mothering, and their story has moved on. This aspect in terms of evaluating the quality of the study is addressed in discussion of the study limitations [8.4].

The thematic analysis was a synthesis of the data that drew on the women's re-storied narratives of personal experience to construct a collective story that encapsulated experiences from across the participant group. My vision was to present it in a manner that enabled the emergent commonalities and differences within the longitudinal threads of the women's experiences to be illuminated and explored (Clandinin and Connelly 2000). My aspiration in this was to format the story in a way that enabled these aspects to be critically expounded in regard of how they resonated with midwifery practice and educational philosophy and the wider international literature. Choosing this form of presentation enabled the thematic analysis to be progressed to the

sixth and final phase (Braun and Clarke 2006). As Creswell (2013) points out, the re-telling of women's experience in narrative studies can take many different forms. The manner in which I chose to re-tell the women's collective story of experience and addressed the sixth and final phase of analysis is discussed below in [5.7.1].

5.5 Analytical process: Listening to my inner disquiet

5.5.1 My story of being in the gap of dissonance

Having created and utilised a robust scaffold with which to re-story each woman's story of caseloading experience [5.4], I reflected on the resultant story compositions in my research journal. Via this reflective insight, I recognised how the women's voices appeared somehow muted, whilst mine appeared privileged as 'the icing on the cake'. The journal extract below reflects my thoughts on re-reading 'Anna's story' (Appendix 13).

Why am I procrastinating? I am behind I have not met the deadline I set for writing the women's stories.

I have read and re-read my composition of Anna's story and it seems over imbued with my words, reflections and interpretations (which could be construed as judgemental). It's like an artificial construct of confectionary. An over embellished multi-layered cake piled up on an epilogue base of my reflective thoughts. Layers of sponge sandwiched together with my words, a thin jam amidst Anna's rich narrative. The prologue was meant as an introduction to Anna and the context of our story-sharing conversation. Why then do my words appear as the icing on the cake? Where is Anna's voice?

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Reflecting on my use of the McCormack (2004) model to present the women's re-storied stories. I recognised how insertion of a prologue and epilogue to introduce and close each story-sharing episode had fragmented the women's narrative into isolated accounts. It was a literary device incongruent with the stance of this study, which viewed the narrative data

gathered across time as the women's continuing, unfolding and evolving story [4.2]. Indeed, rather than presenting a holistic view of experience across the childbirth continuum, it appeared analogous to prevailing medical discourse of dissecting childbirth into neat component parts (Tew 1990).

Furthermore, employing the McCormack (2004) approach had required use of my voice within the story-text to give coherence and direction to the women's narrative, a device that appeared non-commensurate with my aspiration for the women themselves to share their stories without interruption or signposting from me [5.4.2]. Because of this, I chose to silence my voice in terms of words within the text [5.6.2]. While I recognise this approach has attracted some criticism (Etherington 2004). I have made transparent in [4.3.2; 4.5.1; 4.6] the interpretative processes of researcher and participant, and our relationship and interaction within the interview context through which they were generated (Kvale 1996; Richardson 1990).

In deciding to change my approach to presenting the women's stories, it was important the methods and medium I used had methodological coherence with narrative research philosophical approach, and supported the narrative analysis aspect of the analytical model [5.3] (Bold 2012; Polkinghorne 1995).

5.5.2 Reflectively revisiting my use of thematic analysis

As discussed more fully below in [5.6.1], following much reflection I chose to use poetry as a medium to present the women's re-storied accounts. Choosing to listen to my inner disquiet and make this decision was challenging. It necessitated a return to the two-stage analytical model developed for the study [5.3], and reflective review of how I had utilised the interpretative processes and applied them to the data. This was important because of the interconnected relational nature of the analytical processes within the model. While the analytic processes in each stage were applied to the story data collected at interview, the thematic analysis also drew on the women's individual stories of experience generated through the re-storying process [5.4]. Thus, emergent themes were derived from the interview data and informed by the women's stories developed via the first stage of the analysis and presented using the McCormack (2004) model. Reflecting on

this, I recognised how re-presenting the women's stories as poems held potential to impact on my use of the thematic analysis process.

Reflecting on this conundrum and my use of thematic analysis enabled me to acknowledge the robust nature of my application of the process to the interview data during phases 1-3 of the Braun and Clarke (2006) model [5.4.1]. To progress the model to phases 4 and 5 had required repeated cycles of reviewing and refining the emerging themes. To inform this process I had drawn on the women's accounts re-storied via the McCormack (2004) approach. Reflecting on my use of poetry to re-tell the women's stories, I recognised how its abridged form succinctly captured the distilled essence of each woman's embodied experience (Poindexter 2002). In gaining this understanding, I was able to draw on the poems to aid the process of refining the emerging themes as discussed in [5.6.2]. This was because the women's stories re-told as poems holistically demonstrate the emergent themes derived from the data and thus inform the collective story of the women as a group.

5.6 Analytical process: Repositioning and reframing the scaffolding

5.6.1 My move towards poetry as a narrative format of holistic re-telling

Being in the gap of dissonance challenged me to reflectively reconsider how I would present the women's individual re-storied accounts. Careful consideration of this aspect of the study was essential, as the meanings the readers of this work can draw from the women's narratives are greatly influenced by the manner of their presentation (Furman et al. 2006). Attendance at a creative writing workshop encouraged me to return to the literature and seek alternative and more holistic ways of re-telling. The creative and expressive arts have become increasingly recognised in qualitative research with poetry having long tradition (Ely et al. 1997; Gallardo et al. 2009; Fitzpatrick 2012; Furman et al. 2006). Inspired by the work of Anderson (2007), Davis Halifax and Mitchell (2013), Furman et al.

(2006) and Poindexter (2002), I felt poetry was a suitable medium through which I could capture the real essence and power of the women's stories.

Poetry is a form of artistic media argued to provide a direct way of engaging empathetically with and learning about women's childbirth experiences (Anderson 2007). Because of its abridged form, it is both aesthetic and empathetic (Ely et al. 1997; Bochner and Ellis 2003), and evocatively re-tells embodied experience through distillation of core issues and emotions in a coherent account (Davis Halifax and Mitchell 2013; Poindexter 2002). Using poetry as a medium to present the women's stories of the caseloading experience brings the potential of metaphoric generalizability to the study (Stein 2004). This is not generalizability in the quantitative statistical sense. Rather it is generalizable because of the potential for the self to be located empathetically within the poem, enabling understanding through emotional connection (Gallardo et al. 2009; Furman et al. 2006).

Because of this potential for emotional connection, using poems to re-tell the women's experiences creates a powerful educational resource (Anderson 2007). Poetry highlights ambiguity (Fitzpatrick 2012; Poindexter 2002), it encourages us to revisit the familiar and see it from a different perspective (Anderson 2007). The apparent simplicity and power of the women's words speak to the heart and can be read in multiple ways and convey multiple meanings. Because it effectively and efficiently communicates the woman's emotional world of care experiences (Stein 2004), it can evoke depth of insight, promote reflective ethical understanding, and thus enable transformative learning for professional practice (Anderson 2007). My hope in choosing this holistic way of re-telling is for the poems to engender compassionate understanding within the reader whilst promoting a 'with woman' approach to care.

5.6.2 My process of creating and refining themes

My decision to present the women's individual re-storied accounts as poems has methodological coherence with narrative research philosophical approach (Furman et al. 2006) and supports the narrative analysis aspect of the study analytical model [5.2]. From an epistemological perspective, poetry

is one of the multiple holistic forms of re-telling that narrative analysis draws on and from (Plummer 2001; Richardson 1990). While poetry can be used as a mode of narrative inquiry (Bochner and Ellis 2003) and in other ways throughout the research process, its most common application, as in this study, is as vehicle to re-present the analysed qualitative data (Furman et al. 2006; Gallardo et al. 2009).

Reflectively I returned to the literature and reviewed the stories I had developed through use of the McCormack (2004) model and how these aligned with poetry creation. Consideration of the way in which the women's re-storied accounts were poetically shaped and constructed was important. This is because different poetic forms and structures can impact on the representation of the re-storied experience and give different emphasis (Furman 2006; Gallardo et.al. 2009). I chose to present the poems in free verse form as this enabled the women's words to be used as spoken without embellishment and in the sequence shared. This form of poetic presentation is not lyrical and comprises text lines of differing lengths without rhythmical pattern (Moon 1998). Here, it is the way in which the words are physically laid out on the page that guides their reading (Moon 1998).

To capture the longitudinal threads of the women's student caseloading experience, I began crafting the poems by arranging the story line chronologies (previously constructed via temporal ordering [5.4.1.1]) in stanza form as advocated by Gee (1991) and Etherington (2004). This provided the story chronology with movement and flow and enabled the reader to follow the women's experience story as it unfurled across her childbearing and caseloading experience. Choice of participant words with which to shape and texture the poem was important. This is because the words used are the medium by which the women's holistic experiences are poetically re-told and via which the reader constructs the meanings contained within them (Moon 1998). To re-present interview data from caretakers of people with HIV, Poindexter (2002) drew on methods from linguistics to code and divide participant utterances in order to form poems. This approach did not appear to support the holistic epistemological perspectives of the narrative analysis approach to analysis (Chase 2005;

Frank 1997; Polkinghorne 1988) or the experience-centred narrative framework which informed the study (Squire 2008).

Drawing on methods used by Poindexter (1998) in her earlier work, I returned to the women's interview story-texts. I reflectively reviewed the narrative processes, styles and language features I had identified using coloured highlighters during the interpretative re-storying process [5.4.1.2]. I abstracted those aspects I felt highlighted the women's unique perspectives, personality and expressions to flesh the stanza formations (Poindexter 1998). At this point the re-storied poems contained a large amount of abstracted story data. Reading the work of Furman et al. (2006), Gallardo et al. (2009) and Poindexter (2002), I recognised the need to condense or crystallise the data in order to create a coherent, resonant yet abridged story. This was important, as it is through poetry's intensity, compression and economy of words that the reader is taken on a compelling journey where story plot and characters vividly re-tell the life experience (Gallardo et al. 2009; Furman et al. 2006). Parallel to data reduction techniques across qualitative research, this necessitated reflective decision-making on what story material was crucial and what extraneous (Furman et al. 2006).

This resulted in the composition of poems that re-told the women's experiences in their own words, in the actual sequence in which they were shared. It is the compression of words that provide a window to the storyteller's feelings and commands attention on the essence of the life story (Ely et al. 1997). The challenge for me in re-presenting each woman's narratives as poems was the balance between capturing the real essence and power of her experience through economy of words, while retaining her meaning-making and descriptions of self and socio-cultural context. As Furman et al. (2006) cautions, parsimony in use of words may strip the story of context, and the sense of the woman and her experience may be lost.

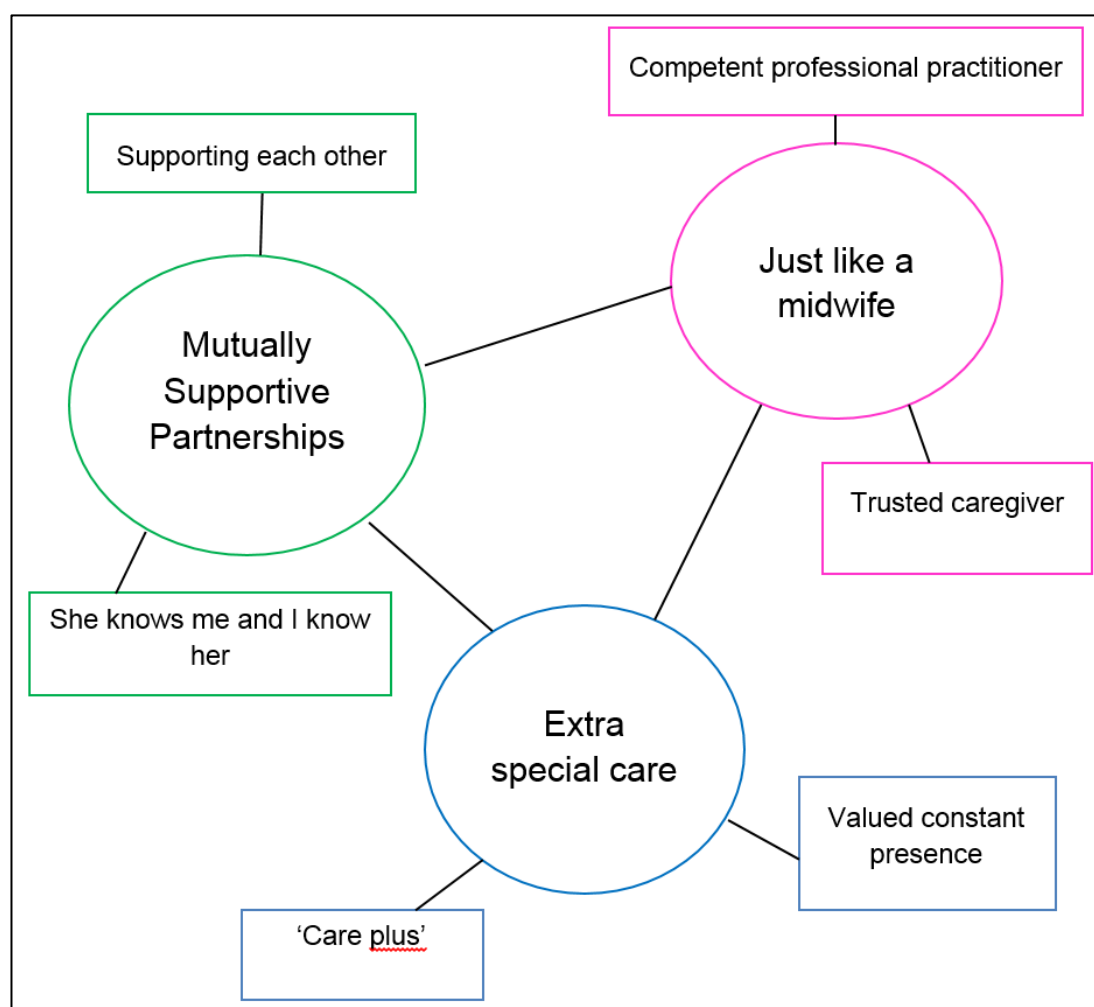
Following composition of the poems, I re-read and reflected on the depth and accuracy of the content. This reflexivity was important in enabling space for amendment. However as discussed in Chapter 4, the story data gathered for this study were recognised as re-presentations of the women's re-telling of

her original experience as shaped through the nature and interaction within the interview context. Composing a story from the raw narrative data is a further abstraction and re-presentation of the original experience (Creswell 2013; Holloway and Freshwater 2007). The poems therefore present a new story, a story generated from the woman's remembered account and the interpretative processes of researcher and participant and our relationship. The poems shared in Chapter 6, are thus recognised as both true and partial, as there can be no singular true story (Bold 2012; Clandinin and Connolly 2000; Richardson 1990).

To progress the fourth and fifth phases of the thematic analysis process, involved repeated cycles of reviewing and refining the emergent themes. This was achieved by reflectively reviewing the data extracts in relation to the validity of the individual themes and the data set as a whole (Braun and Clarke 2006). This included the women's re-storied accounts. This two-stage process enabled the development of coherence within themes and distinctions between themes. During this process, some emergent themes were reflected upon and re-worked to achieve a coherent pattern that represented the collective aspects of data (Creswell 2013; Miles et al. 2014). The second stage involved a similar reflective process focusing on the validity of individual themes in relation to the data gathered (Braun and Clarke 2006).

The fifth phase resulted in themes being refined and defined. Via the analysis, three themes and seven subthemes were discerned, as illustrated in Figure 5-4, p.152.

Figure 5-4: Emergent collective longitudinal narrative themes of phase 5



5.7 Analytical outcomes: creating two interrelated formats of re-telling

To uncover the meanings and significance of receiving continuity of care through being part of a student midwife's caseload to the individual women within the study, and the women as a group, a pluralistic two-stage analytical model was developed that supported both the analysis of narratives and narrative analysis [5.3]. Via the analysis process, two interrelated formats of re-telling or stories within stories were created through generation of individual poems and collective stories of experience. These stories are not distinct entities but relationally interconnected and interdependent [5.4]. While this study did not draw on rhizomatic methodology, a qualitative conceptual practice inspired by the rhizome thinking introduced by the French writers Giles Deleuze and Felix Guattari (Honan 2007; Masny 2013),

the stories generated have parallels with the rhizome as described by Loots et al. (2013), in that they are holistically united and intertwined as a plant root system which branches and coils throughout each part.

5.7.1 Women's holistic experience re-told

While the stories generated via the analysis are recognised as interrelated and not separate entities [5.7], the pragmatics of thesis structural constraints made it difficult to re-tell them together. Because of this, within this work the stories form two chapters. The women's individual stories of experience are shared in Chapter 6, and the collective story of the women as a group in Chapter 7.

As I have reflectively discussed in this chapter, finding a way to re-tell the women's experience stories and share them publicly was a considerable challenge. The medium chosen was important as it is advocated that when using narrative methods, as researcher, I need to make clear to the reader what it is I want them to know (Creswell 2013; Mitchell and Charmaz 1996). My focus was to communicate the embodied stories shared with me at interview holistically, and enable their content and meanings to be understood, without losing sight of the storyteller. My engagement with the literature enabled me to recognise how narrative forms of re-telling can invite activity rather than passivity on the part of the reader, how it has potential to invite the reader into the women's lived world of experience. Choosing poetry as a vehicle to re-tell the women's individual stories of experience, I feel, embraced these ambitions. Its abridged form crystallised core issues and emotions into a coherent account (Gallardo et al. 2009; Furman et al. 2006; Poindexter 2002), using the women's own words (Poindexter 1998). Furthermore, it provided a way for the reader to engage directly and empathetically with each woman and her experience (Anderson 2007; Davis Halifax and Mitchell 2013; Gallardo et al. 2009).

Re-telling the collective story of the women, as a group holistically, was more problematic given the more reductionist qualitative data analytic approach utilised. To illustrate the overall collective experience across time, the final phase of analysis involved viewing the findings from emergent themes within

the wider context of the international literature relating to women's experiences of childbirth and continuity (Braun and Clarke 2006). This was important to promote reader understandings of the significance and meanings of the commonalities and differences within the collective longitudinal storyline threads (Attride-Stirling 2001; Braun and Clarke 2006). To achieve these ambitions, I explore each of the three emergent themes and subthemes, illustrated in Figure 5-4, p.152, as a chronology to illuminate the collective story experience as it unfolded across time (Riessman 2008). Within this discussion, the relational interconnections between themes and subthemes are recognised and their meanings illuminated and critically examined.

The three emergent longitudinal narrative themes of significance to the women as a group, configured around women's perceptions of their caseloading student as:

- learner,
- caregiver, and
- companion

It is useful here to define the term 'companion', which is described as a person who accompanies or journeys with another and spends time with them, assists them and shares in their experiences (www.oxforddictionaries.com 2016). It is interesting to note synonyms of companion include the British formal and informal terms; friend, mate, helper and carer (www.oxforddictionaries.com 2016). These conceptual elements extracted from the emergent themes, create a construct with which to share the collective story of the women's caseloading experiences with a midwifery student. Together, as construct, they act as metaphor to illuminate the collective meanings and significance of receiving continuity of carer from a student care-giver for the study participants.

Metaphors provide a conceptual framework through which we can make sense of and become critically aware of our worlds (Bolton 2005) and are a commonly used tool in qualitative writing to illustrate and communicate meaning (Ely et al. 1997; Miles et al. 2014; Richardson 1990). This is

because, via their comparative qualities, metaphors enable a relationship between what is already known, and the new construct being communicated to be established, to enable understanding (Ely et al. 1997). Constructing meaning through use of metaphoric imagery thus weaves the collective story discussion of student caseloading together as storyline thread, and links its parts to present a coherent whole (Richardson 1990). In discussing these story aspects, women often used the possessive pronoun 'my' to describe their caseloading student. To aid the re-telling, the three conceptual elements; learner, caregiver and companion are used as sub-headings to contextualise and introduce the emergent story themes.

My ambition in re-telling the group stories was to vividly reconstruct the women's experiences, and command attention on their world, their emotions and thoughts (Frank 2004; Holloway 2005). Using an illustrative approach to illuminate my analysis, I provide a detailed interpretation of each theme and subtheme using rich thick descriptions (Creswell 2013), and short quotations from the story data (Holloway and Freshwater 2007). Short quotations verify and "stand out" from the discussion but do not direct attention from it (Richardson 1990, p.40). When grouped, they illuminate diversity within the collective sameness and enable each woman's voice to be heard and distinct (Richardson 1990). This is important when exploring themes or common story threads, as women's voices can be side-lined and "fade into support roles" (Clandinin and Connelly 2000, p.143). The women's quotations are presented in italics, and '...' indicate where speech is omitted, or quotations start mid-sentence. I have added text in square brackets to clarify quotations in regard of people, places and relationships.

Inclusion of rich thick description within the discussion is purported to enhance credibility, and enable the readers to determine whether findings have transferability to other situations with similar characteristics (Creswell 2013). In narrative work, this is concerned with gaining knowledge through socio-cultural understandings and the meanings generated, to illuminate women's perspectives of student continuity (Holloway and Freshwater 2007). I include my voice within the text to enhance "narrative tension" by uncovering incongruities between what I expected and what was shared, and

my surprise at what emerged via the analysis (Frank 2004, p.435). These insights recognise the inter-connectedness of researcher and participant (Clandinin and Connelly 2000), and the body of personal and professional knowledge and understanding I brought to this research [1.1]. Moreover, it is suggested that creating narrative tension in this way may engender new theoretical ideas via enhancing reader awareness and insight into the women's experiences (Holloway 2005).

Chapter 6 Women's individual stories of experience

6.1 Introduction

The unfolding stories narrated by six women at interview generated an abundant amount of rich, evocative and often poignant data affording multiple insights into the meanings and significance of being part of a student midwife's caseload. Via the analysis, two interrelated formats of re-telling or stories within stories were created through generation of individual and collective stories of experience. In this chapter, I re-tell the six women's individual personal experience stories generated via application of a re-storying framework. The chapter concludes with introduction preview to the collective story of the women as a group found in Chapter 7.

6.2 The women's personal stories: An introduction

I present the women's holistic stories of experience in the form of poems without the 'icing' of my commentary or analysis as researcher. This is included in a synopsis of the key aspects that come from each woman's story following its re-telling. My aspiration in this is to promote multiple readings of the stories and enable the reader to bring their own experiences to them. In addition, as I discuss in Chapter 8, choosing this literary presentation created a valuable teaching resource for midwifery education. Within my educational role I can use the stories to inform student preparation for caseloading practice through engaging the students in reflective analysis of the women's lived experiences (Anderson 2007). Engaging students in such practice can promote a rich and powerful learning experience and deeper reflective insights (Leamon 2004; Leamon et al. 2009; Moon and Fowler 2008).

The stories I share here are multi-layered as on one level they are stories of student midwife caseloading on another, stories of childbirth while at the same time, they are stories of women's lives. They are the personal narratives of Jody, Erin, Kelly, Emma, Anna and Ami. I hope they connect with you, the reader, emotionally and speak to you with resonance.

Before reading the stories, you may wish to revisit [4.4.4] to refresh your knowledge of the women and their story context.

6.3 Stories of experience

Jody's Story

It was more reassurance a peace of mind thing

The first time I met her
was the first time I met the midwife
there was a;
'right we need to come round and do your bloods
do all your bits and pieces'
and it wasn't just a flying visit
they were here a good couple of hours
so a good opportunity to chat to her
to gauge her

The thing for me
everybody needs to learn
you've got to start somewhere
and if people like myself don't give them the opportunity
how they going to get their experience or knowledge up
If people aren't giving them the chance?
I thought, I'm easy going
I thought yeah,
I'm okay with it, it's a bonus
I get two midwives instead of one

She was nice enough when she came to see me
and we seemed to get on really well
so I didn't have any issues saying yes to it
and if I've ever got an issue or anything
I can text her and within an hour
I've heard back
literally, if I've got any concerns
I just text her and she gets back to me
and it just puts your mind at rest
cause at the end of the day
I don't want to bother the midwife

I don't see her as a student really
she seems to know her stuff
and comes across as very confident,
knowing what she's talking about.
I've got no doubt that she can do her job properly
anything I ask her,
she's got an answer for me
and if she's not sure she'll say
'I'll find this out for you'
so I've got no qualms dealing with her

It's definitely good to have
I think more so with your first
cause you have a lot more questions
but it's a benefit second time too
cause you've got that extra comfort and reassurance
I know it's a bonus
cause you just think, ha! Got two midwives
but I just see her as my midwife
she's been able to do everything that I've asked her

We established with her last week
if I go into labour
or my waters break,
we'll let her know first
then let the hospital know
then we'll let her know when I'm going in
and it's nice to have her there
just the fact that she said
whatever it is she's doing,
she'll drop and come.

She's always been there
every appointment and
she seems to know when I've got concerns
without me saying anything
and if I'm not sure of something
she can sort of look at me as if to say
'you didn't get that did you?'
so it's a peace of mind thing
cause she always reassures me

She's just very friendly, very approachable
I do see her as a midwife
but she's become a close friend,
a friend that I can ring up
cause it's a very personal time in my life having a baby
and she's played a big part in that for me
I've turned to her and she's been there
and she's done what she can for me
she's a very good friend at the end of the day
and hopefully she's learnt along the way

I knew that when I rung and said I'm in labour
she'd be there
and at the hospital when she turned up it was like
that's it, familiar face!
I know you are going to help me
I know that you know what my fears are
I knew she wouldn't let anything happen to me
I knew she was gonna sort me out, gonna look after me
she knew what I wanted, and how I wanted it
and I knew she would stick by it
which she did, which was fantastic

Yeah I would definitely ask for the student thing again
cause at the end of the day
when she turned up I was like
'oh she's here, she's here'
cause the contractions came so quick
and when she came it was like
'oh she's here, she's going to get it out for me'
and if I had any concerns I could just look at her
and she reassured me
it was so nice to have her there.

I know I will see her at the Friday clinics
I took my son to the doctors'
stuck my head in and she was there
she came round to see the baby
and she said like anything I've got, even now
'just give me a text and I'll help'
you're a friend
and just because I've discharged you
doesn't mean I'm gonna write you off.

I don't see her as just a midwife
I see her as a friend as well
and it's nice I think
cause you do build that relationship with her
and I know that I'll be able to text her
just say hello
see how she's doing
and I'd feel comfortable to text her
if I had any concerns
and yeah, it's really good
I've now got her as a friend

My reflections

Jody begins her unique experience story by sharing her decision-making and rationale for agreeing to be part of a student midwife's caseload. Recognition of the student's need to learn and how she can help is a central aspect within this. Paradoxically however, she articulates strong confidence and trust in her student's knowledge, clinical competence and caring abilities, and identifies the student from the outset as 'midwife'. Within this dichotomy, the caseloading student is perceived as both learner and trusted professional care-giver. As story-receiver, I have found it fascinating how these juxtaposed storyline strands evolved as Jody's story unfolded across the continuum. While Jody expresses concern that her student is benefitting educationally, and is learning from the experience. It is the storyline strand surrounding her confidence and trust in her student's knowledge and abilities as midwife, that for me, becomes the dominant, robust and most vibrant story-strand.

Key threads from Jody's story surround her perceptions of relational continuity, and the meanings and significance of this for her in terms of her comfort and reassurance. While from the outset, Jody, like her colleagues, shares a perception that she will receive better care by agreeing to be part of a student's caseload because she will have not one but two 'midwives'. These storyline threads did not have strong presence at the outset, rather they have woven and meshed across time forming a strong, vibrant and robust story fabric. Jody describes how her student's 'constant' presence, interest, kindness and extra support, contributed to this. Her ability to develop meaningful mutually reciprocal bonds with her student is central strand within this, and she identifies the student's friendly personality traits as an important enabling factor. For me, Jody's story powerfully embodies the meanings and significance of having a known, trusted caregiver for birth for women and the centrality of "familiar face" within this. It is apparent for Jody, her student's presence brought not only joy, but comfort, reassurance and security in an unfamiliar and alien hospital birthing environment.

Like her colleagues, it is apparent Jody experienced feelings of companionship via the caseloading partnership, which enhanced her feelings

of comfort and security. For Jody and some of her colleagues, the companionship engendered grew into feelings of friendship, which Jody experienced as reciprocal. Crafting the skills to develop and maintain professional friendships and therapeutic relationships with women can be challenging, and students may struggle to mitigate relationships within the women-student dyad, particularly following conclusion of the caseloading experience. While maintenance of professional boundaries is foundational theoretical content within the midwifery curriculum (NMC 2009), hearing Jody's story, has the potential to encourage mindful reflective insight (Johns 2005) and aid student preparation for the caseloading experience by providing a lens through which to view self, personal emotions, feelings and perceptions about the educational relational continuity. These key aspects informed the thematic analysis and are explored in the re-telling of the collective story found in Chapter 7.

Erin's Story

Comfort found and comfort lost

I hate going to work
and I just wish
I was on maternity leave already
but I'm so happy
I just can't wait for the baby to be here
but I've always got this little niggling worry
that something's going to go wrong
but that's just me I'm a worrier
I suppose its cause I'm 'high risk'
cause of my high BMI
I just wish I could see the midwives every week
and just get the baby's heartbeat checked
just to hear the heartbeat
just to put my mind at ease.

When I met my caseloading student
I straight away got on with her
and I liked her
and I knew that everything she did
would be checked
but I trusted her
she obviously knew what she was talking about
and she didn't have to ask for any help
and when she asked me
if I would be part of her caseload
I thought yeah why not?
if it helps her learn
cause she's got to learn
everyone needs to start somewhere don't they?

Being part of her caseload
helps me too
cause I get more regular check-ups
than what other pregnant women do
and it's lovely
cause I get to see her once a month
and she listens to the heartbeat
which I like.

She's coming to my
consultant appointments too
and I'm happy she is
cause it's a way for us
to get to know each other better
cause she's gonna be there when I give birth
she's gonna deliver my baby
and that'll be nice won't it?
If we've gotten to know
each other really well.

It's my first baby so I've nothing to go on
I don't know what it's like
not to have a student midwife
but I haven't got any reservations
I trust her
she tells me everything I need to know
so far I've only had her and I don't want it to change
I know her now and she knows me
and I feel comfortable with her
when I take my trousers down
when I bare my tummy
I don't want to have anyone else.

There's nothing
about being part of her caseload
I don't like
I'm not worried about anything
cause I know she's always there if I need her
and if I've got a problem
I can contact her
and she always gets back to me
and I don't feel like I'm missing out on anything
I like having her care for me.

Everything was going fine
everything was normal
then they found I was gestational diabetic
and now I'm on Insulin
it's meant lots of appointments up at the hospital
almost every couple of weeks
and I've seen lots of different people
dietician, diabetic midwife, diabetic consultant...
but I'm dealing with it
and I've been told
my labour is gonna be induced early
so I've literally got two weeks left now.

My student's not my midwife anymore
she was signed off-sick three weeks ago
she wrote me a letter
she explained my community midwife
will take over my care
and obviously her health is really important
but I was sad
I liked her
I got on with her
and I was happy with her
but she did say to text her when the baby comes
cause she wants to pop round for a cuppa
and see me and the baby
so I started off with her and
now I've got the community midwife.

I've gotten to know
my community midwife better since
she's been there to make me feel better
about the little problems I've had
and I'm sure my student would have done the same
it's not her fault she's not been able to
and I kinda feel quite comfortable up at the hospital now
I've been there so much that I've met a lot of the midwives
I'm even on first name bases with the diabetic team
and I know they all know me and I know them
and I've seen women come in with their newborns
and the midwives swarm around cuddling the baby
and I hope they do that with me as well.

They took me in for induction
I had a pessary and then another one
and they didn't work
nothing happened
so they broke my waters
and I had to have three drips
I wanted to move around
I wanted to use the ball
I loved the ball
but I was stuck to the bed
and I was in agony
and after 12 hours of labour
they found her head was stuck
and decided to give me a caesarean
and it was so frightening
cause I'd never had surgery before.

When she was five days old
my wound got infected
and it broke down big time
a big deep hole two inches long
and every single day for the last five weeks
I've had a nurse come round
they tried maggots first
then they put me on a machine
a pump, to draw the wetness out
and the smell
my god the smell
it was so bad we've had to air the flat
an she's five and half weeks old now
and I've only just started to go out
I've been stuck here, stuck here in the flat

My student said to text her when the baby was born
which I did
and I never had a reply
I know she was quite poorly
and perhaps she still is?
and maybe she's upset
because she wasn't able to do my care?
and my community midwife
was only able to come round once
literally I haven't seen the same midwife twice
I've had all different midwives come round
and when I first met my student
and she said she'd be with me the whole way through
it was such a nice feeling
just knowing
that I was literally going to have her
the whole way through.

My reflections

During our preliminary meeting, prior to entering the study [4.4.3], Erin shared her unadulterated joy and excitement at being pregnant and how she had always believed this was something that would not happen for her. Hearing Erin's poignant and evocative story as it unfolded across the continuum was for me, as mother, midwife, student educator, and story-receiver emotionally challenging [4.7.2]. Reflecting here on Erin's story has involved emotion work and proven difficult, but is important to deepen understandings of the embodied meanings shared (Frank 1997).

Erin's unique personal experience story was shaped by strong storyline strands that remained constant across time with no new strands becoming visible or early strands terminated. These storyline strands centred on her desire to build mutually reciprocal bonds with her caseloading student and maternity care givers. The importance of constancy within the caregiving relationship was central within this, and an aspect integral to her comfort and contentment. Erin's serious disappointment and sadness in losing the element of continuity within her maternity care, first with her caseloading student, and subsequently with her community midwife and the 'high-risk' team, is emotively evident. With regard to the educational continuity element, this was unavoidable due to her student's ill-health. But it is important to recognise that health and wellbeing are changing entities, and this can generate a more challenging experience for women. The irony here however, is that Erin sees beyond her student's status as caregiver and views her as an individual with human frailties like her, and the sadness expressed was juxtaposed with compassion and understanding. For me, this not only highlights women's desire to form meaningful partnership bonds with their caregivers but how quickly these relationships were perceived established within the woman-student caseloading dyad.

