Learning and Teaching in the Context of Clinical Practice: The Midwife as Role Model

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Abstract

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The purpose of this study was to develop a theory in order to explain the meaning and process of learning the role of the midwife from midwives in the clinical setting. To achieve the depth and detail required in the absence of literature on this topic, the grounded theory approach was adopted.

The sample consisted of twenty student midwives and seventeen midwives. Data were collected by means of unstructured interviews which were tape-recorded. Each participant was interviewed on a minimum of two separate occasions. The constant comparative method was used to analyse the data. The findings of the research contribute to knowledge by making explicit how the role of the midwife is interpreted and enacted, the effect this has on what role students learn, how it is learned and hence how the role is transmitted from one generation of midwives to the next.

The 'emic' perspective facilitated the emergence of a number of theoretical ideas. Central to these are the rules of practice. When midwives rigidly follow written and unwritten rules they prescribe midwifery care which corresponds to the medical model. In doing so they act as obstetric nurses or handmaidens to the doctor. When everything is interpreted as rules to be followed prescriptive midwives appear to be uncaring and detached from the experience of childbirth. The individual needs of women are not met and the relationship between midwife and client is superficial. Midwives who rigidly follow the rules inhibit the growth and development of students providing them with few opportunities to achieve beyond the level of their role model. Midwives are flexible when they interpret the rules for the benefit of women and provide a woman-centred model of care. These midwives therefore act as autonomous practitioners. When rules are interpreted and adapted to meet the needs of women, flexible midwives demonstrate involvement in women's experiences and are empathic, supportive and caring. Midwives who use professional judgement to interpret the rules provide an environment in which senior students can become autonomous practitioners. When midwives demonstrate the role of autonomous practitioner, practise a woman-centred model of care and meet the learning needs of students, they are appropriate role models and teachers. There is conflict in the clinical setting when practitioners who hold opposing attitudes, values and beliefs practice together. Conflict can be avoided when flexible midwives adopt strategies that involve becoming prescriptive or practising by subterfuge.

In accordance with Bandura's social learning theory students learn by observing and emulating the example of their role models. Learning is vicarious when students observe the consequences of their role models' actions. When learning the role from a role model is interpreted as a passive process, a behaviourist and pedagogical approach to learning and teaching ensures perpetuation of the obstetric nurse role that is no longer considered acceptable. Role modelling serves as a vehicle for transmitting new behaviour when learning is perceived to be an active process. In this case a humanistic, andragogical and cognitive approach to learning and teaching is adopted giving students the freedom to determine their own role. Practice from a number of role models is emulated. In this way each midwife acquires a unique identity which is derived from an abstract role model rather than a particular person. Students are prepared for the autonomous role of the midwife, and it is this role they wish to emulate.

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The aim of this study was to explore how students learn the role of the midwife from their midwifery role models. I am indebted to many people who made it possible for me to achieve this.

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Chapter One

Introduction

The aim of this research was to develop a theory to provide insight and understanding into how students learn the role of the midwife from their role models. It is known that learning in clinical practice has greater impact than what is learned in the classroom (Emmons 1993). Role models are therefore crucial in helping students to learn the role but as a way of learning this has not previously been made explicit. Since 1989 'education' has increasingly replaced 'training' of midwives. Links and subsequent amalgamation of Schools of Nursing and Midwifery into Universities has facilitated this process enabling students to gain academic recognition in the form of a diploma, advanced diploma or degree in combination with professional registration. This education has led to the provision of a balance between theory and practice, thus reducing the amount of time spent in the clinical setting. This makes it more important to understand and make explicit how the role is learnt from role models so that time in clinical practice can be used to good effect.

There is an expectation that the midwife will be an autonomous practitioner (United Kingdom Central Council (UKCC) 1986, Department of Health (DOH) 1993). In response to the report called *Changing Childbirth* (DOH 1993) revolutionary changes have taken place in the way the maternity services are organised. The report advocates woman-centred care in which women have choice of the care they receive, continuity of carer and control of their own birth experience. This has provided the impetus for autonomy to be achieved but raises the issue of whether midwives in the clinical setting can act as role models for an approach to care which meets the needs of women and is based on available evidence. Concern has been expressed that newly qualified midwives who have undertaken a three-year programme lack some practice skills at the point of professional registration (Fraser et al 1997). Learning from role models is therefore as important following professional registration as it is during students' pre-registration educational programme. I promote the autonomous role when teaching in the classroom, but my own observations and feedback from students during this study suggested that while some midwives do practise

autonomously, many more continue to practise as handmaidens to the doctor or, in other words, fulfil the role of obstetric nurses. How the role of the midwife is interpreted therefore differs. This raises the issue of how students can learn to be autonomous practitioners in the presence of midwives who lack this attribute and also suggests a gap between what is taught in the classroom and what is taught in the clinical setting. Students then work in an environment where interpretations of the role and expectations of students may differ, a situation, which has the potential to cause conflict.

It is possible that the approach to learning and teaching adopted by midwives also differs. Traditional midwifery courses were associated with a pedagogical approach to learning and teaching (Turnball 1986). Knowles (1996:82) defines this as 'the art and science of teaching children'. Such an approach does not encourage individuals to become independent but moulds them to fit in and perpetuate the current system. Emphasis is now placed on an andragogical approach defined as 'the art and science of helping adults to learn' (Knowles 1996:83). This approach acknowledges the autonomy of individuals and the value of their prior learning experiences. Learning is a two way process with student and teacher working in partnership. Chamberlain (1993) found that midwives tend to teach the way they were once taught. Midwives who do not have their own experience of an adult approach to midwifery education may therefore still expect students to conform to their own expectations as I once had to. If this is so, the approach to learning and teaching adopted in the classroom will not be reinforced in the clinical setting. The approach to learning and teaching which midwives adopt is an issue for exploration in this study.

Students' perceptions of the role of the midwife, how they learn the role and ultimately the professional identity they acquire is likely to be influenced by their role models. What students become at the end of their educational programme has implications for the care women receive and the image of the profession they present to other health practitioners and the lay public. My study contributes to knowledge by revealing how the role of the midwife is interpreted and enacted, the effect this has on what and how students learn in the clinical setting and thus how the role is

transmitted from one generation of midwives to the next. The provision of this knowledge base will, it is hoped, stimulate midwives to reflect on their practice and the influence they might have on students. It may also enable a programme of preparation for clinical teaching to be developed and included within the students' curriculum. By making the process by which individuals learn from their role models explicit, students will have the opportunity of clarifying the professional role. This, it is hoped, will have a positive effect on the role model they themselves will become.

The 'emic' perspective adopted in this study will facilitate the emergence of both students' and midwives' perspectives on how students learn the role of the midwife from their role models. Previous experience and learning outcomes which students need to achieve will influence perceptions of their role models (Howie 1988). An increasing number of three and four year midwifery programmes have been initiated for students with no prior nursing experience. My study includes participants undertaking these programmes and qualified nurses participating in the eighteen-month midwifery programme. Any differences between the experiences of these students are therefore likely to emerge.

Jung (1986) suggests that role modelling raises more questions than answers. In the absence of any literature to illuminate understanding of this process in midwifery practice, numerous questions arise. This chapter will begin to explore the concept of learning a role from role models and raises some questions and issues which the research study will seek to answer. The context in which the study takes place will also be considered as this is likely to influence participants' perceptions of their role models and how they help them to learn the role of midwife.

Role Modelling

When midwives are allocated to work alongside students, acting as a role model is a requirement of their role. Role modelling relates to modelling behaviour specific to a role (Jung 1986) and is an approach to learning, based on the belief that individuals learn by observation and imitation (Miller & Dollard 1962, Bandura & Walters 1963, Bandura 1969, Bandura 1977, Bandura 1986). Alternatively it can be viewed as teaching

by example (Ficklin et al 1988). The role model demonstrates a skill and the learner emulates what has been witnessed. Kemper (1968:33), a sociologist, defines a role model as an individual who 'possesses skills and displays techniques that the individual lacks and from whom, by observation and comparison with their own performance, the individual can learn'. Bandura's perspective of social learning theory emphasises the importance of role models in helping individuals to learn new behaviours (Bandura & Walters 1963, Bandura 1969, Bandura 1977, Bandura 1986). His experiments, however, took place in the late 1960's and did not occur in natural settings. They also focused on the influence of adults on children rather than on the influence of one adult on another. Nevertheless his ideas are pertinent to the concept of role modelling in midwifery and are applied where relevant throughout my study.

A number of studies have specifically explored the issue of role models in medicine and nursing (Steihl 1977, Gerber 1979, Shuval & Adler 1980, Gerber 1982, Bellinger et al 1985, Dotan et al 1986, Lublin & Driver 1986, Siegler et al 1987, Green 1988, Lublin 1992, Kelly 1992, Wiseman 1994). These studies were undertaken in America, Australia and Israel where culture and practices may differ from those in England. Some adopt a quantitative approach and therefore do not provide the 'insider's perspective. When a qualitative approach has been adopted there is a lack of depth and detail in these studies to provide an understanding of the process by which practitioners learn a role from their role models. Little attention has been paid to the poor role model.

Infante et al (1989) believe that role modelling facilitates an understanding of a role and the expectations associated with it. More specifically learning includes attitudes (Irby 1986, Seigler et al 1987, Lublin 1992, Emmons 1993, Davies 1993, Campbell et al 1994), values and beliefs (Emmons 1993, Davies 1993), knowledge (Irby 1986, Lublin 1992, Campbell et al 1994), skills or behaviour (Irby 1986, Lublin 1992), good practice (Lublin 1992), interpersonal skills (Lopez 1983) and how to enhance the quality of care by using knowledge, experience and intuition to perceive the patient's situation as a whole (Pyles & Stern 1983). In the early stages of development role models assist students to develop their

own professional identity. As students become more experienced these role models help students to increase their level of competence (Dotan et al 1986). This is achieved through the process of socialisation.

Setting an example

Students need good role models to ensure they develop the knowledge, skills and attitudes necessary to become competent to practise, to provide a high standard of midwifery care and ensure a positive birth experience for women. An assumption implicit within the definition of a role model is that a good example will be demonstrated for students. What constitutes a good example may not be an issue on which all midwives would agree. Each midwife will have developed her own attitudes, values and beliefs, which influence her style of practice. Individual skills may be performed in slightly different ways and differing interpretations of knowledge will influence whether that knowledge is applied in practice. Each midwife is therefore unique and her practice derives from what Stolurow (1972) refers to as an abstract rather than a concrete model. How the role is defined, and the example which is set for students, is an area for exploration in my study.

In the context of this study the term 'model' is also used to refer to an approach to care. The expectation that midwives will be autonomous and provide a woman-centred model of care (DOH 1993) implies that midwives who adopt this approach set a good example for others to follow. This model of care is based on a philosophy that childbirth is a normal physiological process. Women are therefore the focus of the midwifery care they receive. Flint (1986) offers a description of what she calls a 'sensitive midwife' whose practice is based on this belief. This description offers a very good insight into the woman-centred model of care as well as the example set by the midwife. Flint was arguably ahead of her time and a pioneer of this model of care. The sensitive midwife values and respects the women she cares for and is able to make them feel 'special'. She can recognise and respond to women's needs and create the confidence for women to believe in their own ability to give birth. The midwife listens to what women have to say, shares her knowledge with each couple so that they know what options are available, and encourages

them to consider the type of care they would like to receive. Sharing information with women provides choice and empowers them to make their own decisions. In this way a mutually participative relationship like that described by Szasz & Hollender (1956) is achieved and the autonomy of the client is acknowledged (Siddique 1999). Continuity of carer facilitates the establishment of this relationship. Personal growth of the woman is therefore an integral part of this model.

During labour the 'sensitive' midwife provides a safe and private environment enabling women's dignity to be preserved. The relationship established during pregnancy is based on confidence and trust, and it is this that helps women to concentrate on their labour and listen and respond to their own bodies. In this way women are in control of their own birth experience. According to Flint (1986) flexibility of care enables the midwife to create a role in which she can intuitively anticipate and respond to needs. She is able to use her interpersonal skills to communicate care and encouragement in a relationship, which is mutually rewarding and provides emotional support and comfort at times when it is most needed. When these skills are combined with a sound knowledge base the midwife practises both the art and science of midwifery (Magill-Cuerden 1993). In addition Page (1995) highlights the importance of decision making based on knowledge and experience and the influence of the midwife in providing a positive or negative experience of childbirth. This woman-centred approach to midwifery care is more commonly found in the community setting (Kirkham 1987, Benoit 1989, Griffith 1996). Few doctors are available, and it is in this setting that midwives can practise autonomously.

Flint's (1986) description is just one midwife's personal view of what might be perceived to be the ideal midwife and is based on her own beliefs and not on those of research findings. It does, however, correspond to what many women want (House of Commons Health Committee 1992, DOH 1993) and an approach to care that many midwives want to give.

A very different example is set when midwives base their practice on the medical model of care. This model is associated with a philosophy that

'childbirth is only normal in retrospect', a view which many midwives have accepted (Comaroff 1977, Schwarz 1990). Childbirth is perceived to be a physical illness which necessitates frequent monitoring and interventions based on an assumption that they avoid complications and ensure health and wellbeing of mother and baby. Many of these interventions were never evaluated prior to their implementation (World Health Organisation (WHO) 1985, Chalmer et al 1989). Medical interventions associated with this model of care are usually recorded in written policies, which have mainly been influenced by obstetricians and anaesthetists (Garcia & Garforth 1989a, Garcia & Garforth 1991). They determine the care women will receive. The way in which such care is prescribed implies that health professionals know what care is best for women. The relationship between doctors and women is therefore paternalistic and can be likened to what Szasz & Hollender (1956) call the activity/passivity relationship. This relationship is associated with doctors actively making decisions about what care women will receive while women are passive recipients of that care. The medical model of care is designed for sick people. Its application to pregnant women was originally for those classified as 'high risk' but has been applied to all women (Oakley 1993, Tew 1995). As Oakley (1993) argues, illness is associated with dependency, and its application promotes the adoption of the sick role, in other words the pregnant woman becomes a patient. According to Walker (1976), physical safety was perceived by obstetricians to take precedence over emotional wellbeing. Oakley (1993) agrees with this view and argues that social needs are also ignored. It is the outcome of childbirth, which is perceived to be important, and not the process. The hospital setting is particularly associated with the medical model of care (Kirkham 1987, Benoit 1989, Griffith 1996), and it is this model which students commonly witness in clinical practice. Walker (1976) argues that midwives who initially trained as nurses are more likely to accept this model of care. The attributes and the example, which midwives set for students, will be investigated in this study.

What model of care and hence the role students learn may depend on whether a student regularly works with the same midwife. Lack of continuity may mean that students work with a different midwife on each work shift. While this is sometimes to students' advantage because of the

variations in practice they may witness, it can also create confusion. Students may emulate the practice of one role model only to discover that this is unacceptable when working with another midwife (Emmons 1993, Chamberlain 1993). How students cope in an environment where interpretation of the roles differs will be considered. The potential for conflict between midwives and midwives and students will also be addressed by my study.

It is important to acknowledge that acceptance of the medical model of care for all women had already begun to be reversed at the time this research study began. Local initiatives by midwives, such as the 'Know Your Midwife Scheme' (Flint & Poulengeris1987) had resulted in some changes in the way midwifery care was organised. An inquiry into the maternity services had expressed concern that the medical model should no longer be the predominant model of care provided for women (House of Commons Health Committee 1992). This was supported by the report called *Changing Childbirth* (DOH 1993). What women want is flexible care that focuses on meeting their needs.

Implicit within the definition of a role model (Kemper 1968) is an assumption that the skills the role model possesses are desirable and appropriate, but this may not be so. Skills may be performed correctly or incorrectly or the skill correctly demonstrated but the communication between client and midwife may be inappropriate. In this way the midwife may set a poor example for students. The skills which students learn and their appropriateness for practice are considered in this study.

The efficacy of role models

If a good example is set this might suggest the midwife is an effective role model. Student midwives in a study by Currie (1999) suggest midwives are good role models when they are competent and confident. Characteristics that have a positive effect on student learning include good communication skills, the ability to empathise with women and remain calm. According to Rauen (1974), a good role model is a practitioner who can meet objectives as well as the expectations of a role. It is not clear whose objectives or expectations these are the practitioners', the clients' or

those of the organisation for which the midwife works. It would, however, be inappropriate to say that a midwife providing woman-centred care sets a good example and is therefore an effective role model. It would equally be inappropriate to state that a midwife providing the medical model of care sets a poor example and is therefore an ineffective role model. Raphael-Leff (1991) has described two types of women whom she places at either end of a continuum. 'Facilitators' are perceived to be women for whom the experience of birth is as important as the outcome (the baby). These women want to be in control of their own birth experience. 'Regulators' are described as women who consider the outcome of birth to be important while the process of childbirth is something which has to be endured. These women want health professionals to be in charge of their birth experience. Midwives who practise the medical model of care may be good role models for students when caring for women who are 'regulators'. The application of policies which determine the care these women will receive, means the midwife will control the 'women's experience of birth. Midwives who practise the woman-centred model of care may be good role models for students when caring for women who are 'facilitators'. The partnership in care which facilitates womens' autonomy will enable women to be in control. If, however, women's needs are not met midwives are unlikely to be effective role models regardless of the model of care adopted. When women are classified as 'high risk' intervention may be essential to ensure the wellbeing of mother and/or baby. Nevertheless I would argue it is still possible for midwives to facilitate a fulfilling experience for women within the bounds of such practice.