During our first story-sharing interview, Erin described her pregnancy status as 'high-risk'. Being labelled as 'high-risk' on entry to the maternity services engenders emotion work and women often feel more physically vulnerable, emotionally anxious and worried about their pregnancies compared to the rest of the population (Behruzi et al. 2010; Berg 2005). This can evoke negative perceptions of lower self-efficacy (Berg 2005) and a general sense of powerlessness amongst women (Behruzi et al. 2010). From an educational perspective, I feel hearing Erin's story has the potential to promote empathy and compassionate care via mindful reflective insight (Johns 2005) amongst students and provide a lens through which the centrality of continuity for women at high risk can be understood.

I find it interesting how from the outset, while acknowledging her caseloading student's learner status and her own lack of experience as first-time mother, like Jody and colleagues, Erin shared a confidence, belief and trust in her

student's caregiving abilities. This trust and comfort appeared underpinned by knowledge that the student would be supervised by a qualified midwife mentor and the care provided double checked. Alongside this, was a perception that by agreeing to be part of a student's caseload, she will receive additional benefits not available to women outside the scheme and the quality of her care will be enhanced. Within this dichotomy, the caseloading student is simultaneously perceived as both learner and trusted caregiver.

For me, Erin's story powerfully highlights women's belief and trust in their maternity caregiver's and like Jody and colleagues, their caseloading student. For these women, the partnership bonds within the woman-student caseloading dyad mattered. When for Erin, the caseloading partnership was abruptly terminated, she clung onto the perceived agreement struck and fulfilled her promise to contact the student following the birth. The meanings and significance of not receiving a response from the student left Erin in a gap of dissonance of knowing and not knowing, and without closure to the caseloading relationship perceived established. It is imperative students recognise their professional responsibilities in this and are honest with the women they care for about what they can and cannot offer. I hope via the mindful reflective processes stimulated through hearing Erin's story (Johns 2005), students will be enabled to understand the importance of not raising women's expectations about care aspects they cannot commit too.

These key threads from Erin's story informed the thematic analysis and are explored in the discussion of the collective story found in Chapter 7.

Kelly's Story

Someone else there along the journey

At my first midwife visit
she like introduced herself
and gave me a letter from the university
and she was really nice
she took my blood pressure
and listened to the heart beat of the baby
and my midwife said
do you want to be part of her caseload?
and I was like, yeah.

It was such a shock
when they told me I was pregnant
but contraception don't work for me
it just don't
apart from my first one
they've all been quite a shock
they've all been little accident's
bless them

I got depressed after my second
and I didn't bond with her at all
my sister had her for about two months of her life
she was this beautiful little thing
but I couldn't even say her name
I couldn't even just call her
and I used to think
shall I just wheel her some where
and leave her there
and you can't explain it
you can't even say why.

I had a student before with her
my second
and it was nice
just to have someone
almost guaranteed to be at your birth
and from a certain week
you can ring her 24/7
and not have to worry
and they're quite up
for doing
anything for you.

My other student I had before
was there through my whole labour
and it's the same face
she don't go home
there's no change of shift
and I quite like the idea of that
do you know what I mean?
so yeah
she's going come and deliver my baby
yeah hopefully she'll come down
and be there.

She's been brilliant when I've seen her
really cheery and friendly
and it's just like having a midwife
I don't realise the difference
she asks the same questions
she does the same things
and it's the same as having a midwife
I trust her.

I'm very all for it
she's gotta learn
and she's a midwife to me
anything she suggests I'll consider
I wouldn't ever dismiss it
cause it's fresh innit
her knowledge
it's more practical
cause she's just learnt it
and she'll do everything by the book.

He hasn't met her
cause we're not really together
well sometimes we are
and sometimes we're not
but I don't live with him
he lives with his two children
but he's here all the time
he's about somewhere now
he was only at the birth of my first
and he was traumatised
he won't come again.

I'm really edgy this time
but I think having my student
makes it better
makes me feel a bit better about it all
cause I likes to have my student
cause at least
there's someone else there
along the journey
that I can call if I need to.

I'm not scared about the labour
I'm more scared about
having another baby financially
cause it's difficult with three children
and now I'm pregnant again
it's hard
cause I have to do a lot more
lift them out of the bath and dress them
and then cause they're of mixed race
moisturise their skin
and I enjoy doing it
I do but it's hard.

It's nice having my student
but it probably
don't make much difference
to the whole pregnancy thing
the most difference is
if she can make it to the birth
cause it'd be like having a friend there
a friend that you've built up
a relationship with.

With all my other ones
I've seen a different midwife every time
and the only time I had someone I knew
was when I had the student midwife
but I'm not stupid
I know she might not be there
but when you've got someone
you've built a relationship up with
actually at the birth
it's just like having your mate there
innit?

I've always plodded on to the end
and been quite happily pregnant
but this time
now I've hit 37 weeks
I've almost turned
into one of those moaning pregnant people
and I'd happily give birth now
and I just hope there's a good midwife
cause my student's gone.

I went to my midwife last Wednesday
and she said
my student had gone off-sick
and she'll be off at least eight weeks
but she'd written me like
an official typed up letter
and said she was sorry sort of thing
dah-de-dah.

So I text her
just to say
it was really nice meeting you
la-la-la
but it's a shame
cause I really started
to get comfortable with her
and I was looking forward
to her being at the birth of it
cause she was gonna be
my birthing partner.

I don't know what I'm gonna do now
cause I didn't want to go to the hospital
I was gonna go to the birthing centre
but then I got paranoid after last time
and I panic about it
cause my little boy when he came out
he wasn't quite right
he was this little purple floppy thing
and they took him away
but I still to this day don't know
what was wrong with him,
what happened
I just don't know

I was gonna ring my student first
and see if she's available
and then go to the hospital
cause at least I know
she'll be there
and she's nice
but she's left
so the plan is out the window
and I don't know what to do now.

It wasn't 100% she was gonna be there
but if she was that's something
cause I'm quite OCD
it's more knowing
cause you don't know
who's gonna be there
what's gonna be there
and I just hate ringing them up
I'd rather just ring her
and be like
I'm in labour.

Their dad wants to come to the birth
with this one
last time I had my sister and my friend
an it was really great
and they were gonna come again
just them two
but now he wants to come
and its awkward
cause you're only allowed two people
and I thought I'm gonna have no-one
none of them
I'm just gonna ring my student to be there
but now she's gone.

It's a shame
she was really friendly
but she did say in the letter
she could try and visit
but that's just being polite innit?
an she's just saying it like
but it's weird
although I didn't see her that much
I did start to get used to her
and I felt comfortable with her.

It was just like having a normal midwife
an she was good,
good at what she was doing
and I trusted her
I didn't ever think
'oh you got that wrong'
do you know what I mean?
and I just got on with her
like she's my mate
like a friend
but it can't be helped can it
if she's sick? Bless her.

She came back,
she came back!
Oh, didn't you know?
a week before my due date
she said is it okay
if I take over your care again?
and we texted a lot
and I really felt I built up a bond
with her.

I thought I was never gonna have a baby
but she came to see me
a week after my due date
and did a sweep
and that started it
cause next day my plug came out
and then the pains started
and it all happened
and I text her and she came.

She was there the whole time
and I had the gas and air
cause the other midwife
wouldn't let her give me my Pethidine
and it seemed to take ages
till she broke my waters
but it was really good
that she was there
she delivered my baby.

She did all my postnatal care
and I just saw my midwife
up at the clinic with her on my 10th day
but we did have a bit of a panic
his armpit was all weeping
all swollen
and it really smelt
but I text her about it
and she said take him to the GP
and he's alright now after the antibiotics
but she saved the day!
cause if it hadn't been for her
I might not have taken him.

It's nice to have someone
with you
who's trained
and knows stuff
to me she is a midwife
and I've put her in my phone
Carla 'my midwife'

My reflections

Reflecting on Kelly's story, I recall how humbled I felt by her trust in me as story-receiver, and her sharing with me of intimate descriptions of her personal relational context, as woman and mother. Sharing of these story details illuminates the mother's context, her version of self, reality and socio-cultural identity (Josselson 2011; Squire 2008). Inclusion of this information in Kelly's story was important to enable reader understanding, but also to highlight the centrality of individualised woman-centred care to midwifery practice and for students to see and understand this imperative. Thus, from an educational perspective, I feel Kelly's story has the potential to promote critical reflective appraisal and enable students to see women as unique individuals, with diverse family structures, communication processes and dynamics. Moreover, it provides a lens via which to facilitate enhanced reflective insight into what, as midwives and students, we see and hear in our communication exchanges with women, and in how we respond. I hope, as others have reported, using Kelly's story as educational resource will engender empathetic understanding amongst students, and the central importance of a humanised consumer-centric approach to midwifery care

(Agnew and Duffy 2010; Happell and Roper 2003; Klein et al. 1999; Maughan et al. 2001; Rush 2008; Wood and Wilson-Barnett 1999).

Dominant storyline threads for me, from Kelly's unique story centre on her desire for continuity from a known caregiver during her childbirth journey. One element in common with other research from midwifery caseloading models, is to be supported during labour and birth by someone with whom she has developed relational bonds (Allen et al. 2017; Corcoran et al. 2017; Jepson et al. 2017a; Leap et al. 2010; McCourt et al. 1998). Within the context of the educational continuity initiative, as Aune et al. (2012) reported, it seemed of little importance to Kelly if this was a student rather than qualified midwife. Drawing on her previous experience of student caseloading, Kelly poignantly shares the meanings and significance of this for her, in her analogous use of it being like having a 'friend' or 'mate' attend her at this intimate and personal time.

The longitudinal threads from Kelly's story illuminate the relationship she developed in this pregnancy with her new caseloading student and the meanings this had for her. Particularly evocative for me, was Kelly's sense of loss, dismay and confusion when the student is no longer available due to sickness, and her subsequent joy at the student's unexpected early return and resumption of care. I found Kelly's description of relational bonds perceived forged with the student across the short time interval between the student's return and onset of labour fascinating. As discussed previously, building these strong relational connections with their student companion appeared an important need for women, and were often established quickly.

Like Jody, Erin and colleagues, from the outset, Kelly shares her belief in the caseloading student's need to learn. However, at the same time, she articulates confidence and trust in the student's knowledge and caring abilities. She perceives no difference in quality and content of the care given by the student from that provided by a qualified midwife. Interestingly, she considers the student's knowledge as more up-to-date and 'practical' because it has just been learnt. Within this paradox, the caseloading student is simultaneously perceived as both learner and trusted caregiver. These

storyline threads inform the thematic analysis and are explored in discussion of the collective story found in Chapter 7.

Emma's Story

Seeing the same midwife all the way through

She was there at
my first midwife's appointment
and she explained a bit about it
and I thought it would be nice
just to see the same midwife
all though the pregnancy
cause I think it's quite nice for that.

With my first
I saw a really nice midwife
all throughout my pregnancy
an I really felt I got to know her
and when she came round
after I gave birth it was nice
but with my second
I had a lot of different midwives
I never saw the same midwife twice really
and it wasn't so good.

Hopefully this will be
a low risk one
cause I'm hoping to have
it at the birth centre
my other two pregnancies
were low risk
well quite low risk
and I was going to talk
to her about it.

She's a very friendly person
and she told me I can ring her
but we tend to text each other
and it's quite nice
like I went to my scan
'how was your scan?'
and I quite like that
it makes you feel
more like it's your friend
and it's really nice.

Even though she's a student
I trust her
she's very confident in her job
and she seems to know what she's doing
where I've had children before
I know what midwives should be doing
and she's doing
everything a midwife would do.

She comes here for my appointments
and she does it all
takes my blood for a blood test
and cause it's all done here
it saves a bit of trouble
I don't have to trek somewhere
and take the kids
and if I've got any problems
I can ring her
and it's much easier.

When I was 33 weeks
I saw the midwife with her
normally it's just my student
on her own
but the midwife took a step back
and my student did all the appointment
so it wasn't any different
It was just the same.

I thought the baby was getting engaged
and she checked
and said the baby's head was low down
but she didn't say
whether it was actually engaged or not
and I don't think she was confident enough to say
I did want to say to the midwife
do you want to see if you can tell?
but I didn't want to say anything
In front of my student
and I just left it
I didn't want to make her feel put out.

It's no different from having
any other midwife really
an it's actually quite good
cause she has more time for me
cause where other midwives are busy
women don't get so much time
like my friend had a bleed
When she was 30 weeks
and her midwife was like
'oh it's my day off today'
whereas I know if I ever need her
I can just text or ring her.

Everything's fine
I just hope I haven't
got too much longer to go
I'm due to see her on Friday
and we're gonna do my birth plan
cause where I do
have the babies early
I need to think about that.

I'm gonna to call her
when I go into labour
cause she made it clear
I need to let her know
when things start happening
but I feel really nervous about the pain
that's what I'm scared off
cause with my last it was really hard
and it was so much pain
It was terrible.

She was born two days before my due date
I went into labour on my own
I was getting backache pains
and I texted my student
and she thought it could be the early stages
and it was
cause then I went into
full blown labour
and I gave birth in the early hours
of the morning
and the pain was horrendous
I just think it gets worse each time.

Would you believe it?
as I got into hospital
my student was going home
I text her a few hours before I went in
and she said
'my other patients in labour'
and I thought oh gosh
what shall I do?
cause she wasn't able to stay for my birth
cause she had already done
a 12 hour shift.

I had hoped she'd be there
cause all through the pregnancy
you plan it
but I suppose nothing goes to plan
when you are in labour
and I felt alright about it actually
it was more my husband
who was worried
but I rang my mum
and she came in
to be my birth partner.

My student did most of my postnatal care
and she helped
with the breastfeeding
and she helped me a lot
cause I didn't breastfeed my other two
she sat me down and did
a breastfeeding observation
and after I had the conversation with her
I could latch the baby on properly.

I enjoyed having my student
I only saw the midwife
twice through the pregnancy
and I was fine with that
and it was nice
cause she came here
and I didn't have to
go to the clinic hardly at all.

I know she's a student
but I always see her as a midwife
cause she's very professional
and she seemed to know
what she was doing
and I trusted her
and I just think
she's a brilliant midwife.

Yeah I'd recommend having a student
cause it's nice
just to see the same midwife
all the way through
I've really enjoyed it
and it was nice to get to know her
and I liked the fact
that she had more time for me
and I could text her at any time
and she'd always reply
and we did say
that we're gonna keep in touch

My reflections

Dominant threads that come from Emma's story surround her desire for continuity of carer and the meanings of this for her. For Emma, a strong correlation exists between continuity and satisfaction. Drawing on her previous pregnancy experiences, Emma equates this type of care as being more personal, more woman-centred and individualised. Embedded within this storyline theme is Emma's desire for mutually reciprocal relationships with her caregivers. It appears of little importance to her if this is provided by a student rather than qualified midwife. Emma's story illuminates the nature of the relationship she developed with her caseloading student and the meanings of this for her. Like Jody, and others, she identifies the student's friendly personality characteristics as an important enabling factor in forging the continuing friendship perceived developed.

I find Emma's disappointment at not having her caseloading student present for the birth as planned and anticipated, particularly evocative. However, it is important to recognise the student's adherence to professional and university guidance (Fry et al. 2008), and I commend her decision-making in this. At the

same time, it is of equal importance to recognise how this can generate a more challenging birth experience for women. Like Kelly, the sense of loss, dismay and confusion Emma expresses, powerfully illuminates the meanings for women of having a known caregiver with them through labour and birth (Allen et al. 2017; Corcoran et al. 2017; Leap et al. 2010; McCourt et al. 1998), and the negative emotional work evoked when this is not possible (Jepson et al. 2017a). It is interesting how on hearing of the student's unavailability, Emma called for her mother, someone known and familiar, to be with her and the meanings knowledge of her mother's availability and impending arrival had for her, in terms of her comfort and ease. This has resonance with recent summarisations of research around doula care (Steel et al. 2014), and Rosen's (2004) conclusions that women find support from other women at this intimate and personal time in their lives beneficial.

From the outset, like Kelly, Emma identifies herself as an experienced consumer of maternity care. While identifying her caseloading student as someone who is learning from the beginning of the caseloading relationship, she articulates trust and confidence in her student's caring abilities. She perceives no difference between the care given by her student and that from a qualified midwife. Within this dichotomy, the student is perceived as both learner and trusted caregiver. Alongside this is a perception that being cared for by her caseloading student enabled her to receive extra information, attention and support and more flexible care than that available to other women. These key story aspects are unpacked in the re-telling of the collective story found in Chapter 7.

Anna's Story

It was amazing better than I expected...

The midwife put forward the student
said she was lovely
and I just thought everybody's got to start somewhere
and thought it would be nice to help someone out
but possibly a little selfish part of me thought
I'm gonna have extra special care
because I've not just got one person
I've got another person looking after me
as well.

I'm going to have the baby at home
cause I've always had a funny little thing with hospitals
and a friend of mine inspired me
she said it was a really great experience
because she felt more comfortable
and she could do whatever she wanted
jump into the bath have a shower
so yeah
it's my first baby
and I'm going to have it at home.

At the initial meeting
the student was due to come with the midwife
but in the end the student just came
and I don't know if that was contrived or not
to make the make the meeting
with me and her more personal
but I don't mind if it was
because it was really nice to have her there
and just get to know her a little bit.

She has been fantastic
she's so very thorough
and she'll explain everything
really, really well
and it's really nice
you can tell she's really excited
and it's just making it a little more personal
I'm not just some lady who's having a baby
I'm Anna.

She's very competent
and very confident
she's always straight in with an answer
but I always try to find some questions to ask
and look on the internet and things
because she needs something to get the brain working
but she's just a star
and explains things so thoroughly.

I'm actually her first case
so I know I'll be special to her
and she'll be special to me
because it's my first baby
and I just feel so lucky
because I know from my friends experiences
they've seen several midwives
and not seen the same one the main event
whereas I know she's going to be there
which is reassuring in itself.

Yeah we've got a little bond
and she's special to me
and I know I'm special to her
I'm not leaning on her completely
but I imagine she's going to be
an integral part of my support and comfort
and I feel really lucky Stella
and I'm very, very happy I've done this
because I've got that extra support
and it's nice.

You know we feel really fortunate
a little spoiled with the care we've had
because this is a big thing for me
I've chosen to have a child and I've never done it before
and it's consistently been the same people
so you build a kind of rapport
and they've picked up I like things a bit more natural
and said things like 'oh 37 weeks
are you going to start your raspberry leaf tea?

Her care's been very consistent
more thorough than I expected
and I feel completely confident
because we've done our birth plan together
and it's quite sweet
she's on call for us now
and we've sent little messages just to say
'oh congratulations you are on-call'
and 'congratulations you can have your baby at home now'.

I had a bit of a show
and a few funny things
and my student predicted
I'd have the baby by the end of the week
and she was more in tune than me
she said 'I was lying in bed and
I thought Anna's gonna have that baby tomorrow'
and then I did
whereas I thought I was just constipated!

All night I had backache and achy pains
but I waited till the morning to phone her
and I kept in contact with her throughout the day
and she was checking up on me
and giving me advice to keep active
keep rocking
and just let the baby move through the passage
and she was really calm as well
cause I thought I was going to cry when I phoned her
but she was so reassuring
absolutely spot on.

It was amazing Stella
better than I ever imagined
it makes me cry thinking about it
cause it wasn't like I had practitioners or midwives
it was like I had friends there
like I had company
like I wasn't on my own
and it was like they cared as well
it was amazing
really amazing.

She was born at home in the water
a little Pisces
and I'm so pleased for my student
to have that memory of her own case
and she was helpful with the breastfeeding
and gave me confidence
to think I was doing it properly
but she was amazing on the day
she literally did do my delivery.

It has been a positive experience
I've had her all the way through
and you do bond with people
to have that experience with them
cause it's been quite a symbiotic relationship
I've been her first case and it was my first baby
I'd hate to think
well that's it now
I just disregard these people.

My reflections

Anna's personal experience story was shaped by strong storyline strands that remained constant throughout her childbearing journey. No new strands became visible or previously existing strands terminated. These storyline strands were firmly grounded within the naturalistic paradigm shaping Anna's view of the world. Relational continuity appeared a central strand enmeshed within this. As story-receiver, I have found it fascinating how these strands have slowly woven over Anna's unfolding story into a strong vibrant fabric embedding her caregivers' story within that of her own. Anna's sharing of the raspberry leaf tea story is insightful, demonstrating the importance of relational continuity. It is apparent this approach enabled her caregivers to work in a way in-tune with her naturalistic beliefs.

From the beginning, Anna has seen her caseloading student as an integral part of her support, as a confident, and competent central member of her maternity care team. She shares a perception that by agreeing to be part of a student's caseload she will receive extra special care. Like Jody and colleagues, this is because she is being given not one but two care providers. Anna describes this enhanced care as extra support and information. This is underpinned by knowledge that her student will be supervised by a qualified midwife mentor and the care provided double checked. Anna continually talks about her student's learner status and her desire to contribute to the student's learning and professional development. For me, it's Anna's description of how this engendered a symbiotic relationship of learning together and the special bonds this engendered that is particularly evocative. Within this dichotomy, the caseloading student is simultaneously perceived as both learner and trusted caregiver. These key

threads for me, from Anna's story inform the thematic analysis and are unpacked in the re-telling of the collective story found in Chapter 7.

Ami's Story

Mutual newness: learning together

My community midwife mentioned it to me
about how the student could take over my care
but she would still be my actual midwife
the student would do most of the stuff
and it would just be more flexible for me
cause she could come to my home
it just seemed more convenient
because my boyfriend and I both work
I thought it would be easier
to have something more flexible

It's been good
she's done all my appointments at home
she's coming in a couple of weeks to do my 28 week one
she's does everything here even takes my blood
she's always comes on her own
she hasn't said anything about coming with anyone
she lets the midwife know after my appointments
and the midwife will come next time
if she's got any concerns
but at the moment it's all been fine
so yeah, bit more convenient

I've got her number
she said contact me whenever
that's another thing I like about having a student
because you've got the two people
you've got the student as first port of call
if you can't get hold of the student
then you can go to the midwife
yeah, two for the price of one!

I feel really confident in her
she's always writing notes down
she fills out my notes like really, really thorough
and she asks me all the questions that need to be asked
any questions that I have
she always answers them
if she doesn't know she'll ring the midwife and double check
she's really, really good with it all

It's my first child
I don't know what to expect
and I've got a lot of questions
it's nice to have someone
who doesn't mind me asking them
no matter how silly they are
and it's nice she's learning too
we can bounce off each other
and she's finding things out she didn't know
because I've asked them

It's nice just having that bit more support
And to have someone who's learning
at the same time as being with me
she's so enthusiastic about wanting to know stuff
when I don't message her
she's like 'message me!
I just want you to ask me questions'
she's so enthusiastic
It just makes me feel a bit more secure
a bit more special

Yeah she's been amazing
she researches my medical condition
she'd never heard of it before
and she's researched what pregnant people
with that condition have gone through
If they've had a natural birth
If they've had a Caesarean
And It's nice cause she
relays the information back to me
so it's helping her
and it's nice for me as well

She's on on-call for me now
and she only said
'call me any time day or night'
so if anything does happen
and I go into early labour
then she's there
she'll be there for my Caesarean
and she's going to come and see me
after my surgery too

It's just nice having someone there all the time
someone who's learning at the same time
it's nice cause we sit here for hours
last time we did my birth plan
time before that we did breastfeeding
and because she's learning
she makes sure she covers every single point
she doesn't just skim over it
like someone might who's done it for years
she teaches me properly
so I get all the information I need

I was booked in for my Caesarean
but I started having contractions a week before
I thought they were Braxton Hicks
but when they got down to every 5 minutes
I rang her
and she was like
'get down to the hospital,
and I'll meet you there'

So he was born 8 days early
and she was there for my surgery,
bless her I got her out of bed
but she saw it all
she did the weighing and the first bit of my care
and she stayed with me
which was good
and she didn't leave till 4 o'clock in the morning

She's been amazing the whole way through
she did all my postnatal care
and it was nice to see a familiar face
a midwife come round once
because we'd moved
It was someone I'd never met before
It was a bit kind of weird, different
It was nice having my student
because she'd been there the whole way through

To be honest
I liked having her there
she was there on the night I gave birth
even though he was early
she was there to be called
and cause she was learning
she was always going over things
making sure I knew everything I needed to know
she would always text or call me
and make sure I'm okay
and it was really nice to have that
all the way through

I'll think we'll keep in touch
she came 'round last week
and brought him a little present
and I think I'll see her quite regularly
so she'll always watch,
watch him grow-up

My reflections

Ami begins her unique experience story by sharing her decision-making and rationale for agreeing to be part of a student midwife's caseload. This centres on a perception that she will receive care that is more flexible, and convenient, and will be tailored to fit around her, and her partner's work needs and context. Alongside this, like Jody and colleagues, Ami also considers that she will receive a better quality of care, and will have greater access to caregivers than other women because she will have not one but two people caring for her. As Ami's story unfolds, however, constructs around convenience have less presence rather it is the concept of having and receiving better care that becomes the stronger, more dominant and vibrant storyline strand.

For me, key threads from Ami's story centre on the meanings and significance for her of relational continuity from someone who is learning, in terms of her comfort, reassurance and security. Ami describes how her student's constant presence, interest, enthusiasm and extra support, contributed to this and engendered a sense of feeling 'more special'. Her ability to develop meaningful mutually reciprocal bonds with her student is central strand within this, and she identifies the student's learner status as an important enabling factor. Ami recognises and respects that the student

needs to learn and rather than being fazed by this, almost sees it as an opportunity for shared learning and thus mutually beneficial, which I feel demonstrates real reciprocity in the relationship.

I find it interesting how from the outset, while acknowledging her caseloading student's learner status and her own lack of experience as first-time mother, like her colleagues, Ami articulates strong confidence and trust in her student's knowledge, clinical competence and caring abilities. This trust and confidence seemed underpinned by the student's professionalism in ensuring all information and caregiving was double checked by a qualified midwife, her abilities in answering questions and thoroughness in caregiving. Within this dichotomy, the caseloading student is perceived simultaneously as both learner and trusted professional caregiver. However, paradoxically, it is because the student is still learning that Ami, like Kelly, considered the information she received was more in-depth and the quality of care enhanced, with no aspect skimmed over. This links with Ami's comment about how she and her student sat chatting 'for hours', which hints towards the student giving of time that qualified midwives might find difficult to accommodate within their working day and other workload commitments (Boyle et al. 2016; Downe et al. 2015) although it's important here to recognise that stories shared at interview are not necessarily factually accurate (Josselson 2011; Lieblich et al. 1998). This could have been an embodied response to the personal relational bonds formed within the woman-student dyad, the sense of connectedness engendered and the concept of sharing time together.

It is apparent from Ami's story, that she experienced feelings of companionship via the caseloading partnership, which enhanced her feelings of comfort and security. For Ami, like some of her colleagues, the companionship engendered grew into feelings of friendship, which Ami experienced as reciprocal. For me, there is something about these expressions of friendship and the time of their sharing with me. This centres on women's expectations that they will move forward in the future, and I wonder how many of these friendships do. Reflecting on this, I also wonder

how and if the boundaries of professional friendships are maintained and upheld over time or if they are re-negotiated and dropped.

These dominant story-strands from Ami's story informed the thematic analysis and are explored in greater depth in the re-telling of the collective story in Chapter 7.

6.4 The women's personal stories: conclusions drawn

The narrative poems of Jody, Erin, Kelly, Emma, Anna and Ami shared in this chapter, powerfully and poignantly portray this group of women's experiences of being part of a student's caseload, and the meanings this had for them personally. The women's stories evocatively identified how important a contribution known carer is for women and provided a window into the reality of the consumer experience within contemporary service delivery in the UK. The significance of relational continuity for women in terms of their comfort, reassurance and security across the childbirth journey, was powerfully evident within the women's stories, and for Jody, Erin, Kelly, Emma, Anna and Ami, it seemed of little importance if it was a student rather than qualified midwife, who provided this care. Having a known, trusted caregiver for birth and the centrality of 'familiar face' was key within this, along with the fundamental importance of a humanised woman-centred approach to midwifery care.

The six women's personal narratives identified that the women in this study wanted to contribute to their caseloading student's education, and felt their involvement not only important, but essential in supporting the students learning journey to becoming a qualified midwife. In addition, the stories powerfully revealed women's desire to form meaningful partnership bonds with their caregivers. For these six women, the mutually reciprocal relational bonds perceived developed within the woman-student dyad mattered and was identified as central to their comfort and sense of security. The women's stories described the feelings of companionship they experienced, which for some grew into feelings of friendship and were perceived as mutually reciprocal. Crafting the skills to develop and maintain professional

friendships and therapeutic relationships with women can be challenging for students and the women's stories revealed that some students struggled to maintain appropriate professional boundaries within the caseloading relationship.

In sharing their stories, the women identified their caseloading student as a learner, as someone who required supervision from a qualified midwife. This was juxtaposed with a belief that the student had competent caregiving skills and did everything a midwife would do and the narratives reveal poignant expressions of emotion as women identified the qualities they most valued in a midwife embodied within their caseloading student care provider. Within this dichotomy, the student is perceived as both learner and trusted caregiver. Alongside this was a perception that being part of a student's caseload would enable a greater level of attention and support and more flexible care than that available to other women. This engendered a sense of feeling more 'special', and the women saw their student as a 'constant companion', as someone who was available to access when required to answer queries and offer support or reassurance. When the caseloading partnership was unexpectedly and abruptly terminated due to student ill health, the emotively palpable sense of loss the women exhibited within the stories powerfully illuminates how this left women feeling bereft and disappointed.

These key story aspects are unpacked and explored in greater depth in the next chapter, which re-tells the women's collective story of experience as a group. This collective story captured the emergent longitudinal narrative themes of significance to the women as a group through application of a thematic analysis.

Chapter 7 The collective story

7.1 Introduction

Via the analysis, two interrelated formats of re-telling, or stories within stories, were created through generation of individual and collective stories of experience. Having retold the women's individual stories of experience in the previous chapter, in this chapter I share the women's collective experience. This story captured the emergent longitudinal narrative themes of significance to the women as a group through application of a thematic analysis. The three story themes discerned of: mutually supportive partnerships, just like a midwife, extra special care, exemplify commonalities and differences across the longitudinal threads of the women's experiences. The women's stories are grounded in the socio-cultural context of time and place of telling but also situated within the wider world story context of the NHS, research, evidence and other world events. During the analysis, this often caused much reflective deliberation as to where story themes sat in the wider context of contemporary service provision, education and practice. This process enabled me to recognise that the emergent story themes and even subthemes are not separate entities but demonstrate many relational interconnections as illustrated in the rhizomatic thematic networks [Chapter 5, Figures 5-3 and 5-4]. In re-telling the collective story across time, I explore the story themes and subtheme strands as a chronology and present in this discussion these meaningful interconnections. This chapter links these key areas to contemporary international literature.

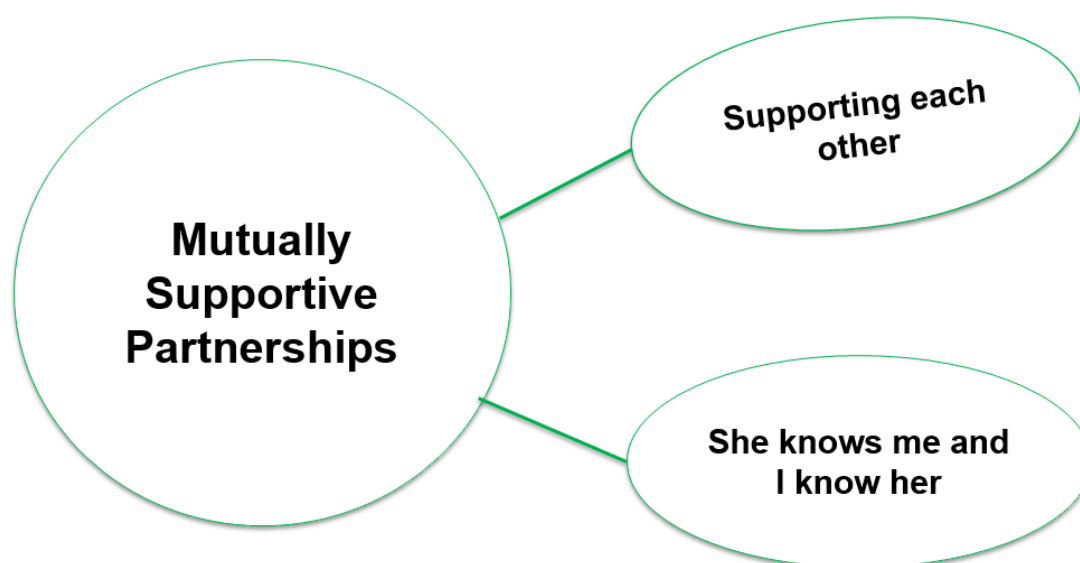
As storyline threads, the three themes shape the re-telling of this collective story. In discussing these story aspects, the three conceptual elements; learner, caregiver and companion, create a construct regarding women's perceptions of student caseloading [5.7.1]. I share the collective story below using these concepts as sub-headings to contextualise and introduce the story themes.

7.2 My student learner: Mutually supportive partnerships

All women recognised their caseloading student midwife companion's status as that of learner, as someone working to develop the relevant knowledge, attributes and skills required for professional practice as a qualified midwife. The story theme 'mutually supportive partnerships', describes women's perceptions of the reciprocal nature of the relationships developed with students within this context through relational continuity, and the meanings and significance this had for them.

Two subthemes made up the overall storyline theme of 'mutually supportive partnerships.' Most women felt they contributed to their student companion's midwifery education and believed their involvement important, as the student needed to learn. They described how this recognition engendered a reciprocal relationship of *supporting each other*. This developed through the mutual supportive 'give and take' within the woman-student dyad, fulfilling the women's own needs as well as those of the student. All women expressed a desire to connect and forge relationships with their student caregivers. *She knows me and I know her* illustrates women's perceptions of relational continuity with a known student across their childbearing experience. The students' personalities positively enhanced relationships within the woman-caseloading student dyad. Women expressed a belief this enabled them to form special bonds with their student and work in partnership with them. These subtheme story strands are illustrated in Figure 7-1, p.199.

Figure 7-1: Story subtheme strands for 'mutually supportive partnerships'



7.2.1 Supporting each other

During our first story-sharing conversation, the women shared why they agreed to be part of a student's caseload. Resonating with Browne and Taylor's (2014) findings, for the majority this was in part articulated as a strong desire to contribute to the student's midwifery education, to help someone out. As Anna and Erin discuss:

"You know everybody's got to start somewhere and I just thought it would be really, really nice to help somebody out" [Anna1, p.2]

"I thought yeah why not because you know if it helps other people...everyone needs to start somewhere don't they?" [Erin1, p2]

The women's recognition of their student companion's need to learn, and how they could help was central within this:

"I'm very all for it [student caseloading], do you know what I mean? She's gotta learn" [Kelly1, p3]

"Everybody needs to learn and you've got to start somewhere and if people like myself don't give people the opportunity to do the studies

then it's the how they going to get their experience or um knowledge up if, if people aren't giving them the chance to help?" [Jody1, p.1]

For Erin and Anna, this altruism was mitigated by knowledge that a qualified midwife would supervise the caseloading student and the care she provided double-checked:

"I knew that she was gonna have a mentor it wasn't like it was just gonna be her um and every time she did anything it was always checked afterwards even if she and I were in a room on our own" [Erin1, p.2]

"They were saying that anything I would have, anything that happened would be reported back to Lauren [midwife] afterwards, anything that she [student] worries about." [Anna1, p.4]

The literature is largely silent about women's rationale for agreeing to midwifery student participation in care. However, this altruistic attitude amongst pregnant women toward students has been consistently highlighted in studies exploring medical student involvement. These studies have reported women's positivity toward medical students as part of the hospital team (Carmody et al. 2011), within the clinic setting (Ching et al. 2000; Hartz and Beal 2000) and during intrapartum care (Grasby and Quinlivan 2001; Magrane et al. 1996; Nicum and Karoo 1998). The desire to contribute to the education of future physicians was reported as the primary factor influencing women's decision-making in a number of studies (Ching et al. 2000; Magrane et al. 1996; Nicum and Karoo 1998; Woolner and Cruickshank 2015). Woolner and Cruickshank (2015), in a UK survey of 207 pregnant women's views on medical and midwifery student clinical education, reported women were more likely to accept midwifery students compared with medical students ($p=0.02$). However, women expressed concerns about a lack of safe and competent care when students are involved. The majority of women 73% ($n=151$) reported knowledge of student supervision would make them more likely to consent to student participation.

Resonating with the wider literature, not all women shared an interest in or a desire to contribute to the student's education from the outset of the caseloading relationship (Carmody et al. 2011; Ching et al. 2000; Grasby and Quinlivan 2001; Hartz and Beal 2000; Magrane et al. 1996; Nicum and Karoo 1998). For Emma and Ami, this was a storyline strand that emerged later in the experience. As story-receiver, I found it interesting to hear how this concept informed and shaped the relational context within the women-student dyad as the women's stories unfolded across the caseloading experience.

Women talked of how relational continuity with someone who was learning, created a sense of connectedness and the formation of personal bonds [7.2.2]. Snow (2010) reported women felt a sense of solidarity with the students caring for them during labour, which was founded on both being novices, a 'mutual newness'. For first-time mothers Ami and Anna, this sense of mutual newness engendered special bonds, a connectedness exemplified as a symbiotic relationship of learning together:

"I'm actually her [student] first case as well, so I know I'll be a bit special to her and she'll be special to me because it's my first baby. You can tell she's really excited, which is really nice because it's making it a little more personal...now that we've got a little bond because she's special to me and I'm special to her, so it's nice."
[Anna1, p.3-4]

"With a first baby you don't really know what to expect so where the student's learning their teaching the first-time mum as well so they're kind of bouncing off each other, which is really nice...it's kind of learning together." [Ami2, p.5]

Research evidence has consistently demonstrated the importance of the quality of relationships with caregivers to women's experience of pregnancy and childbirth (Anderson 2010; Berg et al. 1996; Frei 2011; Halldorsdottir and Karlsdottir 1996a; 1996b; Hunter 2006; McCourt and Pearce 2000; McCourt and Stevens 2009; Proctor 1998; Williams et al. 2010). Women commented on their appreciation of the relationship they had with their student

companion, which was described as mutually supportive. Analogous with the women in Twinn's (1995) English mixed method study of mothers' experiences of student health visitors participation in care, the women expressed a willingness to participate in their caseloading student's learning, often demonstrating a caring approach to students. Being caring necessitates existence of a personal connection, a 'sharing of one's humanity' (Pembroke and Pembroke 2008, p.322). This was manifest through knowing each other, where women felt the student knew them and they knew the student (McCourt and Stevens 2009). Distinction exists between the concept of 'caring for' and 'caring about'. 'Caring for' is constructed within the context of care work whereas, 'caring about' is conceptualised as a 'natural' feminine maternal instinct (Sevon 2007). Congruent with the findings in the study by Finnerty et al. (2007), women in my study sometimes experienced episodes of care where the student appeared uncertain or lacked confidence. When this occurred, women exemplified this caring attitude through a sort of motherly, maternal supportive understanding:

"She [student] took my blood pressure, listened to the baby's heartbeat. She couldn't find it though [laugh], well she did for about 10 seconds and then it went and she couldn't find it again. Though it was very early, so she's alright she's still learning isn't she?" [Kelly1, p.2]

"I felt the baby really low down and I thought the baby was getting sort of engaged and Susie [student] felt it. She said I think the baby's head is down but she didn't say whether it was actually engaged or not...I don't think she was confident enough to say whether it was or not...I did want to say to Sharon [midwife] do you think you want to have a feel to see if you can tell but I thought no, I didn't want to say anything in front of Susie and make her feel sort of put out you know? So I just sort of left it" [Emma2, p.5]

This motherly, supportive understanding extended beyond pregnancy and recognised the student's learner status and clinical expertise, as Anna describes when talking about her home birthing experiences. Research

demonstrates women's primary rationales for choosing home birth are the increased autonomy it affords and a view of birth as a natural process (Jouhki 2012; Sjoblom et al. 2006; Boucher et al. 2009; Walsh 1999). It is a social rather than medical event, where the locus of control rests with the woman (Walsh 1999) and midwives report they used a different approach when attending women at home than in hospital (Blix 2011; Dahlen et al. 2010; Foley et al. 2003). This centred on preventing, avoiding and protecting the woman from disturbance to enable her 'to go into herself' (Blix 2011, p.688). In determining when to perform observations to assess progress of labour and maternal/fetal wellbeing, midwives drew on intuitive/personal knowledge rather than adhering to the regimented regime associated with hospital-based biomedical models (Blix 2011; Dahlen et al. 2010). Home birth figures remain unchanged since 2012, and account for 2.3% of all births in England and Wales (ONS 2016b). Given the small number of women choosing home birth, crafting the skills to work with women in this way can pose challenges for students more used to drawing on biomedical knowledge within institutional settings, as Anna insightfully discusses:

"She [student] was amazing on the day...she literally did do my delivery she may have had advice from the ladies [midwives] um I think it was a little bit difficult for her because she was so used to hospital high risk so whereas she wanted to do everything on the dot the other ladies could see 'okay she's in a full blown contraction, let's just give her a minute and we can see she's safe and we'll do the [fetal] heat beat in a second'. So it wasn't quite as regimented as I think it would be in hospital. I think she found that a little bit difficult at points which I can perfectly understand but she was amazing really."
[Anna3, p.6]

Echoing the wider literature, women talked of the importance for students to have opportunities to work in clinical practice prior to qualification (Carmody et al. 2011; Grasby and Quinlivan 2001; Nicum and Karoo 1998; Richards 1993; Townsend et al. 2003; Twinn 1995; Woolner and Cruickshank 2015). Consumers in these studies felt the experience enabled students to gain knowledge of practice (Carmody et al. 2011; Grasby and Quinlivan 2001;

Nicum and Karoo 1998), practice clinical skills (Townsend et al. 2003; Twinn 1995) and develop interprofessional, communication and empathy skills (Richards 1993). Congruent with Twinn's (1995) findings, for Anna and colleagues it was felt particularly important for students to have opportunities to experience the realities of practice. The caseloading model was felt to afford students good opportunities in this:

"I feel happy that I chose to have a student midwife with me and I feel glad that it's a programme that is being carried out because I don't think it's fair for them to just qualify...and I think it's given Ceri [student] more confidence as well" [Anna2, p.6]

"It's good for the student as well [Caseloading] to have someone trusting them to give them that bit of encouragement as well, it's really good" [Ami3, p.6]

It was often with what seemed a sense of pride, that women described how by agreeing to be part of their student's caseload they offered their student a different learning experience, something the other women in the student's caseload could not provide:

"I'm a different case from what she's [student] had before because I'm high risk. She wants to go to my anaesthetist appointment and my consultant appointment just to find out I suppose....and I'm quite happy for that as well" [Erin1, p.3]

"She [student] did search out my heart problem a lot when I was pregnant. Cause she'd always come back with I've looked this up and I've looked this up and she'd always be like that. So I know I gave her something to look up" [Ami3, p.6]

Some women, as Anna describes, felt a genuine sense of responsibility to participate in their student's education and took a pro-active approach:

"I try and always, even if I look on the internet and things, I always try to find questions because she [student] needs to get something to get

the brain working as well and to know she's got it in her to answer questions" [Anna1, p.3]

Many women in the study showed an active interest in their caseloading student's educational progress, often expressing genuine concerns that they were benefitting from the experience. As Jody shares, these concerns were most often expressed reflectively. These articulations often seemed linked to a sense of disquiet, a concern that the supportive pendulum of 'give and take' within the woman-student partnership had perhaps swung more in their favour than the student's:

"Obviously it's a very personal time in my life that I'm having a baby and she's [student] played a big part in that for me. Like reassuring me, any questions, I can turn to her and she's been there...yeah very good friend at the end of the day. She's done what she can for me, and hopefully she's learned along the way too" [Jody2, p.10]

7.2.2 She knows me and I know her

Retrospective research evidence demonstrates women want to connect and forge relational bonds with their midwifery student caregivers (Aune et al. 2012; Browne and Taylor 2014; Dahlberg and Aune 2013; Finnerty et al. 2007; Kelly et al. 2014; Rolls and McGuinness 2007; Snow 2010; Tickle et al. 2016). Gaining this sense of personal connection was important for women in this study from the outset of the caseloading relationship. During our first story-sharing conversation, women took time to describe their student companion and talk about their personality traits and characteristics analogous with participants in my earlier work exploring student experiences of caseloading practice (Rawnsdon 2011a). Women talked about how these attributes enabled them to feel an instant connection with the student and how this informed their decision to be part of the student's caseload:

"When I met her I straight away got on with her and I liked her...I knew the second I saw her that I'd get on with her, she's that sort of girl." [Erin1, p.2]

“Pippa [student] was nice enough...and we seemed to get on really well. So I didn’t have any issues saying yes to it [caseloading scheme].” [Jody1, p.1]

“She’s [student] just a lovely person...I think as well, she’s got such a nice calm demeanour that she will help me remain calm when the crunch comes to it [during labour and birth].” [Anna1, p.5]

Like women in the Rolls and McGuinness (2007) study, women established strong supportive partnership bonds with their student. As I discussed in the previous section [7.2.1], the women talked about their appreciation of the positive relationships they developed with their student companions. As reported by others, these relational connections were considered personal, genuine and trusting (Aune et al. 2012; Browne and Taylor 2014; Kelly et al. 2014). Research surrounding emotion work in midwifery (Hunter 2004b; 2005) and of the importance of a positive woman-midwife relationship (Anderson 2010; Frei 2011; Hunter 2006; McCourt and Stevens 2009; Williams et al. 2010), suggests that emotional intelligence (Goldman 1996) and the ability to quickly forge effective relationships, are important qualities for midwifery care. Building these relational bonds early in the caseloading relationship with students evoked feelings of security and comfort amongst women:

“So far I’ve always had her [student] and I don’t want it to change because I know her now and I know she knows me and I feel comfortable with her when like taking my trousers down, baring my tummy and that, I don’t really want anyone else.” [Erin1, p.4]

“I’m really edgy this time but I think having Carla [student] makes it better, makes me feel a bit better about it all cause I likes to have my student cause I think there’s someone else there along the journey.” [Kelly1, p.9]

“I don’t know if I’m going to get complications, but I think that Ceri [student], I’m not, I’m not leaning on her completely but I imagine that

she's going to be an integral part of my support and comfort.” [Anna1, p.5]

Developing these strong relational connections with their student companion early in the caseloading journey appeared an important need for women. This centred on women's yearning for a known caregiver for labour and birth, someone with whom they had developed close relational bonds. Continuity of midwifery care throughout the maternity journey has been identified as something that women value (Sandall et al. 2016). However, the importance that women place on continuity of carer during labour, in particular knowing the midwife at the time of birth, is little understood (Lee 1997; Green 1998; Green et al. 2000; Walsh 1995) and it has been suggested that women achieve high levels of satisfaction without this (Lee 1997; Green et al. 1998; Waldenstrom 1998). Hundley and Ryan (2004) in a UK survey of 301 women at low obstetric risk, reported women's preferences were influenced by the systems of care locally available. Women in areas where intrapartum continuity of carer was a realistic option appeared to value this aspect of care more highly. However, the recent National Maternity Review in England (NHS 2016) has highlighted how important it is for women to be cared for by caregivers they know and have formed a relationship with throughout the childbirth journey, including labour and birth. Indeed, congruent with Leap et al. (2010) findings, women said in the NHS London Survey (2010), of what women want from London maternity services, that they both needed and wanted to have a midwife they know staying with them throughout labour and birth. For women in this study, local systems of care did not extend to midwife continuity model for intrapartum care. However, being cared for by a known caregiver during labour and birth was exhibited in the data as an important need for women. Echoing Aune et al. (2012) findings, it appeared equally meaningful for women if this known birth supporter was a student and not a qualified midwife:

“When you've got someone that you've built a relationship up with actually at the birth, that's what makes all the difference...it's just like having your mate there almost innit?” [Kelly1, p.12]

“She’s [student] the one who’s going to be there when I give birth and that’ll be nice won’t it if we’ve gotten to know each other really well?”
[Erin1, p.3]

“I know um even if I don’t have Lauren [midwife], Ceri [student] is going to be there [for the birth] so that’s reassuring in itself.” [Anna1, p.3]

“literally when it’s time [for the birth] she’ll [student] be there. It’ll be nice cause obviously she’s seen me from the start.” [Jody1, p.5]

As story-receiver, I found it interesting to hear as the women’s stories unfolded across the caseloading experience how the partnership bonds within the woman-student dyad evolved and the meanings and significance of this for women. Some women expressed a belief that the close personal connections developed through relational continuity enabled students to be ‘in-tune’ with them, and intuitively know what support they required. This is in contrast to Hall’s (2008) claim that UK midwifery students quickly lose innate intuitive skills or lack opportunity to develop them. This type of tacit knowledge is described as a gestalt capacity for a sudden awareness of knowing, an immediate cognition of women’s needs and situation, without the use of rational processes (Davis-Floyd and Davis 1997). This kind of knowledge is associated with experienced practitioners and those providing ‘expert’ care (Benner 1984; Downe et al. 2007; Davis-Floyd and Davis 1997) and considered an intrinsic skill within many midwives and students (Hall 2008). However, given the prevailing biomedical contexts in many maternity units, in which technological rather than physiological birth is supported, little opportunity for relational continuity exists. It is suggested these innate qualities quickly become suppressed rather than developed (Hall 2008). It is argued, this is because midwives are more likely to rely on technological aids than their innate senses, and have little opportunity to utilise intuition as a tool to understand and facilitate physiological birth or to identify subtle changes within this process (Hall 2008). In addition, for intuitive care to occur, relational connection between the woman and midwife is a central requirement (Davis-Floyd and Davis 1997). It is through knowing the woman

via this interconnectedness that enables midwives to trust their own instincts and those of the woman (Hall 2008; Davis-Floyd and Davis 1997; Olafsdottir 2009).

In an Icelandic qualitative study of 20 midwives, Olafsdottir (2009) reported this intuitive knowledge or 'inner knowing' developed through relational connection with women, encompassed the spiritual and emotional dimensions of midwifery practice. This was exemplified in this study, by stories of how students exhibited perceptive knowledge of women's physical and emotional support needs:

"She [student] seems not, not overly emotional but when my eyes started to well up, I can see her at the scan as well having that same feeling, so yeah I just feel so lucky." [Anna1, p.3]

"She's [student] always been there every appointment...if I'm not sure about something she can sort of look at me as if to say 'you didn't get that did you?' and rather than me ask the question, she will then reassure me. She just seems to know when I've got concerns without me saying anything." [Jody2, p.6]

In parallel with the literature, it is apparent these women valued intuitive care and recognised when their student caregivers utilised these skills (Downe et al. 2007; Halldorsdottir and Karlsdottir 1996b). This finding suggests via the relational connections it engenders, inclusion of educational continuity element within the midwifery curriculum can promote opportunities for students to develop this desirable form of tacit knowledge and way of knowing.

Analogous with women in Browne and Taylor's (2014) study, all women experienced feelings of companionship, which enhanced their feelings of comfort and security. As I discuss in [7.4.2], companionship was in part exhibited in the story data as a 'valued constant presence'. This was exemplified by women as a sense of shared journey of not 'going it alone', as Kelly expressed earlier in this story section. Companionship for many also grew into feelings of friendship:

"I do see her [student] as a midwife but she's just like a friend that I can ring up. I'll probably keep her up-to-date once I've had the baby um things like that." [Jody2, p.10]

"I just get on with her [student] like she's my mate, like a friend." [Kelly2, p.8]

"As a friend I've asked her [student] how her dissertation is going and things like that." [Anna3, p.6]

The feelings of friendship engendered, enabled women to look forward to the impending birth with confidence and positivity. Women talked about their birth plans, often discussing at length where they would birth their baby and anticipated expectations of the student. However, while they recognised their student's presence or availability to support them during labour could not be guaranteed (Fry et al. 2008). As reported by others, many women exhibited a belief that the student would be their primary birth supporter, someone who would act as an advocate on their behalf, and ensure the wider healthcare team understood their wishes (Browne and Taylor 2014; Kelly et al. 2014; Rolls and McGuinness 2007). When the caseloading partnership was terminated early, abruptly and unexpectedly, due to student ill health, the sense of loss women exhibited was palpable:

"Carla's [student] not my midwife anymore um...I went to my midwife last Wednesday...I thought I would be seeing Carla and she had written me a letter and um it explained that she was sorry but obviously her health was really important and that Catherine [midwife] was taking over everything, which I didn't mind...but I was sad because I liked Carla." [Erin2, p.3]

"It's a shame she was gonna be my birthing partner I was gonna ring Carla [student] first see if she's available for the birth, then I'll probably go to Sea City hospital because at least I know she'll be there and she's nice...but then she's left so the plan is out the window, so I don't know what to do now." [Kelly2, p.3]

Women's need to re-gain the 'security blanket' lost in this situation, forging relational bonds with their maternity care-givers, and how this impacts on feelings of comfort are poignantly shared by Erin, as she seeks to establish relationships similar to those lost with her student companion:

"I feel like I know Catherine [midwife] a bit more because where I've had my few problems, Catherine's been there to make me feel better about it and I'm sure Carla [student] would have done the same...so yeah, I started off with her [student] and now I've got Catherine."
[Erin2, p.3]

"I've been up to the hospital so much I've met a lot of midwives and I'm even on first bases with the diabetic team. I know they all know me, and I know them, and um so I kind of feel quite comfortable up there." [Erin2, p.6]

"I've seen loads of women come into the maternity outpatient bit with their newborns and all the midwives have swarmed in taken the baby for a cuddle and I'm thinking I hope they do that with me as well."
[Erin2, p.7]

The potential for women to be left feeling bereft, seriously disappointed and let down if the student is unable to continue the caseloading relationship to its natural conclusion, is a down side of the scheme that can impact negatively on women's childbirth experiences. As I reflected in [6.3], as story-receiver, I found hearing Erin's story particularly emotionally challenging. For me, it was the joy expressed by Kelly, in her sharing of her student's return and resumption of her care and the caseloading relationship that fully illuminated the emotional context of Erin's loss. It is essential women are not left in a vulnerable emotional position and imperative effective support mechanisms are in place to support women in this situation. However, little information is available as to best practice in this. The potential for this disadvantage of educational continuity has not been explored within the educational literature or received much attention in the body of work surrounding midwifery models of continuity.

Resonating with Browne and Taylor's (2014) findings, by the close of the caseloading relationship all women, apart from Erin, believed they had developed a friendship with their student. Women attributing the specific qualities of friendship in describing the relationships they developed with caregivers through relational continuity have been reported by others (Lee 1993; Edwards 2010; McCourt and Stevens 2009; Olafsdottir 2009; Walsh 1999). Professional friendship in this context is reported as different to the intimacy of social or family friendships. While there is 'closeness' there is also 'distance' (Edwards 2010, p.106), and the professional friend is described as being '*like* a family friend' or '*like* kin' (McCourt and Stevens 2009, p.19; Olafsdottir 2009, p.194). Kirkham (2009) asserts this kind of relationship is characterised by mutual trust and respect, where both parties value each other's knowledge and contributions. As reported by others, and as women in this study commented, this kind of mutuality within the woman-student dyad can enable the caregiver to be more 'in-tune' and support the woman through intuitive knowing (McCourt and Stevens 2009; Olafsdottir 2009).

It is important women are enabled to establish appropriate professional boundaries with their student caregivers. Relationships founded on mutual respect and trust and developed via the supportive nature of professional friendships are reported to facilitate this (McCourt and Stevens et al. 2006; McCourt and Stevens 2009). However, the finality of concluding the caseloading experience and saying goodbye to their student was exhibited within the story data as a difficult time of transition for some. Many women found it difficult to truly let go, and expressed a need to continue and maintain the relational connections forged with the student:

"I know I'm not going to be in touch with Hazel [midwife] but I know that Pippa [student] I will be able to text her or give her a ring just say hello, see how she is." [Jody3, p.7]

"I've had Ceri [student] and Lauren [midwife] all the way through so you do bond with them to have that experience with them as well I'd hate to think well that's it now, I just disregard those people. I think you know that

it'll be nice to meet her [student] for the occasional coffee and show her how Candy's [baby] doing." [Anna3, p.6]

"It was nice to get to know Susie [student] as well, we did say that we're gonna keep in touch." [Emma3, p.5]

The research evidence discussed in this story section has highlighted how the intimate nature of the woman-midwife relationship is magnified during the caseloading relationship and how this is mirrored with students who caseload. Congruent with findings from this study [7.4.2], educational research evidences relational continuity with students can evoke feelings of empowerment and self-confidence amongst women (Aune et al. 2012; Rolls and McGuiness 2007; Tickle et al. 2016). Students working in continuity initiatives similarly report enhanced feelings of confidence and belief-in-self as practitioner (Aune et al. 2011; Carter et al. 2015; Rawnsdon 2011a; Yanti et al. 2015). Women's appreciative comments and the close relationships developed also reinforced a sense of being valued amongst students (Aune et al. 2011; Rawnsdon 2011a). McCrea (1993) asserted being 'needed' or being 'important' to women is central to being valued as a midwife. However, as Stevens (2003, cited in McCourt et al. 2006, p.155) cautioned the 'potential to meet one's own need to be needed through such work' can lead to a blurring of professional boundaries and the development of mutually dependent relationships that are counterproductive for women and students (Leap 1997; McCourt et al. 2006). Women centred care is at the heart of midwifery practice and students may struggle to maintain boundaries and mitigate their relationships with women following conclusion of the caseloading experience, as Jody describes:

"Pippa [student] said you've got my number if you ever need me or anything or if you just want to chat whatever just give me a ring...she said just because I've discharged you doesn't mean I'm gonna write you off because obviously you are a friend and stuff, which is really nice...I might in a few weeks' time think 'oh what, what can I do' and I know that I'd feel comfortable enough to text Pippa 'sorry to bother you um can you just give me a call if you can or can you answer this for me' and she would."

Even if she didn't know, she would probably go and find out and let me know so yeah, it's really good." [Jody3, p.6]

Professional boundaries within midwifery practice are clearly defined by the NMC (NMC 2011; 2015b), and are foundational theoretical content in the midwifery curriculum (NMC 2009). However, crafting the skills to develop professional therapeutic relationships with women can be challenging particularly during relational continuity initiatives. A tendency for midwives new to this way of working to over-commit themselves to the women within their caseload was reported (Sandall 1997; Stevens and McCourt 2002b). As McKellar et al. (2014) pointed out this may pose a particular challenge for students due to their supernumerary status within the clinical environment and lack of experience of continuity models.

The small body of work in this area evidences some debate about students' understanding of their role during caseloading and the importance of maintaining boundaries of clinical practice in this context. In an Australian state-wide survey of under and post-graduate midwifery students from all educational years, McLachlan et al. (2013) reported respondents were generally cognisant with their professional responsibilities. Of the 399 who answered the question, 69% (n=275) agreed they were clear about the role of students when involved in continuity of care 'follow-throughs'. Almost two thirds of the 400 students who responded 75.5% (n=303), felt they understood the professional boundaries of clinical practice in this context. However, the authors do not report if this knowledge enabled students to establish clear professional and personal boundaries in managing the continuity experience.

While Aune et al. (2011) found students experienced no difficulty in ending the relationships forged with women at the close of the continuity initiative this could be linked to the team continuity model used, where women received care from a group of students' rather than one-to-one continuity from a known student. Some students in my earlier study struggled to mitigate their relationships with women in their caseload, and a blurring of boundaries was apparent as they strived to provide women-centred care

(Rawnsdon 2011a). More recently, McKellar et al. (2014) in an Australian action research project involving 69 students reported similar findings. Students reported crossing professional and personal boundaries in an effort to meet women's expectations.

Students in Australia have raised concerns about lack of access to women to participate in the educational continuity initiative (Craswell et al. 2016; McKellar et al. 2014), and significant difficulties in recruiting women have been reported (Gray et al. 2012; Gray et al. 2013; McKellar et al. 2014; McLachlan et al. 2013). Students report recruiting women through family, friends or personal contacts (Gray et al. 2012; McLachlan et al. 2013), and thus may have pre-existing personal connections with women prior to commencement of the continuity experience. Given the potential for students to experience challenges in developing appropriate therapeutic relationships with women during continuity initiatives, this practice could further compound issues and more research in this area is needed.

7.2.3 Summing up: Mutually supportive partnerships

'Mutually supportive partnerships' is about women's recognition of the caseloading student's need to learn and develop the professional skills and attributes for professional midwifery practice, and how this engendered a reciprocal relationship of supporting each other. Women shared a desire to contribute to midwifery student education and felt their involvement important and this in part, informed their decision to participate in the educational continuity learning experience. Knowledge of student supervision, particularly the requirement for student care to be 'double-checked' by a qualified midwife, was identified as important and a factor that informed some women's decision to participate. The theme is describing women's altruism in participation and how this was linked to a perception that they, as well as the student, would benefit from the experience. This aspect is explored further in the theme 'Extra special care' [7.4].

The theme exemplifies the reciprocal nature of the relationships developed within the woman-student dyad via the educational continuity. Relational continuity with someone who was learning was felt to generate special bonds

characterised as a mutual newness and a symbiotic relationship of learning together by first-time mothers. Women took an interest in their caseloading student's educational progress and demonstrated a sort of motherly support and a caring, encouraging and understanding attitude. The relational bonds developed with students were described by women as personal, genuine and trusting. Being able to forge such close relational bonds with their student midwife companion from the beginning of the caseloading relationship mattered and was identified by women as an important need. Women spoke of how building these types of partnerships with students early in the caseloading relationship evoked feelings of security, comfort and peace of mind.

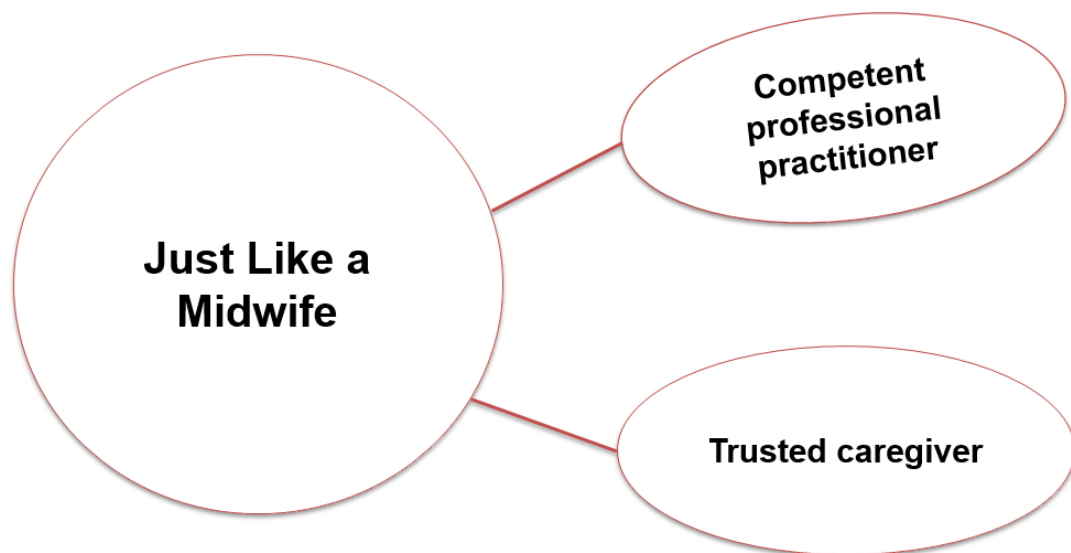
Having a known caregiver for labour was identified as important and something that women wanted. This known birth supporter being a student and not a qualified midwife was held to have equal meaning and this in part, informed women's altruism in participation in the educational continuity. Women felt, via the close relationship developed, their student companion intuitively knew their support needs. This along with the knowledge that the student would be on-call and make themselves available to attend them in labour enabled women to look forward to the impending birth with confidence and positivity. Women experienced feelings of companionship, which for many grew into feelings of friendship. When for some, the caseloading relationship was terminated unexpectedly early and abruptly, the sense of loss women expressed was palpable.

7.3 My student caregiver: Just like a midwife

While 'mutually supportive partnerships' exemplified the reciprocal relationships, women developed with students through relational continuity, 'just like a midwife' describes how women felt about receiving care from their student learner, using their perceptions of what a registered midwife should do as benchmark. Women talked about their levels of confidence in their caseloading student's abilities as caregiver, advisor and supporter and how they rated the care she provided.

This story theme shows the meanings and significance for the women in this study of being part of a student midwife's caseload and receiving care from a known student caregiver. Illustrated in Figure 7-2, two subthemes make up the story line theme of 'just like a midwife'.

Figure 7-2: Story subtheme strands for 'just like a midwife'



'Just like a midwife' illustrates women's perception of the student as *competent professional practitioner*. Women identified the student as a learner, as someone who required supervision from a qualified midwife. This was juxtaposed with a belief that the student had competent caregiving skills and did everything a midwife would do. This was when women perceived no difference between care given by their student companion and that from a qualified midwife. Women expressed high regard for their student's level of knowledge for professional practice. This boosted the levels of confidence and trust the women expressed in the student's caregiving abilities as *trusted caregiver*. Running throughout the theme were poignant expressions of emotion as women identified the qualities they most valued in a midwife embodied within their caseloading student care provider.

7.3.1 Competent professional practitioner

From the outset, as women shared their stories, a contrasting perspective of the student as learner and caregiver was apparent. As discussed in [7.2.1], women talked of the need for students to learn and how important it was for them to gain knowledge, and skills, for professional midwifery practice. Many expressed delight and happiness that the student was benefitting in this way through involvement in their care. Yet to my surprise, during our first story-sharing conversation, women repeatedly identified the student as midwife. While convinced of her student companion's high level of competence, Erin found it difficult to explain the basis on which she had founded this perception:

"I've got nothing to go on, I don't know what it's like not to have a student midwife but if she [student] hadn't told me she was a student, I wouldn't know." [Erin1, p.3]

Her colleagues however, as experienced consumers of midwifery care, drew on their prior knowledge as benchmark to support their claims:

"Where I've had children before, I sort of know what midwives should do be doing really, and she's [student] doing everything that a midwife would do." [Emma1, p.2]

'It's just like having a midwife I don't realise the difference, she [student] asks the same questions, does the same things...I wouldn't tell the difference.'" [Kelly1, p.3]

The literature suggests confusion exists amongst consumers as to healthcare students' role, level of education, knowledge or expertise. In Twinn's (1995, p294) study, some mothers saw the students as qualified health visitors with attendant competencies, whereas others regarded them as 'absolute students, with little to offer'. This is perhaps understandable given the complex status of students in health visiting, where students are registered practitioners undertaking post-registration education. However just over half (54%, n=110) of the 203 respondents in Grasby and Quinlivan's (2001) Australian study, exploring pregnant women's attitudes to medical

student involvement in their intrapartum care, recognised that medical students are doctors in training. Some (29%, n=59) thought the term referred to either a midwife, nurse or a doctor in training, while others thought it referred to anyone training in the healthcare field and a small number could not define the term. Interestingly, elderly consumers in long-term care homes in Mossop and Wilkinson's (2006) qualitative New Zealand study concurred with the women in this study. While the care received was from student nurses in the first year of their education, nine of the ten participants considered the students as capable as the qualified nurses in care provision and receiving care from students was described as a positive experience.

Consumer positivity toward the student rendered care reported by Mossop and Wilkinson (2006, p.52) was linked to perceptions of the students' attitudes toward them. Resonating with women in this study, students' attitudes were commonly described using terms such as 'kind', 'lovely', 'nice', 'friendly', 'pleasant' and 'caring':

"She's [student] been brilliant when I've seen her and she's really cheery and friendly." [Kelly1, p.3]

"Um just very friendly really, just overall she's [student] very approachable...yeah, she's really nice, really friendly." [Jody2, p.11]

Midwifery educational research evidences similar findings (Browne and Taylor 2014; Kelly et al. 2014; Snow 2010; Tickle et al. 2016). Like women in this study, the positive friendly and caring attitudes exhibited enabled women to feel more comfortable to ask questions and seek information (Browne and Taylor 2014; Kelly et al. 2014). Women in this study highly valued the positive interpersonal attributes exhibited by students, and consistently described their student as a 'good midwife':

"It was just like having a normal midwife cause she was friendly she was good do you know what I mean, good at what she was doing...I felt comfortable with her really she was good." [Kelly2, p.8]

"I think Susie [student] is a brilliant midwife I always sort of see her as a midwife even though I knew she was a student." [Emma3, p.6]

This high level of confidence in the student's caregiving abilities as practitioner does not appear reported elsewhere in the midwifery educational literature. Interestingly, in a qualitative analysis of free-text survey responses in an Australian randomised controlled trial of a caseload midwifery model, Allen et al. (2017) report similar findings. Women's perceptions of their caseload midwife's competence were often related to their perceptions of the midwife's interpersonal qualities and kindness.