It is important at this stage of the study to state my preferences for the type of care women receive, as this has the potential to influence collection, analysis and interpretation of data. As a student midwife thirty years ago I was taught only the medical model of care. I was unaware of any other way of practising. I still consider this approach to care to be necessary for those women classified as 'high risk'. There is, however, a danger that models of care become prescriptions or policies for practice to which practitioners rigidly adhere. In this way pregnant women may receive care dictated by the model rather, than as Nicoll (1997) recommends, applying the model to

the situation that the practitioner encounters. Contrary to the belief that models are dynamic (Nicoll 1997), the medical model of care has remained relatively unchanged. This may be because the model is not combined with the midwifery process (Whitfield 1983) and care implemented without reference to women's needs, planning or evaluating care. I now know there are alternative ways of practising and am open to change. I also realise that not all women wish to have the same type of care. I want women to have safe care that meets their needs and provides them with a positive experience of childbirth. Most of all I want women to have a choice in their care and the opportunity to make their own decisions.

The influence of role models

The literature shows that role models in nursing and medical practice have an influence on the students in their care (Steihl 1977, Gerber 1979, Gerber 1982, Shuval & Adler 1980, Pembury 1980, Marson 1982, Pyles & Stern 1983, Lopez 1983, Bellinger et al 1983, Lublin & Driver 1986, Dotan et al 1986, Green 1988, Lublin 1992, Kelly 1992, Davies 1993, Nelms et al 1993, Parathian & Taylor 1993, Wiseman 1994). Role models during teacher training for general education schools are also influential (Steihl 1977). This influence may be demonstrated by following practice which has been observed, or by displaying some of the characteristics of the role model (Dotan et al 1986). The decision about what to emulate lacks clarity. Studies which focus on the role model identify which characteristics or practice students would like to emulate, but whether they do so upon qualification is not stated (Steihl 1977, Gerber 1979, Shuval & Adler 1980, Gerber 1982, Bellinger et al 1985, Dotan et al 1986, Lublin & Driver 1986, Siegler 1987, Green 1988, Lublin 1992, Kelly 1992, Wiseman 1994). Only Steihl (1977) considers the length of contact required for role models to be influential. For this a minimum of six weeks contact is necessary. How frequently within this time span the student must work alongside the role model is not identified.

Midwives have an influence on student midwives, but there is little evidence to support what that influence might be. It is known that student midwives follow the practice of their role models. Kirkham (1987) observed students who very quickly learnt to emulate the 'verbal asepsis'

or blocks to communication, which their role models adopted when they interacted with women in labour. Likewise, in an unpublished thesis which analysed two cultures in midwifery education and practice, Emmons (1993) observed students communicating with labouring women using the same words as their role models, although it could be argued that they used the language associated with midwifery in the absence of any other.

Some midwives are known to have a negative influence on students. According to Barclay (1984), Begley (1997) and Montgomery (1998) a bad day for students is not about workload but the midwife, and the negative attributes that some midwives demonstrate are known to contribute to the rate of attrition from the profession (Mander 1983, Mackeith 1994, Montgomery 1998). In the clinical setting students are allocated to work alongside a mentor or named midwife. The English National Board (ENB) has regularly revised the way in which it defines a mentor but the aim is to guide, and support students in their learning (ENB 1989, 1995, 1997). Some midwives are unsuitable to be mentors (Bewley 1995), but I have found students reluctant to request a change of mentor unless serious problems in their relationship are encountered. That difficulties arise is perhaps not surprising when students have little influence on the choice of their mentor, and there is a philosophy in some instances that 'any mentor is better than no mentor' (Bewley 1995:132). This may be because difficulties are encountered in ensuring an adequate number of suitable midwives are available to be mentors for student midwives (Kent et al 1994). This suggests no criteria are used when identifying role models with whom students can work, or when there is a choice of role model the criteria used are not made explicit.

Of importance to me was whether students were aware of the effect their role models had on them and equally whether midwives were conscious of the effect they had on students. It is possible that role models may not be aware of the effect they have on others. This may be because they do not consciously think of themselves as role models. Alternatively, as Jung (1986) suggests, the influence of role models may only be revealed much later. The long-term effect of the role model on an individual may therefore be more important than their intentions (Jung 1986). Jung (1986)

suggests that accepting similar values is also part of the influence of role models. This implies that values are internalised and corresponds to the belief of Bandura & Walters (1963) that role modelling is a broader process than just imitating. This classic text suggests it is also the process by which an individual identifies with or tries to become like another person. However, other factors may influence behaviour and emulation of practice does not necessarily indicate internalisation of values and beliefs. If students practise alongside role models that implement different models of care the values and beliefs of two opposing models of care cannot be internalised. Davies (1988), Chamberlain (1993) and Yearley (1999) did not identify which version of midwifery students practised upon qualification, but my own experience suggests that they can be pressurised to conform to the medical model. Confidence is required to establish a different pattern of care, and this is not encouraged when the system of active management of childbirth predominates. Kramer (1968) and Green (1988) have identified that the bureaucratic role which emphasises adherence to rules and regulations predominates in the clinical setting. Within three months it is this role that nurses are more likely to have adopted than the professional role which focuses on standards of care. The midwifery culture is changing, and the role which is internalised needs to be challenged. This raises the question of whether there are a sufficient number of midwives with the vision and qualities necessary to implement a new philosophy of care and act as effective role models. Individuals now entering the profession may already have the appropriate values and beliefs associated with a woman-centred model of care, others may not. The influence this might have on which role models students choose to work with, if they have a choice and if so the criteria for making that choice are all issues for consideration.

If students are to emulate the practice of their role models they must first learn the necessary skills. It is implied within Kemper's (1986) definition that a conscious decision is made by the individual to observe and learn from the role model. Social learning theory emphasises that if learning is to take place attention must be given to the role model's performance and the learner must be motivated to learn (Miller & Dollard 1962, Bandura 1969, Bandura 1977, Bandura 1986). Observation alone may result in learning but learners will need to have the ability to retain components of

the skill in their long-term memory (Bandura 1969, Bandura 1977, Bandura 1986). This may be dependent on the amount of contact and the length of contact with their role model (Miller & Dollard 1962). How information is coded, stored and retrieved is also likely to be influential (Bandura 1969, Bandura 1977, Bandura 1986). Bandura (1986) renamed social learning theory, social cognitive theory in acknowledgement of the cognitive processes involved. The inclusion of cognitive abilities as an important part of the learning process suggests that meaning has to be attached to the observed behaviour and consequences perceived before actions are imitated. Vicarious learning takes place when the consequences of others actions are observed (Bandura 1969, Bandura & Walters 1963, Bandura 1977, Bandura 1986). The ability to perform the skill and motivation to do so will also determine whether imitation takes place. Intrinsic and extrinsic factors are all influential motivators (Bandura 1977). The accuracy with which the skill is emulated will be dependent on the opportunity to practise it (Bandura 1977) and the proximity of the role model will influence whether reinforcement is part of the learning process. Reinforcement is not necessary for learning to take place but emulation of practice is dependent on the outcome or consequences of the action (Bandura 1969, Bandura & Walters 1963, Bandura 1977, Bandura 1986). The desire of the learner to be liked by the role model and the prestige of the role model are also important (Miller & Dollard 1962, Bandura 1977). Behaviour is likely to be followed if the outcome of it is valued (Bandura 1977, Bandura 1986). Students need sufficient self-awareness to recognise their lack of certain skills and the commitment and motivation to compare their own performance with that of their role models. Students entering a midwifery educational programme come with varied life experience and are at differing stages of personal growth. The degree of self-awareness and thus the ability to recognise a lack of certain skills may therefore be more developed in some students than others. Self-efficacy or the individual's belief that they can perform the skill is also influential (Bandura 1977, Bandura 1986, Bandura 1997).

What motivates students to emulate practice is an issue for exploration in my study. So too is the process by which students decide what they will or

will not incorporate into their own practice as they develop their knowledge and skills.

Learning and teaching: a passive or active approach

What students learn is likely to be influenced by the model of care adopted by their role models. It is possible that perceptions of role models may also be influenced by their approach to teaching and learning and whether students feel comfortable in their presence. The definition of a role model provided by Kemper (1968) implies that learning is a passive process. No mention is made of interaction between role model and learner. Student midwives do learn by observation and imitation (Davies 1988, Chamberlain 1993, McCrea et al 1994). This is also an important feature of student nurse learning (Coles et al 1981, Burnard 1992, Baillie 1993, Davies 1993, White et al 1993) although senior students perceive it to be less helpful (White et al 1993). When learning is a passive process this implies that learning occurs spontaneously. The clinical teacher does not have to intentionally teach nor the student to consciously learn. Observation does not, however, provide a guarantee that learning will take place although some midwives believe that this is all that is necessary for students to learn (Chamberlain 1993). What is observed may not be understood. With no interaction the student may learn how to perform a skill but might not be able to justify its use. This corresponds to how students will learn if observing the role model from a distance. When an individual responds only to the stimulus of the role model matched dependent behaviour occurs (Miller & Dollard 1962).

Mentorship can be perceived to facilitate learning through a relationship between teacher and learner. Learning from a role model can therefore be viewed as an active process (Bandura 1969, Bandura 1977, Puertz 1985, Bandura 1986, Rogers 1986). Students interact with their teachers and are thus able to question the care that is given and receive answers. In this way the learner can clarify issues of uncertainty and understand the rationale for their own and their role models' actions. Mentors therefore actively help students to learn. Learning becomes a two way process, and how the clinical teacher acts may be influenced by the observer. Copying rather than matched dependent behaviour takes place when the imitators respond to

their own and their role model's stimulus (Miller & Dollard 1962). This active participation in the learning process is clearly outlined by Lopez (1983). She describes how she acts as a role model demonstrating interpersonal skills to nursing students. Interaction takes place between role model and patient. Students then have the opportunity to discuss with the teacher what they have observed. Critical analysis of the scenario enables learning to be identified and feedback given. Erickson et al (1983) suggests that to be an effective role model the person acting as a role model must first empathise with the client so that the client's view of the world can be perceived from the role model's perspective. The planning and implementation of care, which promotes well being of individual clients, combined with knowledge, forms the art and science of role modelling. This unique understanding of an individual's perspective enables the teacher to identify and sensitively demonstrate new skills or present ideas for alternative approaches to action without threatening the position of the learner. To achieve this, individuals must be unconditionally accepted and nurtured to allow personal growth and development. Implicit within this perception of role modelling is a relationship between teacher and learner, which facilitates this growth and the skills of communication as a means of achieving this. It is the interaction and the relationship between role model and learner which facilitates meaningful learning (Rogers & Freiberg 1994). This humanistic approach values individuals for what they are and what they bring to the learning experience. Also crucial to the relationship is genuineness and trust (Rogers & Freiberg 1994). When learning is a two way process there is the potential for midwives to learn from their students which may become apparent in my study.

The preferred mentor is someone who has a personal interest in the student and a commitment to promoting the student's personal and professional growth as well as her own. Some midwives may not have this commitment or might be committed to one student but not to another. A lack of commitment to students might result in less interaction and therefore passive rather than active learning. If an aspect of role modelling is nurturing the individual (Erickson et al 1983) a lack of commitment might mean a midwife is a poor role model because there is little interaction with the student. It is, however, feasible for the same midwife

to be a good role model when practice is viewed from a distance. Emphasis will therefore be on observation of the person's skills rather than interaction with the role model. This suggests that both active and passive approaches to learning and teaching are beneficial. Which of these approaches midwives adopt will be explored in this study.

A few studies have focused on role modelling as a method for demonstrating and teaching how to give nursing care to patients (Davies 1993), aspects of nursing such as 'caring' (Hughs 1992, Nelms 1993), how to give bad news to patients (Parathian & Taylor 1993) and developing skills in critical care nursing (Pyles & Stern 1983). Parathian & Taylor (1993) and Nelms et al (1993) achieve this indirectly through the use of video scenarios. Discussion of what has been observed enables identification of appropriate and inappropriate role model behaviour. Deliberate action can then be taken to avoid emulating negative characteristics (Parathian & Taylor 1993). Additional outcomes that may be unexpected may also be learned (Nelms et al 1993). A potentially passive approach to learning then becomes active.

Transmission of a role

A role can be consciously or unconsciously transmitted to others (Odling et al 1990). An active approach to learning and teaching suggests that the midwife is aware of being a role model although this may not be consciously considered when fulfilling the role. Jung (1986) points out that the word role involves an interaction between two or more people and role modelling is usually a deliberate process. When student learning is formally planned and structured, this reinforces the belief that acting as a role model is a conscious act.

Midwives may be unaware that they are being observed, and anything that students learn will be unplanned. Acting as a role model will therefore be an unconscious process, although midwives might initially set out to be role models. If midwives do not consciously consider themselves as role models, it has to be questioned whether learning from a role model is a process which happens simply because midwives practise in the presence of students. Learning by observation and imitation is believed to be

enhanced when the demonstration of a skill is reinforced with verbal instruction (Miller & Dollard 1962). Lack of instruction might imply that the individual who acts as a role model is not consciously aware of the process. No clear goals may be determined, and there is no pressure on the part of those who observe to imitate and conform to specific behaviours. Although community midwives do provide students with instructions, Chamberlain (1993) claimed that their hospital counterparts rarely do so. I wanted to know if midwives working with students were conscious of being role models, the model of care they practised, the effect this had on students, and whether they were aware of this effect. When the well being of mother and baby is central to the care which is given, observation and imitation alone will not always be an appropriate way to learn. In the setting in which student midwives learn it may be difficult to imagine that as adults they will learn in this way. Passive learning is, however, acknowledged to occur in nursing practice (Marson 1982).

Influential role models

Betz (1985) believes that initially education staff are the most significant persons for nursing students. This is perhaps not unexpected as students are usually introduced to the classroom environment before entering the clinical setting. The findings of a quantitative study by Steihl (1977) support this belief. As experience is gained in the clinical setting the impact of these role models is gradually reduced and clinical practitioners become more important. Green (1988) in a quantitative study contradicted this view when she identified no classroom teachers were chosen as role models. Findings of this study do, however, need to be viewed with caution as the sample of twenty-five is too small for determining significant results. According to Rogers (1986:80) educationalists explain, guide, and 'practise under simulated and often ideal conditions, for this reason clinicians are usually chosen as role models because the abstract image is made concrete by observing the work of the practitioner'. Dotan et al (1986) and Green (1988) confirm this. Bellinger et al (1985) and Green (1988) determined student nurses' choice of ideal and actual role models. Clinical instructors were most frequently chosen by students as their ideal and also their actual role models (Bellinger et al 1985). Less frequently chosen was the staff nurse. This directly contradicts the findings of Green (1988). However,

these studies do differ. Bellinger et al (1985) undertook a large study using a sample of first and second year students. Green (1988) selected students who were coming to the end of their nursing programme. They therefore had more experience of working in the clinical setting. A more extensive questionnaire was also used to include conceptions of the role fulfilled by their role models. In midwifery practice the role of clinical teacher is incorporated within the role of the midwife and is not distinct or separate from it. My study does not consider education staff as role models for students but focuses on midwives who practise on a continuous basis in the clinical setting. Which midwives are the most significant persons for student midwives will be addressed.

The context in which learning takes place

Participants' perceptions of learning and teaching in clinical practice can only be interpreted in the context in which the study took place. The role students learn and how they learn it involves interactions with their role models and their environment, and this is likely to influence their perceptions of the midwife's role and the way in which care is given.

Quinn (1988:395) defines the clinical setting as 'any context where patient or client groups are provided with services relating to health'. In the clinical setting it is anticipated that students will frequently work with the same midwife or mentor. Assessment of students' performance has traditionally been included in this role. In 1996 the ENB introduced the concept of an assessor, an individual distinct from that of the mentor. Despite the ENB's distinction between the two roles, my own experience in clinical practice suggests these roles are not separated. Students are allocated to work alongside one midwife who is called either a mentor or assessor who continues to support learning and assess performance. For the purposes of this study the term mentor will be used to mean mentor and/or assessor because this is the terminology most frequently encountered in the literature.