Examination of the literature on midwives' attributes and quality of midwifery practice, regarding what women value in a midwife and construct as a 'good midwife', reveals this is a widely debated topic. A synthesis of thirty-three studies of the 'good' midwife resulted in eight key concepts, encompassing affective, cognitive and psychomotor domains (Nicholls and Web 2006). Having good communication skills was the principal attribute reported. Additional essential qualities on being a 'good midwife' were the abilities to treat women as individuals, adopt a caring approach and being there for women. More recently, using a Delphi questionnaire, Nicholls et al. (2011) reported postnatal women, midwives and midwifery educators (n=226) considered being a life-long learner and having good interpersonal skills was as important in being a 'good midwife' as technical competence. Good communication skills and providing woman-centred care were also of primary importance. However, in reporting of findings and discussion of data, the authors do not distinguish between women and midwives' answers, and thus it is difficult to separate the participant accounts.

Halldorsdottir and Karlsdottir (2011) introduced an evolving theory synthesised from nine datasets and scholarly work on the empowerment of childbearing women, where the midwife's professionalism is central. According to the theory, the professional midwife cares for the childbearing woman and her family and is professionally competent. S/he has professional wisdom and interpersonal competence and is capable of empowering communication and positive partnership with the woman and her family. Moreover, the professional midwife develops her/himself personally and professionally, which may in part explain why women in this study perceived their student companion as 'good midwife' and the nature of

the mutually supportive relationships developed [7.2]. This is supported by findings from Byrom and Downe's (2010) phenomenological interview survey exploring ten midwives accounts of the characteristics of 'good' leadership and 'good' midwifery. The ability to practice knowledgeably, safely and competently was constructed as a basic requirement. The midwife's emotional capacity was the additional element that made her/him 'good'. Emotional capacity in this context, embraced the multiple concepts of 'empathy, adaptability, approachability, motivation, relational connection or rapport, and supportive guidance' (Byrom and Downe 2010, p.132). Women in this study consistently described story events where their caseloading student companion exhibited emotional capacity within this context.

While Butler et al. (1998) in an earlier qualitative study, exploring qualifying midwives', their assessors', midwives' and midwife teachers' views as to the nature of competence at the point of registration, reported findings similar to those of Byrom and Downe (2010). Being committed to women and having genuine interest in them and their families along with motivation to provide high standard quality care, was further identified as critical to competent midwifery practice. Moreover, care in this context has been described as the ability and willingness to 'see' and 'hear' needs, and to take responsibility for ensuring these needs are met (Sevenhuijsen 1998, p.83 cited Sevón 2007). Women in this study believed they had developed close mutually reciprocal personal and genuine relational bonds with their caseloading student companion [7.2]. Women also commented on the thoroughness of the student rendered care received. 'Thoroughness' was exhibited in the story data by the attention to detail and the time students took to make sure the woman's questions were answered and all care elements assessed and addressed. Thoroughness and genuine interest in the woman and her family were consistent storyline strands, which contributed to women's perceptions of their student companion as 'good midwife':

"She's [student] so very thorough and um she'll explain everything really, really well." [Anna1, p.2]

“Yeah, she’s definitely going through it all thoroughly with me and she always makes sure that I’ve got no questions before she leaves, she’s like ‘are you sure, are you sure?’ bless her.” [Ami2, p.5]

Women in the study believed the thoroughness exhibited by students was linked to their learner status. As previously discussed [7.2.1], being cared for by someone who was learning to become a midwife was viewed with positivity. For women in this study, this was in part linked to perceptions that care provided would be done properly, to a high standard and “by the book” [Kelly1, p.11] with no aspect superficially addressed or skimmed over:

“She [student] runs through the check list like point by point whereas like sometimes if someone has done it for years they can just kind of skip the bits they don’t think are important whereas, because she’s learning, she makes sure she covers every single point so I get all the information that I need.” [Ami2, p.3]

For these women, it is apparent their caseloading student companion embodied the principles of competent quality midwifery care, which enabled them to receive a better level of care than that available for other women [7.4]. Women’s perceptions in this, link with the International Confederation of Midwives (ICM 2017) definition of competency within midwifery practice:

‘The successful demonstration of essential knowledge, skills, attitudes and professional behaviour on a specific task, action or function to a defined level of proficiency’ (ICM 2107, p.3)

7.3.2 Trusted caregiver

During our first story sharing conversation, women talked about meeting their caseloading student for the first time at the initial midwives ‘booking’ appointment. Following that occasion, women commented they had met their student subsequently either once or twice. For the majority, this was during an antenatal appointment in the woman’s home or midwife’s clinic and for some women, when the student attended their scan. When describing the care, the student provided on these occasions, I was impressed and rather struck by the high level of trust and confidence women expressed in the

student's caregiving capabilities. As discussed earlier [7.3.1], this could be linked to women's understanding of the nature of the student role, level of education, knowledge and expertise. However, alongside the positive emotional attributes previously described, this trust in the student's abilities seemed informed by the student's professional demeanour and confident approach:

"Oh she's [student] very competent, very confident, she's straight in with answer definitely." [Anna1, p.3]

"I don't see her [student] as a student I just see that's a midwife um she comes across as very, what's the word? Yeah confident I suppose, and knowing what she's talking about um which, that just restores my, I've got no doubt she can do her job properly and I've got no qualms dealing with her." [Jody1, p.3]

While for Anna, this was a story strand that emerged later, as Jody indicates, the majority of women exhibited a high level of confidence in their student companion and saw them as knowledgeable practitioners from the outset of the caseloading relationship. Resonating with Bluff and Holloway's (1994) findings, this appeared linked to embedded sociocultural and historical perceptions of healthcare professionals, such as midwives, as 'experts'. This acknowledgement recognised the student's status as learner, as someone training to become a qualified midwife, and was not diminished by it. Rather, as Kelly explains, this appeared conceptualised as a benefit because the student was in receipt of the most up-to-date knowledge and was more able to recall and draw on this information as s/he had just learnt it:

"I'll be quite happy, anything she [student] suggests I'll consider...yeah I wouldn't ever dismiss anything she says, definitely not...it's just, I don't know, like it's fresh innit, her knowledge, the student's knowledge is a lot fresher...it's right there in her mind because she's just learned it." [Kelly1, p11-12]

The notion and construction of risk in women's own discourses of childbirth is widely discussed (see for example, Barber et al. 2006; Chadwick and Foster

2014; Coxon et al. 2014; Hallgrimsdottir and Benner 2014; Lindgren et al. 2010; Possamai-Inesedy 2006; Viisainen 2000). While it could be argued that childbirth in the UK and in developed world contexts, where women have access to free healthcare, and educated and qualified birth attendants, has become increasingly safer (Coxon et al. 2014; Chadwick and Foster 2014). Studies suggest that rather than decrease, paradoxically, women's perceptions of pregnancy and birth as being inherently 'risky' events have intensified (Coxon et al. 2014; Dahlen 2010; Possamai-Inesedy 2006). It is argued, the continued dominance of biomedical models of childbirth within Western cultures, which endorse technological birth and permeate the language of risk, suffuse and inform women's perceptions of risk (Lindgren et al. 2010; Possamai-Inesedy 2006; Viisainen 2000) as well as, widely held contemporary societal understandings of pregnancy as potentially dangerous and a more hazardous experience than in the past (Dahlen 2010; Hallgrimsdottir and Benner 2014). These widely held sociocultural beliefs, promulgated via television (for example reality programmes such as 'One Born Every Minute') (Roberts et al. 2017) and the media (for example, newspapers, magazines and debates, advertising), lay support agencies and health professionals (Coxon et al. 2014; Luce et al. 2017), ensure women are made fully aware of their moral responsibilities in decision-making and mitigating risk in pregnancy and birthing choices (Coxon et al. 2014; Hallgrimsdottir and Benner 2014; Lindgren et al. 2010; Possamai-Inesedy 2006; Viisainen 2000). As others have reported, women in this study, actively sought to source information to inform decision-making, and often talked of searching the internet (Possamai-Inesedy 2006; Viisainen 2000):

"Where I'm one of them people that look up everything, I'm a Googler, I Google everything...and I'm really someone who reads into everything, I think everything's going to happen to me." [Kelly1, p.9]

As Kelly describes, accessing information via the internet and the wider multi-media can evoke negative feelings of anxiety and fearfulness amongst women as well as, increasing anticipation of poor pregnancy outcomes (Luce et al. 2017). Interestingly, none of the women in this study described contacting their named midwife, GP or other health professionals and lay

agencies involved in supporting parents to be, to access information or to seek reassurance and clarification. Rather, in a quest for the knowledge gained to be explained and confirmed, women talked of how they shared the information they accessed with their student companions for this purpose, as Anna explains:

"I see her as a very good support um but also I thought for advice and to give me confidence in the things that I am reading and that she can confirm those for me." [Anna1, p.5]

The midwifery literature indicates women value the opportunity to build trusting relationships with students via educational continuity (Aune et al. 2011; Browne and Taylor 2014; Kelly et al. 2014; Tickle et al. 2016). As story receiver, I found it fascinating to hear how the trust expressed in the caseloading student's knowledge informed women's decision-making and comfort as their stories unfolded across the continuum. As Bluff and Holloway (1994) reported, this seemed linked to a perception that the midwifery student had received relevant education and training and thus possessed knowledge that the women themselves lacked and would be able to advise them appropriately, irrespective of the situation or areas of concern:

"I'm hoping to have the baby at the birthing centre, I was going to talk to Susie [student] about it." [Emma1, p.1]

"I know in what pain I'm going to get in [during labour] ...and of course I told her [student] that, and she said 'well at the end of the day your body's done it once before so your body knows what to do um it's just how you cope with it'...she said, 'all you've got to do is remain calm'". [Jody2, p.10]

"I phoned Ceri [student], [during early labour], she gave me her advice she said it might not be for real, this might, you know you might go through the day with some contractions and then they'll stop, so like practice. So, I prepared myself for that as well". [Anna3, p.2]

Women listened to the advice given by their student companion and gave it serious consideration. Resonating with Bluff and Holloway's (1994) findings, it was apparent women's trust in the caseloading student's knowledge influenced their decision-making, and many shared stories of how they had incorporated this knowledge into managing aspects of their pregnancy and labour with positive effect as Jody and Anna describe below:

"Pippa [student] sort of gave me some advice, she said um 'get your iPod, do relaxing music, even if it's just like upbeat music, just so it takes you away from where you are sort of thing' and then she was doing some um some psychology stuff like she did a course or something where you just sort of think of somewhere where you are like on a beach and that's what I did. I said, 'right you are on a beach', and obviously they [midwives] were checking me out, 'I'm on the beach, I'm on the sand, I've got the hot sun on me', and then that was it." [Jody3, p.2]

"As far as her [student's] advice [during labour] went as to keep active and um you know, keep rocking, let the baby move, you know through the passage nicely, that was all good." [Anna3, p.4]

As Tickle et al. (2016) reported, women want someone that is known and knowledgeable as their care companion, particularly at the time of birth. For the majority of women in his study, it was the caseloading student who was perceived as meeting this need, as Kelly indicates:

"It was really good Carla [student] was there [at the hospital], she delivered my baby. It's nice to have someone with you who's trained and knows stuff. To me she is a midwife, she's in my phone 'Carla my midwife". [Kelly3, p.2]

The research evidence in this story section has illuminated the nature of the high level of trust women in this study placed in their caseloading student's knowledge and abilities. While, from the women's descriptions, it appears these students worked within their scope of practice, level of knowledge and ability [7.4.2] it is of paramount importance the parameters of safe practice

are maintained. Given the way women actively sought, listened to and adopted student advice, raises strong potential for women to be vulnerable to miss-information and support. Accountability and sphere of practice are among the most important elements of the caseloading scheme (NMC 2008). This is because by its very nature, caseloading promotes autonomous practice (NMC 2009), and is likely to entail mentor supervision which is indirect and devolved rather than direct (Rawnsdon 2011a). It is therefore imperative that women always have direct access to the midwife mentor supervising the caseloading student, who is, ultimately, accountable for the student's practice and the care given (NMC 2008). They need to be able to ensure that everyone involved in the care is supported and safe. It is therefore of primary importance that all information, advice and care given by the student is discussed, reviewed, checked and agreed by the supervising midwife mentor and there are robust systems in place for this to occur. This aspect is addressed further in [7.4.2].

7.3.3 Summing up: Just like a midwife

'Just like a midwife' is about women's recognition of the attributes and qualities they most valued in a midwife embodied within their caseloading student companion and the meanings and significance of this for them. Women acknowledged the caseloading student's status as learner, as someone training to become a midwife but at the same time, shared a belief that the student was as competent as a qualified midwife and consistently described their student as a 'good midwife'. Women's perceptions in this was informed by the student's professional demeanour and confident approach as well as the positive friendly and caring attitudes the students exhibited, which enabled women to feel more comfortable to ask questions and seek information. The theme is describing women's high level of confidence, trust and belief in the student's abilities as caregiver and how this was linked to the relational connections perceived developed with the student, the student's thoroughness in caregiving, genuine interest in them and their family, and motivation to provide high standard quality care.

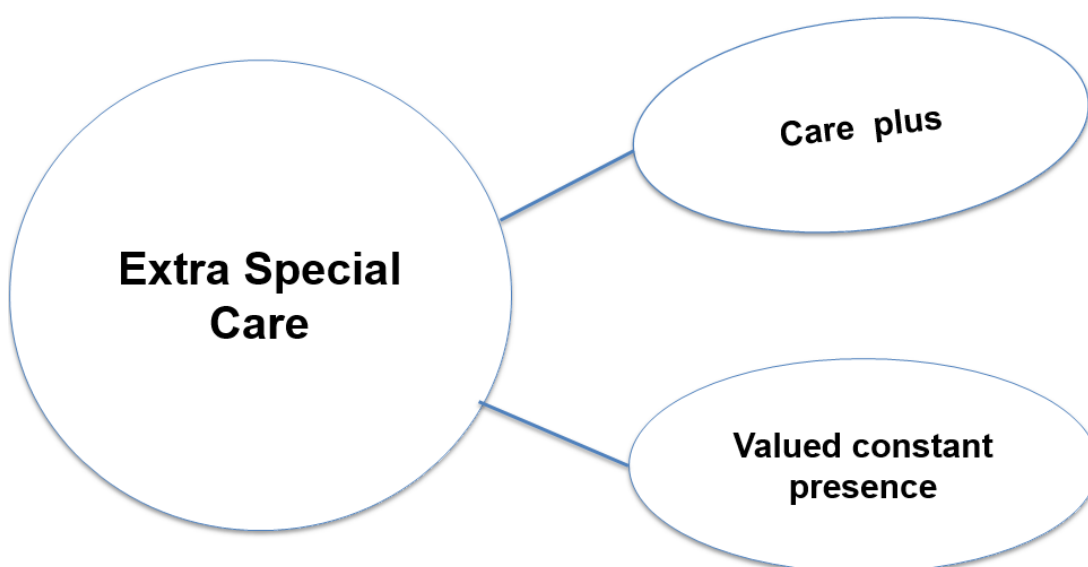
The theme exemplifies the importance of having a caregiver for pregnancy and birth that is known, knowledgeable and able to engender a trustful relationship based on mutual respect. Women exhibited a high level of confidence in their student companion from the outset of the caseloading relationship and saw them as knowledgeable practitioners. This trust in the caseloading student's knowledge informed women's decision-making and comfort, irrespective of the pregnancy situation or areas of concern as their stories unfolded across the continuum. Women spoke of how they turned to their caseloading student for information and of how they shared information sourced via the wider multimedia with the student, so this could be clarified and confirmed. Women perceived the student as possessing knowledge they themselves lacked and shared stories of how they had incorporated student advice into their management of their pregnancy and birth experience. This acknowledgement recognised the student's status as learner, and was not diminished by it. Rather, this appeared conceptualised as a benefit because the student was in receipt of the most up-to-date knowledge and was more able to recall and draw on this information as s/he had just learnt it.

7.4 My student companion: Extra special care

The first two story themes highlighted how educational continuity facilitated mutually supportive partnership bond development within the woman-student dyad, and exemplified the meanings for women of receiving care from a known and trusted student caregiver. Women referred to their motivations for agreeing to be part of a student's caseload and this next theme illustrates how women perceived this as a 'win-win', a way of fulfilling their own needs as well as those of the student.

'Extra special care' shows the meanings and significance to the women in this study of having a known student companion throughout their childbirth journey via student caseloading. Illustrated in Figure 7-3, p.229, two subthemes make up the overall theme story line.

Figure 7-3: Story subtheme strands for 'extra special care'



The theme 'Extra special care' illuminates women's perceptions that being part of a student's caseload afforded better care or *care plus*, a level of enhanced service provision over and above that available to other pregnant women. Women saw the student as being just for them, that they were the main focus of the student's attention, which reinforced a sense of being more 'special' and of receiving a higher quality of care. Relational continuity with a known student caregiver boosted these perceptions and exemplified by women as a *valued constant presence*, engendering a sense of shared journey across the childbirth continuum, of 'not going it alone'.

7.4.1 Care plus

During our first story-sharing conversation women shared why they agreed to be part of a student's caseload. For the majority, this in part was expressed as a strong desire to help someone out and contribute to the student's midwifery education [7.2.1]. From the outset, all women articulated a belief the opportunity would afford them 'extra special care', a level of enhanced service provision over and above that available to other pregnant women. I found it fascinating how this was often expressed as a 'win-win', a way of fulfilling the individual women's own needs as well as those of the student via a two-way process of mutual 'give and take':

“Pippa [student] is the one that is going to be learning and wanting to do her case studies and then if I text her, I think well she’s getting that bit of extra bit of her work and everything else.” [Jody1, p.2]

“I hope she is there till the end but if she’s not I’ll understand as well, I hope she is for her because it is a good experience for her too” [Erin1, p.4]

“It’s definitely nice to have someone who’s learning at the same time as being with me cause she’s [student] so enthusiastic about wanting to know stuff and she, when I don’t message her, she’s like ‘I just want you to ask me questions, message me!’” [Ami1, p.4]

This dominant strand within the story data held different meanings for women and was exhibited in multiple nuanced ways. Some women believed they would receive additional and more frequent antenatal visits than women receiving mainstream midwifery care. Being more convenient was expressed as a motivator for some, as the caseloading student could provide all antenatal care in the home (with indirect mentor supervision) including the taking of blood for blood tests:

“Ellen [student] would do most of the stuff and it would be more flexible for me ‘cause Ellen could come to my home...and it just seemed more convenient...she’s going to take my blood here [home] and do everything here so, yeah bit more convenient” [Ami1, p.1-2]

“she came round [to Emma’s home] last week she took my blood for a blood test, so that saves a bit of trouble. I don’t have to trek somewhere and take the kids, so it’s much easier, it’s all done here really.” [Emma1, p. 3]

Walsh (1999) in an English ethnographic study of women’s experiences of midwifery caseload practice, reported women want and value home antenatal care. The fact that this home care was provided by students with indirect and devolved mentor supervision, appeared as equally appreciated by the women in this study. As previously discussed, women expressed high levels of trust and confidence in their student companion’s abilities as

caregiver from the outset of the caseloading relationship [7.3.2] and this may have contributed to the women's comfort in receiving this care from students as well as, the knowledge that all care the student provided would be reviewed, discussed and double-checked by a qualified midwife (Woolner and Cruickshank 2015). The opportunity for relational continuity with a known caregiver, particularly for labour and birth, was a further factor that informed women's decision to participate [7.2.2] and was associated with extra special care:

"They're [Caseloading students] almost more guaranteed to be at your birth. It's the same face...she don't go home and change shift or whatever. So I quite like the idea of that do you know what I mean? So she's going to come and deliver my baby hopefully" [Kelly1, p.3]

I was particularly struck by how alongside these factors, from the outset all women equated being part of a student midwife's caseload to receiving extra special care because it ensured two rather than one maternity caregiver, as Anna and Jody explain:

"A little selfish part of me thought I'm going to have extra special care as well because I've not just got one person, I've got another person there looking after me as well." [Anna1, p.2]

"It's definitely a good thing to have, I know it's a bonus 'cause you just think ha! Got two midwives!" [Jody1, p.3]

The recent National Maternity Review (NHS 2016) reported how important it is for women to be able to choose the care that is right for them and their family. Moreover, women do not want to feel like they are receiving only routine antenatal care, rather they want care that is tailored to them and their individual circumstances (Novick 2009). As previously discussed [7.2], important within this is the opportunity to form trusting and meaningful relationships with care providers through relational continuity. However, despite contemporary UK Government agenda for partnership working (DH 1993; 2007; 2010), women have found this difficult to achieve in mainstream maternity care (Homer 2006; Murray and Bacchus 2005). Recently Boyle et

al. (2016), in a UK qualitative study exploring 16 women's experiences of partnership working with midwives, reported women rarely described developing such meaningful relationships with midwives due to lack of time and a lack of continuity of midwifery caregiver. Furthermore, antenatal care was described as 'ticking the box' (Boyle et al. 2016, p.23) with midwives focussing on the biomedical aspects of care rather than meeting women's psychosocial and emotional needs.

A systematic scoping review of what women from around the world want, need and value in pregnancy (Downe et al. 2015) reported similar findings to those of Boyle et al. (2016). The review concluded that women's expectations were only in part met, and greater focus on social, cultural, emotional and psychological support rather than biomedical aspects of care was required. The data also highlighted the importance for women of feeling enabled to have enough time to ensure their needs were met and permit social exchange with staff (Downe et al. 2015). It has been reported that NHS midwives often struggle to meet women's needs and deliver policy objectives of personalised maternity care, whilst working within an over-stretched 'bureaucratic health system designed for processing people en-masse' (Finlay and Sandall 2009, p.1228; Boyle et al. 2016; Bryson and Deery 2010). In fact, UK maternity services are sometimes characterised by a lack of caring for women and their families (Eliasson et al. 2008; Larkin et al. 2012). Short staffing, busy-ness and medicalised models of care may contribute to this perception (Boyle et al. 2016; Larkin et al. 2012; Sandall et al. 2011). This may in part explain women's motivation and rationales for agreeing to participate in student educational continuity initiatives.

As the women's stories unfolded across the caseloading experience, I found it interesting as story-receiver to hear how for the majority, anticipated expectations of perceived benefits were met, and even surpassed. Echoing the findings of Tickle et al. (2016), women described their student companions as '*amazing*' [Ami2, p.2] people who made a significant difference to their childbirth experience. Women talked about how '*lucky*' [Anna1, p.5] they felt and what a '*good decision*' [Ami1, p.5] it had been to agree to be part of a student's caseload and even how '*spoiled*' [Anna2, p.4]

they felt by the care they had received. Women want to maintain a healthy pregnancy and achieve effective transition to positive labour and birth and motherhood (Downe et al. 2015; Hallgrimsdottir and Benner 2014), and as previously discussed [7.3.2], it is suggested most pregnant women worry (Heron et al. 2004; Homer 2002; Paradise 2002). England and Horowitz (1998, p.6) believe that 'worry is the work of pregnancy', even suggesting there is a 'right amount of worry' for pregnant women that could be the stimulus to problem-solving and activation of coping resources (England and Horowitz 1998, p.190). Homer et al. (2002) differentiate this normal functional worry amongst women, associated with problem solving and coping, from dysfunctional worry, associated with feelings of helplessness and depression. Women described how having not one, but two caregivers was a '*bonus*' [Jody1, p.3], and a source of comfort and reassurance as their pregnancy progressed:

"It's definitely a benefit because you need your mind put at rest...it's a peace of mind thing having the second person there, it's reassuring."
[Jody2, p.6]

Whilst women talked about how beneficial it was to have more than one maternity caregiver, they differentiated between how they felt themselves regarded by midwives and their student companion. As reported by others, women believed that the student was 'for them' [7.2], and regarded themselves as the main focus of the student's attention (Aune et al. 2012; Browne and Taylor 2014; Rolls and McGuiness 2007). Like women in Norway, and as I discuss further in [7.4.2], being the main focus of student care was exhibited in the story data as important (Aune et al. 2012; Dahlberg and Aune 2013). Echoing Rolls and McGuiness's (2007) findings and the wider contemporary literature, some women talked of how busy midwives were, with many competing demands and calls upon their time, and how reluctant they were to disturb or interrupt them (Boyle et al. 2016; Cescutti-Butler 2017). Whereas in contrast, women in this study perceived their student companion as having more time, which contributed to their sense of receiving extra special care:

“I spoke to a lot of my friends about it...I’ve said it’s quite good really cause like Susie [student] has got more time for me, other midwives haven’t got enough time you know they are very busy.” [Emma2, p.3]

Congruent with the educational literature, women in this study reported numerous benefits of being the main focus of student care. Women talked of the extra attention, information and support they received and of how their student companion would go the ‘extra mile’ to ensure their individual physical and emotional support needs were met (Browne and Taylor 2014; Kelly et al. 2014; Rolls and McGuinness 2007). As Kelly et al. (2014) reported, this extra support extended beyond that of providing clinical midwifery care and was equally positively valued by the multigravida, as well as primigravid women. Women talked of how the student accompanied them to scans and/or consultant appointments, and gave practical advice and assistance following the baby’s birth:

“I was breastfeeding Rosie [baby] but she didn’t gain quite enough weight...so Susie [student] helped with that. Susie sat down with me and did like a breastfeeding observation and she did help with it a lot and I think after I had that conversation with her, she [baby] did latch on properly.” [Emma3, p.4]

As Boyle et al. (2016) reported, analysis of the story data clearly elucidated women in this study wanted supportive and caring experiences over and above that offered by local mainstream maternity services. Being part of a student midwife’s caseload, having relational continuity and being the central focus of care gave women an *“extra security blanket”* [Anna3, p.6]. Women talked of how they turned to their student companion for access to provision of support perceived unavailable in local provision. As reported by others, it was the caseloading student’s presence and focus on women which eased women’s worry, provided reassurance, gave confidence and empowered women in this study (Kelly et al. 2014; Tickle et al. 2016).

7.4.2 Valued constant presence

From the outset, all women articulated a belief that by agreeing to be part of a student midwife's caseload they would receive extra special care. Extra special care was exhibited within the story data by the multi-faceted support role the student carried out. Women perceived this as care over and above that available to other women [7.4.1]. Students in the research location make themselves available for non-urgent contact during working hours (within a given timeframe), and are required to be on-call from 37 weeks to attend the women in their caseload for labour and birth (Rawnsdon 2011a). This aspect of the student support role was demonstrated in the story data as a valued constant presence and was exemplified by women as a sense of shared journey, of not 'going it alone'. Women commented that knowing their student companion was available for contact re-enforced a sense of being more 'special', that they were receiving a higher quality of care than other women, which evoked feelings of comfort and reassurance from the outset of the caseloading experience:

"Yeah it makes me feel a bit more secure and a bit more special and I've got just a bit more support as well, which is really nice." [Ami1, p.4]

For the majority of women, the journey through pregnancy, labour and birth into motherhood is a normal life event often seen as a rite of passage from girlhood to womanhood (Oakley 1993). However, pregnancy profoundly affects every aspect of a woman's life and is a time of great adjustment physically, socially and psychologically (Paradice 2002). Each pregnancy is unique and often experienced differently, and women may experience mood swings, anxiety and heightened emotionality (Raphael-Leff 2005). As discussed in [4.7.1], it had been my hope that being heard and listened to, and having experiences acknowledged and validated at interview, would be beneficial for the women who participated in this study. I therefore felt rather humbled, and at the same time, a sense of happiness when in sharing their stories during our third and final interview conversation, some women indicated this had been the case:

“I tell people you are my lady that comes, and I likes it when you come, cos I get to talk it through, you’ve been my therapy!” [Kelly3, p.4]

Women report concerns with current UK National Institute for Health and Care Excellence [NICE] (2008) recommendations for frequency of antenatal appointments, particularly in the first half of pregnancy, perceiving the gap between visits as too long (Boyle et al. 2016). Prior to the revised guidelines being published in 2008, healthy women with uncomplicated pregnancies received an average of thirteen antenatal appointments (NICE 2003). Current guidelines recommend a reduced schedule of antenatal visits with primigravida women receiving an average of ten appointments, and multigravida women seven (NICE 2008). Boyle et al. (2016) reported reluctance amongst women to contact a midwife in between scheduled visits, with women often waiting until the next antenatal appointment to discuss their concerns. As previously discussed [7.4.1] a perception exists amongst women that midwives are ‘busy’ people with many competing demands upon their time. However, interestingly, lack of access for some women in the Boyle et al. (2016) study was linked to confusion as to the correct communication pathways for accessing a midwife. This was not identified as an issue for the women in this study, and all women were cognisant with how to access a qualified midwife and the student’s supervising mentor, which was commonly the woman’s named midwife, from early in the caseloading relationship. However, while all women identified their named midwife as a point of contact for information, advice and support, some women identified the caseloading student as the person they would contact in the first instance, and as a point of referral:

“I’d contact her [student] first (if I had a concern) um if I couldn’t get hold of her I’d contact Catherine [named community midwife].” [Erin1, p.4]

“You’ve got the student as first port of call and then if you can’t get hold of the student, then you can go to the actual midwife.” [Ami1, p.4]

“I know if I’ve got any issues I’ve only got to ring Pippa [student] and she’ll do what she needs to do...literally, if I’ve got any concerns I just text Pippa and she gets back to me, mm yeah, it just puts your mind at rest.” [Jody1, p.6]

Resonating with the findings of Williams et al. (2010), in an Australian survey of primiparous and multiparous women who had received midwifery care via a midwifery group practice programme, women in this study, saw their student as a ‘constant companion’, someone who was available to access when required to answer queries, support or offer reassurance. Women expressed a sense that they only had to call, and the student would instantly respond. This access and contact with the student became a more dominant story strand and was described as more regular, as the women’s stories unfolded across the caseloading experience. Women spoke of their comfort in accessing support and information from students in this way, and this seemed linked to knowledge that any information or advice the student gave would be checked by a qualified midwife, and there would be a speedy response and resolution to their query as Anna and Ami describe:

“I tend to text rather than call um and she [student] usually gets back to me pretty quick, pretty immediately, she always goes through Lauren [community midwife] though as well, just to confirm her own thoughts.” [Anna1, p.2]

“If she [student] doesn’t know the answer (to my questions) she’ll ring, I think last time she rang Carol (community midwife) and just double checked with her about my back pain.” [Ami1, p.3]

While Browne and Taylor (2014) report women appreciated the information and support provided by students, this finding does not appear reported elsewhere in the midwifery educational literature and more research in this area is needed.

As Ami and Jody described earlier, women valued having access to additional support and guidance from their student companion via the educational continuity, and spoke of how this engendered a greater sense of

security, comfort and peace of mind. Women also talked about their high level of confidence and trust in the student's knowledge and in how the information and advice the student gave informed their decision-making and preparations for labour and birth [7.3.2]. As reported by others, working with students in this way, boosted women's self-confidence and engendered a sense of empowerment (Rolls and McGuiness 2007; Tickle et al. 2016). The ability to engender trust, empowerment and self-confidence, are concepts associated with quality, woman-centred midwifery care (NHS England 2016), and thus central tenets within the International Code of Ethics for Midwives (ICM 2014). However, the evidence-base discussed here is not in relation to women's experiences of care provided by qualified midwives', rather it is about student rendered care. It is therefore of paramount importance women and students are not placed in a potentially vulnerable position or at risk. As discussed earlier [7.3.2], it is imperative robust systems are in place to ensure that all information, advice and care given by the student is reviewed and agreed by the student's supervising midwife mentor.

It is also of primary importance that robust mechanisms and communication processes are in place both within education and practice to ensure women and students are supported throughout the continuity experience. The literature suggests being 'with woman' via the caseloading relationship can place significant emotional demands on students (McKellar et al. 2014; Sweet and Glover 2013), evoke feelings of stress (Carolan-Olah et al. 2015; Dawson et al. 2015; Rawnsdon 2011a) and negatively impact on family life (Browne et al. 2014; Dawson et al. 2015; McLachlan et al. 2013). It is imperative that students are not placed in a position where they feel out of their depth, and/or due to the woman's continued contact, a heavy onus of responsibility or feel they are the sole provider of care. Supervising midwife mentors must be prepared to step in and ensure women are cognisant with the nature of the student role and responsibilities during the caseloading experience. Where necessary, this may entail institution of direct supervision of all student care and/or the re-negotiation of ground rules for the caseloading relationship within the woman-student dyad (Fry et al. 2008). It is also imperative robust systems are in place to support women, if the

caseloading relationship is terminated prior to its conclusion as experienced by Kelly and Erin [7.2.2].