The morale of students' mentors is crucial to the atmosphere of the learning environment and their attitude towards students. Expectations of midwives are determined locally and nationally. How these are interpreted

can have a positive or negative influence on how midwives view their role and the atmosphere, which is created. Unremitting change within the NHS and an acceleration of change within the midwife's role has left many midwives demoralised, unsupported and devalued (Henderson 1995). In addition women's expectations have increased as have those of the UKCC (1994) Evidence based practice is now expected and there is a legal requirement for all midwives to maintain a professional portfolio to demonstrate how they maintain and update their knowledge and skills and their relevance to practice. The effects of a clinical regrading exercise in 1988 were of continuing concern to midwives. With students participating in midwifery diploma, advanced diploma and degree programmes, it has been suggested that there is now pressure for qualified midwives to achieve the same academic level (Sidebotham 1993). All of these factors have increased demands made on midwives.

All students participating in this study gained clinical experience working in the hospital environment. Some students acknowledge there are not enough mentors in the hospital (Pulzer 1996), and it is in this setting that students often feel unsupported (Kent et al 1994). When *Changing Childbirth* was published, the Department of Health (DOH 1993) acknowledged that 99% of births took place in hospital. The type of maternity unit in which students worked varied according to the particular midwifery programme they were undertaking (see page 54). All maternity units provided students with experience of caring for women and babies during pregnancy, labour and the postnatal period. Each site was, however, unique because of its geographical position and the population it catered for. The extent to which students were exposed to the medical model of care differed. This model was most notable in the Teaching Hospital and maternity units attached to the District General hospitals. These hospitals cater for women classified as 'high' and 'low' risk. The Teaching Hospital serves not only the local population but is also designated a Regional referral unit for women in other catchment areas with complications requiring specialised treatment. It is also a regional centre for special and intensive neonatal care and the general hospital sited near by is a centre for paediatric cardio-thoracic surgery. An extensive range of complications is encountered, more than would otherwise be expected.

Anforth (1992) suggests a mentor should provide continuity over a period of time. The more traditional approach of allocating students to different clinical areas every six weeks meant that students who were based in a Teaching Hospital were given a new mentor with each move. During the time span of this study maternity care was fragmented in all units with the exception of the Midwifery Led Unit. This means women move between the antenatal ward, labour ward and postnatal ward to receive the relevant care (Robinson et al 1983) and midwives work in a ward providing only one aspect of midwifery care (DHSS 1970, Robinson et al 1983, Robinson 1989, WHO 1985, Robinson 1990). Even when wards were combined antenatal and postnatal, staff still tended to be allocated to provide one aspect of care according to students. Some midwives, particularly those with junior status, rotated between departments to consolidate their midwifery training. Students were therefore allocated to work in hospital ward areas catering for a specific aspect of care or the community setting for a number of weeks. Many of these allocations were for no more than six weeks. Like student nurses in occupational socialisation studies by Mackay (1989) and Melia (1987) student midwives participating in my study were just 'passing through' the clinical setting.

The Midwifery Led Unit which, as its name implies, was led by midwives who catered only for women, classified as 'low' risk. The philosophy of this unit was based on childbirth as a normal physiological process. Students witnessed midwives using all their skills, with doctors only participating in care if invited to do so. There were no paediatricians on site and so an essential requisite for midwives working in this unit was regular updating in the skill of resuscitating the newborn infant. The organisation of the maternity services can influence the length of the relationship and the number of mentors any one student has. Students participating in this study who worked in the innovative midwifery led unit had the continuing support from one mentor throughout their course, but worked alongside other midwives when gaining experience elsewhere.

Despite the recommendations of *Changing Childbirth* (DOH 1993) minimal changes had occurred within the organisation of the maternity

services in the geographical sites in which this study took place. Throughout the data collection period, changes did take place in all units but according to students appeared to be minimal. Nevertheless there was considerable pressure to identify and explore new ways of organising care. The Midwifery Led Unit was innovative and a leader of its kind. A gradual change in philosophy means that women are encouraged to be ambulant if they wish and intervention kept to a minimum for women classified as 'low risk', but this is dependent on the midwife giving care.

At the start of this study one maternity unit had established teams of carers comprising different grades of staff including midwives and an obstetrician. Each team operated from a ward providing antenatal and postnatal care. Midwives in the team attended the obstetrician's antenatal clinics and, where possible, provided care in labour to women booked for care under the same obstetrician. On evaluation it became apparent that the aim of providing continuity of carer for women, if it occurred, was due more to chance than planned organisation. The large size of the teams was thought to be responsible for this and the strategy was discontinued. The Teaching Hospital had also established four teams of midwives who practised in the community but delivered women in hospital. Towards the end of data collection further reorganisation took place with the establishment of two teams of midwives linked to a hospital ward but working in the community setting. Those midwives practising within the hospital sought to provide women with continuity of carer by organising themselves each day to work in an area of care where women they had previously cared for were sited.

All students gained experience in the community setting. In this setting midwives provide care, supervision and advice to women in all socioeconomic groups. A limited amount of experience is available in providing care to a variety of ethnic minority groups. Students have the opportunity to participate in the full scope of the midwife's role providing care for mothers and babies within their own environment. Students may gain experience in assisting women to give birth at home. The small percentage of home births does, however, mean that this experience is minimal and some students did not have this opportunity. In this setting

students perceive that they 'learn' normal midwifery (Pulzer 1996). When working in the community, students lacking in knowledge and skills cannot be left on their own and therefore work alongside a midwife often achieving continuity.

Students who were based in the Teaching Hospital had the opportunity of working in one of a number of General Practitioner Units. These units are a community resource and therefore also associated with a woman-centred model of care. In this setting students participated in the full scope of the midwife's role sometimes alternating between giving care in the unit and in the women's home. The units are small with four to eight beds. At the time of my data collection they were organised by midwives who provided most of the care in conjunction with the woman's General Practitioner. If mother or baby experience complications referrals are made to an obstetric unit.

The reality for students appeared to be work carried out mainly by midwives who practise a medical model of care. Whether this reality has changed is one of the questions of my study. From my own observations and from listening to students, the woman-centred version of midwifery continues to be found more often within the community environment where the restrictions of hospital practice are not imposed upon community midwives. Not all community midwives will, however, practise in this way. Likewise in the hospital environment students may encounter the woman-centred version of midwifery, but despite some changes in organisation of the midwifery services a woman-centred approach to care may still be difficult to achieve, despite the desire to do so.

Summary

The aim of this research is to focus on how students learn the role of the midwife from their role models. In the ensuing chapters the way in which the role of midwife is interpreted and enacted is examined. The approach to learning and teaching which midwives adopt, the influence this has on what and how students learn and the professional identity they acquire are also explored. The midwifery culture until recently supported a medical model of care. Emphasis is now placed on ensuring midwives provide a

woman-centred approach which meets the needs of all women. Knowledge generated from this study will provide an increased understanding of how the culture is transmitted from one generation of midwives to the next and how over a period of time that culture can change.

Footnote 1

This research study is written in the first person. I concur with Webb's (1992) view that in qualitative research the researcher interacts with participants and becomes part of the research study, thus enhancing the trustworthiness of the data. For this reason, and because the researcher is the main research tool in qualitative research, I have adopted the use of the first person when directly referring to my own actions.

Footnote 2

Midwives and students who participated in this study were all female. For this reason and, because midwifery is a predominantly female profession, the term 'she' is used throughout the text. It is acknowledged however, that there is a small minority of men practising within the profession.

Chapter Two

The Initial Literature Review

Introduction

Glaser & Strauss (1967) and Strauss & Corbin (1998) advise that a review of the literature, prior to commencement of a grounded theory study should not be a detailed one. Development of theory may be hindered if the researcher has preconceived ideas about the phenomenon studied. I undertook an exploration of the main literature to gain an overview of issues relevant to my study. In doing so, gaps in knowledge were ascertained. The literature review was also used to justify the research approach and attempted to show how the study contributes to existing knowledge.

Role models in midwifery practice help students to learn the role of the midwife. For the purpose of this study it was considered appropriate to briefly explore the scope of the midwife's practice and the factors which inhibit full achievement of the role. The way in which the role has evolved over a period of time and how students come to learn it was also considered to be relevant. Attention has also been given to the role of the midwife as a clinical teacher. In doing so I have 'set the scene' and broadened the context in which the study took place. Ultimately an extensive literature review has been undertaken. This helped me to relate the literature to the emerging themes and the findings of other studies to confirm or refute those of my own.

The role of the midwife

The formal definition of the term midwife adopted by the profession's statutory body and quoted in the Midwives code of practice (UKCC 1998) can be found in Appendix 1. The activities required to enable the midwife to fulfil this role are also clearly stated (UKCC 1998, Appendix 2). Some midwives will not, however, participate in the full list of activities. Midwifery practice is governed by legislation and all midwives should be familiar with the Midwives rules (UKCC 1998) which determine their role and responsibilities. Within these rules the midwife's level of

responsibility is clearly stated. Complementary to these rules is the Midwife's code of practice (UKCC 1998) which outlines a standard of practice and offers further guidance and more detail on some of the issues included within the rules. An acceptable standard of practice is that which is achieved in the light of current knowledge and clinical developments (UKCC 1998). In addition the Code of Professional Conduct (UKCC 1992) outlines a national standard of behaviour expected of midwives. The accountability practitioners have for their own practice is also highlighted by the UKCC (UKCC 1992, 1996, 1998). Supplementary guidance is given by the UKCC on such aspects as the administration of medicines (UKCC 2000), professional practice (UKCC 1996) and records and record keeping (UKCC 1998a). When fulfilling the role of the midwife the expectations of the UKCC (UKCC 1998) must be met because it is a legal requirement to do so. Infringement of these rules can result in allegations of misconduct or negligence (UKCC 1998) even if mother and baby come to no harm. Local Hospital and Community Trusts also determine policies which influence the way in which midwives fulfil their role. These rules or policies should be followed although it is not a legal requirement to do so.

The scope of the midwife's practice

According to Pope et al (1996) the definition of the term midwife fails to determine the boundaries of the midwife's responsibilities. This suggests that the role has no beginning or end and is therefore open to interpretation. What role students learn will therefore depend on the midwives with whom they work. The midwife can provide supervision, care and advice to women during pregnancy, labour and the postnatal period (UKCC 1998). In the event of deviations from the normal, midwives must legally notify a doctor or other qualified health professional that has the experience and skills to help them (UKCC 1998). In these situations the midwife continues to provide care and support for women in conjunction with other health professionals. The House of Commons Health Committee (1992) and the report called *Changing Childbirth* (DOH 1993) acknowledged childbirth as a normal physiological process and the midwife as the most suitable person to provide maternity care for women classified as 'low risk' or experiencing normal childbirth. The concept of normality is, however, not easy to define. It raises not only the issue of what it is, but also who defines

it. Normality can be viewed from different perspectives (Kitzinger et al 1990, Robinson 1990, Hartley 1997), and Downe (1996) acknowledges that perceptions of normality are not static but evolve over time. The role of the midwife is therefore not easy to determine, and what is perceived to be normal will influence the way in which midwives practise. The inability to define normality inevitably poses dilemmas for midwives. Hartley (1997), in exploring this concept suggests that many midwives are practising outside the bounds of normality. Without a clear definition of normality there is, however, a lack of clarity about when medical assistance needs to be obtained. In learning the role of the midwife, students must therefore learn how to use professional judgement, to make decisions related to care and develop the confidence which will enable them to take the risks associated with making decisions. Currie (1999) explores some aspects of the preparation of student midwives for their autonomous role. How this is achieved in an environment associated with many constraints is not, however, clear. My study will focus on the midwife as a role model with the purpose of making explicit how students are facilitated to learn the autonomous role.

The way in which an individual behaves within the role is known as role performance or role enactment (Ruddock 1969). The DOH (1993) provided opportunities for midwives to be innovative and flexible in developing their role and in organising the maternity services to provide a woman-centred approach to care. This model of care supports the belief that roles are negotiated and developed in response to interactions between individuals (Mead 1934, Turner 1962) rather than a passive response to a stimulus. A variety of patterns of care have been developed within the woman-centred model of care including team midwifery, midwifery managed delivery units and caseload management (Wraight et al 1993, Pope et al 1996, DOH 1998). Midwifery group practices, similar to those of general practitioners have been set up and evaluated (Allen et al, 1997, Ness 1998) and schemes such as the 'One to One Midwifery' (McCourt & Page 1996) have also been established. In this way midwives provide total care for women, which meets their needs and expectations.

These new schemes demonstrate the considerable scope for practice and the UKCC (1998) does not appear to limit the activities of a midwife. There will always be legal boundaries within which the midwife must operate and the UKCC (1998) acknowledges that new skills can become an integral part of the midwife's role. It has been suggested that when new skills are developed the role is extended (Mulholland 1997) or 'enhanced' (Pope et al 1996). Many midwives have, for example, become skilled in interpreting cardiotocographs (CTGs), topping up epidurals, supporting women requesting waterbirth, performing intravenous cannulation, episiotomies and suturing perineums (Pope et al 1996). Some skills are adopted by only a few midwives (UKCC 1998) but nevertheless become incorporated within their role. These skills, such as ventouse extraction (Mulholland 1997, Tinsley 1998) and ultrasound scanning (Proud 1992) are not determined by the UKCC, but the midwife is accountable for identifying and ensuring the training and experience she needs to perform such skills is acquired (UKCC 1998). It could be argued that in taking on technical skills previously undertaken by doctors, midwives might have less time for their caring role (Isherwood 1995). A government decision to reduce the long working hours of doctors (NHS Management Executive 1991) provides greater opportunities for midwives to acquire new skills. More recently the midwife's role has extended to include the development, maintenance and evaluation of standards, audit of practice and performance reviews, all of which are included within clinical governance (DOH 1998a). It has also been suggested that midwives should use their knowledge and skills to make a greater contribution to women's health particularly in relation to health promotion (DOH 1999). This has always been a part of the role but it could be argued that midwives have not made the most of opportunities available to achieve this. The role of the midwife is therefore dynamic, and students need role models who can show them how to be flexible and innovative in developing their own role and cope in a constantly changing environment. When students work with midwives involved in new schemes, they learn what it means to be autonomous and provide total care (Henty & Hartley 1997). The way in which role models prepare students for this role and create confidence in their ability to do so will be explored in my study.

In a Nursing Times Survey 32% of 257 midwives believed their practice reflected the full scope of the midwife (Reid 1993). Pope et al (1996) identified 14% out of a sample of 771 midwives believed this to be so but an additional 44% thought their practice generally reflected the full scope of the midwife's role. The way in which autonomy is defined can, however, differ. Some midwives perceive this to mean providing all care without involvement of a doctor while others interpret autonomy to mean the provision of all midwifery care whilst at the same time collaborating with doctors (Pope et al 1996). In exploring how role models help students to learn the role of an autonomous practitioner the concept of autonomy and how it is defined will be addressed.

The restricted role of the midwife

The law acknowledges the midwife's right to act as an independent and autonomous practitioner (House of Commons 1979, 1992, UKCC 1998). Nevertheless studies such as those by Walker (1976), Robinson et al (1983), Davies (1988), Brooks et al (1987), Emmons (1993), Chamberlain (1993), McCrea et al (1994), McCrea & Thompson (1995) Askham & Barbour (1996), have demonstrated that a large proportion of midwives in the United Kingdom do not practise in this way and the assertion that midwives are 'practitioners in their own right' is mainly rhetoric (Walker 1976, Davies 1988, Emmons 1993, Griffith 1996). Midwives have generally perceived the amount of responsibility incorporated within their role to be appropriate (Robinson et al 1983, Brooks et al 1987, Askham & Barbour 1996). It is, however interesting to note that midwives often perceive themselves to be autonomous when in reality doctors make decisions for them (Robinson et al 1983, Henderson 1984, McCrea & Thompson 1995).

The restricted role of the midwife is associated with the medical model of care. It is important, however, to acknowledge that this role can also be extended by acquiring new skills. Policies associated with this approach to care are mainly influenced by doctors (Garcia & Garforth 1989). These determine how midwives will practice and the care women will receive (Robinson et al 1983, Garforth & Garcia 1987, Garcia & Garforth 1989, Garforth & Garcia 1989, Pope et al 1996, Griffith 1996). The doctors'

position of power in the hierarchy, which Freidson (1975) recognised, enabled them to exert their authority over midwives. In doing so they defined what was normal and abnormal childbirth. In this way doctors were able to control not only the process of childbirth but also the practice of midwives. The loss of identity and status associated with this subordination means that midwives practise as obstetric nurses or handmaidens to the doctor (Robinson et al 1983, Towler & Bramall 1986, Donnison 1988, Davies 1988, Emmons 1993, Chamberlain 1993, Tew 1995, Hunt & Symonds 1995, Begley 1997).

The medical model of care and the control of midwives' practice supports a functionalist perspective of socialisation which believes that roles are clearly defined and learnt with rules to inform behaviour. Individuals therefore enact their role by following directions as though they are reading from a script (Parsons 1951). This corresponds to the views of Linton (1969) who argues that the status an individual occupies is associated with rights and duties. These determine how the individual will behave. Status and role cannot be separated and when these rights and duties are fulfilled a role is performed. Roles, which are prescribed and controlled by rules, ensure everyone behaves in a similar manner. The expectation that midwives follow a script written by doctors has meant that doctors have acted as role models for midwives imposing their values and beliefs on them. The functionalist perspective could also be seen to imply that roles are static. Acceptance of the attitudes, values and beliefs associated with the medical model of care have until recently ensured the role of an obstetric nurse is perpetuated. Viewed from this perspective role is interpreted to mean the expectations others apply to the incumbent of a particular position (Ruddock 1969). If the expectations of some midwives are that students learn the restricted role this raises a question about whether students can also be prepared for the role of an autonomous practitioner and, if so, which role students will practise when their name is entered onto the professional register.

While some midwives may be happy to fulfil the medical model of care Ruddock (1969) acknowledges that role may be interpreted to mean the way individuals actually behave within the role. This perspective might

imply that some individuals are unhappy with their role and only fulfil it in a certain way because they consider it is what they should, or have to do. The medical model of care does not meet the needs of all women (House of Commons Health Committee 1992, DOH 1993, Oakley 1993) and is in direct conflict with what was once the midwife's role in normal pregnancy, labour and the postnatal period in the early 20th century. Some midwives opted out of the National Health Service and became self employed because they perceived this to be the only way of practising an alternative model of care which met the needs of women (Hunter 1998). The role set (Conway 1978, Biddle & Thomas 1979, Handy 1993) comprising of other midwives and members of the health care team may therefore influence the way midwives perceive they should practise. Hunter (1998) points out, that new initiatives in midwifery care resulting from *Changing Childbirth* (DOH 1993) now mean the distinction between the provision of the service and the role fulfilled between NHS and the small minority of independent midwives has now become blurred. How the role is defined and enacted is likely to be influenced by the midwife's philosophy. When expectations of others differ from those of the role incumbent conflict may occur (Ruddock 1969, Biddle & Thomas 1979, Handy 1993). Currie (1999), Emmons (1993) and Griffith (1996) have, for example, revealed the conflict between midwives when those who implement the restricted role attempt to restrict the practice of midwives who want to be autonomous. Prevention of such conflict was not considered. How students and midwives cope with conflict and whether it can be prevented will be addressed in my study.

The environment in which midwives work is known to influence the way in which they practise (Benoit 1989, Kirkham 1987, Robinson et al 1983, Pope et al 1996). In the hospital setting students encounter midwives who provide routine, task orientated care and follow doctors' instructions (Davies 1988, Chamberlain 1993, Emmons 1993, Begley 1997). Midwives work in a ward providing only one aspect of midwifery care (Robinson et al 1983, Robinson 1989, Robinson 1990, DHSS 1970, WHO 1985). This fragmentation resulted in the loss of continuity of carer for women and completion of tasks by the midwife rather than the provision of total care and fulfilment of the full scope of the role (Robinson et al

1983). Numerous references have been made to the under utilisation of the midwife's skills (DHSS 1980, Maternity Services Advisory Committee 1982, 1984, & 1985, Robinson et al 1983, WHO 1985). Students do not see the decision-making process of midwives but observe their role models referring to a doctor (Chamberlain 1993). This suggests that students cannot learn to be autonomous in the presence of these midwives. A lack of autonomy means midwives act as role models for the role of an obstetric nurse. This restricted role is a reason why some students believe they will not remain in midwifery practice (McCrea et al 1994). When midwives have direct access to consultant obstetricians they exercise greater responsibility (Green et al 1994). The role which students learn will therefore be influenced by the environment in which they work. Away from the consultant unit many policies do not apply in the community setting and the midwife's role is therefore less restricted (Benoit 1989, Kirkham 1987, Robinson et al 1983). In this setting students are more likely to observe the midwife as an autonomous practitioner providing the woman-centred model of care. Most women, however, give birth in hospital (DOH 1993). Time spent learning the role from a role model in the community setting may therefore be limited.

The Role of the Clinical Teacher

The roles of health professionals including midwives are complex, and while observation and emulation might enable attitudes and skills to be learned, students need instruction and knowledge to justify their practice and help them to develop their role. Some midwives are reluctant to fulfil this aspect of their role (McCrea et al 1994, Chamberlain 1993, Barclay 1984). This may in part be due to lack of preparation for their teaching role (McCrea et al 1994). Factors such as motivation (Robinson 1991), staffing levels (McCrea et al 1994, Begley 1997), workload (Robinson 1991, Walker 1990, Bewley 1995), time (Kent et al 1994), interest in teaching (Robinson 1991, Begley 1997) and the need for mothers and babies to take precedence over students (Robinson 1991, Bewley 1995, Begley 1997) all influence whether students are taught. Some midwives have been known to expect senior students to teach junior students when these senior students feel they lack the experience to do so (Chamberlain 1993). This suggests that students are also role models at a time when they

may still lack expertise in clinical skills. They may therefore be inappropriate role models for junior students.

Clinical teaching is implicit within the role of the midwife. This may account for the dearth of literature specifically about the midwife as a clinical teacher. Many midwives complete the ENB 997 Teaching and Assessing in Clinical Practice Course, but how effective this is in preparing midwives for their teaching role is not known. Student midwives have been known to receive little clinical teaching (Chamberlain 1993, McCrea et al 1994, Barclay 1984, Walker 1990), a deficit not made up by midwifery educationalists (Bewley 1995, Chamberlain 1993, Robinson 1991). McCrea et al (1994) identified that quality of clinical teaching influenced students' self-confidence and their desire to remain in midwifery practice. A perception of quality and the amount of clinical teaching students receive may also be affected by how clinical teaching is defined. Bewley (1995) acknowledges that midwives and students perceive clinical teaching as a formal, teacher led process, which takes place away from the bedside. When client care is a priority student learning suffers when the ward is busy (Cavanagh & Snape 1997). In reality far more learning takes place when students work alongside midwives and participate in care. Teaching strategies for enhancing learning from experience are not, however, used (Bewley 1995).

Acting as a role model is an important component of the clinical teacher's role (Rauen 1974). The clinical teacher is also a practitioner and a person. Literature which explores the learning environment (Fretwell 1982, Ogier 1989, Orton 1981), attributes of the effective and ineffective teacher (Jacobson 1966, Marson 1982, Morgan & Knox 1987, Nehring 1990, Kotzabassaki 1997), mentoring (Cahill 1996, Earnshaw 1995, Gray & Smith 2000), socialisation (Campbell et al 1994, Nolan 1998), quality of nursing care (Redfern & Norman 1999) and role models (Stiehl 1977, Gerber 1979, Gerber 1982, Dotan et al 1986, Lublin & Driver 1986, Irby et al 1987, Lublin 1992, Davies 1993) provide evidence of the attributes necessary to effectively or ineffectively fulfil these roles. What emerges is a profile of competent and knowledgeable practitioners who enjoy their role and are accountable for their actions. They have the interpersonal and

teaching skills requisite for giving quality care to clients and helping students to learn. Cognitive abilities assume greater importance for senior students although affective attributes remain important throughout the learning phase (Dotan et al 1986). Also of importance are personal attributes particularly confidence and enthusiasm. Davies (1993) relates qualities of the nurse practitioner to the care clients receive, positive attributes being associated with a humanistic and client-centred approach and negative attributes to routine care with little interaction between practitioner and client. How the qualities of practitioners and their approach to care is related to the learning and teaching strategies which they adopt for students has not been explored. My study will rectify this situation. Midwives have rated flexibility as the most important attribute they should demonstrate in their practice (Pope et al 1996). The ability to work within a team, reflect, be analytical, autonomous, creative and assertive are also rated highly. Ten percent of the sample of midwives in this study believed conformity was an attribute they should possess although whether this is conformity to the rules (UKCC 1998), Trust policies or doctors' expectations is not clear. Conformity implies a lack of innovation or ability to adapt the role and the influence of this on what students learn needs to be addressed.

Students have an expectation that the clinical teacher will be a positive role model (Rauen 1974). The 'best' clinical teachers are known to be good role models. Conversely the 'worst' clinical teachers are known to be poor role models (Morgan & Knox 1987, Nehring 1990, Kotzabassaki et al 1997). These studies relate to nurses in clinical practice. Whether this applies to midwives who act as role models for students will be considered by my study.

Helping students to learn the role

When the midwife acts as role model and teacher she helps students to learn the role. The process of learning a role is known as socialisation and is defined by Merton (1949:248) as 'the process by which the appropriate values, attitudes, interests, skills and knowledge of the cultural group are learnt'. As a result of socialisation a person is able to function within the group (Elkin 1960:4). According to Cohen (1981) professional

socialisation is achieved when the professional role identity becomes integrated with an individual's self-concept.

A small number of studies have been undertaken, which explore the socialisation of student midwives in England (Davies 1988, Chamberlain 1993, Yearley 1999, Currie 1999), Australia (Barclay 1984), Ireland (McCrea et al 1994, Begley 1997), America (Reid 1986) and Newfoundland and Labrador (Benoit 1989). The depth and detail provided by these studies varies according to the research paradigm which has been adopted. It is also important to remember that midwifery programmes vary in content and length according to the country in which they take place, as do the laws that govern the midwife's practice. Findings of these studies therefore cannot be generalised to all midwives and students. Davies (1988), Chamberlain (1993), Barclay (1984), McCrea et al (1994), Begley (1997) and Currie (1999) focus on students who undertook a traditional certificated course designed for those who were first socialised into nursing. This system corresponds partially to an apprenticeship system associated with 'sitting with Nellie'. Reid (1986) and Benoit (1989) have explored this system and although no longer typical it could be argued that aspects of apprenticeship are incorporated within midwifery education in this country today. Reid (1986) believes prolonged contact with the same role model facilitates learning yet students frequently complain to me that they never work with the same midwife. Yearley (1999) focuses on one group of students undertaking a three-year pre-registration programme for students with no nursing experience. The similarities and differences between these students' experiences are outlined later in this chapter. Yearley (1999) does not clearly determine whether students learn the restricted role of the midwife or the role of an autonomous practitioner. While it appears clear that students in Ireland learn the role of the obstetric nurse (Begley 1997) time of data collection might also suggest that this is the role all students learn when undertaking the shortened programme. In Newfoundland and Labrador (Benoit 1989) this role is associated with a university programme which students in England now participate in.

The functionalist perspective of socialisation perceives the process of learning a role to be a passive one involving little cognition (Parsons

1951). This could be because socialisation is viewed at a high level of abstraction when it might better be described as an 'ideal type'. The functionalist view of society could be placed at the extreme end of a continuum where little in that society changes. Well known studies of socialisation such as Becker et al (1961), Dingwall (1977), Lacey (1977), Fretwell (1982) and Melia (1987) do not, however, support this view. Instead they recognise an interactionist approach where students actively participate in their socialisation process identifying, negotiating and creating their own role.

An assumption is made by (Davies 1988) that qualified nurses already socialised into the nursing profession bring with them the attitudes, values and beliefs that support the medical model of care implemented for sick patients. This assumption has not been challenged. It is my intention to rectify this situation. Since these studies were undertaken there has been a change in culture and Salvage (1990) talks of the 'new' nurse. Involving clients in decision making and being flexible might suggest that qualified nurses who become student midwives enter the profession with a philosophy that supports flexible care. My study will identify what values and beliefs students bring with them when they enter their midwifery programme and their compatibility with the woman-centred approach to care.

It is not easy to make the transition from nurse or lay person to student midwife (McCrea et al 1994, Chamberlain 1993, Davies 1988, Yearley 1999). The process is associated with reverting to the status of a novice and this creates anxiety. A lack of respect for students demonstrated by midwives' failure to recognise past nursing experience contributes to this anxiety (Davies 1988, Chamberlain 1993). Mature students undertaking the long midwifery programme experience more anxiety than younger students and anxiety for all students on these programmes is compounded by the attitude of midwives who believe students cannot become proper midwives unless they are also a nurse (Yearley 1999). Anxiety is also generated by the evident gap between what is taught in the classroom and what is practised in the clinical setting (Davies 1988, Chamberlain 1993). Davies (1988), Emmons (1993) and Chamberlain (1993) noted that

student midwives were introduced to two versions of midwifery which Davies (1988) refers to as the professional and bureaucratic models similar to those identified in nursing by Oleson & Whittacker (1968), Kramer (1974), Bendall (1976), Orton (1981), Ogier (1989), Fretwell (1982), Alexander (1983), Buckingham & McGrath (1983), Melia (1987), Smithers & Bircumshaw (1988) and Mackenzie (1992). The professional version of an independent practitioner who provides holistic care was taught in the classroom, and only when a teacher was challenged did it become evident that the reality might be different (Davies 1988). This theory/practice gap is known to result in 'reality shock' (Kramer 1974) which may influence qualified midwives to leave the profession (Davies 1988). The threat to leave the profession to reduce anxiety caused by this gap was acknowledged by Chamberlain (1993) as a coping strategy adopted by student midwives. It was not my intention to explore the education students receive in the classroom but this cannot be isolated from what happens in clinical practice. How students cope with anxiety generated from working in the clinical setting is a further issue for exploration in my study.

Fitzpatrick et al (1996) comment that students will be socialised whatever educational programme they undertake. The social process will, however, be different depending on the teacher. The purpose of midwifery education is to produce a practitioner who can fulfil the scope of the midwife's practice and act autonomously. Shuval & Adler (1980) suggest that the functionalist perspective of socialisation implies that students internalise the norms shared by the predominant group. This ignores the possibility that students are introduced to one set of norms and values by the school and another set in the clinical setting. Nor does such a view take into account the possibility that in a changing culture a minority group with power may restrict the way in which others practise. When student midwives adopt the attitudes, values and beliefs that incorporate the nursing model, students return to their former role (Emmons 1993, Davies 1988, Begley 1997) which is contrary to expectations.

If students are to learn from their role models they must work alongside midwives so that their practise can be supervised. The amount of

supervision students receive may be limited when mothers and babies have priority (Robinson 1991, Bewley 1995, Begley 1997). In a quantitative study which explored their experiences as student midwives, Australian midwives perceived their supervision to be inadequate (Barclay 1984). In a study of the occupational socialisation of nurses (Melia 1987), student nurses were noted to say they had little opportunity to work with qualified staff while a similar group of students in a research study by Jacka & Lewin (1987) made an approximate quantification when they stated they spent more than half their time in clinical practice working on their own. A frequent lack of supervision and support often due to staff shortages (Barclay 1984, McCrea et al 1994, Chamberlain 1993, Begley 1997, Hindley 1999) means that some student midwives are never shown how to perform a skill. 'Thrown in at the deep end' learning takes place by trial and error (Chamberlain 1993, McCrea et al 1994) and monitoring progress to ensure competency is then inadequate (Chamberlain 1993). When unsupported, junior students turn to students who are more senior for support (Chamberlain 1993, McCrea et al 1994). Anxiety generated from a lack of supervision and information to give care to women has adverse effects on student learning. Left to their own devices there may be little or no control over what students learn in the clinical setting. In the absence of a role model students cannot learn their role. This raises the issue of what influence other health care workers have on students and the effect of this influence on students' conception of the midwife's role.

Learning can be facilitated or inhibited by the environment in which students work. A number of studies have emphasised student nurses and midwives as learners of a practitioner's role and members of a work force providing client/patient care (Wyatt 1978, Fretwell 1982, Barclay 1984, Melia 1987, Ogier 1989, Cahill 1996, Chamberlain 1993, McCrea et al 1994, Begley 1997). This can lead to the perception that students are pairs of hands which enable the work to be done (Mackay 1989, Hunt & Symonds 1995). More recently supernumerary status means that students are not counted in the work force, but to fit in with their role models compromise this status by acting as workers (White et al 1993). In a climate where service needs have priority, it has been questioned whether it is possible to create an environment conducive to learning (Marson

1982). The atmosphere of the ward is crucial to student learning (Ogier 1989, Orton 1981, Fretwell 1982, Jacka & Lewin 1987) and is determined by the ward sister who acts as a role model (Ogier 1989, Pembury 1980, Orton 1981, Fretwell 1982). The style of leadership is influential in the environment created (Ogier 1989). A positive learning environment is associated with an interest in students (Jacka & Lewin 1987, Fretwell 1982, Smith 1992, Marson 1982) and a commitment to teach them. Teamwork is also important (Orton 1981, Fretwell 1982). The findings of these studies may have relevance to maternity wards but it has to be remembered that workload, the way in which care is organised and arrangements for leadership of the ward differ in midwifery practice.