As identified in [7.2.2], resonating with the educational literature, women in this study exhibited a belief at the outset of the caseloading relationship that the student would be available to attend them for labour and act as their primary birth supporter. This in part informed women's decision to participate in the scheme, and was associated with perceptions of extra special care [7.4.1]. Women's experiences of this aspect of the student educational continuity and the meanings this had for them are not well illuminated within the educational literature. Rolls and McGuiness (2007) reported women valued the continuous support by a known student throughout their childbearing experience but do not discuss the birth experience specifically. All women in the Aune et al. (2011) study experienced a known student present throughout the birth and this was identified as being very important to women. However, while the women in the Aune et al. (2011) study found the student's presence reassuring, this study reported on a team approach to educational continuity rather than a one-to-one model of care. More recently however, Tickle et al. (2016) reported women's particular disappointment if the student missed the birth. As illustrated in [6.3], in sharing their stories women in this study revealed contrasting perspectives and not all women experienced having their known student companion attend them during labour and the birth. The midwifery literature provides strong evidence as to the importance women place on the continuous presence of a known and trusted midwife during labour and birth and how this is associated with a better birth experience (Allen et al. 2017; Corcoran et al. 2017; Huber and Sandall 2009; Jepsen et al. 2017a; McCourt et al. 1998). The significance of having a known student present for the birth for the women in this study was illustrated by the joy women expressed when sharing stories of their student companions' arrival to attend them during labour:

"When she [student] turned up (on labour ward) it was like, that's it, familiar face. I know, I know you are going to help me, I know you know what my fears are...Polly [hospital midwife] was lovely and

brilliant but obviously I had a personal bond with Pippa [student], which helped me relax I think.” [Jody3, p.9]

In parallel with the midwifery literature, the student’s presence enabled women to feel safe, more at ease (Allen et al. 2017; de Jonge et al. 2014; Huber and Sandall 2009; Jepson et al. 2017a), which evoked a strong sense of comfort: As others have reported, this seemed linked to a perception that the student would act as an advocate on their behalf (Browne and Taylor 2014; Kelly et al. 2014; Rolls and McGuinness 2007) and intuitively understand their support needs:

“As soon as Pippa [student] turned up when I was in labour I was like ‘Oh Pippa’s here, Pippa’ here!’ So, if I had any concerns I could just even only look at her and she’s like ‘you’re alright, you’re alright’ (spoken softly, soothingly)” [Jody3, p.10]

When the student was not able to be in attendance for labour and birth, as planned and anticipated, resonating with the Tickle et al. (2016) findings, women’s stories poignantly reveal the serious disappointment, dismay and confusion evoked:

“I text her [student] a few hours sort of before (I gave birth) when I knew I was getting like contractions and she said, ‘oh my other patient’s actually in labour at the moment, I’m on the labour ward’ and I thought ‘oh gosh!’ Okay, what shall I do? cos...sort of all through pregnancy you sort of plan it, don’t you?” [Emma3, p.3]

It is important to recognise that the students’ presence or availability to support the women within their caseload for labour and birth cannot be guaranteed (Fry et al. 2008). At the same time, it is of equal importance to recognise how this can generate a more challenging birth experience for women, and engender significant negative emotional work. This is an unavoidable disadvantage of one-to-one approaches to educational continuity schemes, which is not well addressed within the educational literature. Interestingly, despite the plethora of midwifery literature, the experiences of women in midwifery continuity models who are not attended

by their known midwife during labour and birth is little explored. In an English qualitative study exploring women's experiences of a pilot team midwifery project, Tinkler and Quinney (1998) describe one woman's disappointment at not being attended by a team midwife for her planned caesarean section birth. More recently, in a qualitative study of how caseload midwifery is experienced by couples in Denmark, Jepson et al (2017a) further report on one couple's disappointment and dissatisfaction when their midwife was unavailable to attend them for the birth. However, the authors of these studies do not include recommendations as to how women in this situation can be supported. Currently, the standards for midwifery education (NMC 2009) are under review. However, it seems likely that the mandated continuity requirement will be retained when the standards are revised, given the growing body of work and interest in this initiative from a global perspective. If this is the case, it is essential women and students are supported appropriately, and more work in this area is needed.

7.4.3 Summing up: Extra special care

'Extra special care' is about women's motivations for agreeing to be part of a student midwife's caseload and how women perceived the opportunity as a 'win-win', a way of fulfilling their own needs as well of those of the student. Women's perceptions in this were underpinned by a belief that they would receive better care, a level of enhanced service provision over and above that available to other pregnant women. While the concept of extra special care held different meanings for women and was exhibited in the story data in multiple nuanced ways. All women saw the student as being just for them, that they would be the main focus of the student's attention, which reinforced women's sense of being more 'special' and of receiving a higher quality of care. Alongside this, was women's recognition that by being part of a student's caseload ensured two rather than one caregiver, the student as well as the midwife, and a belief that this would enable better care. The theme is describing women's expectations and aspirations for the educational continuity and the meanings of the experience for them.

The theme exemplifies the importance women place on having a known and trusted caregiver with whom they have developed relational bonds throughout the continuum. Women saw their student as a 'constant companion', someone who was available to access when required to answer queries and offer support or reassurance. Women spoke of how they only had to call, and the student would instantly respond and how this engendered a greater sense of security, comfort and peace of mind, and of being more 'special'. Running throughout the theme were poignant and contrasting expressions of emotion as women shared the meanings and significance for them of experiencing labour and birth with their known student companion present, and of not having their student present.

The next chapter concludes the thesis, identifying the original contributions and recommendations for education and practice and suggestions for further research.

Chapter 8 Learning from stories: taking them forward

8.1 Introduction

My desire to enhance the quality of women's experiences via development of midwifery education, and passion to gain holistic understandings of what it is like to be part of a student midwife's caseload, resulted in this exploration of educational relational continuity through hearing women's personal stories of experience.

The development of a pluralistic analytical model that supported both the analysis of narratives and narrative analysis enabled creation of two interrelated formats of re-telling or stories within stories. This method has enabled me to share the meanings and significance of receiving student continuity to both the individual women within the study and the women as a group, via generation of individual and collective stories of experience. In addition, choosing poetry as a vehicle to re-tell each woman's embodied story has enabled reader understanding of its content and meanings without losing sight of the storyteller.

While some findings are consistent with international research, others offer new insights into women's real-time holistic experiences of relational continuity with a student. In addition, this study has enabled me to develop the women's stories, re-told as poems, as an educational resource providing insights into how they might be used to inform best practice midwifery education and student preparation for the continuity experience.

This chapter reflects upon the findings, and the contributions to new perspectives on knowledge achieved through the undertaking of this study, and how the knowledge gained can inform future midwifery education and practice provision for the educational continuity curriculum element.

8.2 Constructing meaning: Considerations for education and practice

My study has explored women's experiences of educational continuity via a one-to-one student midwife caseload model using a narrative interpretative framework. The findings demonstrate the uniqueness of each woman's personal experience and the meanings this had for them, and the collective aspects of significance to the women as a group. Choosing poetry as a way of re-telling the women's personal stories in Chapter 6, has offered me an insight into the value of creative approaches in presenting data and how this can invite activity rather than passivity on the part of the reader. It has enabled me to recognise how poetry creates succinct versions of the woman's stories and provides a way for the reader to engage directly and empathetically with each woman and her experience (Anderson 2007; Davis Halifax and Mitchell 2013; Gallardo et al. 2009).

The artistry of poetry has enabled me to communicate the embodied stories shared with me at interview holistically and enable their content and meanings to be understood. The poems in Chapter 6, thus provide a rich and valuable tool for education purposes. The poems invite the reader into each woman's lived world of experience and using the woman's own words [5.6.2] succinctly share the core issues, experiences and emotions into a coherent account (Gallardo et al. 2009; Furman et al. 2006; Poindexter 2002). Using the poems as a teaching strategy, will enable the real power of woman's knowledge, gained through this study, to be shared and provides a resource with which to facilitate engagement (Healy and Smith 2017) and promote mindful reflective ethical and compassionate understanding amongst midwives and students.

Through this lens of women's knowledge, my research has concluded there are some overriding themes for education and practice that merit consideration. Data from the women's individual stories re-told in chapter 6, and the three emergent longitudinal narrative themes of significance to the women as a group, configured around women's perceptions of their caseloading student as learner, caregiver, and companion. These conceptual

elements, extracted from the emergent themes, create a construct with which to shape and contextualise the discussion and are used as sub-headings.

8.2.1 Learner

It is important to recognise the context and content of learning for midwifery students within the academic and clinical practice environments. It is generally held that the theory and philosophical underpinnings of midwifery are learnt within the academic setting, and it is the practice environment in which students apply the theory and learn the art of midwifery and midwifery ways of being 'with women' [1.2]. In the UK, learning undertaken through clinical placements provides up to 50% of the educational experience during which students are required to achieve a significant number of mandated clinical experiences and competency requirements (NMC 2009). While students welcome the opportunities to engage in practice and develop their theoretical learning as a developing midwife (Sidebotham et al. 2015), it is argued that student allocation to fragmented clinical placements in different care settings forces prioritisation of requisite skill acquisition and accumulation of specified mandated clinical experiences, rather than focus on establishment of women-centred relationships (Ebert et al. 2016; Licqurish and Siebold 2013). It is suggested this leads to a task orientated approach, which constrains learning and devalues the quality of the clinical learning experience (Ebert et al. 2016).

Within the current context of staff shortages, lack of time and high workloads [2.2.3] emphasis on a task orientated approach to care is likely to be reinforced. Midwifery work in many UK units is described as intense and midwives as stressed and unsupported (Bryson and Deery 2010; RCM 2015), and the need for resilience amongst the midwifery workforce is identified (Crowther et al. 2016; Hunter and Warren 2014; Mollart et al. 2013). The concept of time and how it is orientated and managed by midwives in different work contexts, models and settings is discussed by Stevens (2010). Hospital-based work necessarily centres on the shift-system of 'clock time' and the needs of the service rather than the physiological rhythms of time of women's pregnancies and labours. 'Clock time' reinforces

a focus on the time divisions of midwifery shifts, time allocation for care completion and thus a task orientated approach rather than women's needs or relational continuity (Stevens 2010).

Preliminary research into student experiences of the educational continuity of care experience suggests this offers students a learning opportunity that is unique and contrasts with that experienced in standard, more fragmented clinical placements (Gray et al. 2013; McLachlan et al. 2013; Yanti et al. 2015). The literature provides insights into how students learn to be 'with woman' via the experience, and why educational continuity can be effective in assisting students to develop a 'with woman' philosophy (McKellar et al. 2014; Rawnsdon 2011a; Sweet and Glover 2013; Yanti et al. 2015). Moreover, rather than fostering a task orientated approach to care, working in the model enables students to understand the importance of working in partnership with women (Browne et al. 2014; Dawson et al. 2015; Gray et al. 2012; Rawnsdon 2011a; Sidebotham et al. 2015; Sweet and Glover 2013), through a symbiotic relationship of learning together. From the women's accounts discussed in Chapters 6 and 7, it is evident the experience enabled students to learn and develop the midwifery ways of being 'with women' reported by others (McKellar et al. 2014; Rawnsdon 2011a; Sweet and Glover 2013). Given contemporary context of service realignment in the UK, learning these attributes and qualities via the educational continuity experience, will greatly assist students to meet the 'Enabling professionalism' directives (NMC 2017b), and embrace the Better Births (NHS England 2016) agenda on qualification as a graduate midwife.

Sharing women's stories is a rich and powerful educational tool that promotes reflective insight (Leamon 2004; Moon and Fowler 2008) and provides a lens through which to view self and personal emotions (Leamon 2009). It is argued, use of poetry as a teaching strategy within the academic environment, even when incorporated within traditional lecture format within a large group setting, facilitates student engagement, aids information recall and provides an enriched learning experience (Healy and Smith 2017). This is because it effectively and efficiently communicates the woman's emotional world of care experiences (Stein 2004), enabling us to engage

empathetically, and revisit the familiar and see it from a different perspective (Anderson 2007). It is reported that implementing clinical skills in the practice arena can be challenging for students, particularly when working in new models of care (Gilmour et al. 2013; Houghton et al. 2013), and students have reported a lack of confidence about engaging in the educational continuity (McKellar et al. 2014), as well as anxiety about how they might be received by women (Rawnsdon 2011a). Study findings evidence strong benefits of integrating continuity of care opportunities for students into the midwifery practicum experience. However, issues around professional relationships and boundary maintenance were identified [8.2.2; 8.2.3] and there is need for the authentic and realistic preparation of students for the experience. This is imperative to ensure sustainability within the future workforce, given the vision set out in Better Births (NHS England 2016) for service reform in the UK,

My aim in choosing poetry as a holistic way of re-telling the women's stories was to enable the real power of woman's knowledge, gained through this study, to be used to promote learning prior to engagement in the educational continuity experience [5.3]. It was hoped, hearing the power and simplicity of the women's words will engender confidence amongst students and enable understanding that women want to contribute to their education. Moreover, for students to understand that it is okay not to know how to perform a skill and not to have the knowledge to answer questions, women understand and recognise their status as learner, and will offer their support and encouragement. Reflecting on my original intentions in light of the study findings, and contemporary context of service reforms, highlighted the importance of disseminating this women's knowledge more broadly. The women's storied poems powerfully portray women's desire for relational continuity of care, the importance of known, trusted caregiver for birth and the fundamental importance of a humanised woman-centred approach to midwifery care. Sharing the women's stories with midwives, educationalists, students and service providers at a wider national and international level, has potential to inform best practice midwifery education. My ambitions in this are discussed in [8.6.1].

8.2.2 Caregiver

The ability to see women as individuals with unique needs and context, and work in partnership with women to facilitate collaborative care provision is central to the 'Enabling professionalism' agenda (NMC 2017b). Compassionate person-centred care is central within this and in 2012 the Director of Nursing for England launched a strategy for the development of a compassionate culture within the NHS (DH 2012). This strategy calls on practitioners to underpin their practice with six key values that are believed to maximise provision of high quality care. These values are care, compassion, competence, communication, courage and commitment (DH 2012). As discussed earlier [8.2.1], midwifery students learn the art of midwifery in the clinical environment and the women's stories revealed strong potential for students to learn to develop and embed these values within their personal practice via educational continuity.

Resonating with the educational literature, women in this study evidenced strong desire to form close connective bonds with their caseloading student companions (Aune et al. 2012; Browne and Taylor 2014; Dahlberg and Aune 2013; Kelly et al. 2014; Rolls and McGuinness 2007; Tickle et al. 2016), and perceived the relationships established within the woman-student dyad as genuine, personalised, trusting (Aune et al 2012; Browne and Taylor 2014; Kelly et al. 2014) and mutually reciprocal. The women's stories illuminated the high level of commitment the students exhibited to the women in their caseload, and as reported by others, of how they were prepared to go the 'extra mile', and offer time, information or practical assistance to ensure the woman's individual needs were met (Browne and Taylor 2014; Kelly et al. 2014; West et al. 2016). This hints towards students going over and above women's expectations of care. Whilst women in this study appreciated the levels of support offered by students, it is important students recognise the actual effects of the support may not necessarily positively impact on health. This is because the outcome is intrinsically linked to the perceived intentions of either participant within the social support exchange (Shumaker and Brownell 1984). Support is unhelpful if it undermines the woman's own coping resources, self-esteem or sense of control (McCourt 2006) or if it is

linked to the student's own need to be valued by the woman (McCrea 1993). Additionally, the concept of reciprocity and exchange within social support may engender a sense of indebtedness, and a need to reciprocate among women (Shumaker and Brownell 1984). Furthermore, striving to go 'above and beyond' to meet women's envisaged needs raises the potential of enhanced stress and emotional work for students (Hunter and Warren 2014; McAra-Couper et al. 2014; Stevens 2003), particularly if these are perceived as unmet (Beaumont et al 2016). It is therefore important that students clarify with women the limits of support they can provide (McCourt and Stevens 2009).

The women's stories further hints towards students and of giving of time that on qualification, whether working in a caseloading or more traditional model of care, will be challenging to incorporate within the working day or shift (Boyle et al. 2016; Downe et al. 2016; Fereday and Oster 2010). Working with women in a relational continuity model, without the structure of hospital or clinic-imposed time constraints on care was identified as a particular challenge that midwives new to this way of working found difficult (Stevens 2010). For students, this represents contrasting concepts of time and how it is managed from that previously experienced during the midwifery practicum allocations (Fereday and Oster 2010; Stevens 2010). Sustainable practice within caseload midwifery is linked, amongst other factors, to workable practice arrangements that enable midwives to manage their work time (Crowther et al. 2016; Fereday and Oster 2010; Gilkison et al. 2015; McAra-Couper et al. 2014). Learning time management skills is considered integral to professional practice within the caseload model (McCourt and Stevens (2006). It is important students recognise this and understand the differences between the time they are able to offer as students and that of a qualified midwife, who will have many competing calls and commitments upon their time (Boyle et al. 2016; Downe et al. 2016).

While study findings evidence women appreciated the students' efforts to meet their needs and in of giving of time, it is of central importance students understand the nature of the mutual reciprocal commitment women perceived established within the woman-student dyad. The literature around

sustainability in caseload practice evidence the importance of partnership working with women (McCourt and Stevens 2006), this includes sharing the caseloading remit (Gilkison et al. 2015) in terms of what the student can and cannot offer with women (Gilkison et al. 2015; McAra-Couper et al. 2014). Sharing this information is important in establishing professional boundaries and the setting of realistic expectations for women, as well as students, from the outset of the caseloading partnership. Students need to recognise that they are not indispensable to the woman and that they have the ability to say 'no' (McAra-Couper et al. 2014) and it is important women are enabled to understand this. Erin's story [6.3] powerfully portrays the importance of this and it is hoped in sharing her experience story will evoke depth of insight and promote mindful reflective ethical understanding amongst students and midwife mentors. It is imperative students recognise their responsibilities in this, and the importance of not raising women's expectations about something they cannot guarantee or will not be able to deliver.

Women in this study expressed a high level of confidence, trust and belief in the student's abilities as caregiver and described their student companion's as 'good midwives'. This was linked to the relational connections perceived developed with the student, the student's thoroughness in caregiving, genuine interest in them and their family, and motivation to provide high standard quality care. This trust in the caseloading student's knowledge informed women's decision-making and comfort and women spoke of how they turned to their caseloading student for information, advice and support. As reported by others, working with students in this way boosted women's self-confidence and engendered a sense of empowerment (Rolls and McGuinness 2007; Sidebotham et al. 2015; Tickle et al. 2016). Given the way women actively sought, listened to and adopted student advice, raises strong potential for women to be vulnerable to miss-information and support. It is of paramount importance the parameters of safe practice are maintained at all times, and students fully understand the student role and the midwife's accountability. This is because by its very nature, caseloading promotes autonomous practice (NMC 2009), and is likely to entail mentor supervision which is indirect and devolved rather than direct (Rawnsdon 2011a).

My hope in dissemination of these study findings will enhance and enrich student understandings of their responsibilities in this, and the importance of negotiating and maintaining appropriate ground rules for the caring relationship during educational continuity experience. However, the requirement to undertake a continuity of care experience as part of midwifery pre-registration education is widely interpreted with little guidance on the 'best way' and it could be argued, this places the requirement at risk. My study adds to the body of emerging information about student continuity of care within the midwifery practicum and provides valuable evidence of impact on women. This knowledge can inform the collective evidence of understanding at a local and wider international level.

8.2.3 Companion

The women's stories reveal how the student being part of a life changing event, which was described as an intimate and personal time in their lives by the women in this study, being trusted by women, journeying with them and becoming part of their life story provided a powerful learning experience for students. It also highlights the importance women place on having a known and trusted caregiver with whom they have developed relational bonds throughout the continuum. Women saw their student as a 'constant companion', someone who was available to access when required to answer queries and offer support or reassurance and, resonating with Williams et al. (2010) findings, how this engendered a greater sense of security, comfort and peace of mind. This evoked a sense of being more 'special' amongst women, and of receiving an enhanced level of service provision over and above that available to other pregnant women.

Resonating with Browne and Taylor's (2014) findings, for many women, the close relational bonds this engendered within the woman-student dyad evoked feelings of companionship and, for some women, friendships with students that were perceived as mutually reciprocal. The ability to develop professional therapeutic relationships with women is an important midwifery skill that enables important practical emotional support for both women and midwives (McCourt and Stevens 2009; Stevens 2003). However, crafting

such skills can be challenging particularly during relational continuity schemes (Stevens 2003), and it was apparent from the women's stories that some students struggled to maintain professional boundaries within the caring relationship. In agreement with McKellar et al. (2014) and West et al. (2016), this finding appeared linked to student desire to provide women-centred care, and commitment to meet women's envisaged expectations. Stevens (2003) ethnographic study identified learning to develop professional relationships with women was an important part of the adaptation period for new caseload midwives that took time to learn. This finding indicates the imperatives for authentic and realistic preparation for the caseloading initiative, and the development of creative and reflective learning strategies that support student understanding of their role, responsibilities and the limits of 'skilled companionship' (McCourt and Stevens 2006, p.155), as well as, how to negotiate and maintain these boundaries.

Women's stories revealed the possibility that the close relational connections established, and journeying with women across the continuum, could assist students in developing intrinsic intuitive skills. Developing this desirable form of tacit knowledge and way of knowing will promote the ability of students to meet the 'Enabling professionalism' agenda (NMC 2017b) on qualification. In parallel with the literature, the student's ability to personally perceive their support needs was highly valued by women (Downe et al. 2007; Halldorsdottir and Karlsdottir 1996b) and engendered an enhanced sense of comfort and security, particularly during labour and birth. Resonating with the midwifery literature, women's stories powerfully portrayed the meanings and significance of experiencing labour and birth with their known student companion present and when this was not possible (Jepson et al. 2017a; Walsh 1999). It is important women recognise and understand that the students' presence or availability to support them for labour and birth cannot be guaranteed (Fry et al. 2008). As previously discussed, [8.2.2] my study findings highlight the imperatives of establishing boundaries within the caseloading relationship and the need to set realistic expectations for women, as well as students (Fereday and Oster 2010; Gilkison et al. 2015; McCara-Couper et al. 2014) At the same time, it is equally important to

recognise how this can generate a more challenging birth experience for women and engender significant negative emotional work..

The possibility of 'losing' their caseloading student appears to be an unavoidable potential disadvantage of one-to-one approaches to educational continuity schemes for women that students, women, supervising midwife mentors and educators need to be aware of. While it is imperative women are prepared for the possibility and arrangements are made for suitable transfer of care if the student is no longer available, this finding highlights the emotional impact this can have on women. Introduction of different models that enable students the opportunity of continuity of care within the curriculum could be one way to protect women from harm and more research in this area is needed. Considerations of potential models that align with the Better Births (NHS England 2016) agenda and support student learning are discussed in [8.5.1.3].

Concluding the caseloading relationship and saying goodbye to the student was further exhibited within the story data as a difficult time of transition for some women, particularly when the caseloading relationship was terminated unexpectedly early pre-birth, due to student ill health. The latter is a particular disadvantage of continuity initiatives, which left women in this study feeling bereft, lost and confused and evoked a strong sense of disappointment. Resonating with the midwifery literature, many women found it difficult to truly let go and expressed a need to continue and maintain the relational connections forged within the woman-student dyad at the end of the experience (Beake et al. 2013; Jepsen 2017a; Walsh 1999). It was apparent too, that some students struggled to mitigate their relationships with women following conclusion of the caseloading experience. In sharing their stories, women revealed an expectation that the friendships forged with students would move forward in the future, which raises implications for how the boundaries of friendship are maintained within a professional context, particularly as the student moves to qualification. Within contemporary context of service reforms, this finding identifies is an important consideration for future education and practice and the preparation of midwives and women for continuity of carer models.

It is hoped the simplicity and power of the women's words will promote mindful reflective insight and enable students to understand and prepare for the potential emotional toll caseloading may make through hearing the women's experience stories. Moreover, my aspiration in choosing to re-tell the women's stories as poems is to provide an educational resource for education and practice that will engender compassionate understanding within the reader and promote a 'with woman' approach to care.

8.3 Study implications and conclusions

The study identified how important a contribution known carer is and provides evidence around the impact of loss on the woman when this is not possible. Given the context of maternity service realignment in the UK and the Better Birth's (NHS England 2016) agenda, education has a key role to play in the preparation of the future workforce to enable them to embrace working in continuity of care models on graduation. The positive impact of working with women in a continuity relationship on the students learning are becoming well documented (Aune et al. 2011; Browne and Taylor 2014; Dawson et al. 2015; Gray et al. 2012; Gray et al. 2013; Carter et al. 2015; McLachlan et al. 2013; Rawnsdon 2011; Sweet and Glover 2013). Through the lens of women's knowledge, my study findings identified some important aspects for consideration for the preparation and support of students for the experience, and these are discussed in the following sub-sections below; [8.3.1] authentic preparation for the caseload practice; [8.3.2] workforce wellbeing; [8.3.3] Contribution to educational standards.

8.3.1 Authentic preparation for caseload practice

Publication of the Better Births (NHS England 2016) report in 2016, shone a light on maternity services for the right reasons. The report sets out a vision for safer, personalised, family centred care incorporated within a continuity of carer model of service delivery and reflects the needs of women. Following implementation of the recommendations, the face of maternity services will be transformed. With the contemporary focus on maternity service reform in the UK, education will be central in the preparation of the emergent midwifery

workforce. Imperative within this is the authentic and realistic preparation of students to work in continuity of carer models on graduation. While students are provided opportunities to work in a continuity of care relationship with women during their pre-registration midwifery programme (NMC 2009), study findings demonstrated students struggle with professional boundaries finding it difficult to differentiate between friendship and a professional relationship. The study confirms the findings of other studies (Browne and Taylor 2014; McKellar et al. 2014; Rawnsdon 2011a; West et al. 2016) and highlights the importance of education in the development of these skills however, goes further to evidence the need to establish boundaries and set realistic expectations for women, as well as students, within the continuity relationship.

Evidence suggests new graduate midwives have high job satisfaction when working in continuity of carer models but lack the skills to establish effective professional partnerships with women and find it difficult to maintain appropriate boundaries in the caring relationship (Cummins et al. 2015; Cummins et al. 2017; Fereday et al. 2010). Enabling students to develop these skills during their midwifery education will enable them to meet the Better Births (NHS 2016) agenda on qualification and facilitate their on-going sustainability in the workforce. Literature from New Zealand, where midwives work within a well-defined caseload model (Pairman 2006) that has been established for over 25 years (Hunter et al. 2016) identifies the fundamental nature of partnership working with women to midwife on-going sustainability (Hunter et al. 2016; Gilkison et al. 2015; McAra-Couper et al. 2014). Central within this is taking time to explain and discuss with women the way in which the initiative works at the outset of the relationship (Fereday et al. 2010; Gilkison et al. 2015). In this way, the context for the caring relationship is set and the women knows exactly what to expect in terms of what the midwife can and cannot offer and the limits of her availability (Gilkison et al. 2015). McAra-Couper (et al. 2014) highlight the importance of this and identify the imperative for the individual midwife to recognise s/he is not indispensable to women and have agency to define limits of support provision and the ability to say 'no'. The women in this study saw their student as a 'constant

companion', someone who was available to access when required, answer queries or offer support or reassurance. This finding is in accord with the body of work in this area. The educational literature identifies that whilst students understand the need to maintain professional boundaries, the strength of the bond they developed with women led to a blurring of these boundaries and led to students going beyond the expectations of their role (Browne and Taylor 2014; Rawnsdon 2011a; West et al. 2016).

The ability to work in partnership and develop reciprocal relationships with women is identified as a major factor that sustains midwives in their abilities to work within the model over a prolonged period (Hunter et al. 2016; McAra-Couper et al. 2014). The nature of these relationships are central to the model and associated with increased job satisfaction (Collins et al. 2010; Cummins et al. 2015; Jepson et al. 2016; Newton et al. 2016), which sustained midwives joy and passion for midwifery (Hunter et al. 2016; McAra-Couper et al. 2014). Moreover, establishing such therapeutic relationships with women affords a practical and emotional support system for midwives, as well as women (McCourt and Stevens 2009). Evidence suggests students value the opportunity to develop such positive relationships with women (Browne et al. 2014; Dawson et al; 2015; Gray et al. 2012; Gray et a. 2013; McLachlan et al. 2013; Rawnsdon 2011a; Sweet and Glover; West 2016). Findings from this study, suggest forming these bonds with students was equally valued by women, and resonating with the educational literature a factor central to the one-to-one student continuity model for women (Browne and Taylor 2014; Kelly et al.2014; Tickle et al. 2016).

It is essential to prepare students realistically for practice within these models and this includes the establishment of boundaries and setting realistic expectations for women, as well as students. While the issues are complex, they clearly need to be addressed highlighting the need for realistic and authentic preparation for the experience. Education, making use of innovative teaching methods such as participative theatre (Hunter 2004a) or use of simulation technology-based learning that enable students to engage in clinical situations within a safe environment through role play (Ruyak et al.

2018) could play a role in this. Peer mentoring (Fisher and Stanyer 2018) and creation of curricula opportunities that facilitate peer reflection and peer support development through story sharing (Leamon 2004; 2009), or to have 'women in the room through sharing the women's storied poems developed via the analysis in this study could be an important innovation. In addition, it is essential students are supported in practice by midwife mentors this is a challenge within fragmented models of care delivery but essential for safe practice.

8.3.2 Workforce wellbeing

In recent years there has been an increasing focus on the emotional wellbeing of midwives (Creedy et al. 2017; Dawson et al. 2018; Dixon et al. 2017; Fenwick et al. 2017; Fenwick et al. 2018; Hildingsson et al. 2016; Jepson et al. 2017b; Jordan et al. 2013; Newton et al, 2014; Mollart et al. 2013), resilience amongst the midwifery workforce (Crowther et al. 2016; Hunter and Warren 2014; Mollart et al. 2013) and levels of workforce attrition (Fenwick et al. 2017; Hildingsson et al. 2016). Midwifery work in many UK units is described as intense and midwives as stressed and unsupported (Bryson and Deery 2010; RCM 2015), and a shortage of midwives has been identified in a number of resource rich countries (Fenwick et al. 2017; Hildingsson et al. 2016). The context of midwifery and midwifery work will impact on students during the midwifery practicum, and the continuity of care of care experience in terms of how they are supported and facilitated in the provision of woman-centred care. Relational continuity with women is reported to facilitate a 'with woman' approach to care (McKellar et al. 2014) that taught students how to be 'with women' and the importance of relationships and partnership working (Browne et al 2014; Dawson et al. 2015; Gray et al. 2012; Gray et al. 2013; Rawnsdon 2011a; Sidebotham et al. 2015; Sweet and Glover 2013). Not being able to work to this ideal was reported to engender negative emotions and conflict amongst students (Hunter 2004a). This suggests the degree of emotional dissonance experienced during the continuity experience may be increased if the reality of practice provision is mismatched to personal beliefs about care (Blomberg and Sahlberg-Blom 2007; Hunter 2004a; 2005). This will have significant

impact on student's emotional wellbeing (Zapf 2002), their ability to learn from the caseloading initiative and desire to work in this way on qualification.

The women in this study saw their midwife as busy and overworked and welcomed having their caseloading student. High work-loads, stress and burnout are identified as key factors associated with workforce attrition (Fenwick et al. 2017; Hildingsson et al. 2016) and concerns about attracting and retaining midwives have been expressed (Fenwick et al. 2017). The literature has long evidenced debate about the potential of burnout for midwives within a caseload model, due to the integral on-call commitment and client-focussed nature of the work (Sandall 1997; Stevens and McCourt 2002c; Young et al. 2015). The belief that caseload practice causes or contributes to burnout has long cast a shadow over the model and a major factor to its implementation within mainstream midwifery. The literature has evidenced significant growth in the number of studies using standardised tools to measure aspects of emotional wellbeing amongst midwives working within hospital-based environments and caseload models. Regardless of risk or pregnancy outcome, the evidence indicates caseload practice is less likely to cause emotional stress for midwives than working in fragmented models of care (Dixon et al. 2017; Fenwick et al. 2017; Fenwick et al. 2018; Hildingsson et al. 2016; Jepson et al. 2017b; Jordan et al. 2013; Newton et al. 2014; Pallant et al. 2015; Pallant et al. 2016).

Moreover, the research evidence indicates caseload practice affords many benefits for midwives. Working in the model is reported to promote professional autonomy, increased job satisfaction and fulfilment (Collins et al. 2010; Jepson et al. 2016; Newton et al. 2016; Yoshida and Sandall 2013) that sustained midwives joy and passion for midwifery (Gilkison et al. 2015; Hunter et al. 2016; McAra-Couper 2014). This understanding adds weight to the Nursing Midwifery Council expectations and reinforces the value of educational continuity initiatives. In addition, within the context of current maternity service realignment in the UK supports the growing need for the expansion of continuity of care models within mainstream practice and the vision for midwifery outlined in Better Births (NHS England 2016).

8.3.3 Contribution to educational standards

The requirement to undertake a continuity of care experience within the midwifery practicum, as part of midwifery education is widely interpreted with little evidence on the “best way”, and this places the requirement at risk. This is perhaps illustrated in the context of Australia, where the mandated requirement was arguably, weakened without evidence, at the time, of impact. The current standards require students to undertake ten continuity experiences (ANMAC 2014). This demonstrates a reduction in the number of continuity experiences from twenty in the previous standards (ANMAC 2009). Wide variation in how the experience is integrated within the educational curriculum is evident in the UK (NMC 2010). In some institutions students work in a one-to-one continuity model, whereas in others organising care for a small group of women who are part of the mentor’s caseload each day, is considered to equate to caseload practice. Variance in when the learning experience occurred within the curriculum, the size of caseload undertaken, and whether students negotiated their own personal caseload or assigned women was further reported (NMC 2010). A growing body of evidence supports the continuation of this element with midwifery education and demonstrates the positive impact of the experience on the students learning for midwifery practice (Browne et al. 2014; Carter et al. 2015; Dawson et al. 2015; Gray et al 2012; Gray et al. 2013; McLachlan et al. 2013; Rawnsdon 20011a; Sidebotham 2015; Sweet and Glover 2013; West 2016). Many students report feeling inspired by the caseloading model (Carter et al. 2015), more prepared to work in this way on qualification (Dawson et al. 2015) and of future career aspirations to work in the model (Carter et al. 2015; Dawson et al. 2015; Rawnsdon 2011a). Within the context of current maternity service realignment in the UK (NHS England 2016) and the role of education in development of the emergent workforce to work in the model, reinforces the value of educational continuity initiatives.

Study findings provide evidence to further support the continuation of this element within midwifery education. Women highly valued the student contribution to their care and their stories powerfully illuminated the significance of the relational continuity experience with a student, and the

sense of comfort, reassurance and security it engendered. The findings also indicated areas that need attention in order to maximise the learning experience for students such as professional boundary maintenance and the importance of setting realistic expectations for women, as well as the students [8.3.1]. The study identifies how important a contribution known carer is and provides evidence around the impact of loss on the woman when this is not possible and highlights the need to protect women from harm. Women's experiences in this may be transferable to other women participating in student continuity of care initiatives both within the UK, and other countries such as Australia and New Zealand where students are provided opportunity to work in a continuity of care relationship with women as part of their midwifery education.

My study provides valuable evidence on impact on women and highlights the importance of creation of models for the student continuity initiative that promote sustainable practice amongst students and minimise the potential for women to 'lose' their student. Within the context of service reforms within the UK, Better Births (NHS England 2016) sets out a vision for maternity services in which midwives will work in small teams of 4-6 with each midwife within the team providing continuity across the continuum for a defined number of women. This model ensures women have a 'back-up' of another known midwife from within the team if their identified midwife is unavailable. Aune et al. (2012) and Dahlberg and Aune (2013), report on a similar model in a Norwegian student continuity pilot project in which a team of six midwifery post-graduate students worked to provide continuity of care for a group of women. The women met each of the six students during antenatal care provision and received care from one of the students during their labour and birth. The same student subsequently attended the woman at home for the one postnatal visit. A team model has value in that it is commensurate with the Better Births (NHS England) agenda and protective of women and students and may mitigate some of the issues highlighted in the literature and this study around professional boundary maintenance. However, this may minimise the opportunities for students to develop mutually reciprocal relationships with women found to be central to the one-to-one model for

women (Browne and Taylor 2014; Kelly et al. 2014; Tickle et al. 2016) and students (Browne et al. 2014; Dawson et al. 2015; Gray et al. 2012; Gray et al. 2013; McLachlan et al. 2013; Rawnsdon 2011a; Sweet and Glover; West 2016) and much is dependent on the size of the team.