In the absence of role models to demonstrate autonomous practice student midwives learn routine, task-orientated practice (Davies 1988, McCrea et al 1994, Emmons 1993) and how to get through the work (Davies 1988). There is an expectation that students will meet the expectations of those with whom they work (Davies 1988, Hindley 1992, Emmons 1993, Chamberlain 1993, Hunt & Symonds 1995, Turnball 1995a, Yearley 1999). This has also been demonstrated in nursing practice (Melia 1987). To help them 'fit in' students have been known to adopt specific strategies which include carrying out nursing observations (Davies 1988, Chamberlain 1993, Emmons 1993), keeping a low profile (Emmons 1993, Oleson & Whittacker 1968) and running errands for midwives and doctors (Chamberlain 1993). This raises the issue of what students with no nursing experience do to help them fit in. Yearley (1999:629) identified that very early on in their midwifery programme these students concentrated on 'looking busy' by reading their books when their was little clinical work to do, making tea and utilising their interpersonal skills to develop good relationships with the midwives with whom they worked. My study may confirm this or extend knowledge by identifying alternative strategies. Despite some community experience students learn how to work in the hospital setting where technology predominates and lack confidence to work anywhere else (Chamberlain 1993). By fitting in, students fulfil the role of student rather than qualified practitioner (Chamberlain 1993, Melia 1987, Emmons 1993). They are not prepared for the autonomous role (McCrea et al 1994, Barclay 1984, Emmons

1993, Chamberlain 1993) and lack confidence. This is also a feature of nurse socialisation (Melia 1987, Mackay 1989). Failure to 'fit in' results in being labelled a 'trouble maker' (Humphries 1997) and fear of failure to achieve their desired goal (Hindley 1992). When learning opportunities are not available during the pre-registration midwifery programme, midwives learn from their own personal and professional experiences. This type of learning includes the application of care by trial and error (Mander 1992). According to Bandura (1977) observation of role models means mistakes associated with trial and error learning can be avoided.

In England midwives now receive an education rather than training. My study will focus on some of the differences in the way in which students learn the role of the midwife and the qualities clinical teachers need to help students become autonomous practitioners.

Summary

Students now work in an environment where some midwives continue to allow their practice to be restricted while others strive for autonomy. Learning the role of the midwife therefore involves working alongside midwives with different sets of values and beliefs. Role models are influential but studies that have specifically explored the concept of role modelling lack the depth and detail necessary to understand the process. This study explores how students learn the role of midwife at a time when the midwifery culture and expectations are changing. The process by which midwives act as role models and facilitate or inhibit learning will be traced.

Chapter Three

Methodology

Introduction

The study focused on midwives' and student midwives' perceptions of learning the role of midwife from midwifery role models in the clinical setting. The 'emic' or insider's perspective was therefore obtained. A qualitative approach to the research study was adopted because it facilitates understanding of phenomena in the natural setting (Patton 1990).

Qualitative researchers seek to explore the meaning individuals give to their experiences or events in their lives, and the way they behave in response to those interpretations (Leininger 1985). The significance of participants' experiences is then analysed and inferences drawn by the researcher. To understand the participants' view of those experiences necessitates an examination of the context in which the study took place. Both the participants and the environment are recognised as dynamic and the way in which individuals interact within their environment influences their view of the world. A 'holistic' perspective is obtained by using qualitative approaches. Because neither the participants nor the environment are manipulated, this type of research is also known as 'naturalistic enquiry' (Lincoln & Guba 1985).

Perceptions of the midwife as a role model are subjective. They are likely to be influenced by the midwives students work with, the length of time they work with them, the type of relationship they have and numerous other factors. A qualitative research strategy was therefore seen as appropriate to study the phenomenon of role modelling and learning the role of midwife from role models.

The qualitative approach used in this study is that of grounded theory based on the work of Glaser & Strauss (1967). Detailed, practical advice on how to carry out this process was mainly obtained from Strauss & Corbin (1990) and more recently Strauss & Corbin (1998). Grounded

theory according to Strauss & Corbin (1998) is an approach to collecting and analysing data and is both inductive and deductive. Predetermined outcomes are not identified. Data collection proceeds from the specific to the general and the data have primacy. Questions generated by the data result in working propositions that are subsequently tested or verified by means of theoretical sampling. For example junior students had a need to learn the rules of practice to enable them to fit in and meet the expectations of their role models. The proposition that having learned the rules students would no longer need to fit in was not proven. Through the process of collecting and analysing data important issues emerge and from these a theory is developed which provides an explanation or understanding of what is happening in the setting. Theory is thus generated from and grounded in the data (Glaser & Strauss 1967, Strauss & Corbin 1998). Grounded theory is therefore a creative process facilitating the development of new theory or modification of existing theory. When little is known about a topic this is an important means of generating knowledge (Glaser & Strauss 1967, Stern 1980). It is also a suitable means for exploring phenomena that have been investigated by others but not by one's own discipline (Stern 1980). Role modelling is a concept that has been explored and applied in the disciplines of nursing, medicine and education. The lack of literature to provide an understanding of the midwife as a role model suggests this was an appropriate approach to adopt.

The Relevance of Grounded Theory

Grounded theory is based on symbolic interactionism. Symbolic interactionism focuses on the belief that interactions between individuals provide meaning for the experiences those individuals encounter. The way in which individuals react to these experiences will be influenced by their interpretation of events (Blumer 1971). Interpretations are based on symbols that have shared meanings for individuals in specific social groups. These shared meanings enable individuals to predict the behaviour of others and respond accordingly. Individuals therefore create the social environment and in turn are shaped or moulded by it as they interpret and respond to the behaviour of others. Our perceptions of reality are therefore socially constructed, and the way in which roles are learned

is an active rather than a passive process when viewed from this perspective. Symbolic interactionism, in emphasising the shared nature of meaning is an appropriate perspective to adopt because it facilitates an understanding of how students come to make sense of the world of midwifery, learn the behaviour which is expected of them and learn the role of the midwife.

In recent years it has become evident that Strauss and Glaser view grounded theory from different perspectives (Strauss &Corbin 1998, Glaser 1992). This may be because their backgrounds differ. Glaser appears to be less rigid in his approach to analysis of data (Glaser 1992) while Strauss appears to be very systematic (Strauss & Corbin 1998). Indeed the process could be perceived to be prescriptive providing little opportunity for divergence. Following the approach as it is prescribed does not enable ideas from other methods to be introduced into the study. Initially I thought I had adhered to Strauss and Corbin's approach. The reality of applying grounded theory to the exploration of role modelling in the discipline of midwifery did, however, result in adapting the process to meet my own needs as it will later be shown in chapter eleven.

Sample

A purposive sample of midwives and student midwives was selected who had knowledge and experience of the topic to be explored. The sample was mainly one of convenience, because students in one school, and many midwives sited in the maternity units were unknown to me. I was therefore reliant upon midwifery managers to obtain midwife volunteers and a Head of Midwifery Education in another school to gain access to some cohorts of students. Each intake or 'set' of student midwives in two schools of nursing and midwifery were informed of the research by me, and two or three volunteers sought from each group. Convenience sampling does not fit comfortably with the grounded theory approach. Strauss & Corbin (1990, 1998) acknowledge that the researcher can initially select anyone from whom to gather data. Thereafter analysis of data guides sample selection and theoretical sampling is most appropriate (Strauss & Corbin 1998). I was, however, able to remain true to the grounded theory approach by sampling concepts such as 'bullying' as

they emerged and became important to the developing theory. In this way theoretical sampling was carried out.

It was not necessary at the outset of this study to state the sample size because theoretical sampling proceeds throughout the research. Qualitative research is associated with small numbers of participants but this is compensated for by the 'richness' or complexity and detail of the phenomenon that is obtained (Strauss & Corbin 1994). It is the number of ideas that emerge rather than the number in the sample that is important. This type of research seeks to gain insight and understanding of a phenomenon rather than findings which can be generalised to other settings. The sample size of thirty-seven (consisting of both students and midwives) was determined by the theoretical saturation of each category (Glaser & Strauss 1967). According to Strauss & Corbin (1990, 1998) this saturation is achieved when each category is conceptually dense, variations in the category have been identified and explained, and no further data pertinent to the categories emerge during data collection.

Student midwives participating in this study were all women, either single or married with ages ranging from 18-45 years. They were all participating in one of several educational programmes:

An eighteen-month pre-registration (shortened) programme leading to Diploma in Higher Education/Registered Midwife.

A three-year pre-registration (long) programme leading to Diploma in Higher Education/Registered Midwife.

A three year pre-registration (long) programme leading to Bachelor of Science (Hons)/Registered Midwife.

A four year pre-registration (long) programme leading to Bachelor of Midwifery (Hons)/Registered Midwife.

My first participant was in the process of completing the last of an eighteen-month midwifery certificated course. Because of concerns

related to anonymity and confidentiality the interview, data collected and the analysis of this data acted as a pilot study. Morse & Field (1996) suggest a pilot study is not necessary in qualitative research but this did enable me to practise my interview technique, gain some idea of the data that might emerge and begin the process of immersing myself in the data. The data from this interview was not, however, included in the study.

Students undertaking the shortened eighteen-month programme were registered general nurses. Some had been trained or educated locally while others came from different parts of the United Kingdom. Their experience since gaining a professional qualification varied in length and type. For example while one student had worked in an accident and emergency department another student had gained experience working in a hospital ward caring for patients who had undergone neurosurgery. A number of these students had completed the ENB 998 Teaching and Assessing in Clinical Practice Course for Nurses. As its name suggests, this course prepared qualified nurses for their role in teaching students in the clinical setting and assessing their performance. Many of the student midwives had also participated in continuing education study days that focused on current issues related to practice, management and education.

Students participating in the long programmes had no nursing experience prior to their entry into midwifery. It is important to remember though, that some were classified as mature students and had a considerable amount of life experience which they brought with them to the course. Some also had their own experiences of childbirth.

Because of the small number of participants in the study and the need to preserve anonymity, pseudonyms have been used, and students are referred to in the text as either junior or senior students. This distinction was based on a cut off point placed exactly half way through each of the courses. Details of each student who participated in my study can be found in Appendix 2. Some were married and some single. Ages ranged from 18-45 years and the amount of life experience varied from one individual to another.

Students participating in this study were undertaking one of four midwifery programmes which on successful completion provided them with an educational and a professional midwifery qualification. Which programme they undertook influenced where they gained clinical experience. Students completing a pre-registration (long) four year Bachelor of Midwifery Honours degree programme and those on the pre-registration (short) programme of eighteen months for Registered General Nurses gained experience in a Teaching Hospital purpose built for maternity care and care of women with gynaecological problems. All students were allocated to the community setting for various lengths of time and in addition students who were registered general nurses were allocated to one of two General Practitioner Units. Students participating on a three-year Diploma in Higher Education or a three-year Bachelor of Science degree programme gained experience in one of three maternity units attached to a district general hospital. Those completing the degree programme were also allocated for a period of time to a Midwifery Led Unit.

Midwives who participated in the study were also all women. Details of each midwife can be found in Appendix 2. Their ages ranged from 24-55 years. Most of these midwives had received training as opposed to an education. Younger midwives were gaining clinical experience by rotating from one ward to another in the hospital setting. Some midwives worked mainly in the community setting. Older midwives, some of whom had been qualified for fifteen or more years, had been working in the same setting such as the labour ward for a considerable number of years. In settings where midwives where unknown to me I wrote to the Head of Midwifery Services. I explained my research study and requested permission to interview an approximate number of midwives who might be willing to participate in my study. This information was communicated to midwives in the hospital and community settings and a list of volunteers whom I could contact was sent to me. Prior to interview I discovered that one midwife had been told by her manager that she should participate in the study because she was a good mentor for students. I expressed my concern that she had been coerced into the study and emphasised the importance of voluntary participation. When the purpose

of the study was discussed this midwife insisted that she wanted to participate and was therefore included in the study.

It is possible that some individuals may feel a sense of obligation to participate. Sensitivity to the reluctance of an individual to participate in the study is therefore important (Ford & Reutter 1990). Two students gave me the name of a midwife whom they considered to be a good role model for students. When I approached this midwife she agreed to participate in order to help me but also verbally expressed discomfort at the thought of being interviewed. I interpreted this as reluctance to participate and therefore chose not to include her in my sample.

Data Collection

Data collection which took place between October 1993 and December 1997 was achieved by interviewing participants. The study was explained to each participant and verbal consent to participate in the study and to tape record each interview was obtained. Participants were contacted by phone or in person to make arrangements for when and where the interviews would take place. At the beginning of each interview the purpose of the study was reiterated. Confidentiality and anonymity were assured and the right to not answer certain questions or to withdraw from the study was emphasised. Swanson (1986) considers it appropriate to convey to participants the value of any responses they might make. Participants in this study were therefore informed there were no right or wrong answers to questions, and that I was interested in anything they had to say; no judgements would be made. These issues are considered more fully in the section on ethics.

Each interview took approximately one hour. Initially an unstructured approach to interviewing was adopted. This reflects the need to avoid preconceived ideas (May 1991). Students were asked one open ended question 'how do you learn the role of the midwife in the clinical setting?' Midwives were asked 'how do you think students learn the role of the midwife when they work with you in the clinical setting?' This open ended question was designed to enable participants to explore in depth, and in their own words, the phenomenon of role modelling from their own

perspective. As the interview proceeded clarification and elaboration probes (Patton 1990) were used to clarify participants' views and to stimulate further thoughts. In this way the interviews proceeded rather like a conversation between two people (Minichiello et al 1990). This conversational style enables the collection of a greater range and depth of data because the issues are discussed as they arise. It is an ideal strategy for facilitating the process of discovery and may result in the emergence of ideas that the researcher may not have thought of. As important issues emerged from analysis of the data, data collection became progressively more focused. These issues were listed on an interview guide. If not spontaneously included in the conversation by participants, I raised questions relating to these issues. Topics were excluded from the interview when it became apparent that they lacked relevance to the emerging theory. Unlike many conversations the emphasis on gaining the participants' perspective resulted in an unequal relationship (Spradley 1979) between participants and myself. As the study progressed this was inevitable, but it did allow participants to talk freely while at the same time helping me to ensure data collection remained focused. Throughout each interview notes in the form of headings were taken, these acted as reminders of other questions which needed to be asked.

The quality of data collected during an interview is largely dependent on the interviewer (Patton 1990, Barker 1991) and the relationship that is established between researcher and participants. During each interview there is an interaction between the researcher and participant that requires certain skills (Barker 1991) and qualities (Swanson 1986). Some of these were developed while completing a smaller research study (Bluff 1993, Bluff & Holloway 1994). The initial rapport had to be achieved quickly as I had not met, face to face, with many of the participants prior to their interview. To put participants at their ease, something other than the research study was first briefly discussed. The topic of this discussion varied with each participant and may have had the added advantage of overcoming what Morse & Field (1996) refer to as 'stage fright' associated with the presence of the tape recorder. Use of the tape recorder avoided the loss of eye to eye contact associated with note taking and enabled me

to concentrate on maintaining a rapport and observing non verbal communication.

Some midwives and students who participated in this study knew me. Seidman (1991) suggests it is inappropriate for teachers to interview their own students because they may not tell the truth. This raised the issue of trustworthiness and how I, as the researcher, would know if participants were telling me the truth as they perceived it. I had no reason to believe they were anything other than honest in what they told me. Although I was a personal teacher to two students who participated in the study, outwardly they appeared at ease when talking to me. Other students knew me as a teacher in the department but may have felt safe expressing their views because the opportunity for me to work alongside them in the clinical setting was limited. I knew none of the students from the second School of Nursing and Midwifery. The story that emerged from the data collected from students and midwives who knew me corresponded to the story recounted by those who did not know me. Although participants might have been tempted to withhold information, neither verbal nor non-verbal cues gave this impression. It is possible that students' honesty was associated with a perception that as a teacher I was on 'their side'. They might have perceived that in illuminating how they learned in the clinical setting I would in some way be able to help them and other students through the results of my study. Trust is an essential ingredient in a relationship if individuals are to confide and tell the truth. Midwives are familiar with working in an environment where information given by clients to health professionals is confidential and information shared by health professionals is similarly treated.

Following each interview participants were thanked verbally and in writing, and consent to reinterview at a later date was obtained. This second interview lasted between thirty and forty five minutes and took place after a detailed analysis of the first interview. This sometimes took place within three of four weeks of the first interview. On other occasions several months went by as I had data to analyse and participants had holidays, time off sick and pressures of course work to complete. There were also occasional difficulties making contact with students. This

second interview provided an opportunity to clarify issues which were unclear, ask questions which had arisen from the data analysis and to confirm my interpretation of what they had said.

Data Analysis

To familiarise myself with the data the interview tapes were replayed and then transcribed verbatim, by me, using a word processor. I chose to do all the transcribing because as Minichiello et al (1990) suggest it is a valuable opportunity to become familiar with the data. The vital process of analysing the data also begins at this stage of the study. Reinterviews were also transcribed verbatim. Anything which might have altered the significance of what was said such as pauses, tone of response, laughs and coughs were indicated in the text.

The data was analysed by means of the constant comparative method. This method was first described by Glaser & Strauss (1967). Analysis initially involved conceptualising the data. Each transcript was carefully examined to identify and code concepts. To give meaning to the data concepts were labelled using codes developed from my own understanding of the data. 'Sticking to the rules', 'keeping quiet' and 'being innovative' were all examples of such codes. The term 'sussing and sizing' originated from a study by Davies (1988). 'Sussing and sizing' is something all individuals do when encountering new situations. My interpretation of the term corresponded to that of Davies (1988) and hence its adoption. Students sought information about the midwives with whom they worked from their own observations of these midwives. To invent a new code for something that has the same meaning has the potential to create confusion for readers. As the study progressed 'sussing and sizing' was renamed 'seeking information'. This was partly to avoid idiomatic expressions and also because students in this study not only learned information from the midwives but also from their peers. 'In vivo' codes (Strauss & Corbin 1998) originated from the participants' own words and reflected the 'emic' perspective. These included 'bending the rules', and 'the way its always been'.

This process of conceptualising the data involved separating words, sentences and paragraphs and generating questions from the data that enabled one incident to be compared with another. One interview was also compared with another. Strauss & Corbin (1998) call this 'open coding' within a constant comparative perspective. In this way similarities and differences within the data were identified. The search for meaning therefore, initially involved expanding the data (Strauss 1987) as answers to questions were sought, new data collected and further questions raised. Codes were in turn compared and where similarities existed they were linked together to form categories. These were named to achieve a higher level of abstraction. Codes such as 'telling lies', 'withholding information' and 'practising behind closed doors' were grouped together to form a category called 'cheating' which was then labelled 'being evasive'. These were all strategies which enabled some midwives to practise midwifery based on a philosophy which did not correspond to that of other midwives with whom they worked, and at the same time avoid criticism. The process of categorising data in this way reduces the data and makes it more manageable (Coffey & Atkinson 1996). This is therefore an important process.

Categories that were formulated were further developed by identifying their properties and dimensions (Strauss & Corbin 1998). A property is a characteristic of the category, while dimension refers to placement of properties along a continuum. Role modelling for example formed one category. A property of role modelling was the philosophy of practice adopted by midwives. The dimension of this property could be placed on a continuum with the midwife's philosophy of childbirth ranging from only normal in retrospect to a normal physiological process. Another property was the model of care midwives adopted. This too could be placed on a continuum with the medical model of care and the woman-centred model placed at either end. Midwives whom I named 'prescriptive' and 'flexible' represented the extreme ends of this dimensional range.

'Axial coding' took place when categories and sub categories were linked together by using the paradigm model (Strauss & Corbin 1998). This

model facilitates the connection or relationship of a category to a sub category by determining the phenomenon, causal conditions, context, conditions and consequences (Glaser 1978). A subcategory of role modelling for example was labelled 'fitting in'. Making such connections was not always easy. For example, 'keeping quiet' was a passive reaction or consequence of being criticised. It was also a strategy students adopted for fitting in with prescriptive midwives. Similarly 'keeping quiet' was an expectation of prescriptive midwives and a characteristic or condition of submission to authority to those above them in the midwifery hierarchy. Cheating was a strategy for fitting in but it was also a way of practising in the hospital environment.

A process of 'selective coding' enabled the core category of 'interpretation and use of the rules' to integrate the data and provide the basis on which the theoretical ideas are formulated. It was this category or basic social psychological process that helped to provide an explanation of how students learn the role of midwife from their role models.

The collection and analysis of data is a parallel process. Each interview was analysed, and on the basis of this analysis the data provided direction for further sampling. Analysis of the next interview was then compared with the first and so on. Further comparisons were made as new ideas emerged. As the important issues became apparent those ideas which were irrelevant to the core category were dropped from the content of the interviews. Interviews therefore do not remain constant in time (May 1991) but continue until all categories are saturated. This process of adjusting data collection and reducing the data by linking categories with similar meanings can result in what Lofland & Lofland (1984:138) call the 'agony of omission'. It is worth remembering that this 'dross' (Patton 1990) although not relevant to the story that emerged from the data was important to the participants who verbalised it. In particular many eloquent quotes from participants were not included in this study because they lacked relevance to the theoretical ideas, or because they expressed what others had already said. Their inclusion within the study would have disturbed the balance between the provision of quotes and the theoretical component of the study.

To carry out such an analytic process and develop an integrated and conceptually dense theory requires sensitivity on the part of the researcher. By this Glaser (1978) means the researcher must have a feel for the data, be able to understand it and give meaning to the data. It also requires an ability to identify and separate those ideas that are important from those which lack relevance to the study.

Using the Literature

The initial literature review at the beginning of the study was limited to avoid preconceived ideas as suggested by Glaser & Strauss (1967) and Strauss & Corbin (1998). If allowed to develop these might have resulted in confirmation of what was already known about role modelling rather than facilitating the process of discovery. However, as the core category and theoretical ideas emerged, the literature was extensively reviewed. As Strauss & Corbin (1998) and Morse & Johnson (1991) recommend, it was noted when the research findings of this study supported what was already known. Where disagreement was identified, the reasons for this were explored. Questions generated by this process were therefore influential in the subsequent collection of data. When an issue pertinent to the subject of my study was referred to in the literature but was not recorded in my data this also raised the question 'why not?' For example, Davies (1988) revealed that student midwives who were already qualified nurses often resorted to performing the routine observations of maternal physical well being such as temperature, pulse and blood pressure. This enabled students to fit in with the midwives with whom they worked at a time when they lacked knowledge and skills to provide other forms of care. This aspect of 'fitting in' did not emerge spontaneously from my data but when the subject was introduced to students they readily concurred. This then raised the issue of how students with no prior nursing experience were able to fit in during the early weeks of their course. Data collection was directed towards answering this question. In this way the literature was incorporated into the data.

In the absence of any literature exploring the concept of the midwife as a role model, the phenomenon of role modelling was reviewed in literature

related to other disciplines such as medicine, sociology and psychology. In this way it was possible to extend my ideas to encompass the perspective of others.

Trustworthiness and rigour of the data

Ensuring the 'truth' of the data is important to the qualitative researcher. If trustworthiness can be demonstrated the study can be said to have rigour (Sandelowski 1986). Brown & Sime (1981) refer to 'authenticity' and 'attestibility' while Lincoln & Guba (1985) prefer the use of 'credibility', 'transferability', 'dependability' and 'confirmability'. These are the terms generally used by qualitative researchers as alternatives to validity and reliability used by quantitative researchers.

A number of precautions were taken to ensure the credibility of the data that are presented in this thesis. A detailed description of the context in which the study took place can be found in chapter one. A clear and logical account of the research process is provided in this methodology chapter. This is designed to enable readers to draw their own conclusions as to the accuracy of my interpretation of what the concept of learning a role from role models means to the participants. Quotes are used within the text which make explicit how the core category and theoretical ideas emerged from the data, this also offers readers the opportunity to decide for themselves whether they agree with my interpretations. Member checks (Lincoln & Guba 1985) were carried out when I returned to participants to share the findings of this study. This provided confirmation of the accuracy of my interpretations when participants recognised my interpretations of the data as their own. The constant comparison of data and achievement of theoretical saturation of categories and subcategories was also a means of verifying the accuracy of my data. The attempt to identify and minimise researcher bias was enhanced by documenting the events, thoughts and feelings that were experienced throughout the study. A record of this 'reflexivity' was kept in a diary as recommended by Fetterman (1998).

Theory generated from the data represents reality as perceived by the participants. This is not to say that the reality identified in this study is

representative of the reality of all midwives and student midwives. The individual's view of reality will vary and will in part be dependent upon past experiences and the environment in which the work takes place. Neither the individual nor the environment remains constant. It is however, likely that all those with knowledge of the midwifery profession can relate to the findings of this study. If findings could be shown to apply to other settings where maternity care is given, they would have transferability. Morse (1994:34) suggests that theory can be developed or 'recontextualised' so that it can be applied to other settings. No attempt has been made to do this but when I talked to colleagues in different parts of the country they confirmed a number of ideas which emerged from the data in this study.

A qualitative research study cannot be replicated. As a researcher I am the research tool and my life experience and knowledge will inevitably influence the collection and interpretation of data. Participants also have their own unique view of the world. There are thus multiple realities. An 'audit trail' (Lincoln & Guba 1985) has, however, been made explicit so that readers can follow the research process. If another researcher using a similar sample in a similar setting undertook the same study, the expectation would be that findings would be comparable (Sandelowski 1986).

The data are linked to the participants from whom it was derived. So too are the findings of the study, the interpretations and conclusions. A study that has been demonstrated to be credible, transferable and dependable can also be said to be confirmable (Lincoln & Guba 1985).

Ethical Considerations

Qualitative research like quantitative research is associated with a number of ethical issues, none of which can be ignored. Fowler (1988) suggests that most of the ethical issues are common to qualitative and quantitative research but that some aspects of these issues are more likely to be encountered in qualitative research.

Seeking ethical approval

The research proposal was submitted to the University Degrees Committee and approval to undertake the study was granted. Any research study must be designed to ensure that no harm comes to the participants. As a midwife the principle of doing no harm was not a new one to me. My study was concerned with professional colleagues as participants, nevertheless it was considered appropriate to approach the Ethics Committee for each Hospital Trust in which the research took place, to inform them of my intentions, and establish whether they required submission of a research proposal to gain permission to undertake the study. In all instances approval was given without referral to the research proposal because clients/patients were not involved. This did not, however, absolve me from considering the issue of harm. Colleagues also have a right to expect a certain standard of behaviour from the researcher.

Gaining access

To carry out the research study it was necessary to gain access to participants via 'gatekeepers' who are in a position to grant access to the setting. The study was designed to take place in the South of England. Permission to interview qualified midwives was obtained from the appropriate Directors of Midwifery Services. Students were allocated to work in one or two of a total of seven available hospital sites. In addition they gained experience in the community setting. Midwives who acted as role models for students on three hospital sites and the community were accessed. Midwives on all sites were not interviewed because the very small sample size from each hospital would have increased the difficulties of maintaining anonymity. The Head of Midwifery Education for one midwifery school and the Acting Head of Midwifery Education for the other school gave their consent to student interviews. Being personally known to all the 'gatekeepers' in my capacity as a midwife teacher may have facilitated this ease of access.

Confidentiality and anonymity

The issue of confidentiality had to be examined in conjunction with the concept of anonymity. To ensure confidentiality and anonymity each

interview tape was labelled 1, 2, and 3 and so on to indicate the order in which the interview was carried out. The prefixes S and M were used to distinguish between student and midwife interviews. The name of the participant was not included on the tape. A few basic details of each participant including name and background information was recorded on an index card and stored separately from the interview tape. Each transcript was labelled to match the relevant tape recording and was stored separate from the tape and relevant index card. At the beginning of each interview participants were told that all information would be confidential and how it would be stored.

Qualitative research is usually associated with a small sample size that in itself poses dilemmas. A small sample size increases the risk of individual participants being identified. For this reason the research study was based on three sites in the South of England, a wide geographical area.

Minichiello et al (1991) state that the issues of confidentiality and anonymity extend to the presentation of the research study. Pseudonyms have therefore been used when writing up the report and when necessary details have been altered to disguise individual identities.

Informed consent

Polit & Hungler (1993) emphasise that the participants' dignity must be respected and to achieve this the three issues they outline, informed consent, the right to self-determination and the right to full disclosure were considered. Participants can only give their informed consent if the researcher has given them a full explanation of the purpose of the study. While in theory this may seem perfectly reasonable, in practice, the issue, when related to qualitative research necessitates some discussion. The qualitative researcher has an aim to achieve but no specific objectives. Qualitative research is a creative process of discovery. Unexpected ideas often emerge and can be followed up, but this means participants cannot be informed of the exact route the research will take. Detailed attempts to do so would influence the outcome of the study (Archbold 1986). To overcome this dilemma I followed Couchman & Dawson's (1990:127) recommendation and was as 'accurate and honest as possible' in the

explanation I gave to participants. Participants were informed that I was exploring how student midwives learned the role of the midwife in the clinical setting. This was indeed true, although I was specifically looking at the influence midwives had on this learning process. When participants were reinterviewed and my interpretations confirmed participants were then informed that role modelling was the focus of the study.

The right to withdraw from the study

Following an explanation of my intentions, potential participants were informed that participating in the research study was voluntary. I emphasised there was no obligation to participate and if there was agreement to do so, a decision could still be made to withdraw from the study at any time or a refusal made to answer specific questions. In this way participants' autonomy to decide their own course of action was acknowledged.

Ongoing analysis of the data may result in a need for the researcher to go back to the participant and with this in mind permission was requested and granted to go back to the participants later.

The researcher/participant relationship

It is possible that lack of familiarity with the research process may have led some participants to perceive me as a teacher and midwife rather than a researcher. On occasions it appeared that participants were feeling embarrassed or guilty and were looking to me for professional reassurance that what they were saying was all right. It was not my intention to stimulate such feelings but they arose in response to the disclosure that in clinical practice 'corners are cut'. At this point in the interviews I intervened. Reassuring participants that this was often the reality in the work environment was considered necessary to ensure participants felt their views were respected and it was safe to be honest in further disclosures. Looking back on the transcripts it was in relation to this same issue that I realised I had revealed some of my own values and beliefs through these disclosures. Swanson (1986) notes that participants are likely to respond to subsequent questions to fit in with those beliefs. Wilde (1992) disagrees with most researchers' views that this is

detrimental and contrary to the research process and suggests that the roles one acquires within one's professional career cannot be separated from the research role. While care must be taken to limit this effect, the data and the participants are inevitably influenced to some extent and this needs to be acknowledged (Robinson & Thorne 1988). The relationship I had with participants was an important one. Honest and accurate data collection is associated with a relationship based on trust (Robinson & Thorne 1988) and this I believe I achieved. Many of the participants were known to me in my capacity as a midwife teacher. With other participants I had no previous contact and rapport therefore had to quickly be established and put participants at ease.

Summary

Qualitative research facilitates an understanding of phenomena in their natural setting. It is therefore the appropriate paradigm to adopt to explore the concept of role modelling. Little is known about the process of role modelling in midwifery practice although it has been explored in other disciplines. Grounded theory is a systematic approach that will enable role modelling to be explored in depth and detail. Unstructured interviews will provide the 'emic' or insider's perspective.

Chapter Four

Findings and Discussion

Using the Rules

Introduction

In accordance with qualitative research the findings of this study have been integrated with the discussion. Findings reveal the characteristics of the role models with whom students worked and the model of care they practised. The influence these role models had on how students learned, the environment they created, the role students learned and the effect this was likely to have on their future practice as qualified midwives also emerged. Analysis of data revealed that some midwives with whom students worked were notable for following what were regarded as the rules of practice while other midwives were perceived to bend the rules. Black (1967:93) defines a rule as 'a general instruction, expressed in a formula that states what is to be done in order to achieve some stated or understood end in view'. To achieve the desired outcome, the sequence of instructions is clearly specified. When students worked alongside midwives who acted as their role models they observed the different ways in which the rules were interpreted and used. It is the rules and the way in which midwives interpreted and used them that is explored in this chapter.

Following the written rules

All midwives were seen to follow the format of policies and protocols as they were recorded in writing:

> **Catherine**
>
> It's just that they have these protocols and they follow them to the letter and it's just assumed that something will happen or you will do this, you'll deliver there. It's the same for everyone.

Policies are a statement of a course or principle of action adopted or proposed by management. They stipulate midwifery and obstetric care women will receive in specific circumstances. Protocols provide the written detail of how the policies will be achieved and the responsibilities

of those delegated to implement them. Devised by employees of the hospital or community Trust there is a requirement for all practitioners to adhere to these written rules. Some of the rules apply to all health practitioners whatever their discipline; others refer specifically to care of pregnant and postnatal women and are associated with the medical model of care and specifically for women classified as 'high risk'. They are therefore more likely to be encountered in the hospital setting. It should be remembered that hospitals usually provide care for sick people but the majority of pregnant women are not sick. Nevertheless as students observed, in this environment the philosophy that childbirth is only normal in retrospect has led to the application of these rules of practice for all women irrespective of whether they are classified as 'high' or 'low' risk (Oakley 1993, Tew 1995).

There appeared to be a lack of understanding of what were written rules that had to be followed and what were rules which could be interpreted and used to facilitate midwifery care. Procedures provide guidance on how to carry out a specific task or physical skill such as management of the third stage of labour. Guidelines as their name suggests, offer practical guidance and facilitate the provision of care. Students observed some midwives who made no distinction between obligatory policies and protocols and the procedures and guidelines. Everything was interpreted as rules to be abided by no matter what situation they encountered.

Students often heard midwives using the terms policy, protocol, procedure and guidelines interchangeably. This might imply a lack of understanding and an inability to differentiate between them. Zeta whose prior experience as a nurse meant she had some understanding of the differences corroborated this view:

> I've heard them (midwives) use all these terms but quite often they just say 'well that's what the policy says'. I'm not sure they really know what it is but because they've got into the habit of following it it must be a policy (laughs).