Students working in partnerships akin to caseload practice in New Zealand, where one student is backed up by another, to ensure known carer (Hunter 2016; Pairman 2006; McCourt et al. 2006), is a model that would facilitate relational continuity, whilst mitigating against the potential issues discussed above, as well as the potential of loss for the woman. This model of working in New Zealand has been operational for over 25 years with caseload midwives providing care to the majority of women in New Zealand (Hunter et al. 2016), demonstrating the sustainability of the model. However, there is need for more research in this area.

8.4 My learning from the study outcomes: for research, education and practice

This study adds to the existing small, but growing body of knowledge surrounding women's experiences of midwifery educational continuity and has provided areas of original contribution to knowledge linked to my research dissemination plan [8.5], in the following ways:

- The experience of UK women engaged in educational continuity initiatives is largely unknown despite NMC mandate for its inclusion within the undergraduate midwifery curriculum (NMC 2009). My findings provide evidence that this group of women highly valued the student contribution via continuity to their care and this experience may be transferable to other women participating in student caseloading. This understanding adds weight to the NMC expectations and may provide an incentive to midwifery curriculum developers nationally and internationally.
- While evidence indicates the desire to contribute to the education of future physicians is a primary factor influencing pregnant women's

agreement to medical student involvement in their care, there is little understanding as to why these women agree to participate in midwifery student educational continuity initiatives. The women in my study identify the 'win-win' of agreeing to students providing continuity- they help the student to learn and the student provides them with 'care plus', reinforcing the value of continuity educational schemes.

- My thesis explores these women's experiences in real-time as they moved through pregnancy and motherhood via their unrestricted stories, which has not been done previously. It has highlighted critical subtleties and nuances surrounding the nature of the reciprocal relationships women perceived they developed with their caseloading student and how these evolved within the woman-student dyad over time, providing useful insights for educators and practitioners.
- While not a commonly used method in midwifery research, the creation of succinct versions of the women's stories through poetry has demonstrated the value of using creative approaches to communicate women's experiences and perspectives.
- Whilst this study has illustrated many aspects, a major focus was on the high level of confidence the women exhibited in their student caregivers. Women consistently described their student companions as 'good midwives' and considered them competent and knowledgeable practitioners. The need for effective mentor support in supervising students who are delivering care 'at a distance' is reinforced through this finding to ensure the women's confidence is justified and students are providing safe, evidence based, high quality support.

8.5 Reflections, learnings and insights

The findings from this study add to the breadth of knowledge surrounding midwifery educational continuity and sheds light on how the experience impacts on women. Through this lens of women's knowledge, the highly valuable information gained adds weight to the NMC expectations for the

experience and provides useful insights for educators and practitioners. Curriculum developers nationally and internationally should pay attention to study outcomes, in particular the need for effective mentor support in supervising students who are delivering care without direct supervision and the potential emotional work involved for women if the student withdraws from the care experience.

While it is important to acknowledge the strengths of this study, it is also imperative to recognise its limitations. Limitations relate to potential weaknesses in the design or conduct of the study, which could influence the outcome. This thesis has acknowledged the limitations of this study and these are summarised and addressed more fully here.

This study presents interpretations of the embodied story data shared at interview by six women, in a university in the South of England. While these data may not have national or international generalisability for educational practice across HEIs, my findings are supported by and have added depth to the international body of work previously undertaken using both quantitative and qualitative methods. Additionally, my inclusion of rich, thick description within the discussion promotes the ability of educationalists and readers of this work to make decisions as to transferability of study findings to other midwifery curricula with similar characteristics (Creswell 2013).

My decision to select a locally based university for the research location could have resulted in convenience sampling, which arguably, could affect the depth of information gathered and credibility of the study (Creswell 2013). To enhance the potential of gathering narrative data that was of relevance to the study focus and offered rich in-depth findings, the purposeful sample of women recruited was criterion-based (Holloway and Wheeler 1996). While the final sample reflected a mix of socio-economic groups, age and parity, all participating women were white British. This limitation partly reflected the population within the research locality and was partly due to the criterion-based sampling strategy, which excluded non-English speaking women from participation because there were no resources to employ a translator. This limits the transferability of findings to non-English speaking cultures and

backgrounds and was a pragmatic necessity. I also did not interview women in same sex relationships who may have shared different perspectives. This study could therefore be replicated in different contexts in future to elicit a broader range of experiences with which to construct meaning.

The recruitment strategy that I used to invite women to participate involved community midwives working within the target areas distributing invitation packs to women who met the study inclusion and exclusion criteria. As Holloway and Wheeler (1996) assert, these midwives as 'gatekeepers' had control over the recruitment process and thus the power to offer or deny access to participation. My ability to protect potentially vulnerable women from participation was therefore limited, and reliant on local midwives' adherence to study inclusion criteria. To mitigate this impact, I met with community midwives to explain the research carefully, to ensure they understood how to introduce the research to women and the study inclusion criteria. In addition, to underpin and reiterate this information I gave each midwife a leaflet providing an overview of the study, inclusion and exclusion criteria and my contact details. Following issue of invitations to participate in this study, recruitment was reliant on self-selection. All women that registered an interest, and thus self-selected, were included as they met the inclusion criteria. Whilst it was important to ensure participation was voluntary, this sampling strategy could mean the sample I recruited comprised the most motivated women and those with a real interest in midwifery education. It also took a longer time than anticipated to achieve the final sample; this may have been because the gatekeepers were too busy or perhaps somewhat disinterested.

Within narrative methods, reciprocal interactive researcher/participant relationships are integral aspect of the data gathering process. Because of this relational interconnectedness, stories shared at interview are a co-constructed product, constructed within a social process of speaker and listener interaction and the stories shared tailored to whom they are narrated. The women participating in this study may have made assumptions about my sociocultural identity as midwife, educator and mother and modified their stories accordingly.

Member checking, where participants' views are sought as to the credibility and accuracy of the study findings and interpretations, is one of an array of techniques used to evaluate the quality and validity of qualitative research (Creswell 2013). This involved determining the degree to which my claims about knowledge as researcher, corresponded with the woman's constructions of reality as research participant, and a recursive approach was used. Following each story-sharing interview, I reflected on the interview and its process and appraised the field notes documented. Via this reflexivity, I formulated questions and queries about aspects of the stories shared and clarified these with the woman during our subsequent interview conversation(s). Following data collection, all of the women who participated were provided with the transcripts of their three story-sharing interviews and subsequently, following data analysis, a copy of their story for review and comment. None of the women provided feedback on the story content composed via the re-storying process or in how I had re-presented and re-told their experiences and I have reflected in chapter 5, as to why this might be the case. I therefore cannot completely guarantee these women would agree with my findings and discussion of their experiences or the way in which I have re-presented their unique stories in chapter 6. However, I believe that I can assume that they would have raised concerns if they felt that I had mis-represented their story significantly.

8.6 Sharing stories: Making a difference

Women's experience is central to quality practice provision (Green 2012; HMSO 2013; NHS 2016) and at the heart of midwifery student education (NMC 2009; 2015a). Research should be undertaken that is of value to women and enables their voices to be heard, with the findings leading to change or actions benefiting women (Green 2012). My research is embedded in the industry of midwifery, education and practice and co-constructed with women via the re-telling of their experience stories.

I hope my findings make a difference to women engaged in educational continuity initiatives and for the students and midwives caring for them, by advising on what these women enjoyed and appreciated, as well as what

they found difficult or challenging as they moved through the caseloading experience.

8.6.1 Dissemination and publication plan

8.6.1.1 Work to-date

My fervour to enhance midwifery education and student learning for the continuity experience encouraged me to consider how I might bring women's experiences of this form of care into the classroom. I initially considered inviting women to attend the taught sessions and share their experience stories. However, the ability to access and recruit consumers with the relevant experiences to contribute to classroom teaching can be somewhat challenging, as well as time consuming (Forrest et al. 2000; Lathlean et al. 2006; Masters et al. 2002; Scheyett and Diehl 2004). In addition, given the context of childbirth and the likelihood of family and work commitments, arguably women's ability to engage in midwifery education may be particularly problematic. Sharing the women's experience stories developed via the data analysis from this study for students to 'hear' therefore, appeared an effective and less resource intensive alternative to 'have' women in the classroom.

My approach has been to use the women's poems in the format shared in Chapter 6, as they became available via the data analysis, as one teaching strategy within a large group lecture setting. Using such creative methods was alien to my normal practice at the time that I first used the poems and my initial foray into using the approach was a little tentative. However, encouraged by the strong positive student feedback, I now use the women's poems with confidence and have no doubt as others have reported, that they provide an enriched learning experience (Anderson 2007; Healy and Smith 2017). Rather than forming one strategy, the women's poems now comprise the primary teaching method and are shared using a 'snowballing technique'. In this method, I ask the students to individually make notes of thoughts and words that occur to them as they read one of the six poems. The students then move into small groups, each focussed on a particular poem, and share

their individual notes and agree on the key sentiments/aspects that have resonance for the group members. Each poem is then read aloud to the whole group and the relevant small group share the listed aspects and the meanings they hold for the group. Hearing each poem read aloud gives a richness to the session and brings the woman's story to life. Students have commented that it was "as if the woman was sitting in the room" and have expressed emotion, empathy and compassion as her words are shared. The student's engagement in the session and with the poems, has been abundantly evident and I have been struck by the depth of insight and learning students have shared in the concluding session discussion.

Reflecting on the student evaluations of the taught sessions and my use and sharing of the women's experience stories has enabled me to recognise the value of the poems as a rich, powerful and vibrant educational resource. As discussed earlier, I have used the women's poems during teaching in the format in which they are shared and re-told in Chapter 6. Here the poems are re-told using the women's own words in a format embedding the colloquialisms and language features the women used to nuance, enrich and embellish the stories they shared with me at interview [5.4.1.2]. This can almost appear to impede the coherence and flow of the poems in some parts and may make the ease with which they are read more difficult. The poems are also quite lengthy, as they encompass the continuum of the student caseloading experience and include detailed descriptions of story characters, places and situations the women shared with me to provide story context (Chase 2005; Rosenthal 1993). Inclusion of this detail, I feel aids reader understanding of the stories and the woman's personal socio-cultural context in which they are situated and provides a credible and authentic account. However, it is important to acknowledge that in their current format, these poem features could potentially limit the opportunities for their use with midwives, within education, and their access by some student groups.

My ambition is to promote wide dissemination of the women's knowledge gained from this study to facilitate enhanced understanding of women's experiences and to inform future educational and practice provision [8.5.1.2]. To potentiate their use to facilitate this, there is potential for the poems to be

edited and adapted to formats conducive to different student groups, settings and purposes. For example, to enhance coherence and flow, some of the poem line breaks could be removed and lines of text linked to become part of the same line. To facilitate ease of reading, some sentences could be shortened by editing out some particular conjunctions (e.g. 'and') and adverbs (e.g. 'just') and rather than a continuing sentence, each line break could start with a capital letter. These adaptations may enhance readability by giving emphasis to the woman's key words without diluting the essence of her story. Words could also be added to the poem text lines or removed, to enhance sense making and readability. However, in doing the latter, it is important to recognise that this level of adaptation has potential to impact on the power, authenticity and credibility of the woman's story. This is because the woman's intended meanings may become muted or lost through the changing of her words, and with the addition of 'new' words, shaded by the voice of the editor. An example of these possible adaptations is provided in Appendix 14, using Jody's story 'It was more reassurance a peace of mind thing'.

My desire to enhance the quality of women's experiences via development of midwifery education has led to publication/dissemination from early in the research process and as the early emergent findings became available. In developing the study research proposal, I wrote out my thought processes in the form of an article for publication in a professional journal (Rawnsdon 2011b). Early emergent findings from the study were also shared via poster presentation at the Royal College of Midwives Annual International conference, Telford 11-12th November 2014 and the "Innovation in Midwifery Education – What Works?" International conference Bournemouth, 3rd July 2015. Given the limited body of information around women's experiences of student midwife involvement in their care, this provided a mechanism to invite educational and practice colleagues to share insights into work conducted in this area, and 'flag-up' that this study was being undertaken and the emergent early findings.

In addition, the early emergent study findings informed a chapter, 'Caseloading', in a non-academic book, 'The Hands-on Guide to Midwifery

Placements' (Rawnsdon 2016). This provides a credible, practical and informative resource for student candidates contemplating midwifery education and enrolled students about to embark on their caseloading experience. At a local level, study findings contribute positively to a quality contemporary student learning experience providing insight into women's experiences via the powerful medium of their personal stories. As discussed above [8.3], this provides a valuable educational resource with which to inform taught sessions around student preparation for the caseloading experience, with the participant experience poems providing stimulus for discussion and debate.

8.6.1.2 Future work

My dissemination plan includes provision for the study findings to be shared with midwives, educationalists and students at a wider national and international level. This is an important priority given the current lack of information as to UK women's views and limited evidence-base for best practice for educational continuity initiatives. To promote wide dissemination, I will re-tell the women's collective story of experience via publication in a peer reviewed international midwifery journal, as well as midwifery and educational conference presentation. This story captured the emergent longitudinal themes of significance to the women as a group through application of a thematic analysis. Wide dissemination of this women's knowledge will promote an enhanced understanding to inform future educational and practice provision that will benefit both women and students.

I will share the six women's individual and unique personal stories of experience via midwifery and educational national and international conference presentation. In addition, I will create a credible and vibrant educational resource via publication of these women's stories as a book that will be of interest to both midwifery educators and students. As discussed earlier, the women's storied poems, developed via the analysis, provide a rich and powerful educational tool with which to promote mindful reflective insight amongst students and personal and professional development in preparation for the continuity experience.

In congruence with the 'with woman' ethos of this study, and underpinning personal midwifery practice and educational philosophy, I also feel it of vital importance to 'feedback' study findings to women as consumers of maternity services and student rendered continuity of care. This dissemination will occur nationally via on-line forums such as 'www.mumsnet.com' and 'www.netmums.com'.

8.6.2 Recommendations from this study

For research:

Recommendation 1: that involves women

Rationale:

The findings of this study reinforce the value women place on the opportunities to contribute to the education of midwifery students as well as the perceived benefits for themselves. The dearth of research that assesses and evaluates the involvement of women, as consumers of maternity services, across a range of activities such as curriculum shaping and development, contributing to the assessment of students and consumer reference groups, demonstrates that further empirical work in this area is needed.

Recommendation 2: that explores UK women's experiences

Rationale:

The majority of existing work comes from an international perspective and little information is available that includes UK women's views and experiences of student midwife educational continuity. Given the multiplicity of ways the mandated continuity element has been embedded within the UK curriculum (NMC 2010), there is need for more empirical work in this area to inform a currently limited evidence-base and help inform future curriculum development and educational provision.

Recommendation 3: that involves women from diverse groups

Rationale:

In order to strengthen the midwifery curriculum and contribute positively to woman-centred care, there is a need to qualitatively research the views of non-English speaking women and women from ethnically diverse socio-cultural backgrounds and same sex relationships of participation in this type of student involvement in their maternity care.

Recommendation 4: that elicits women's envisaged support needs

Rationale:

Women experienced a tangible sense of loss and disappointment when the caseloading relationship was terminated early/pre-birth and/or when the student was unable to attend them for labour and the birth. This study did not elicit how existing support mechanisms could be enhanced or what additional mechanisms could be instituted and there is need for information to underpin best practice in this area.

For education

Recommendation 1: the development of creative learning tools and approaches

Rationale:

It is imperative students are effectively prepared for the lived realities of caseloading and the nature of the relational bonds that may be developed within the woman-student dyad and the potential emotional toll this may make upon them. This should include educational provision around mitigating relationships, professional boundary setting and the role of supportive agencies and networks e.g. midwife mentor(s), personal academic tutor, university counselling service etc. Using poetry and other creative teaching strategies 'to have women in the room', has strong potential to facilitate student understanding through promotion of mindful reflective insight.

For practice

Recommendation 1: preparation of women for the experience

Rationale:

So that optimal learning for students occurs in tandem with high-quality care, it is imperative women are prepared for this type of student midwife involvement with regard to the nature and scope of the student role and responsibilities. Imperative within this is ensuring women are cognisant with potential limitations to the student's availability, and that their ability to attend them for labour and the birth cannot be guaranteed.

- Supervising midwife mentors have an important role in ensuring women know how to access assistance in an emergency, as well as appropriate information, advice and support from a qualified midwife on an on-going day-to-day basis.
- It is important educationalists and university link tutors maintain effective communication links with supervising mentors and practice partners. Feedback via these networks will inform student preparation and optimise supportive provision for students when required.

Recommendation 2: effective mentor supervision of students

Rationale:

Women in this study exhibited a high level of confidence in their student caregivers, and consistently described them as 'good midwives' and competent and knowledgeable practitioners. It is imperative students are effectively supervised, particularly when working without direct mentor supervision to ensure the woman's confidence is justified and students are providing safe, evidenced-based, high quality support. It is therefore of primary importance that all information, advice and care given by the student is discussed, reviewed, checked and agreed by the supervising mentor and there are robust systems in place for this to occur.

8.7 Last words and reflections

It has been an immense privilege to conduct this study, and an absolute honour to work with the women who agreed to participate and to hear their personal experience stories. Reflecting on this journey of discovery has enabled me to recognise what a worthwhile endeavour it has been and imbued me with confidence as to the robust nature of the research design, study conduct and processes. I am proud of this work and the contribution it makes to the breadth of knowledge surrounding midwifery educational continuity. Study findings shed light on how the experience impacts on women and the highly valuable information gained will provide useful insights for educators and practitioners.

However, journeying with each woman as she moved through the childbirth continuum involved emotional work and was not without challenge. As others have reported, I found hearing the women's often poignant and evocative stories at interview emotionally challenging, particularly when hopes, dreams and pregnancy aspirations were shared, re-shared and shared again with sadness and emotion when not realised and lost (Carter and Delamont 1996; Frank 1995; Kiesinger 1998). I learnt the importance of reflexivity in these situations (Guillem and Gillam 2004) and the value of documenting my thoughts and feelings in my research journal. This proved cathartic, and together with supervision kept me grounded, and a strategy that supported my development of a reflexive stand throughout the interview process.

A major source of learning, has been in understanding the importance of reflecting on my story/journey amidst that of the women's as it evolved across the research continuum and I have learnt much about myself. This self-scrutiny has enabled me to re-evaluate my core philosophical beliefs and the centrality of the 'with woman' ethos within this. It has enabled me to recognise how important it was for me for this study to be developed and conducted in a manner commensurate with the concept of a 'woman centred' approach, such as placing focus on the woman, partnership working, and a valuing of her experiences (DH 1993). Not being able to work with women in this way evoked negative emotion work of angst and frustration, as I share in 'Uninvited voices' [4.6].

Moreover, I have come to understand the central importance of feeding forward the findings from this study and my role in continuing this work as Jody anticipated:

“Obviously, at the end of the day you can give this feedback to where it needs to go and then obviously the student’s get feedback and it’s good to know that...and then it helps future trainees.” [Jody3, p.7]

In addition, the highly valuable knowledge gained from this study adds weight to the NMC (2009) expectations and I hope the dissemination of this women’s knowledge, will help support the continuation of the educational continuity learning opportunity within the midwifery curriculum as Anna and her colleagues expressed:

“I think it’s really, really important that I have done this (take part in the study) because it’s um important to give this positive feedback to ensure this scheme keeps going.” [Anna3, p.6]

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Appendix 1 Appraisal of papers for consumer involvement in student educational development

Table 1: Curriculum Development				
Author(s) and place	Discipline	Strategy	Evaluation strategy	Key findings
Alahlaifi, A. Burge, S. (2005) UK	UG medical education (psoriasis element)	Delphi Study involving consumers and professional staff to determine content	None	<ul style="list-style-type: none"> Consumers placed greater emphasis on psychosocial aspects of psoriasis, financial burden and complementary therapies than professionals did.
Calman, L (2006) UK	Pre-registration Adult nursing	Qualitative interviews with consumers to ascertain their perceptions of a competent nurse and their willingness to be involved in student assessment (<i>n</i> =27)	None	<ul style="list-style-type: none"> Being friendly, kind, having human skills and going the extra mile were viewed as added extras. Most felt the reality of assessing performance of nurses would be difficult.
Flanagan, J. (1999) UK	Post-registration BSc (Hons) Adult nursing. CPD cancer specialist module	Involvement of carers and consumers with cancer in the curriculum design group.	None	<ul style="list-style-type: none"> Consumers and carers suggested that the educational process must promote not stifle the effective elements of care. Better preparation was advised as was the avoidance of jargon which promotes professional exclusivity.
Forrest, S. Risk, I. Masters, H. Brown, N. (2000) UK	Pre-registration mental health nursing	Qualitative focus groups used to elicit mental health consumers views about the attributes of mental health nurses (<i>n</i> =34)	None	<ul style="list-style-type: none"> Being able to function as a friendly human being was seen as key. Emphasis should be placed on learning with service consumers.
Fraser, D. (1999) UK	Pre-registration midwifery	Qualitative interviews with pregnant women	None	<ul style="list-style-type: none"> Women prioritised good communication and interpersonal

		during pregnancy and twice post birth (n=41), to elicit views on curriculum.		skills over technical skills. <ul style="list-style-type: none"> • Led to curricular change and informed student recruitment process.
Greenfield, S Anderson, P. Gill, P. Loudon, R. Skelton, J. Ross, N. Parle, J. (2001) UK	UG medical education	Lay and professional representatives from 10 established groups representing a range of ethnic minorities were consulted in discussion groups.	None	<ul style="list-style-type: none"> • Recommendations included recruiting more students from ethnic minority groups, students learning basic greetings in different languages and cultural awareness sessions being delivered by people from the Black community.
Griffiths, J. Speed, S. Horne, M. Keeley, P. (2012) UK	Pre and post registration nursing	Qualitative focus groups with consumers and carers (n=52) to elicit views on curriculum and qualities of an adult nurse.	None	<ul style="list-style-type: none"> • Consumers required professionals with technical competence, knowledge and willingness to seek information. • 'A caring professional attitude' was considered a priority.
Jordan, S. Davies, S. Andrade, M. (2000) UK	Pre-registration mental health nursing	Qualitative interviews with Consumers (n=7) and community health nurses (n= 14), and a survey of students (n=354), and lecturers (n= 73), regarding the bioscience aspect of the programme.	None	<ul style="list-style-type: none"> • Students and lecturers placed minimal value on bioscience content. • Consumers identified that nurses lacked knowledge of pharmacology and would like curriculum to include non-pharmacological interventions.
Masters, H. Forrest, S. Hartley, A. Hunter, M. Brown, N. (2002) UK	Pre-registration Diploma in mental health nursing	Strategy development group collected data to inform a consumer involvement strategy for the curriculum.	Survey of participants including consumers, carers and staff (n=17)	<ul style="list-style-type: none"> • Issues of representation and representativeness were a concern. • Involvement led to changes in curriculum philosophy.
Molyneux, J.	Post qualifying	Set up series of working parties	None	<ul style="list-style-type: none"> • Generated ideas for consumer

Irvine, J. (2004) UK	social work (Specialist mental health training)	with 14 consumer groups and 3 carer groups to elicit views on curriculum and greater consumer Involvement.		<p>involvement in teaching and assessing.</p> <ul style="list-style-type: none"> • Consumers and carers identified practice issues of concern (e.g. poor social worker personal qualities). • Led to formation of quarterly working party meetings.
Rudman, J. (1996) UK	Pre- registration mental health nursing	Qualitative focus groups held with two consumer groups to elicit views on curriculum and qualities of a mental health nurse (<i>n=20</i>)	None	<ul style="list-style-type: none"> • Consumers required nurses with a wide knowledge base tailored to needs and good interpersonal skills.
Sawley, L. (2002) UK	Child health nursing programmes	A consumer group was set up to inform curriculum development.	None	<ul style="list-style-type: none"> • Led to changes to educational content and practice development.
Scheyett, A. Diehl, M. (2004) USA	Post qualifying social work	Facilitated dialogue process between mental health consumers and students to elicit views on curriculum and helpful social worker actions.	None	<ul style="list-style-type: none"> • Consumers sent strong message they want to be involved and identified ways they could do so. • Consumers identified need for greater focus on communication and relational skills.
Whittaker, K Taylor, J (2004) UK	Post- qualifying parenting skills module for community nurses	Parents and professionals were asked their views on local parenting support services to inform a parenting module.	None	<ul style="list-style-type: none"> • General dissonance was noted between practitioners and parent's views • Sound interpersonal skills and inclusion of parents in decision making were seen as crucial by parents.

Table 2: Assessment of student work				
Author(s) and place	Discipline	Strategy	Evaluation strategy	Key findings
Bailey, D (2005) UK	Social work First year MA Module in mental health	Mental health consumers participated in summative assessment and giving feedback on student work	Action research approach. Qualitative focus groups of students (n=9)	<ul style="list-style-type: none"> Students recognised the value of receiving consumer feedback on their work Feedback was constructive and meaningful Some students felt consumer feedback was overly negative and de-motivating
Davis, C Lunn, K (2009) UK	Podiatry	Consumers were asked to formatively assess student communication skills using a communication skill assessment tool	Pre- and post-test communication skills perception scales completed by experienced students (n=44) and novice students (n=58). Qualitative interviews with experienced students (n=6) and novice students (n=6)	<ul style="list-style-type: none"> The communication scale demonstrated a perceived improvement over a 10 week period with 86% for experienced students and 80% for novice students Increased student awareness of importance of communication and interpersonal skills Students found the assessment non-threatening and non-judgemental and welcomed the 'real life' feedback
Debyser, B Grypdonck, M Defloor, T Verhaeghe, S (2011) Belgium	Pre-qualifying final year psychiatric nursing	Consumers were asked to provide feedback on student clinical skills	Qualitative interviews of students (n=4), consumers (n=7), nurses (n=2) and teachers (n=2)	<ul style="list-style-type: none"> Consumers felt they were listened to and recognised as of equal value in the assessment process Overall the experience was valuable and meaningful to all participants
McMahon-Parkes, K Chapman, L James, J (2016) UK	Pre-registration Adult nursing	Consumer completion of a 5-question feedback tool on student interpersonal skills	Qualitative interviews of consumers (n=4), students (n=5), and nurse mentors (n=4)	<ul style="list-style-type: none"> Consumers wanted to be involved in giving feedback and felt comfortable doing so Students and mentors felt it important consumer feedback was elicited Consumer feedback

				was felt to enhance student competence and confidence.
Muir, D Laxton, J.C (2012) UK	UG medical education – third year students	Consumer feedback on student completed e-portfolio clinical skill self-assessment tool	Qualitative focus groups with consumers (n=3) and written feedback (n=1) (pilot study)	<ul style="list-style-type: none"> • Consumers brought a valuable dimension to the formative feedback, which bridged the gap between practice and theory • Practical and organisational issues for consumer engagement identified e.g. access of e-portfolio system slower outside the university environment
Munro, J Whyte, F Stewart, J Letters, A (2012) UK	Pre-registration adult nursing	An expert panel of consumers and carers assessed and graded student IBS EBL work	Informal evaluation (n=52)	<ul style="list-style-type: none"> • Panel members enjoyed the opportunity and were impressed with student work • Some students found being assessed by people with IBS stressful, but overall the experience was reported as positive
Speers, J (2008) UK (Guernsey)	Pre-registration mental health nursing	Study to ascertain stakeholder views on consumer involvement in assessment of student competence	Qualitative interviews with consumers (n=5), students (n=7), ex-students (n=4), mentors (n=6) and lecturers (n=2)	<ul style="list-style-type: none"> • Consumers were largely positive about the proposal • Nurse participants were more ambivalent and expressed reservations about implementation but on balance, were in favour in principle
Stickley, T Stacey, G Pollock, K Smith, A Betinis, J Fairbank, S (2010 & 2011) UK	Pre-registration mental health nursing	Study to ascertain the feasibility of consumer involvement in the practice assessment of students	Qualitative interviews with participating students (n=15), students who declined to participate in pilot (n=8) and consumers (n=16)	<ul style="list-style-type: none"> • Initiative positively valued by consumers (2010) • Some consumers raised concerns about the potential for students to bully the assessor to receive a more favourable report (2011) • Students gained confidence and benefited from

				positive relational interaction <ul style="list-style-type: none"> Some students failed to forge trusting bonds with consumers and received more critical feedback
Webster, B Goodhand, K Haith, M Unwin, R (2012) UK	Pre-registration adult nursing	Consumers provided feedback on student performance in simulated clinical scenarios	Qualitative focus groups with consumers (n=18)	<ul style="list-style-type: none"> Consumers were concerned about the responsibilities of giving feedback to students Wanted greater clarity on feedback elements Reported a strong sense of empathy for the students

Table 3: Teaching and Learning Strategies

Author(s) and place	Discipline	Strategy	Evaluation strategy	Key findings
Agnew, A Duffy, J (2010) UK	Social work programmes (palliative care)	Students observed and DVD excerpts and live facilitated interview with consumer with cancer at a young age	Survey of UG students (n=12) and PG students (n=12)	<ul style="list-style-type: none"> Consumer reported altruistic reasons for involvement All students felt their learning and confidence was enhanced.
Brown, I Macintosh, M (2006) UK	Adult nursing CPD module on heart disease prevention	Consumer involvement in e-learning learning materials development including video stories	Qualitative study with consumers (n=27) and students (n=10)	<ul style="list-style-type: none"> Consumers found process rewarding and enjoyable Students reported that the video's heightened interest and motivation to learn Assessors noted that the consumer's perspective was well evidenced in the module assignment
Butterworth, M Livingston, G (1999) UK	UG medical education	Carers of dementia suffers, as part of a formal lecture programme, talked with students	Informal evaluation (numbers not stated)	<ul style="list-style-type: none"> Students rated sessions highly Carers felt their caring had meaning and value and they wished to enhance the knowledge and practice of future doctors