My own observations from communicating with midwives and working in the clinical setting support this. Confusion is compounded by written documentation which similarly fails to distinguish one from another. This inability to distinguish policies from guidelines has also been found by Chamberlain (1993) in a study which explored the educational experience of student midwives in the clinical setting.

Following unwritten rules

Students sometimes could not find the rules these midwives followed; this suggests that many of the rules of practice were not recorded in writing. Many of society's rules are unwritten and might be more appropriately referred to as 'shared understanding' (Anderson & Sharrock 1991). Hospitals are known to be bureaucratic organisations and bureaucratic organisations are also associated with unwritten rules (Blau 1963). These unwritten rules are the 'norms' as opposed to the organisational rules (Sims et al 1993). Unwritten rules may emerge when individuals formulate their own guidelines for an act and use them to guide their behaviour in similar situations (Polanyi 1962). Individuals will thus have their own unwritten rules. These unwritten rules are based on personal or professional judgement for the use of the individual. If these rules become official, there is the potential for them to be imposed on others, and it may be this that Polanyi (1962) implies when he suggests their 'formalization' could 'go too far'.

Emmons (1993) suggests that unwritten rules are most noticeable when Consultant Obstetricians are flexible with their own policies allowing midwives to interpret them. I would dispute this because the unwritten rules which emerged from the data referred to issues which I know from my own experience doctors have no interest in, nor are doctors renowned for their flexibility. It is possible that midwives were either conforming to their own unwritten rules and/or adhering to the unwritten rules of the culture. An example of the latter was offered by Mary:

> I think some of the rules need looking at because some of them don't exist (laughs). It's sort of silly rules like you musn't deliver in a certain room because there's carpet on the floor

(laughs). In the midwifery led unit, yes they do avoid this room because it's got carpet on (laughs).

The expectation was that this delivery room would not be used other than as a last resort when no other was available. The concern about getting blood on the carpet might suggest that these midwives were in some way slip-shod in their management of birth. Midwives providing care in the woman's home would not be able to dictate where the woman would give birth and would therefore have to take adequate precautions to confine the flow of blood. That midwives were perceived to be unhappy with the presence of carpet on the floor suggests they may have been concerned about hygiene and the risk of infection either to their clients or themselves. Alternatively it may not have been their idea to put the carpet there in the first place. This decision may have been imposed by someone further up the midwifery hierarchy. In response to this decision, midwives developed their own unwritten rule to control the use of the delivery room. It was not the midwives' responsibility to clean the carpet, but they appear to claim ownership of this resource and therefore protected it. Another unwritten rule stated that relatives were not permitted to lie on the woman's bed. Had the woman been at home such rules would not have applied. Hunt & Symonds (1995:103) identified a number of unwritten rules related to admission of women to the labour ward. Such rules enabled midwives to 'get through and exert control over their work'. In a well-known study of the occupational socialisation of nurses Melia (1987) uncovered a number of unwritten rules which nurses followed. These included the expectations that everyone would do their fair share of the work, work quickly and keep busy doing practical tasks rather than talking to patients. Medicine is also associated with unwritten rules (Atkinson 1981).

Emphasis is now placed on practice based on evidence (DOH 1996). Some policies and protocols have changed in response to the research evidence which is available. According to students some midwives continued to practise in the way they always had done. Rather than following the revised written rules they now followed outdated unwritten rules and in doing so failed to acknowledge the research evidence that had

been instrumental in changing the rules. A typical example of this concerned a recent change in policy related to eating and drinking in labour. This provided midwives with the opportunity to offer women classified as 'low risk', with refreshment if they wished. Previously the written rule had stated that all women in labour could have sips of water only. According to students the change in policy was not associated with a corresponding change in their role model's practice:

Faith

> The unwritten law is that once you're (the woman) in established labour you can't eat or drink. All the research seems to point to the fact that women need something to sustain them through labour and yet we routinely starve them here. It hasn't changed. It's the way it's always been.

What emerged from the data suggests that some midwives unquestioningly accepted the written and unwritten rules. Ausubel (1968) acknowledges that some blind obedience to rules exists but also suggests rules should be questioned when circumstances or conditions change. However, as Rachel commented 'there's no thought or rationale behind what they do'. Over a period of time, practice and the rules on which it was based had become a ritual (Ford & Walsh 1994) or habit, and doing what 'we've always done' had become ingrained. Black (1967) suggests that if individuals deliberately obey a rule, the rule justifies their behaviour. In the absence of thought Jarvis (1983) argues that if asked individuals could explain their behaviour. In contrast Black (1967) believes unquestioning acceptance of rules means that actions cannot be justified, and this supports the findings of my study. Students reported that even when presented with research evidence the attitude of these midwives was 'it's what we've always done and it works'. 'It works' was interpreted by students to mean either that they achieved the outcome of a live healthy mother and baby or, that the midwives got through the workload.

It might be suggested that midwives were unaware their practice was out of date. According to students these midwives had not read any recent

literature which would have demonstrated to them that their practice was often unjustified. They were also perceived to make no effort to attend study days or relevant courses except those that fulfilled a statutory requirement (UKCC 1998). This could be interpreted as a lack of commitment and motivation. Jarvis (1983:36) questions whether, in the absence of up to date knowledge, it is morally right to continue practising. In response to this critical stance it is important to review the background of these midwives. According to students they were usually older women who had undergone a training although it was not unknown to students for a few midwives who had undergone a degree or educational programme to behave in a similar way. Training is associated with learning specific skills which enable individuals to do a job (Jarvis 1983). These skills enable specific outcomes such as fulfilment of a rule to be achieved (Peters 1970). This contrasts with education which provides individuals with the knowledge and understanding to enable them to justify their actions (Peters 1973, Jarvis 1983,). Training is then a component of education but can also be distinct and separate from it. The lack of education and the subsequent lack of updating or professional stasis of some midwives may have been a reflection of the culture in which they learned their role.

Following the rules in the way some midwives did may have stemmed from the time of their origination. The Midwives Rules were first introduced by the Central Midwives Board which came into effect as a result of the first Midwives Act 1902. The rules at this time were very detailed (Donnison 1988) and could therefore be classified as rigid. They came into being at a time when most midwives had little or no training. They were therefore ill equipped to deal with many emergency situations, and mortality of mothers and babies was high. The women for whom midwives provided care were usually living in poor social circumstances, their health and well being therefore at greater risk than that of most women today. Over the years the rules have been revised and become more flexible. Prior to 1986 for example the rules stipulated daily postnatal visits by the midwife irrespective of individual needs. Since then it has been left to midwives to determine when and how often they visit women based on individual needs. In a survey which reviewed the pattern

of postnatal home visiting Garcia et al (1994) determined that while some midwives were allowed to use their initiative or professional judgement to determine when to visit mothers and babies, others had to adhere to local policies formulated on this issue. Whether all midwives do adhere to the local policies is another issue but there is an expectation that they will do so.

So far some midwives have been shown to view everything as rules to be rigidly followed and in the specified sequence. According to students not all midwives practised in this way and some were perceived to bend the rules.

Bending the rules

Competence in the application of rules is demonstrated by the ability of individuals to adapt their actions to achieve the appropriate outcome (Blau 1963). Zimmerman (1971) argues that the real meaning of a rule only becomes clear when it is applied in practice. According to students, if the rules lacked relevance to the situation some midwives adapted them to meet the needs of individual women. Students suggested that these role models saw the rules as stated in broad terms, allowing for flexibility of interpretation. While students referred to rule bending, midwives frequently talked of 'cutting' or occasionally 'skipping corners', or taking 'short cuts'.

'Cutting corners' could be perceived to imply that in giving care to women, midwives omitted some aspect of a rule and in doing so were less thorough in their practice or failed to provide optimal care. An extract from Midwife 4's interview indicated this was not midwives' interpretation of the term although there was an underlying concern expressed that this might be how others perceived it:

Midwife 4

The policies and procedures are written so that everything is incorporated into them but just sometimes you think oh well in this case it's alright to miss that little bit out. When it's busy we take short cuts because you will know that's a safe short cut.

You know what you're doing. I'm trying to think of an example um... I'm not talking about anything that's clinically dangerous or detrimental to the woman but there're just little things that I know, normally we should do this but because it's really busy we are going to by-pass a little way. And some days you are aware that you're tired or you're rushing a bit for whatever reason and that's when you have a guilt about it and that's not a very pleasant feeling so you don't do that very often. When I do it, because I know what I'm doing, but I'd... I can't even think of an example.

Comments from midwives like 'we're all guilty', or 'oh dear, now I'm getting myself into deep water' and the laughs which I interpreted as feelings of guilt suggested many midwives were uncomfortable admitting they adapted what they perceived to be rules when giving care. Midwife 4 who was over 40 years of age had only been taught the medical model of care. She and other midwives like her appeared to experience guilt because of the belief instilled during their training that care was only safe when rules were followed. The distinction between policies and procedures had never been made hence the assumption they were breaking the rules and, in doing so, perhaps compromising the care of mother and baby. The frequent references to the issue of safety may have been because they were learning to adapt and become more flexible but had a need to consciously reassure themselves, and me, that their practice was safe.

Although Midwife 4 could provide no examples, some were given by other midwives, such as not cleaning the woman's vulva and perineal area prior to birth of her baby. In the above quote it is apparent that many components in the sequence of care were, of necessity omitted, because the imminent arrival of the baby left no time for what another midwife suggested were the 'niceties'. In omitting an aspect of the rule it could be argued that the rule was bent but the purpose of the rule was achieved. However, examples of cutting corners related to aspects of care specified in procedures and in reality professional judgement was used to determine

actions. There was no evidence to support this as rule bending behaviour. Omitting aspects of care was recognised by students:

Elena

It was just little things. If the baby's asleep she won't wake it even though it's supposed to be weighed on three different days. But if baby's sleeping she won't wake it up. She feels that its sleep is more important and she won't take temperatures unless she thinks it's necessary.

Rules may be perceived to consist of a number of tasks performed in an accepted sequence. As Zimmerman (1971) suggests rules can be adapted by altering the sequence of individual tasks or components within the rule. In a study of how receptionists in an American Public Assistance Bureau behaved, Zimmerman (1971) provides evidence of how this can be achieved. The receptionists had a responsibility to ensure clients seeking financial help were allocated to a caseworker. The rule stated this should be done in sequential order, the first client being seen by caseworker number one and so on. However, an interview with one client could take longer than another, in which case the next client allocated to the same caseworker was reassigned to another case worker. In this way receptionists adapted the rule to meet prevailing circumstances. When applying the rule, receptionists assessed the situation and made judgements and decisions based on their experience of what would happen if they did not adjust the rule. A further dimension of cutting corners was this adjustment to the order or sequence in which skills were performed. Midwives acknowledged they adapted the care they gave to clients in this way and students' observations of their role models confirmed this:

Midwife 1

I won't do any harm and when I really think about it ...it's a bit more sensible so we'll leave that bit and try it this way because it would be better for this woman. It might be I turn them (women) to one side and then turn them to the other, but sometimes it's just easier to lift them up and change them and it's introducing little things like that, they're variations. There's

procedures and there's policies, so there's supposed to be an order in which you do things as well but I'm not sure it really matters. I mean you might do it one way one day and the next you do it in a slightly different order. The results the same whatever way you do it.

Elena

She doesn't necessarily do the postnatal checks for mother or baby in the order they're supposed to do.

De Maio et al (1976) acknowledged that pilots in their study scanned each instrument on the instrumental panel in the cockpit of their aeroplane. These researchers suggested the pilots adapted the scanning sequence they were taught and in doing so became flexible in their approach. Midwives were also able to 'scan' the rules and pick what was appropriate to use. According to Weber (1947) efficiency lies in achieving the goals of the organisation and rules facilitate this process. Contrary to expectations, bending the rules can actually achieve this (Blau 1963). If receptionists in Zimmerman's (1971) study had rigidly adhered to the rule when allocating clients to caseworkers they would not have achieved efficiency. Adjusting the rule meant they still fulfilled the purpose of the rule which was to avoid delays and ensure all clients were interviewed. In doing so efficiency was achieved and, if questioned, deviations from the rule could be justified. According to midwives, by bending what they perceived to be written rules they were able to get the work done when there was an inadequate amount of time or staff to do it in the 'proper way'. In this way they were also able to act in the interests of clients but still adhere to the principle of the rule. Bending the rules therefore had the additional purpose of meeting the needs of the situation as it was encountered. It was therefore possible to operate within the rules (or guidelines) but adapt to situations and achieve flexibility. Students did not perceive this as bending the rules and again it is important to emphasise that from my perspective as a midwife and teacher the examples above refer to procedures and not policies. No formal or explicit rule was actually manipulated. Although policies and protocols should be adhered to, procedures and guidelines permit flexibility of practice. When procedures and guidelines are viewed

by some midwives as rules to be followed, it perhaps is not surprising that students interpreted behaviour as bending the rules if midwives did not adhere to them. A perception of rule bending may also be because these midwives were observed to know the difference between policies, protocols, procedures and guidelines.

It was interesting to note that the four midwives working in the Midwifery Led Unit made no reference to cutting corners or rule bending and when asked their views had no understanding of what I meant. Although a hospital environment with some policies and guidelines it was, however, like the community setting considered to be more relaxed with less restrictions imposed on practice. The unit was also well staffed in the absence of doctors on site and midwives therefore had the time they needed to give high quality care to women.

Analysis of data revealed additional information which demonstrated how midwives used their judgement to make decisions within the scope of the rules and by bending informal or unwritten rules. Students and midwives frequently referred to a rule related to the second stage of labour. Students believed this rule stated all primigravid women should only be allowed to push for one hour in the second stage of labour. If not delivered within this time scale a doctor should be called with a view to instrumental delivery. Midwives' interpretation of this rule corresponded to that of students. Students, however, observed some of their role models allowing women to push for longer than one hour and this was supported by the actions of midwives:

Elena

Some of them (midwives) are really good and like a primip (primigravida) is supposed to only have an hour from full dilatation (of the cervix) to delivery (birth of the baby) but they'll (midwives) let her push for more than that.

Midwife 16

I'd taken over from somebody (another midwife) at seven 'o'clock the other day. The woman (cervix) had been fully dilated for an hour and I was supposed to be getting her to push, and er we pushed for an hour and we weren't really getting anywhere and I just phoned up one of the doctors and said 'we've been pushing for an hour but I'm sure she's going to do it so are you alright for another twenty minutes? Perhaps you'll come and see her in twenty minutes, and whoever answered the phone said 'oh fine'. I said 'the fetal heart is fine'. But because I feel confident, there, I'm saying um this is what I'm going to do.

Some students thought this additional time for pushing enabled women to give birth normally rather than having to have an operative vaginal delivery. It could be argued that in permitting the woman to push for longer the midwife contravened or broke the rule. Midwife 16 admitted to previously calling doctors in the expectation that they would do a forceps delivery if women had been pushing for one hour and had not yet given birth. By informing a doctor of the situation she continued to follow what she perceived to be the written rule and could therefore record in the woman's maternity notes that she had done so. The written rule had, however, been updated and now stated that 'if after pushing for one hour delivery was not imminent a doctor should be called'. This midwife was also aware of evidence which does not support limiting the length of time a woman pushes in the second stage of labour so long as mother and baby are well (Saunders et al 1992). Unknowingly Midwife 16 was following the updated written rule. According to Bittner (1973) operating within a rule while fulfilling what needs to be done is a characteristic of sound judgement. Rather than bending a rule, the midwife practised within the rule using her professional judgement to interpret the word 'imminent'. Midwife 16 and others like her, however, indicated they had either not read the rule or had practised for so long they had forgotten how the rule was worded. This supports the view of Black (1967) that when something becomes a habit, the actual rule is forgotten.

Students' observations of their role models revealed that midwives did not always apply the rules to their practice because they were perceived to lack relevance to the situation encountered. The environment in which midwives work is known to influence their practice (Robinson et al 1983, Kirkham 1987, Benoit 1989, Pope et al 1996) and it is the context in which an event occurs that influences which rule, if any should be applied (Edgerton 1985). It has already been noted that midwives who rigidly followed rules practised in the hospital setting. Role models who were able to adapt the rules were usually found in the community setting where the midwife's role consisted mainly of the provision of care for women classified as 'low risk'. Emphasis was therefore on the practice of 'normal' midwifery. When these community midwives entered the hospital environment to assist women giving birth and provide some postnatal care they adjusted the care they gave to women. In this way they adhered to the policies of the maternity unit in which they were practising and demonstrated their autonomy by deciding which rules were relevant to their practice. Examples included the use of cardiotocographs (CTG's) for monitoring fetal well being and care of the baby's umbilical cord:

Mary

They do them (CTG's), not all the time, but when they come in (admitted to the ward) they have a (fetal heart) trace. I don't think the literature supports their use if the woman's low risk but they (women) get it, usually whether they like it or not. They don't at home but then they (midwives) don't have the equipment.

Anne

She (midwife) was working in the (hospital) unit the other day and she told this woman to clean her baby's (umbilical) cord with sterets (chlorhexidine swabs) and sterzac (powder) but she didn't do that when we went in the women's homes. It was a case of tap water will do.