Coleman, K Murray, E (2002) UK	UG medical education (GP attachment)	students examine and question consumers at home or in surgery	Qualitative interviews with consumers (<i>n</i> =15)	<ul style="list-style-type: none"> Altruism and personal gain were incentives for participation Embarrassment and anxiety about student access to medical records identified as potential barrier to involvement
Cooper, H Spencer-Dawe, E (2006) UK	UG medical, nursing, social work, OT, physiotherapy programmes	Consumers co-facilitate interprofession al team working work shops	Analysis of student's reflection (<i>n</i> =63), a focus group with IPE facilitators (<i>n</i> =7) and in- depth consumer interviews (<i>n</i> =10)	<ul style="list-style-type: none"> Students and facilitators found the experience rewarding Students felt it enhanced their understanding of consumer-centred perspective Consumers felt well prepared and enjoyed contributing to better relationships between professional groups
Costello, J Horne, M (2001) UK	Pre- registration Adult nursing	Involvement of 3 consumers in a classroom session facilitated by a lecturer	Basic end of session evaluation (<i>n</i> =67) and discussion with consumers (<i>n</i> =3)	<ul style="list-style-type: none"> Students felt it helped them gain an understanding of the consumer perspective although some felt embarrassed Consumers found the experience cathartic
Frisby, R (2001) UK	Pre- registration mental health nursing	Involvement of consumers in classroom based client review using student role plays	Informal feedback (numbers not stated)	<ul style="list-style-type: none"> Consumers reported enhanced feelings of empowerment. Very little resistance from tutors noted Involvement promoted learning about consumer perspectives
Gutman, C Kraiem, Y Criden, W Yalon- Chamovitz S (2012) Israel	Pre- qualifying Social work programme (Disabilities element)	Co-teaching model in which all sessions were facilitated by a professional academic and a consumer	Informal feedback (numbers not stated)	<ul style="list-style-type: none"> Student's raised issues regarding 'tokenism' Students identified the need to address paternalistic attitudes in practise
Happell, B Roper, C (2003) Australia	Post graduate psychiatric nurse Diploma programme	Consumer appointed to an academic role and took responsibility for majority of teaching for 'Psychopathol	Informal survey at end of semester (<i>n</i> =21)	<ul style="list-style-type: none"> Students reported enhanced understanding of the consumer perspective, impacting on current practice Some expressed concerns that the

		ogy in context' module.		consumer had portrayed psychiatric nursing negatively.
Haq, I. Fuller, J Dacre, J (2006) UK	UG medical education (3 rd year)	Involvement of 4 'Patient Partners' (PP) with back pain in 2 clinically based teaching sessions	Non-randomised comparison (<i>n</i> =60) PP group and (<i>n</i> =54) in control group and qualitative focus groups with PPs (<i>n</i> not given)	<ul style="list-style-type: none"> PPs took part for altruistic reasons and benefitted from increased knowledge of their condition and increased confidence There were no difference in OSCE scores between the two groups of students
Ikkos, G (2003; 2005) UK	Psychiatric training for qualified doctors	Involvement of consumers from user groups in a basic clinical interviewing workshop	Informal evaluation: 2003 (<i>n</i> =36) 2005 (<i>n</i> =57)	<ul style="list-style-type: none"> Sessions were highly rated and facilitated empathy and an appreciation of consumer role in decision making The need for balanced expression of opinion and viewing the sessions as a mutual learning opportunity was emphasised
Jackson, A Blaxter, L Lewando-Hundt, G (2003) UK	Accelerated UG medical education (inequalities in health module)	Students interview consumers who live in socially and economically deprived areas in their home and staff from 3 services involved in their care	Qualitative study with consumers and carers (<i>n</i> =18)	<ul style="list-style-type: none"> Half of the consumers were apprehensive, and most were positive about being involved. All were willing to take part again Being listened too was seen as a positive benefit Involvement was seen as a way of improving the health service
Jones, C (2006) UK	Advanced clinical practice programme (Adult nurses)	Consumers acted as 'patients' in history taking and physical examination skills delivery	Qualitative interviews with consumers (<i>n</i> =7)	<ul style="list-style-type: none"> Consumers found the process empowering and it increased their knowledge about their condition They felt a sense of belonging and felt their contributions were valued
Khoo, R. McVicar, A Brandon, D (2004) UK	Postgraduate Diploma/MA in mental health	Involvement of consumers in classroom seminars	Survey of students (<i>n</i> =26) and consumers (<i>n</i> =5) at the start of the	<ul style="list-style-type: none"> Students rated the consumer sessions as good or excellent Experience fostered desire to change services

			project	<ul style="list-style-type: none"> Representativeness was questioned
Klein, S (1999) UK	UG medical education (3 rd year)	Involvement of either consumers with cancer (experimental group <i>n</i> =123) or consumers with other diagnoses and tutor (control group <i>n</i> =126) in an interview skills training programme	RCT with measurement at the end of the sessions and at a 2 year follow-up. An interview rating instrument was also used to rate a 'real life' interview with a consumer with cancer	<ul style="list-style-type: none"> Students taught interviewing skills by consumers with cancer demonstrated better communication skills than those taught by consumer with other diagnoses
Lathlean, J Burgess, A Coldham, T Gibson, C Herbert, L Levett-Jones, T Simons, L Tee, S (2006) UK	Pre- and post-registration Mental health programmes	Consumer and carer participation in an external reference group to inform curriculum development and programme delivery, appointment of a 'service user academic' and participation in a co-operative research project	Student feedback on consumer teaching (numbers not given). Qualitative Interviews with students (<i>n</i> =35), consumers (<i>n</i> =6), staff (<i>n</i> =10) to evaluate 'service user academic) initiative.	<ul style="list-style-type: none"> Students were highly positive about consumer participation in teaching finding it enlightening and providing greater insights into consumer perspectives Staff commented on the commitment, energy and time needed to nurture consumer participation as well as the time to attend meetings etc.
Maughan, T Finlay, I Webster, D (2001) UK	UG medical education	Students meet a patient with cancer regularly over a 6 month period. Interactions are recorded in a diary	Informal evaluation (<i>n</i> =144)	<ul style="list-style-type: none"> Students reported increased confidence talking to consumers with serious illnesses and gained insight into multidisciplinary working and problems consumers faced. Found it emotionally challenging when consumer dies and problematic in relation to the assessment
McAndrew, S Samociuk, G (2003) UK	Pre-registration mental health nursing	Consumer involvement in classroom-based reflection	Survey of students (<i>n</i> =7) and consumers (<i>n</i> =5) at the	<ul style="list-style-type: none"> Consumers felt they were in a dominant position as they could offer real life experience

		sessions	start of the project.	<ul style="list-style-type: none"> Students felt the process would facilitate sharing and growing for all concerned
McKeown, M Malihi-Shoja, L Hogarth, R Jones, F Holt, K, et al. (2012) UK	All health and social care pre- and - post qualifying programmes	Consumer involvement span all aspects of programme development, teaching and research	Participatory action research using qualitative interviews, focus groups and observations with members of the 'Community involvement team' (CIT) (numbers not stated)	<ul style="list-style-type: none"> Participants became involved primarily for altruistic reasons Consumers reported enhanced feelings of self-worth and well-being Participation had expanded social networks and grow friendships.
O'Donnell, H Gormley, K (2013) UK	Pre-registration BSc (Hons) Mental health nursing	Recently graduated student perceptions of involvement of consumers in formal assessment of student work	Qualitative focus groups with recently graduated students (n=12)	<ul style="list-style-type: none"> Students welcomed consumer involvement in assessment strategies Felt consumer feedback would add value to their learning Concerns raised about potential vulnerability risks for consumers, students and lecturers.
Ottewill, R Demain, S Ellis-Hill, C Hutt Greenyer, C (2006) UK	Pre-registration physiotherapy	Two consumers who had experienced a stroke shared their stories in the classroom	Qualitative interviews with students (n=6)	<ul style="list-style-type: none"> The impact on learning was considerable The unconventionality of the sessions raised anxieties Students assumed a more passive role than usual
Raj, N. Badcock, L Brown, G Deighton, C O'Reilly, S (2006) UK	UG medical education	Involvement of 'patient educators' (PE) with arthritis to deliver the rheumatology curriculum.	RCT with experimental group (PE) (n=25) and a control group (n=25). Qualitative interviews with PE's (n=6) and students (n=6)	<ul style="list-style-type: none"> PEs were equally affective at teaching examination skills as consultants and were less costly to employ Students evaluated PE teaching well and felt adequate for their learning needs PE's enjoyed the training and reported an increase in self-worth and confidence to use their illness in a

				positive way
Read, S Spall, B (2005) UK	Post-registration palliative care Diploma course (Adult nursing)	Consumer stories and biographies used to explore palliative care	Informal evaluation (n=6)	<ul style="list-style-type: none"> Session gave an insight into consumers and carers feelings and enhanced their understanding of the meaning of illness
Rush, B Barker, J (2006) UK	Pre-registration Diploma in mental health nursing	Involvement of consumers in 3 EBL sessions	Survey of students (n=26)	<ul style="list-style-type: none"> All students reported positive impact on their learning and consumer involvement improved the EBL trigger
Rush, B (2008) UK	Pre-registration Diploma in Mental health nursing	Involvement of consumers in classroom-based teaching	Qualitative interviews with students (n=26) and mental health consumers (n=12)	<ul style="list-style-type: none"> Learning from consumers in the classroom was found to be qualitatively different for students from learning in clinical placements. All students reported examples of insights or/and actions gained from the sessions for future practice. Stimulated reflective insight, empathy and better understanding of consumer lived experiences amongst students.
Shah, R Savage, I Kapadia, S (2005) UK	UG pharmacy education (first year of programme)	Consumer volunteers led a tutorial, and interviewed as part of history taking and communication skills development and gave formative feedback on performance	Qualitative interviews with consumers (n=14)	<ul style="list-style-type: none"> Consumers reported altruistic reasons for involvement Enhanced knowledge about their illness and medication Became more questioning of health care professionals Enhanced self-esteem and confidence and relief from social isolation
Stacy, R Spencer, J (1999) UK	UG medical education	Students visit a consumer regularly over a 6 month period	Qualitative interviews with consumers (n=20)	<ul style="list-style-type: none"> Consumers saw themselves as experts in their own condition Felt they benefitted from having someone to talk to and for some it relieved loneliness Facilitated insight into their own condition Some gained satisfaction from

				helping students in their education
Thomson, D Hilton, R (2013) UK	Pre-registration physiotherapy	Consumers and carers interacted with students in different year groups as, historians, in a Q & A session, led critical debates and took on the role of assessor for student work	Qualitative interviews with consumers (n=8)	<ul style="list-style-type: none"> All consumers wished to foster a sense of partnership and communicate what it was like on the 'other side' Consumers wanted to challenge student assumptions about disability and communicate their dissatisfaction with current health care provision
Turner, P Sheldon, F Coles, C Mountford B Hillier, R Radway, P Wee, B (2000) UK	Pre-registration programmes including medical, nursing, social work and rehabilitation therapy students	Students interview carers of people with a terminal illness (or are recently bereaved) in inter-professional groups in workshops	Qualitative interviews with carers (n=12) and focus groups with students (n=40)	<ul style="list-style-type: none"> Students felt privileged to hear the stories and behaved sensitively when carers became upset. Carers found it cathartic but would have liked more guidance and time to tell their stories
Walters, K Buszewicz, M Russell, J Humphrey, C (2003) UK	UG medical education (year 4 psychiatry attachment)	Consumers with mental disorders are interviewed by students in the GP surgery	Survey of consumers (n=115) and qualitative interviews with consumers (n=20) GP tutors (n=12) and students (n=14)	<ul style="list-style-type: none"> Consumers reported enhanced self-esteem, development of a coherent illness narrative and new insights into their health Students were viewed as non-judgemental and enthusiastic
Waterson, J Morris, K (2005) UK	Pre-qualifying social work	Consumers and members of an advocacy group interacted with students in a series of 4 workshops. Women were also involved in creating a video DVD	Informal evaluation (numbers not given)	<ul style="list-style-type: none"> Students felt more enthusiastic to work collaboratively with consumers and had more respect for consumer views Consumers enjoyed the experience and felt students were interested in their stories
Wood, J Wilson-Barnett, J (1999)	Pre-registration mental health nursing	Involvement of consumers in classroom activities	Non-randomised comparison with 15	<ul style="list-style-type: none"> Consumer input led to less use of professional jargon, more empathy and less distancing

UK			students in each group using a user centred measurement tool	<ul style="list-style-type: none"> • Students were more likely to take an individualised approach to assessment and intervention • Students expressed concern about potential discomfort and representativeness
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Appendix 2 Appraisal of papers for women's evaluation of student midwife rendered care

Table 4: Women's experiences of student involvement in their care

Author(s) and place	Strategy	Evaluation strategy	Key findings
Aune, I. Dahlberg, U. Ingebrigtsen, O. (2012) Norway	Six pre-registration midwifery students provided continuity of care throughout pregnancy, birth and the one postnatal visit to 58 women via a 'team approach'	Qualitative pilot study, postnatal focus groups with women ($n=8$) and their partners (men) ($n=5$) approx. 4 months after birth	<ul style="list-style-type: none"> Both women and men experienced a trusting relationship with students Relational continuity was important to women throughout the entire care continuum but for men, was most valued during the labour and birth
Browne, J Taylor, J (2014) Australia	Bachelor of Midwifery pre-registration students provided one-to-one continuity of care (COC) from early in pregnancy to the early days of parenting.	Questionnaire survey of all women involved in the COC initiative between 2009-2011 ($n=1008$) with a 34% response rate ($n=354$)	<ul style="list-style-type: none"> Women's satisfaction of being with a student in a COC measured by a visual analogue scale was high 8.88 (SD=1.9) Women valued the opportunity for a 'constant presence' across their childbearing experience. 67.8% of women ($n=240$) felt the experience was better than expected.
Dahlberg, U Aune, I (2013) Norway	Six pre-registration midwifery students provided continuity of care throughout pregnancy, birth and the one postnatal visit to 58 women via a 'team approach'	Q-method approach, postnatal women between 3 and 8 months postpartum, who had participated in Aune et al. (2012) pilot project sorted a sample of 48 statements regarding their subjective view of their birth experience ($n=23$)	<ul style="list-style-type: none"> Relational continuity was identified as a key factor in promoting a positive birth experience Experiencing closeness to the midwifery student was identified as important for the birth experience. The quality of the relationship developed with the midwifery student was identified by the women as important for their birth experience.
Finnerty, G Magnusson, C Pope, R (2007) UK	Pre-registration midwifery students working in clinical placements in antenatal clinics, antenatal wards, delivery suites and postnatal wards at	Qualitative structured telephone interviews with women who had experienced an isolated episode of student care at	<ul style="list-style-type: none"> Students provided invaluable physical and emotional support for some women Most women expressed appreciation for the student's presence Women reported student tentativeness and reduced

	5 case study sites across England.	some point during their midwifery care (<i>n</i> =18)	confidence in some aspects of clinical care
Kelly, J West, R Gamble, J Sidebotham, M Carson, V (2014) Australia	Aboriginal and/or Torres Strait Islander pre-registration Bachelor of Midwifery students provided COC to Aboriginal and Torres Strait Islander women across the childbearing continuum	Qualitative interviews with Aboriginal women (<i>n</i> =4)	<ul style="list-style-type: none"> • Women acknowledged students provided a vital interpretative role and culturally appropriate communication processes that enabled them to feel comfortable to ask questions • Women positively welcomed the support and practical assistance students provided • Women forged close bonds and trusting relationships with the COC student
Rolls, C McGuinness, B (2007) Australia	Bachelor of Midwifery pre-registration students provided one-to-one continuity of care (COC) from early in pregnancy to the early days of parenting.	Qualitative interviews with postnatal women who had been involved in the COC programme at 3-5 months post-birth (<i>n</i> =7)	<ul style="list-style-type: none"> • Women felt they developed close, trusting relational connections with the COC student. • Women felt they were the main focus of the student's attention, which was appreciated. • Women felt the student contributed positively and made a difference to their birth experience.
Snow, S (2010) UK	Critical exploration of the contribution student midwives working on clinical placement make to women's experiences of labour and birth	Qualitative interviews with primigravid and multigravida women who received care from student midwives during labour and birth (<i>n</i> =7)	<ul style="list-style-type: none"> • Women highly rated the care they received from students • Women consistently identified the students as kind, supportive and helpful • Women particularly valued the uniqueness of their relationship with student's, which was characterised as a 'mutual newness', of both being learners.
Tickle, N Sidebotham, M Fenwick, J Gamble, J (2016) Australia	Bachelor of Midwifery pre-registration students provided one-to-one continuity of care (COC) from early in pregnancy to the early days of parenting.	Questionnaire survey of all women involved in the COC initiative in 2013 (<i>n</i> =698), with a response rate of 34% (<i>n</i> =237)	<ul style="list-style-type: none"> • There was a significant positive correlation ($p<0.05$) between the number of ante and postnatal visits the student attended and women's levels of satisfaction. • Women valued the experience and reported receiving respectful, individualised care from COC students that met their physical and emotional needs.

Appendix 3 Information sheet for student midwives



REC reference number: 11/SC/0193

8th April 2011 – version 2

Information Sheet for Student Midwives

**Bournemouth
University**

Title of research study:



Listening to Women:

Exploring women's experiences of being part of a student midwife's caseload

Dear Student

I am a PhD student at Bournemouth University, and also a midwifery lecturer based at the Bournemouth University Lansdowne Campus. I am writing to you because you are clinically placed within Portsmouth NHS Hospital Trust and have begun, or are about to begin, your student caseloading experience as part of your midwifery educational programme. I wanted to have an opportunity to tell you about a research project I am planning to undertake within this locality for my PhD study. This research aims to explore women's experiences of being part of a student midwife's caseload.

What is the purpose of the research?

Currently, little research has been done into women's experiences of receiving continuity of care provision throughout their childbearing journey from a known student midwife (supervised by a qualified midwife) through caseload practice. My purpose is to hear women's personal stories, to develop an understanding of how this approach to student involvement in their care might have impacted on their childbearing experience. As the Nursing and Midwifery Council now require all student midwives to experience caseload practice, the knowledge gained from this study will be very valuable. Through hearing the woman's story, I want to find out how they develop and maintain relationships with the student, how it feels to be cared for in this way, and what impact they feel student involvement in their care has had on their childbearing experience. The valuable insight and knowledge gained from this study will inform future midwifery education and student preparation for caseload practice, and ultimately, enhance women's and students experience of this approach to care.

What is the research process?

I am seeking to recruit a sample of 6-8 women. Following receipt of ethical approval, community midwives working within Portsmouth NHS Trust will identify potential participants from the caseload of the student midwife that they are supervising. Women who meet the study criteria will be given an information leaflet about the study and a letter of invitation to participate in the study, by their named community midwife.

To follow women's experiences of continuity of care provision from a student midwife throughout pregnancy, birth and the early postnatal period, women who consent to participate, will be interviewed at their home on three occasions; twice during pregnancy and once post-birth.

What will happen to the findings of the research study?

The findings of the research will be written up as a PhD thesis and shared by publication and conference presentation.

What are the possible advantages and disadvantages for me if a woman from my caseload decides to participate?

This will be a unique opportunity for women to use their voices through sharing their story, and contribute to the future development of midwifery education, and student preparation for caseload practice. Ultimately, the valuable insight and knowledge gained will help students and midwives understand the needs of women who agree to be part of a student midwife's caseload better. However, it is important to recognise in sharing their stories, women may report both positive and negative aspects of their experiences of being part of a student's caseload. Students and midwives may perceive that their practice is being judged or assessed by this research. I want to assure you that the primary aim of this research is to gather women's accounts. I will report the findings of the research sensitively, and will not make any judgements about the information disclosed by the woman at interview. Any reference the woman makes to names of locations or people, such as her health centre, midwife, student, GP etc. will be anonymised in any written reports, such as my PhD thesis, or publications of study findings.

In the unlikely event that a woman's story reveals her perception of an amount of unacceptable practice, I will discuss this initially with my research supervisors. Where further investigation regarding the student's or supervising midwife's practice is felt necessary, contact to relevant personnel at the University/Portsmouth NHS Hospital Trust will be made, to uphold the woman's safety. If a woman has an issue with an aspect of practice, she will be advised to contact a supervisor of midwives within Portsmouth NHS Trust.

Are there any limits to confidentiality?

I do not expect that I will have to share details of any participant. However, in line with the law, I will be compelled to report to the authorities any disclosures the woman makes suggesting serious harm to others such as abuse or neglect of children.

Who is funding this study

My PhD study is being funded by Bournemouth University

Who has reviewed and approved this study?

All research in the NHS is reviewed by an independent group of people, called a Research Ethics Committee to protect the interests of the public. This study has been reviewed and approved by South Central Research Ethics Committee. It has also been approved by Bournemouth University.

Where can I get further information and support?


I hope this information sheet has provided you with a sound overview of the planned research project. If you would like further information or have any queries about the research project now or in the future, please contact:

Carol Wilkins, Senior Lecturer in Midwifery

Tel: 01202 968317. email: cwilkins@bournemouth.ac.uk

Many thanks for taking the time to read this information leaflet

Appendix 4 Information sheet for midwives

	REC reference number: 11/SC/0193	25th March 2011 – version 2
Bournemouth University	Information Sheet for Midwives	
>>>	Title of research study: Listening to Women: Exploring women's experiences of being part of a student midwife's caseload	
Dear Midwife		
<p>I am a PhD student at Bournemouth University, and also a midwifery lecturer based at the Bournemouth University Lansdowne Campus. I am writing to you because you are working within Portsmouth NHS Hospital Trust and are currently, or are about to begin, supervising a Bournemouth University student midwife during her/his caseloading experience as part of their midwifery educational programme. I wanted to have an opportunity to tell you about a research project I am planning to undertake within this locality for my PhD study. This research aims to explore women's experiences of being part of a student midwife's caseload.</p>		
What is the purpose of the research?		
<p>Currently, little research has been done into women's experiences of receiving continuity of care provision throughout their childbearing journey from a known student midwife (supervised by a qualified midwife) through caseload practice. My purpose is to hear women's personal stories in order to develop an understanding of how this approach to student involvement in their care might have impacted on their childbearing experience. As the Nursing and Midwifery Council now require all students to experience caseload practice, the knowledge gained from this study will be very valuable. Through hearing the woman's story, I want to find out how they develop and maintain relationships with the student, how it feels to be cared for in this way, and what impact this student involvement in their care has had on their childbearing experience. The valuable insight and knowledge gained from this study will inform future midwifery education and student preparation for caseload practice, and ultimately, enhance women's and students experience of this approach to care.</p>		
What is the research process and how can you help?		
<p>I am seeking to recruit a sample of 6-8 women. I would be very grateful if you could give women who meet the study criteria an information leaflet about the study and a letter of invitation to participate in the study.</p>		
I am looking to recruit women who:		
<ul style="list-style-type: none">• are in the first trimester of their pregnancy• have agreed to be part of a student midwife's caseload• are aged 18 years and above• do not have serious obstetric, medical or emotional complications		
I am not looking to recruit women who:		
<ul style="list-style-type: none">• are not able to communicate in written and verbal English• have serious obstetric, medical or emotional complications• have experienced early pregnancy loss		
<p>To follow women's experiences of continuity of care provision from a student midwife throughout pregnancy, birth and the early postnatal period, women who consent to participate will be interviewed at their home on three occasions: twice during pregnancy and once post-birth on a day and time that is convenient to them.</p>		

What are the possible advantages and disadvantages for me or my student if a woman from her/his caseload decides to participate?

This will be a unique opportunity for women to use their voices, through sharing their story, and contribute to the future development of midwifery education, and student preparation for caseload practice. Ultimately, the valuable insight and knowledge gained will help students and midwives understand the needs of women who agree to be part of a student midwife's caseload better. However, it is important to recognise in sharing their stories, women may report both positive and negative aspects of their experiences of being part of a student midwife's caseload. Students and midwives may perceive that their practice is being judged or assessed by this research. I want to assure you that the primary aim of this research is to gather women's accounts. I will report the findings of the research sensitively, and will not make any judgements about the information disclosed by the woman at interview. Any reference the woman makes to names of locations or people, such as, her health centre, midwife, student, GP etc. will be anonymised in any written report, such as my PhD thesis, or publications of study findings.

In the unlikely event that a woman's story reveals her perception of an amount of unacceptable practice, I will discuss this initially with my research supervisors. Where further investigation regarding the student's or supervising midwife's practice is felt necessary, contact to relevant personnel at the University/ Portsmouth NHS Hospital Trust will be made, to uphold the woman's safety. If a woman has an issue with an aspect of practice, she will be advised to contact a supervisor of midwives within Portsmouth NHS Trust.

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I do not expect that I will have to share details of any participant. However, in line with the law, I will be compelled to report to the authorities any disclosures the woman makes suggesting serious harm to others such as abuse or neglect of children.

Who is funding this study

My PhD study is being funded by Bournemouth University.

What will happen to the findings of the research study?

The findings of the research will be written up as a PhD thesis and shared by publication and conference presentation.

Who has reviewed and approved this study?

All research in the NHS is reviewed by an independent group of people, called a Research Ethics Committee to protect the interests of the public. This study has been reviewed and approved by South Central Research Ethics Committee. It has also been approved by Bournemouth University.

Where can I get further information and support?

I hope this information sheet has provided you with a sound overview of the planned research. If you would like further information or have any queries about the project, please contact either:

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Phone: 01202 961544
jleamon@bournemouth.ac.uk

Many thanks for taking the time to read this information leaflet

Appendix 5 Letter of invitation to participate in the research project

 Bournemouth University	REC reference number: 11/SC/0193	10th March 2011 – version 2
<hr/>		
Letter of Invitation		
Title of research study:		
> > >	Listening to Women: Exploring women's experiences of being part of a student midwife's caseload	
Dear		
<p>I am a PhD student at Bournemouth University. I am writing to you because you are pregnant, and have agreed to be cared for by a student midwife through the Bournemouth University student midwife caseloading scheme. I would like to invite you to take part in a research study about women's experiences of being part of a student midwife's caseload.</p> <p>Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read the enclosed information leaflet carefully. Do talk about it with your family, and your midwife and student midwife too if you wish. You can contact me or my research supervisor by phone or email if you have any questions.</p> <p>If you are interested in taking part in the study, please complete the reply slip enclosed with this letter, and post it back to me in the stamped addressed envelope. I will contact all women who return this reply slip to discuss their possible involvement.</p> <p>I will then arrange to visit you in your home, at a time which is convenient for you. I will explain the study further and answer any questions you may have. If you agree to take part in the study, I will ask you to sign a consent form and then arrange a date and time for your first interview.</p> <p>Thank you for taking the time to read this letter.</p> <p>Yours sincerely</p>		
Stella Rawnsdon PhD Student School of Health and Social Care Bournemouth University Royal London House Christchurch Road Bournemouth Dorset BH1 3LT Phone: 01202 961546 srawnsdon@bournemouth.ac.uk	Dr Jen Leamon Professor Gail Thomas PhD supervisors School of Health and Social Care Bournemouth University Royal London House Christchurch Road Bournemouth Dorset BH1 3LT Phone: 01202 961544 jleamon@bournemouth.ac.uk	
<hr/>		

Reply slip

If you are interested in taking part in the research study, please complete this slip and return it in the stamped addressed envelope.

I confirm that I have read the attached information sheet.

Please tick

☐

I am interested in taking part in this study and I am willing to meet the researcher to find out more about what is involved.

☐

Name.....

Address.....

Contact number.....

Email.....

Date of birth.....

Please tick the relevant box below.

Is this your:

First
baby

☐

Second baby

☐

Third baby

☐

Fourth
baby

☐

Fifth baby

☐

Sixth or more
baby

☐

This information is required so that I can capture stories of experience from a variety of women, from those who have had no previous experience of maternity care to those who have had a range of experience.

Appendix 6 Participant information sheet

REC reference number: 11/SC/0193			24th June 2011– version 4		
What will happen to the findings of the study?					
The findings of this research will be written up as a PhD thesis. I will report the findings of the research sensitively, commenting on what we can learn from your and other women's experiences. The findings will be shared by publication and conference presentation.					
What are the disadvantages and risks of taking part?					
At the interview you will be sharing your personal experiences and feelings. Talking about these could bring up some memories and you may feel a bit emotional at times. Whilst these emotions are important to capture in order to find out what it is like to be part of a student midwife's caseload, I do not want to cause you any added stress. I will be sensitive and respond to your needs regarding continuing with the interview.					
If, through sharing your experiences, you feel you are unhappy with the care that you are receiving from your student or midwife, I will not personally be able to provide advice or support. But I would be able to recommend another health professional or specialist midwife, such as a supervisor of midwives, for you to contact.					
What are the possible benefits of taking part?					
This will be a chance for you to tell your story and share your experience of what it's like to be cared for by a caseloading student midwife during pregnancy and childbirth.					
By sharing your experiences you will provide valuable information that can be used to improve midwifery education. This will help student midwives and midwives understand the needs of women who agree to be part of a student midwife's caseload better.					
Who has reviewed the study?					
To protect your interests all research is looked at by an independent group of people called a Research Ethics Committee. This study has been reviewed and given a favourable opinion by South Central Research Ethics Committee (Portsmouth). It has also been approved by Bournemouth University.					
What do I do if I am interested in taking part?					
Please complete the reply slip included with the letter of invitation and send it to me within 2-3 weeks of receiving this leaflet in the prepaid addressed envelope. When I receive your reply slip, I will contact you to arrange to visit you at home at your convenience. At that meeting, I will explain the study to you again and answer any questions you may have. This meeting may take up to one hour. If you are willing to take part, I will ask you to sign a consent form. I will give you your own copy of the consent form. I will then arrange a date and time for your first interview.					
Contact for further information					
I hope this information sheet has told you what you need to know about this research study before deciding whether or not to take part.					
If you have any queries at all about the project or wish to make a complaint, please telephone Stella Rawnsdon on 01202 961546, or Jen Leamon on 01202 961544.					
Many thanks for taking the time to read this leaflet.					
 Participant information sheet					
			Listening to Women:		
Exploring women's experiences of being part of a student midwife's caseload					
Stella Rawnsdon PhD Student			Dr Jen Leamon Professor Gail Thomas PhD supervisors		
School of Health and Social Care Bournemouth University Royal London House Christchurch Road Bournemouth Dorset BH1 3LT Phone: 01202 961546 srawnsdon@bournemouth.ac.uk			School of Health and Social Care Bournemouth University Royal London House Christchurch Road Bournemouth Dorset BH1 3LT Phone: 01202 961544 jleamon@bournemouth.ac.uk		

Hello

My name is Stella Rawnsdon. I am a PhD student at Bournemouth University. I am also a midwife, a midwifery lecturer and the mother of three children.

I am inviting you to take part in my research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read this information carefully. Do talk about it with your family, and your midwife and student too if you wish. Ask me if you have any questions. You can contact me by phone or email.

Why is this study being done?

The purpose of this study is to find out what it's like to be part of a student midwife's caseload from the mother's point of view. I want to find out about the relationship that develops between the mother and student. I want to know how women feel about the care that they receive, and what effect they feel being cared for in this way has had on their childbirth experience.

As all student midwives are expected to experience caseload practice as part of their midwifery education, the knowledge gained from this study will be very valuable. This will help us to develop midwifery education in the future.

Why have I been invited?

You have been given this leaflet because you have agreed to be part of a Bournemouth University student midwife's caseload. I want to find out what it's like to be cared for in this way when having a baby.

Working with pregnant women and new mothers

As a researcher working with pregnant women, mothers and new born babies, I have an up-to-date Criminal Record bureau (CRB) check.

What will happen to me if I take part?

If you are interested in taking part I will arrange a visit to your home to explain the study further and answer any questions you may have.

If you consent to take part I will visit you at your home on three occasions to interview you. The first two interviews will take place during your pregnancy, one when you are about 5 months pregnant and one a few weeks before you give birth. The final interview will take place after your baby has been born.

At each interview I would like to hear about whatever is on your mind in relation to student caseload at the time. Please feel free to share with me any notes or comments you have made in your hand held maternity notes that indicate your thoughts, for example, your plans for your baby's birth.

Each interview will take place on a day and time convenient for you and should last no longer than 1 hour. If you agree, I will tape each interview using a small digital recorder.

Do I have to take part?

No, you don't. It's entirely your choice. If you choose not to take part or decide to withdraw at any stage of the study, it will not affect the care you receive now or in the future from your student midwife, midwife or any healthcare worker.

What happens if I or my baby become ill?

This study is looking at the experiences of women who would normally be considered suitable to be cared for by a student midwife through Bournemouth University's caseload scheme. If, after you agree to participate, you or your baby develop complications, we will discuss your continued involvement and probable withdrawal from the study.

What if I decide to withdraw from the study?

You are free to leave the study at any time. However, with your consent, I would like to continue to use the information that you have already shared at interview.

How will the taped interviews be used?

I will interview eight different women. After each interview I will type up the discussion on the audiotape. I will read the typed interview discussions many times to find issues that are important to you and the other women that I interview. During this process, all research data will be kept strictly confidential and stored on password protected computers in accordance with the Data Protection Act (1998). If you wish, after your final interview, I will provide you with a copy of your typed interviews.

Will my taking part in this research be kept private?

Yes. To ensure that you cannot be identified in written reports of the research you will be invited to choose an alias name for yourself. Any reference you make at interview to locations or people that could be linked to you, such as where you live, your GP or midwife's name, will also be made anonymous.


Are there any limits to confidentiality?

Yes. There might be occasions where I may need to share information with other health care professionals. If this arises I will discuss any concerns with you in the first instance. In line with the law of this country, I will be compelled to report any disclosures you make suggesting serious harm to others such as abuse or neglect of children.

Who is funding the research study?

My PhD study is being funded by Bournemouth University

Appendix 7 Consent to participate in the research project

 Bournemouth University	REC reference number: 11/SC/0193	25th March 2011– version 2
Consent Form		
Title of research study: Listening to Women: Exploring women's experiences of being part of a student midwife's caseload		
Name of researcher: Stella Rawnsdon		
		Please initial box
1. I confirm that I have read and understood the information leaflet dated 24 th June 2011 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.		<input type="text"/>
2. I understand that my participation is entirely voluntary and that I am free to withdraw from the study at any time, without giving any reason, without the care I receive from my student midwife, midwife or any healthcare worker being affected.		<input type="text"/>
3. I understand that my involvement will be to participate in an interview on three occasions. These interviews will be held at my home and will last about 1 hour.		<input type="text"/>
4. I understand if I wish to I can share with the researcher entries I have made in my handheld maternity notes.		<input type="text"/>
5. I understand that by participating I am agreeing for the interviews to be recorded on audio tape and that my anonymity will be ensured by the alias name I choose for myself being used in all written reports of the research throughout the study, the resulting PhD thesis, publications and conference presentations. I agree that my individual quotations may be used within the research and within any outside publications		<input type="text"/>
6. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from regulatory bodies or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.		<input type="text"/>
7. I agree to participate in this study		
_____ Printed name of participant	_____ Date	_____ Signature

Appendix 8 Interview aide-memoire

REC reference number : 11/SC/0193

14th April 2011 – version 2

Aide-memoire: First Interview

Aim of study

To explore women's experiences of being part of a student midwife's caseload during their childbearing event through listening to their personal stories of care, in order to inform future educational and practice development.

Introduction:

Story sharing process, I don't have a series of specific questions for you to answer but I do, have some that can prompt your stories, so there are no right or wrong answers.

Possible question/triggers for story descriptions

- Can you tell me about your pregnancy to date
- Can you tell me how and why you got involved in student caseloading
- Can you tell me about the first time you met the student (and what she did)
- How is being cared for by a student midwife in this way, working for you?

Memo for interviewer / prompts that could be useful

Seek moments / stories of description following experience shared i.e. what the student did / how that felt

- So looking back on the experience you have just told me can you describe what the student did and how this made you feel?
- How are you feeling about that
- In what way?
- Can you give me any examples?
- Can we just go back to....
- What you said earlier was really interesting....
- Is there anything you have written in your hand-held maternity notes you would like to share with me?

Aide-memoire: Second Interview

Aim of study

To explore women's experiences of being part of a student midwife's caseload during their childbearing event through listening to their personal stories of care, in order to inform future educational and practice development.

Introduction (remind):

Story sharing process, I don't have a series of specific questions for you to answer but I do, have some that can prompt your stories, so there are no right or wrong answers.

Possible question/triggers for story descriptions

- Can you tell me about your pregnancy to-date and how things been for you since we last met
- Can you tell me about the care you are receiving from your caseloading student (and how you feel about it)
- Can you tell me about the last antenatal appointment you had with the student (and what she did)
- How is being cared for by a student midwife in this way working for you (and what do you think you have got out of it so far?)
- When we last met, you told me about.... Is this still important to you? / do you feel the same way?

Memo for interviewer / prompts that could be useful

Seek moments / stories of description following experience shared i.e. what the student did / how that felt

- So looking back on the experience you have just described can you describe what the student did and how this made you feel?
- In what way?
- Can you give me any examples?
- Can we just go back to....
- What you said earlier was really interesting....
- Is there anything you have written in your hand-held maternity notes you would like to share with me?

Aide-memoire: Third Interview

Aim of study

To explore women's experiences of being part of a student midwife's caseload during their childbearing event through listening to their personal stories of care, in order to inform future educational and practice development.

Introduction (remind):

Story sharing process, I don't have a series of specific questions for you to answer but I do, have some that can prompt your stories, so there are no right or wrong answers.

Possible question/triggers for story descriptions

- Congratulations –Can you tell me about your labour and xxx birth (and what the student did / how you felt)
- Can you tell me about the care you are receiving from your caseloading student since your baby was born (and how you feel about it)
- Looking back, how do you feel being cared for by a student midwife through the caseloading scheme worked for you?
- Now that you have said goodbye to your student, what advice would you give other women who were thinking about whether or not to agree to be caseloaded by a student midwife?
- How have you felt about meeting with me and sharing your experiences?

Memo for interviewer / prompts that could be useful

Seek moments / stories of description following experience shared i.e. what the student did / how that felt

- So looking back on the experience you have just described can you describe what the student did and how this made you feel?
- In what way?
- Can you give me any examples?
- Can we just go back to....
- What you said earlier was really interesting....

When we last met, you told me about.... Is this still important to you? / do you feel the same way?

Appendix 9 Research field notes example

Jody. Interview 1. Post transcription reflections and actions:

This has been a challenge!! It amazes me how quickly at times Jody speaks. It's not just her pace and flow, as this changes, and is reflective at times but it is the way in which she quickly interjects in response to questions/prompts. On a couple of occasions she almost talks over me in her haste to speak. I've listened to my prompts/questions and mostly these have been clear and I am pleased at my spontaneity, my light conversational tone and smiley voice. Listening to the tape has reassured me that I did not cut Jody off when speaking or jump in too quickly with a further prompt. It was clear she had finished saying what she wanted to say in response to the question posed, although I could give a little more time and space, which may be effective in evoking further reflection/comments. Overall I am pleased with the way in which I conducted this first interview with Jody. It was clear when listening to the tape that she was engaged and comfortable. Listening to our joint laughter re-enforces the sense I had at interview of rapport, of a sense of partnership in our relationship. I look forward to meeting her again in March. I have found listening to the tape and reading the transcript interesting – Jody seems focussed in time on the 'now', her pregnancy, and questions on the past or looking to the future e.g. how she feels about having Pippa present at the birth of her new baby, are in some sense answered but her response quickly moves to the 'now' e.g.

'it'll be nice 'cause obviously she's seen me from the start and then she'll know what we are going to have'

moves quickly to discussion around her scan and not knowing the sex of the baby

'because we were going to find out, we asked to find out at the scan'.

Listening to her talk about the way in which she sees Pippa, is illuminating, particularly one particular phrase 'she's as good as gold', which she uses twice each time said almost reflectively as she finishes talking in response to a prompt/question – I have some thoughts on this, so would be good to discuss. I am also fascinated by the way Pippa seems to be embedded in every aspect of Jody's conversation and I wish that I had asked Jody to clarify how she saw Pippa and if that had changed over time e.g. not seeing her as a student, bonus, having 2 midwives – something to discuss!!

Action / discussion points

- Review Aide memoir questions
- Discuss data analysis – possible model
- ? Theme to take forward for discussion at next interview

with Jody - concept of 'having two midwives rather than one' & 'I don't see her as a student really' - is this what she had thought from the beginning, had she viewed Pippa in this way from the start or was this something that had gradually evolved over time?

Appendix 10 Provisional opinion from National Research



National Research Ethics Service

NRES Committee South Central - Portsmouth

South West Research Ethics Centre

Level 3, Block B

Whitefriars

Lewins Mead

Bristol

BS1 2NT

Telephone: 0117 342 1334/ 0117 342 1382

Facsimile: 0117 342 0445

31 May 2011

Mrs Stella Rawnsdon
Senior Lecturer in Midwifery
Bournemouth University,
R608, Royal London House,
Christchurch Road,
Bournemouth,
BH1 3IT

Dear Mrs Rawnsdon

Study Title: Listening to women: an exploration of women's experiences of being part of a student midwife's caseload during their childbearing journey

REC reference number: 11/SC/0193

The Research Ethics Committee reviewed the above application at the meeting held on 20 May 2011. Thank you and Dr Leamon for attending to discuss the study. Please confirm that the following is an accurate record of the discussion that took place.

- The Committee thanked you for presenting a thorough and well written application.
- The Committee suggested that you arrange for the themes you identify from your interviews be checked by another person to control for any bias you might introduce. You agreed to this suggestion.
- The Committee asked you how you will deal with the possible situation where you receive expressions of interest in taking part from participants in excess of the number you require. You reported you will communicate with the midwives and let them know when you have reached your sample size. If mothers continue to contact you (i.e. those who are initially slow to respond), you also hope to include these. If a participant is not suitable to take part, you reported that you will take the time to explain why. You also reported that by liaising with midwives before visiting each mother, you will keep informed of the health of the baby.
- The Committee asked you how many midwives you will be working with. You reported that you will work with three midwives across three areas of Portsmouth – East, West and Central.
- The Committee explained that it had noted that you plan to use a suitable relative or friend to translate if they are willing and able to, and pointed out that this would be a lot of work for this translator. You reported that you would really like to recruit mothers from a range of backgrounds, but do not have the funds to arrange for translators, so have considered this as an alternative. The Committee agreed that whilst it would be best to include those who do not speak English, using a relative as a translator is not always suitable for confidentiality reasons.
- The Committee asked you who you are relying on to ensure that the mothers can

This Research Ethics Committee is an advisory committee to the South Central Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

give informed consent, and who will be giving out the invitation letters. You reported this would be the midwife, who would be informed of the inclusion criteria and will have them in mind when distributing the letter. You will then make a visit to any mother who has expressed an interest in participating to discuss the study and answer any questions. At this point, you will make a judgment about whether the mother is able to make an informed decision about participation.

- For interest, the Committee asked you why you do not plan to interview student midwives themselves. You reported that you are interested in the views of mothers primarily, but agreed that it would be interesting to interview student midwives in the future. You reported you have also conducted interviews with student midwives in the past for your MSc.
- The Committee asked you how you plan to choose your sample to ensure you achieve a mixture. You reported that you will attend the midwife's team meeting and inform them of what you hope to recruit. You reported that you do want to recruit a mixture of mothers, including first time mothers and more experienced mothers, and will ensure that not all mothers are of the same type.
- The Committee asked you whether you plan to inform participant's GPs of their participation. You reported that you plan to ask whether mothers would like GPs to know about their participation, and if they do, you will then create a letter.

The documents reviewed at the meeting are summarised at Annex 2. The Committee gave the following opinion:

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

Application:

- Please arrange for a second person to review the themes you identify from your interviews to allow for any bias you might bring to this.

Documentation:

- Documents mostly assume that midwives will be female, but this may not necessarily be the case. Please check wording in the documents to ensure that they do not solely address females.
- Please re-write the PIS for mothers, to make it more readable. Please ensure it is readable by those with a reading age of about ten years.
- Please state very clearly in the PIS to mothers that if they do not wish to take part, or if they withdraw, their own care and that of their baby will not be affected.
- Please remove the wording in the PIS at the top of page 2: "a unique opportunity" to give more of a balanced introduction to the research.
- Please rewrite the information on the PIS relating to limits to confidentiality as it is currently not very clear.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Ruth Middleton, Committee Co-ordinator.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 28 September 2011.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

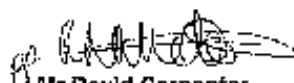
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

11/SC/0193

Please quote this number on all correspondence

Yours sincerely


Mr David Carpenter
Chair

Email: scsha.sehrec@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

*Copy to: Ms Sara Githro
Ms Christine Bevan, Portsmouth Hospitals NHS Trust*

Annex 1

Document	Version	Date
Covering Letter		18 April 2011
Evidence of insurance or indemnity		18 April 2011
Interview Schedules/Topic Guides	2	14 April 2011
Investigator CV		18 April 2011
Letter of invitation to participant	2	10 March 2011
Other: Patient information leaflet - 'Support for parents'		18 April 2011
Other: CV Dr Leamon		
Other: CV Professor Thomas		
Other: Risk assessment form	1	10 February 2011
Participant Consent Form	2	26 March 2011
Participant Information Sheet: Expectant mother	3	26 March 2011
Participant Information Sheet: Student	2	08 April 2011
Participant Information Sheet: Midwife	2	25 March 2011
Protocol	1	23 November 2010
REC application		18 April 2011
References or other scientific critique report		23 December 2010

27th June 2011

Ruth Middleton
NRES Committee South Central - Portsmouth
South west RHC Centre
Level 3 Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

REC Reference Number: 11/SC/0193

Dear Ruth

I would like to thank the Research Ethics Committee for reviewing my application at the meeting held on 21st May 2011. I confirm that the meeting minutes are an accurate record of the discussion that took place in relation to my application.

The Committee indicated that they would be content to give a favourable ethical opinion of my research, subject to receiving a complete response to the request for further information in relation to the following elements:

Application:

A second person to review the themes you identify from your interviews to allow for any bias you might bring to this.

I have two experienced research supervisors who will review the themes I identify from my research interviews with participants.

Documentation:

Re-write the Patient Information Sheet to make it more readable, removing the words 'a unique opportunity' at the top of page 2 and ensure that it is clear to mothers that if they do not wish to take part, or if they withdraw, their own care and that of their baby will not be affected. Ensure wording in documents are not gender specific in recognition that not all midwives are female.

I trust I have enclosed all relevant information to support my submission

Kind regards

Appendix 11 Letter of favourable ethical opinion from National Research Ethics Services



National Research Ethics Service

NRES Committee South Central - Portsmouth

South West Research Ethics Centre
Level 3, Block B
Whitefriars
Levins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1382
Facsimile: 0117 342 0445

04 July, 2011

Mrs. Stella Gwyneth Rawnsdon
Bournemouth University
R609, Royal London House,
Christchurch Road, Bournemouth,
BH1 3IT

Dear Mrs. Rawnsdon,

Study title: Listening to women: an exploration of women's
experiences of being part of a student midwife's
caseload during their childbearing journey
REC reference: 11/SC/0193

Thank you for your letter of 29 June, 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

This Research Ethics Committee is an advisory committee to the South Central Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		18 April 2011
Covering Letter		27 June 2011
Evidence of Insurance or Indemnity		18 April 2011
Interview Schedules/Topic Guides	2	14 April 2011
Investigator CV		18 April 2011
Letter of invitation to participant	2	10 March 2011
Other: Patient information leaflet - 'Support for parents'		18 April 2011
Other: CV Dr Leamon		
Other: CV Professor Thomas		
Other: Risk assessment form	1	10 February 2011
Participant Consent Form	2	25 March 2011
Participant Information Sheet: Student	2	08 April 2011
Participant Information Sheet: Midwife	2	25 March 2011
Participant Information Sheet: Expectant mother	4	24 June 2011
Protocol	1	23 November 2010
REC application		18 April 2011
Referees or other scientific critique report		23 December 2010
Response to Request for Further Information		29 June 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July, 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views

known please use the feedback form available on the website.

The attached document *'After ethical review – guidance for researchers'* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk

11/SC/0193

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely,



PP

Mr. David Carpenter
Chair

Email: scscha.sehrec@nhs.net

Enclosures: *'After ethical review – guidance for researchers'* – sent via e-mail

Copy to: *Ms. Sara Glithro*
Ms. Christine Bevan, Portsmouth Hospitals NHS Trust

Appendix 12 Poster for Narrative Research Symposium



B**U**
Bournemouth
University

Listening to Women:
Exploring women's experiences of being part of a
student midwife's caseload



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Appendix 13 First story draft example – Anna’s story

Anna’s Story

It was amazing, better than I expected...

At the moment I’m just in retail I’ve got a little temporary job until after Christmas. I was a restaurant manager but I was finding it really hard to get pregnant so as soon as I quit that within a month I was pregnant. I think that stress was a factor at the time but it’s the hours as well, you know when you’re getting in at 1 o’clock in the morning you might not feel quite like it! [We both laugh]

I’m an older mum as well, I’m 38 years old um so I think we weren’t, but we just let nature take its course really. I finish work next Friday, I know a lot of ladies work up until two weeks beforehand but I think come on take this time, this is an experience unlike any other so enjoy it really, be kind to your body plus you don’t know if it’s going to come early.

I’m going to have it at home [pause] yeah. I’ve always had a funny little thing with hospitals anyway and um a friend of mine inspired me, lovely lady, and she’s had both of hers at home.

And she just said it was a really great experience and you know, she felt more comfortable because she was at home she could do whatever she wanted, jump into the bath, if she wanted to have a shower, she could have a shower. She could just do her own thing.

And we’re so close to Parsons Field hospital as well. People say well what about the risks of, if anything goes wrong, and I think well, it’ll only take me 10 minutes to get to one part of Parsons Field hospital to the next so, yeah, not a problem.

You know, Parsons Field’s a bit of a factory, and I think surely when you’re in your own environment, you’re going to feel more comfortable, you’re gonna feel more relaxed really, which is going to help things a lot.

Yeah my friend recently went into Parsons Field and she said they didn’t even have a birthing suite, she wanted a water bath but they were all in use.

You know, you’ve got this vision when you do your birthing plan, I know it’s

going to change, but you've got this image in your head and then when it's this chaotic [pause] I just, I just don't want that [pause], you are a bit more in control in your own home.

Having chosen home birth, Anna's maternity care provision was undertaken by the Parson's Field home birth midwifery team, the Amber team. It was through Lauren, Anna's named Amber team midwife, that Anna met student midwife Ceri.

That was in my home umm and then she asked me at that time um would it be okay to come to the 20 week scan um so I um talked to my partner [Dan] about that and um he said yeah absolutely fine.

So then I met her again at the 20 week scan, and then I've subsequently seen her another two times, so four times in total.

So we had the initial meeting, um she was due to come with Lauren, but um in the end Ceri just came I don't know if that was contrived or not to sort of to make um the meeting with me and Ceri more personal. Um but I really don't mind if it was, it was really, really nice just to have her there and to get to know her a little bit.

I think um I was initially carried away with Lauren's enthusiasm um just in general about being pregnant and having a baby. And I felt really comfortable with Lauren, I did feel a bit conscious that someone's coming into my home and doing it that way it was a little bit strange because you think this is essentially a stranger.

Um but you know within 5 minutes I was just chatting away with her like I'd known her for ages um and she put forward Ceri, said she was really lovely. Um and I just thought it would, you know everybody's got to start somewhere and I just thought it would be really, really nice to help somebody out possibly a little selfish part of me thought I'm going to have extra special care there as well because I've not just got one person I've got another person there looking after me as well [laugh].

Ceri has been fantastic I think um [pause] she's just a lovely person for starters so she's got that but as far as her care for me though, 'cause she's so very thorough, and um er she'll explain everything really, really well.

Umm you can tell she's really excited as well, which is really nice because

it's just making it a little bit more personal rather than I'm not just some lady who's having a baby, I'm Anna.

I'm actually her first case as well, so I know I'll be a bit special to her and she'll be special to me as well because it's my first baby.

Um she seems to be not, not overly emotional but she's, you know when I, my eyes started to well up I can see her at the scan as well having that same feeling.

So yeah, I just feel so lucky because I know from friend's experiences of um hospital births and care in other areas they've not seen the same midwife, they've seen several midwives throughout the course of their care and then they may be lucky to have the same one on the main event, whereas I know um even if I don't have Lauren, Ceri is going to be there. So that is reassuring in itself.

Ceri's very competent, very confident. She's, she's straight, straight in with an answer definitely. I try an always, even if I look on the internet and things, I always try to find some questions because she needs something to get the brain working as well and to know that she's got it in her to answer questions.

Um so, I recently I had a really nasty little cough and cold so I sent her a little message told her what I was doing and within 10, 15 minutes she'd got back to me and saying that was fine and all the usual. You know really you should avoid that and that she'd had actually been in contact with Lauren as well so she was so thorough.

But um yes when she does come for my appointments I always try and make sure I've got something, some questions to ask as well, and she's just a star, and explains things thoroughly.

I see her as a very good support um but also for advice and to give me confidence in the things that I am reading, and that she can confirm those for me.

And umm I think as well as she's got such a nice calm demeanour that she will help me remain calm when the crunch comes to it [during the birth]. I'm a pretty calm person anyway but you just don't know how you are going to be obviously you get some women giving you their horror stories and then you

got a whole load of women who are just like 'well what are they on about'. So you don't know what your experience is going to be like. I don't know if I'm going to get complications but I think that she will, I'm not leaning on Ceri completely but I imagine that she's going to be an integral part of my support and comfort.

And she was really excited to say that whereas normally your midwifery care will stop after 10 days but they now allowed up to 28 days which she can pop in, she can see the baby developing properly, breastfeeding okay and that's quite nice as well, yeah. You know, I feel really lucky Stella based on my friends experiences.

Now nearly 38 weeks pregnant, Anna continues to share her unfolding story....

I try not to think about being late, I'm thinking oh I would like it to be a bit early though, that would be really nice, especially now!

I've got just under three weeks to go but when you feel like this you just think oomph you know? [laugh]

Like my boyfriend today, he needed some bits, packing up some bits for eBay and he's like 'oh you're going to have to sit down and do it', swollen ankles and oomph [laugh].

I think baby's been pretty good every time um Ceri's come round and does her little tests it seems to have been engaged for weeks and weeks um and now obviously that's another sign so that's good.

Really one of the things for me that's really helped me is walking everywhere. I mean I've still been going to the car boot sales and stuff like that, walking to there and into town and I think that's been good for me.

But it will all be worth it, it will. Yeah I think it's been pretty low for quite a long time actually. I've been getting sort of like shooting pains and stuff up in that area as well. But again you do sort of think there is an end to it, and the end result is that I get to meet our little baby.

I think students benefit from this experience before they qualify, I feel confident, happy that I chose to have the student midwife with me and um I feel glad that it's a programme that is being carried out.

Because I don't think it's fair for them to just qualify and then this to be thrown at them quite like that. I think you know the mentoring is quite important, and I think it's given Ceri more confidence as well.

She's just passed her exams as well. I didn't know if that's given her more confidence even though all of us have been saying you, you are absolutely brilliant you will just be flying through them.

I'll see her at the end of the week anyway, Friday, 38 weeks and she's on-call now for us as well so that's quite sweet. We've sent little messages just to say 'oh congratulations you are on call', and 'congratulations you can have your baby at home now', that's nice to know yeah.

Still got my bag packed just in case but I think it'll be alright.

Ceri's care has been very, very consistent it's probably been more thorough if anything than I expected um because obviously she's in her third year so she's, she's very confident and capable

Um but yeah it's been, it's been really nice to have this especially as this is my first baby because I know this is quite special for her too because I am her first case and it's my first baby so it's quite a nice symbiotic relationship really.

I will um contact her just too sort of put my mind at rest I mean the internet's great obviously because you can look up a world of information, but there's nothing like having it first-hand. Because you've got such conflicting information so you can kind of get a little idea um but yeah.

I tend to text rather than call um and she usually gets back to me pretty quick, pretty immediately she always goes through Lauren though as well just to confirm her own thoughts.

Like I've recently text her because we've got um a heated pool to have the baby in and I just wanted to know about the sanitation of that really, because obviously I just wanted to be in it all the time, but I needed to know about the chemicals.

I think the pool's a nice thing to have but I didn't know that I couldn't really use it for the initial labour, it has to be for the birth. Because they said it can actually stop the labour because the warm water calms you down [laugh].

So I thought oomph okay, so it can prolong labour by doing that in a sense.

So I've had to sort of choose that's what I want it for, I want it for the birth, but that's good that's, that's nice, something to look forward to [laugh].

We've got it set up in our little summerhouse, well it's Dan's bike shed actually but it's like a little conservatory, so we've got it set up out there. We [laugh] went out there one Sunday, we were freezing but when we got in it, it was just so lovely, to be buoyant and to be weightless is a nice feeling right now [laugh].

But they [Ceri and Lauren] were very enthusiastic about the water birth they didn't have a problem that it was a home birth at all.

I feel completely confident, I do because Ceri's not going to put me at risk, Lauren isn't going to put me at risk or whichever of the lovely ladies I get on the day, they're not gonna put me at risk.

We've done our birth plan together now, and they've made it quite clear they are literally my backup. They are not here to tell me what I should be doing but I have requested that they advise me. So I haven't said I want to be in an upright position or I'm going to be in the birthing pool because I know that is not realistic and they must just advise me.

So they've made me feel confident that I'm in control and um Ceri said 'I'll be doing a lot of notes', which they've got to do um and they said you know obviously they check the baby's heart beat and check everything's okay there.

So I know, I know that they're not going to put me at risk, I feel confident in that, I feel confident that I'm not too far away from Parson's Field hospital as well if anything, you know if anything's dodgy, yeah.

So you know, it's a bit more empowering to know and they can pop in when I'm in the first stages and just say okay 'oh this what you are doing, perhaps you could do this, perhaps this might help you with your pain, this might help move things along a little bit' but then they're going to go.

So there's not going to be the pressure of being in the hospital where people are counting time, clock watching, waiting, yeah. Like you know they said take Sparky [Dog] out for a walk, not too far away, just you know anything to distract yourself basically [laugh].

You know we feel really fortunate, in fact a little bit spoiled with the care that

we've had, because I just talk to my friends and even a friend whose now decided that she will have a home birth she's seen different midwives every single time.

I know a lot of women that wanted home births and they've had to battle for it or have been persuaded not too because it's their first baby etc. whereas, you know, I've just been so encouraged all the way through. So yeah we do feel lucky with Ceri because she's just a warm person as well.

I think because it's been consistently the same people you know because this is a big thing for me. You know I've chosen to have a child and I've never done it before.

You can take advice from your friends and family but to have that professional help there if I've talked to Lauren and Ceri about something at 20 weeks then I'd see them again at 24 weeks and I'd say 'oh do you remember I had that?' They'd know, whereas some midwife I've never met before would look through my notes, they haven't got that same kind of rapport, they don't know me.

I mean these girls even without me saying that I like things to be a little bit more natural they've picked up on that and they've said things like 'oh 37 weeks, are you going to start your raspberry leaf tea?'

You know, yeah they suggested that so I'm taking my raspberry leaf. But obviously they did say this is not a midwifery thing but we have heard that raspberry leaf is good and that's nice.

Following the birth of her baby and end of midwifery care, Anna brings her unfolding story to conclusion...

She re-tells the story of sciatica and frustration but now it's shaped differently, configured around her impending labour, an omen of its arrival, and a sign that she should rest in preparation.

All the signs were there Stella so her birth was imminent really, it was really clear and Ceri and Lauren knew. They were far more in-tune than I was.

They came around on the Monday and I had a few um different things, there was a bit of a show and things like that and they basically they went out of here, sort of conniving, saying 'she's going to have that baby by the end of

the week', and Ceri said, 'as I was lying in bed that night I thought she's going to have that baby tomorrow' and then I did.

So they were in-tune more than I was. I thought I was constipated [laugh] for most of the night but it had started. That was it, that was me and then I'd read a few bits on the internet I was thinking, 'hang-on a minute if you are constipated you don't feel a regular pain every sort of however often' umm and I'd been to the loo as well so I thought no I can't be, I can't be.

So I waited until 8am in the morning until I phoned Ceri and then I phoned her mmm.

Umm when I phoned Ceri she gave me her advice she said it might not be for real, you know you might go through the day with some contractions and then they'll stop so like practice.

So I prepared myself for that as well but I was all the while thinking please let it, please let it be time um Dan had a lie in that day he got up at like 10 o'clock and when he got up I said I think it's the day um and so he said 'right anything you say to me today is the law' and that was that.

He played music for me all constantly throughout the day um I cleaned the fridge, I just rocked about, just kept active and then um phoned Ceri. I was in contact with Ceri throughout the day.

You know she was checking up on me and I was letting her know what the contractions were like and then I think it got to about 4 or 5pm um and I said to Dan 'I think this is pretty full on now' and he said, 'yes I can see it in you, you know you are in a different pain zone' to where I was previously and it turns out I was every 4 in, 4 in 10 by that point [laugh].

So umm I phoned Ceri she said 'oh really'. So she phoned, it wasn't Lauren, Lauren wasn't on, it was her night off umm so it was, how can I forget her name?

Barbara, Barbara was on-call so Ceri phoned Barbara um and Barbara was here pretty swiftly because they thought 'oh 4 in 10 that's a lot' and she came in sat down and looked at me and she said you really are having 4 in 10!

Most ladies who call us are not [laugh] um and Ceri came just after that. They checked me over, 20min past 6pm they said, 'you can jump in the pool'. So that was good wasn't it?

I loved the pool, that was like my space and I think that it really, really did help with pain. Because we went a step further and we bought the heated hot-tub thing there was a little um must have been the filter or something but there was just a little shoot of water and just feeling like that little shoot of water almost was bringing on the contractions but was quite soothing as well and yet when I'd sat in the hot-tub previously and that, that annoyed me [laugh].

So Candy's [baby daughter] a little Pisces and she was born in water, she loves her baths, she's definitely a water girl, definitely and that was about 14 minutes past 9pm that I had her.

We named her Candy Coralie Amber, we got the 'Amber' after the Amber team, Candy Coralie was what we decided and then we popped the Amber in umm.

I think actually, Ceri dealt with it correctly really because I didn't want her to just come rushing round to me because I felt fine.

But then there was part of me that was thinking 'oh should I have someone here' but then I got my head round it and thought no, no it's much better that we just do as much as we can together and then let the girls come when I really need them.

Mmm but as far as Ceri's advice went, to keeping active and um you know, keep rocking, let the baby move you know through the passage nicely, that was all good and she was really calm as well when I phoned her and I thought I was going to cry at first because I still wasn't sure if the baby was coming or not.

I think maybe we all were a bit emotional towards the end of it but not during the day Ceri was absolutely spot on yeah. I mean it was lovely, it wasn't like I had practitioners or midwives it was like I had friends there and yet they were, you know they were encouraging, they were telling me how well I was doing.

Yeah it was just lovely and they were very, very quietly talking among themselves as well and it was like that little buzz going on I couldn't tune into it but it kind of made me feel more comfortable, It was like I had company.

I think Ceri was really lucky with my home birth being her case as well

because she has attended quite nasty births since mm yeah. I think they had another home birth just after me and the lady haemorrhaged big time, I mean that's awful but you know you are a midwife these are the things that are going to come.

But I just thought that I'm so pleased, well pleased for me as well that it went well but also pleased for her that she'll have that memory of her own case.

And um the lovely thing was that Lauren did come even though it was, I mean it was Ceri's day off as well umm and obviously she had to come because I was her case. Barbara was obviously here but then Lauren came just as support which is just, that's phenomenal isn't it? That's way and above the call of duty really isn't it?

And literally she, she walked in at about 7pm and my waters hadn't broken and the minute Lauren walked in 'pop'! Literally the minute she walked in, it was very, very strange but they were wonderful it makes me cry thinking about it really you know because they were.

Yeah it was amazing, it was like I wasn't on my own and that they cared as well you know, and it was amazing Stella, it really was amazing yeah.

It wasn't a long labour really but the placenta took a while to come. I stayed in the water, Dan jumped in um we had um I think it was probably an hour in total. So bless Dan he held me up for quite a bit of the time and then I sort of stood up, he held the baby um and then we waited for the cord to stop pulsating and then they said okay you can deliver the placenta and it didn't, nothing was really happening. And then they gave me some Clary Sage to sniff, and then within minutes it popped out, literally popped out.

Yeah so that was good, yeah no intervention, no nothing, no anything so really lucky Stella, really very lucky.

Ceri was helpful with the breastfeeding and um you know she gave me the confidence to think that I was doing it properly and that I wasn't going to have any issues, so that was good. It's going fine now.

She did some of the postnatal visits on her own and then the final visit she come round with Lauren. Mmm yeah, that was emotional as well, and Lauren's just found out she's going to be a grandma so that's amazing.

I've had a text from Ceri today actually. They've asked me to go to the umm

the 'Meet the Midwives' so she's been in contact about that. I mean I generally as a friend, I have asked her how her dissertation is going and things like that because she's just so lovely.

So I think you know that it'll be nice to meet her for the occasional coffee and show her how Candy's doing and I asked her how does that go with you know the professionalism, and she said that as long as I wasn't talking to her about anything to do with midwifery or anything relating to Candy then that's absolutely fine.

Yeah well if you think if, you know when you go for hospital-led care you get a different midwife every time but I mean I've had Ceri and Lauren all the way through so you do bond with them to have that experience with them as well. I'd hate to think well, that's it now, I just disregard those people.

I think it's really, really important that I have participated in the study because it's um important to give this positive feedback to ensure this scheme keeps going because I think it must be so important for the midwife to be able to caseload. I think it has been a positive experience and I would definitely recommend it to people if they came across the same thing.

Yes I would say, if it was offered to them, I would definitely say take it on especially as a first time mum. It gives you that extra security blanket almost because you've got more people that are caring for you, and because um Ceri is having to refresh her brain all the time about what she's learned I think she was so on the case with things and so enthusiastic that it was fantastic.

The advantages where definitely having that extra person either to text or call if I had any queries about anything um just knowing that Ceri would be really be efficient and on the case with things because it was fresh in her brain and she had to make sure that she was giving me the correct information.

Ceri was amazing on the day when Candy was born. Barbara did the notes, literally, Ceri did my delivery, she literally did do my delivery she may have had advice from the ladies.

Um I think it was a little bit difficult for her [Ceri] because she was so used to hospital high risk, so whereas she wanted to do everything on the dot the other ladies could see okay she's in a full blown contraction, let's just give

her a little minute and we can see she's safe and we'll do the heartbeat in a second you know, so it wasn't quite as regimented as it would be in a hospital.

I think Ceri found that a little bit difficult, which I can perfectly understand but she was amazing, really mmm.

Appendix 14 Edited poem example – Jodie’s story

Jody’s story

It was more reassurance a peace of mind thing

As shared in chapter 6	Edited poem
<p>The first time I met her was the first time I met the midwife there was a; 'right we need to come round and do your bloods do all your bits and pieces' and it wasn't just a flying visit they were here a good couple of hours so a good opportunity to chat to her to gauge her</p> <p>The thing for me everybody needs to learn you've got to start somewhere and if people like myself don't give them the opportunity</p>	<p>The first time I met her was the first time I met the midwife There was a; 'right we need to come round and do your bloods' 'Do all your bits and pieces', It wasn't just a flying visit, they were here a good couple of hours So a good opportunity to chat to her, To gauge her.</p> <p>The thing for me is everybody needs to learn You've got to start somewhere If people like myself don't give them the opportunity How they going to get their experience or knowledge up If people aren't giving them the chance?</p>

<p> how they going to get their experience or knowledge up If people aren't giving them the chance? I thought, I'm easy going I thought yeah, I'm okay with it, it's a bonus I get two midwives instead of one </p> <p> She was nice enough when she came to see me and we seemed to get on really well so I didn't have any issues saying yes to it and if I've ever got an issue or anything I can text her and within an hour I've heard back literally, if I've got any concerns I just text her and she gets back to me and it just puts your mind at rest cause at the end of the day I don't want to bother the midwife </p> <p> I don't see her as a student really she seems to know her stuff </p>	<p> I thought, I'm easy going, I thought yeah, I'm okay with it, It's a bonus I get two midwives instead of one </p> <p> She was nice enough when she came to see me We seemed to get on really well So I didn't have any issues saying yes If I've ever got an issue or anything I can text her and within an hour I've heard back literally, if I've got any concerns I just text her and she gets back to me it puts your mind at rest At the end of the day I don't want to bother the midwife </p> <p> I don't see her as a student really She seems to know her stuff She comes across as very confident, She knows what she's talking about. I've got no doubt that she can do her job properly Anything I ask her, she's got an answer for me </p>
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<p>and comes across as very confident, knowing what she's talking about. I've got no doubt that she can do her job properly anything I ask her, she's got an answer for me and if she's not sure she'll say 'I'll find this out for you' so I've got no qualms dealing with her</p> <p>It's definitely good to have I think more so with your first cause you have a lot more questions but it's a benefit second time too cause you've got that extra comfort and reassurance I know it's a bonus cause you just think, ha! Got two midwives but I just see her as my midwife she's been able to do everything that I've asked her</p> <p>We established with her last week if I go into labour</p>	<p>If she's not sure she'll say 'I'll find this out for you' I've got no qualms</p> <p>It's definitely good to have her I think with your first you have lots of questions But it's a benefit second time too You've got that extra comfort and reassurance I know it's a bonus I think, Ha! Got two midwives I see her as my midwife She's been able to do everything that I've asked her</p> <p>We established with her last week When I go into labour, or my waters break, We'll let her know first, then let the hospital know Then we'll let her know when I'm going in It's nice to have her there The fact that she said; "Whatever it is she's doing, she'll drop and come.</p>
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<p>or my waters break, we'll let her know first then let the hospital know then we'll let her know when I'm going in and it's nice to have her there just the fact that she said whatever it is she's doing, she'll drop and come.</p> <p>She's always been there every appointment and she seems to know when I've got concerns without me saying anything and if I'm not sure of something she can sort of look at me as if to say 'you didn't get that did you?' so it's a peace of mind thing cause she always reassures me</p> <p>She's just very friendly, very approachable I do see her as a midwife</p>	<p>She's always been there, every appointment She seems to know when I've got concerns without me saying anything If I'm not sure of something she looks at me as if to say 'You didn't get that did you?' So it's a peace of mind thing She always reassures me</p> <p>She's very friendly, very approachable I do see her as a midwife She's become a close friend, a friend that I can ring up It's a very personal time in my life having a baby She's played a big part in that for me I've turned to her and she's been there She's done what she can for me She's a very good friend at the end of the day Hopefully she's learnt along the way</p>
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<p>but she's become a close friend, a friend that I can ring up cause it's a very personal time in my life having a baby and she's played a big part in that for me I've turned to her and she's been there and she's done what she can for me she's a very good friend at the end of the day and hopefully she's learnt along the way</p> <p>I knew that when I rung and said I'm in labour she'd be there and at the hospital when she turned up it was like that's it, familiar face! I know you are going to help me I know that you know what my fears are I knew she wouldn't let anything happen to me I knew she was gonna sort me out, gonna look after me she knew what I wanted, and how I wanted it and I knew she would stick by it which she did, which was fantastic</p>	<p>I knew that when I rung and said I'm in labour She'd be there at the hospital When she turned up it was like that's it, familiar face! I know you are going to help me I know that you know what my fears are I knew she wouldn't let anything happen to me I knew she was gonna sort me out, gonna look after me She knew what I wanted, and how I wanted it I knew she would stick by it Which she did, which was fantastic</p> <p>Yeah I would definitely ask for the student thing again At the end of the day When she turned up I was like 'Oh she's here, she's here' The contractions came so quick When she came I was like 'Oh she's here, she's going to get it out for me' If I had any concerns I could just look at her and she reassured me</p>
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<p>Yeah I would definitely ask for the student thing again cause at the end of the day when she turned up I was like 'oh she's here, she's here' cause the contractions came so quick and when she came it was like 'oh she's here, she's going to get it out for me' and If I had any concerns I could just look at her and she reassured me it was so nice to have her there.</p> <p>I know I will see her at the Friday clinics I took my son to the doctors' stuck my head in and she was there she came round to see the baby and she said like anything I've got, even now 'just give me a text and I'll help' you're a friend and just because I've discharged you doesn't mean I'm gonna write you off.</p>	<p>It was so nice to have her there.</p> <p>I know I will see her at the Friday clinics When I took my son to the doctors' I stuck my head into the midwives' room She was there, she came round to see the baby She said like any questions I've got, even now 'Just give me a text and I'll help, she's a friend Just because I've discharged you doesn't mean I'm gonna write you off.</p> <p>I don't see her as just a midwife I see her as a friend as well It's nice I think that because you do build that relationship with her I know that I'll be able to text her just say hello Ask how she's doing I'd feel comfortable to text her, if I had any concerns Yeah, it's really good I've now got her as a friend</p>
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