Black (1967) acknowledges that rules can be good if they achieve their purpose and are efficient at doing so. Such rules are likely to be followed

because they are good and not because they come from an authority (Black 1967). Rules which do not meet these criteria he suggests, are 'misdirected'. Knowledge is therefore required to determine whether a rule is good. Evidence does not demonstrate benefits for the routine use of fetal heart traces (Enkin et al 2000) Nevertheless the written rule where Mary worked stated one should be performed on admission for thirty minutes. In another unit this rule was for twenty minutes. Similarly there is no evidence to support cleaning the baby's umbilical cord with sterets and sterzac powder (Enkin et al 2000). In these units it was a written policy which midwives had to adhere to. One could argue that if these forms of care had not been proven to be beneficial the policy was not up to date, and following these rules did not justify the midwife's practice. Viewed from a different perspective these interventions had not been shown to cause harm, therefore a judgement has to be made about whether to perform the procedure or not. It has already been noted that doctors have considerable influence in the hospital environment and these practices continue because obstetricians and paediatricians have the greatest influence in formulating policies. In the community setting, where mothers and babies are cared for in their own home, these doctors have little influence. Such rules do not apply and indeed some equipment such as the cardiotocograph is not available. The risk of cross infection is also reduced.

It is possible that students' perceptions of rule bending behaviour by community midwives may have occurred because the care of women labelled 'high risk' was not applied to women with a low risk of complications. Away from the hospital environment the policies and protocols related to the care of 'high risk' women were of little relevance and indeed were not written rules for the community setting. A more relaxed environment was experienced by students and rather than allowing rules to restrict their practice, midwives were perceived to use them for the benefit of the women.

March (1988) interprets rule following as the appropriate selection and application of a rule to a given situation. This perspective appeared to correspond to the behaviour of midwives who were perceived by students

to 'bend the rules'. Rule bending in my study is interpreted as adapting rules to enhance care and includes omitting a component within a sequence, changing the sequence, interpreting words incorporated within the rule such as 'imminent' and not using a rule if it is inappropriate to do so. If rules are interpreted there is the possibility that they may be broken.

Breaking the rules

If the rules are not known there is the potential for them to unconsciously be broken. Alternatively they may be known but deliberately broken. Rules are broken when the actions of an individual are contrary to that specified within the rule (Hugman 1991). This clearly differs from bending or adapting the rules but the terms are sometimes used synonymously (Hutchinson 1990).

Failure to adhere to the Midwives rules and code of practice (UKCC 1998) can lead to accusations of negligence and misconduct even when mother and baby come to no harm. Lack of knowledge provides no defence (Montgomery 1997). According to students some midwives did break the rules. Untruths were sometimes observed to be recorded in writing:

> **Elena**
> They just write active pushing started at 10.48 or 10.28 so there's that twenty-minute leeway, when actually she (the woman) started pushing at say five past ten.

This untruth allows the woman longer to push in the second stage of labour and thus increase her chances of a normal vaginal birth. My reaction to this was that the Midwives rules in relation to record keeping (UKCC 1998) were being violated. No where in this document is the word accurate referred to. However, a supplementary document (UKCC 1998a) expanding on the requirements of the rules clearly specifies the need to provide accurate records. It is worth noting that in making a decision related to care no rules were broken but in recording the decision a formal rule was violated. This is an illegal practice (UKCC 1998). Such practice is not unknown. Irish midwives have for example been observed recording

fetal heart rates without listening to the fetal heart and inaccurately recording cervical dilatation (Begley 1997). American nurses have administered drugs without a doctor's prescription (Hutchinson 1990). Fulfilment of the role itself has also been illegal in some countries such as America and Canada (Murphy-Black 1995). All midwives should be familiar with the rules related to record keeping because they are a legal requirement. The onset of the second stage of labour cannot, however, be accurately determined and it is therefore difficult to challenge any midwife on this issue. It is equally difficult to challenge the findings of another midwife's vaginal examination. Midwives confirmed students' perceptions although they did not admit recording the untruth in writing. The covert nature of such actions implies the individual is consciously breaking the rule (Hugman 1991) and midwives were aware of the consequences of breaking the Midwives rules (UKCC 1998).

Between April 1998 and March 1999 the UKCC Preliminary Proceedings Committee closed 71 professional conduct cases for practitioners on part 10 of the Professional Register. At the time of the alleged incident 30 of these were practising midwives. One hundred and thirty three new cases were considered 6 of who were practising midwives. No midwife was struck off the Register (UKCC 1999). Rules related to aspects of practice which are contravened include record keeping, breaches of confidentiality, failure to collaborate with colleagues and verbal abuse of staff. Publicity generally surrounds those midwives who are well known within their profession or a case which creates considerable discomfort for midwives. One such case was that of Jilly Rosser practising as an independent midwife at the time she was struck off the register in 1988. This example and others where policies have been broken are briefly described as they may subsequently help readers to understand the behaviour of some of the role models students encountered. Clarke (1996) provides a thought provoking insight into Rosser's case and questions whether some of the rules are realistic. The claims made against Rosser included taking a woman to hospital in her own car rather than waiting for the obstetric flying squad when the woman was experiencing a postpartum haemorrhage. Her record keeping was also called into question. The case was referred to the High Court which subsequently over ruled the

UKCC's decision. Clarke argues that the rules incorporated within the Code of Professional Conduct are open to interpretation and raise numerous questions to which there are no easy answers. To judge midwives' practice based on these rules which emphasise autonomy when midwives practise in a clinical setting which is generally restricted is unethical. When some rules are so vague it is easy to acknowledge that they may be unintentionally broken. A more recent case concerns that of Ann Kelly a midwife practising privately in Southern Ireland. Like midwives in England and Wales midwives in this country must also notify a doctor in the event of deviations from the normal (An Bord Altranais 1994). Ann was charged with waiting too long before referring a woman to hospital for obstetric care and this she disputes. It was noted in chapter two the difficulties associated with defining normal midwifery practice. When to call for medical assistance is therefore open to interpretation. Nevertheless her license to practise was removed before her case was heard in the High Court. Rynne (1998) who provides some background information to this case readily acknowledges that this midwife was treated as guilty until proven innocent.

Illegal practice does occur in other professions. I had anticipated that literature related to the armed forces, particularly the army would acknowledge rule following behaviour. Contrary to my expectations the only evidence I found revealed behaviour associated with breaking or interpreting rules (Priest 1997). American policemen have also been shown to break the rules (Waegel 1984). The extent of this rule breaking is not clear because the rules are ambiguous and therefore open to interpretation. Pearson (1975:29) refers to bending and breaking rules by social workers as 'industrial deviance'. This can involve failing to act to enforce regulations when clients themselves break the social security rules. The purpose of this rule breaking is to facilitate getting the work done and is also seen as being in the interests of some individuals.

Inaccurate recording of the time of onset of the second stage of labour was the only formal legal written rule I discovered was broken. Policies and protocols may also be infringed although no evidence emerged from my data to demonstrate that any midwife contravened a policy. Begley (1997)

has, however, observed midwives rupturing women's membranes when it is the doctor's responsibility to do so. Midwives in Carlisle have admitted to acting in opposition to their Trust by secretly visiting women after the tenth postnatal day (News 1999). Ireland et al (2000) identified that 10% of midwives who responded to a postal questionnaire on cord-care practice in Scotland did not follow the written policy. They suggested a number of reasons for this including a lack of knowledge of research methods which would enable the research to be effectively utilised and the greater value placed on knowledge derived from experience. It is worth briefly referring to several situations which received publicity in the professional and national press. The content of Trust policies and protocols are not legal requirements which midwives have to fulfil nevertheless failure to adhere to them can also lead to accusations of negligence and misconduct. Chris Warren, a community midwife helped a woman give birth at home (Timmins 1988). The Health Authority's policy stated two midwives should be present at a home birth. The second midwife was called but arrived after the birth of the baby because events happened so quickly. Warren was charged with misconduct and dismissed from her job. Following a successful appeal the Health Authority reinstated her. Another midwife, Mary Cronk (News 1987) was informed she would have to conform to a policy that stated she must give all her clients intramuscular syntometrine at the birth of the baby's anterior shoulder. The purpose of this drug was to shorten the third stage of labour and minimise blood loss. Cronk challenged this policy but was offered no evidence to support it. Instead she was informed that this was the hospital Consultant's wish. The dilemma was eventually resolved but practising in an environment which enforced rules was not a comfortable experience for a midwife who wanted to be autonomous. A further case concerned two midwives who helped a mother give birth in water (Anderson 1994). The Trust stated that the woman could labour in water but not give birth in it even though the birth was to take place in her own home. During the second stage of labour the woman refused to leave the birthing pool. Both midwives were suspended from duty. One received a first written warning. At appeal the demand to undertake professional updating was removed. The second midwife received a final written warning and underwent a process of professional updating and supervision of her practice. In this instance the Trust policy

was contravened. What made this case so interesting was not only the attitude and expectations of the Trust but that these midwives found themselves in a 'no win' situation. The expectations of the UKCC conflicted with those of the employing authority. The midwives could not remove the woman from the pool assuming this was a physical possibility because legally this would be classified as assault. Nor could they withdraw their care because in doing so it could be argued they would not be acting in the best interests of the client. Such action would then have contravened the UKCC rules (UKCC 1998) and the Code of professional Conduct (UKCC 1992). These examples like those of breaking the UKCC rules highlight two important issues which cannot be ignored. The environment in which midwives practice can be viewed as one in which there is an expectation that midwives will conform to the expectation of others and if they do not they will get 'into trouble'. The second issue is that of professional control. Both Clarke (1996) and Rynne (1998) refer to the possibility of a hidden agenda. Rules are a means of exerting control over individuals (Weber 1947, Etzioni 1969). In terms of midwifery practice they therefore provide a means of inhibiting autonomous practice. These issues will be explored in more detail in this thesis.

In England, Wales and Scotland practice varies from one maternity unit to another because the content of the rules differs (Garcia et al 1987, Garforth & Garcia 1987, Garcia & Garforth 1991, Ireland et al 2000). What is a requirement in one unit may not be in another. Midwives therefore have a responsibility to ensure they determine the rules they should follow when relocating to practice midwifery in a different geographical area. While some midwives may be very diligent in doing this other midwives may make an assumption that the way in which they have previously practised will be acceptable in their new environment. Midwife 14 had moved from one maternity unit to another. When asked if she had seen the policy which stated a woman should only push for an hour in the second stage of labour she responded:

> I have a feeling it is in the protocol file under the second stage of labour. I have a feeling that it is. I've definitely seen it in

writing in another unit and I'm almost sure I've seen it in this unit, almost sure. It isn't something I've made up (laughs)

When questioned it was clear to me that Midwife 14 was not breaking any policy or protocol but her lack of knowledge created the potential to do so.

Some midwives were perceived to place themselves at risk by failing to follow written guidelines for their own protection, such as wearing gloves when carrying out certain procedures:

Rachel

I mean, like I was on postnatal (ward) and I've been there when they've checked the woman's (sanitary) pad and perineum, and some of them, well, they don't wear gloves.

It would appear illogical that midwives chose to ignore rules or guidelines devised for their own protection and contrasts with the observations of Hunt & Symonds (1995). They observed that midwives in the labour ward wore gloves for most of the time. They suggest that this may be due to a lack of knowledge and feelings of vulnerability associated with not knowing which women are carriers of the hepatitis B infection or the Human Immuno Deficiency Virus. When rigidly following rules midwives gave no thought to the care they gave to women. This might imply they were also unlikely to consider the dangers of failing to follow good practice outlined in the guidelines. Arguably they were placing their own health at risk. Midwives who bent the rules were also observed to undertake some procedures without wearing gloves. Students suggested these midwives might have been confident their skin was intact, were aware of what they were doing and took great care to avoid direct contact with body fluids.

I found no evidence to show that midwives had been reprimanded for failing to use gloves. My reaction to this I admit is a cynical one. Viewed from one perspective it could be argued that the guideline enabled midwives to make a decision not to wear gloves. In this and similar situations midwives were permitted to be autonomous practitioners as they

are entitled to be. If the purpose of wearing gloves is to protect the midwife it might be appropriate to question why their use was not incorporated within a policy. It would appear that the Trust was willing to let midwives place themselves at risk. If the individual is not valued their health is hardly an issue for concern. Failure to follow the policy has the potential to save the employing authority money because the issue of vicarious liability would no longer apply. It could almost be interpreted to mean that the midwife could be autonomous when those who control her practice will allow her to be. This implies a paradox that the midwife can be both autonomous and lacking in autonomy. Viewed from the clients' perspective, however, gloves are also designed to protect them. A failure of the midwife to take precautions by wearing gloves can place clients at risk.

Some midwives were observed to break unwritten rules for example relatives were sometimes permitted to lie on the woman's bed although according to students everyone in the Midwifery Led Unit adhered to avoiding using the delivery room which was carpeted. Some midwives were observed by students to withhold some information when updating the midwife in charge of the labour ward of the progress of the women for whom they were caring. Susan in her quote refers to newly qualified midwives who have undertaken a midwifery degree course:

Susan

Well they don't let it be known that the lady's gone over an hour more than her line (Studd's curve) says that she should (laughs), but there'd never be any danger at all, and they know what the research says.

Studd's curve refers to a curve which is drawn on the woman's labour record and is associated with the active management of labour (Studd 1985). Progress of labour is recorded by assessment of cervical dilatation which is plotted on a graph. If the result of an assessment when recorded falls two hours to the right of the curve line this indicates a need to augment labour. I could find no rule to support this practice although I know from my own practice that once upon a time one did exist. Hence

Susan in her quote refers to an unwritten rule but nevertheless the midwife in question withholds information from a more senior colleague.

The midwife is accountable for her own practice practice (UKCC 1992, 1996, 1998) nevertheless it is usual for midwives to keep the midwife in charge of the hospital ward up to date. This is a courtesy but also provides the senior midwife with the opportunity to offer advice if she considers it to be appropriate and to up date other practitioners such as doctors if they enter the practice area. This midwife was disregarding an unwritten rule and not breaking a formal rule.

Zimmerman (1971) acknowledges that formal rules cannot account for all behaviour within an organisation. It is not surprising that rules are sometimes broken when so many of them are implicit (Abraham & Shanley 1992). These 'unofficial practices' were not acknowledged by Weber (1947) but are a recognised feature of any organisation (Blau 1963). Indeed it is acknowledged that rules cannot cater for every act or situation (Ausubel 1968) and Schön (1987:4) suggests that practitioners frequently encounter 'messy indeterminate situations' for which rules do not provide the solution. It may be for this reason that I found no evidence to support other practitioners or professionals rigidly following the rules as some midwives were observed to do.

Zimmerman (1971) drew attention to the importance of exploring how rules are used. In doing so he suggests that individuals in organisations sometimes use the rules to explain and justify behaviour. This is supported by students' observations of some midwives who rigidly followed written and unwritten rules without thought. Such a view is, however, simplistic because it fails to account for the behaviour of those midwives whom students' perceived to bend the rules and also ignores the many other factors which may influence behaviour. Research by Dreyfus & Dreyfus (1979a, 1979b, 1980a, 1980b) and Benner (1984) disputes the notion that all behaviour is governed by rules and this is supported by the findings of my study.

Summary

It has been shown that the way in which midwives interpret and use the rules of practice varies. Rules may be rigidly followed or professional judgement may be used to adapt the rules to meet the individual needs of women. In the next chapter the influence of the rules on the way in which students' role models practiced and the influence of this on the midwifery care women received will be explored.

Chapter Five

The Role Models

Introduction

According to students the way in which rules were used governed the way in which midwives practised and the midwifery care women received. This chapter examines the influence of rules on the way in which midwives fulfilled their role.

The influence of rules on the midwife's practice

The way in which rules were used and interpreted influenced the autonomy of midwives and hence the way in which they practised. Autonomous individuals make their own decisions and are in charge, or, in control of their own lives and work. Pritchard (1996:196) defines autonomy to mean 'the practitioner's right to make her own decisions without interference from doctors'. Pope et al (1996) identified that midwives interpret autonomy in different ways. For example it could mean the provision of midwifery care with or without involvement of a doctor. When all care is provided by midwives this might suggest that it is midwives who make decisions related to a woman's care, while participation of a doctor could mean either that the doctor alone makes decisions or there is collaboration in decision making. In support of a woman-centred model of care a suggestion by Fraser (1995:175) appears to be more appropriate. She claims that autonomy 'implies a responsibility (of the midwife) to know when she is free to take a decision, when her own judgement is sufficient-or insufficient-and when she needs to involve others'. In this study students perceived their role models to be autonomous if they used their professional judgement to make decisions related to care rather than relying on rules to dictate their practice. Role models who practised autonomously were also seen to be capable of acting independently, seeking help from other health professionals or support services only when it was appropriate to do so. Some midwives did practice autonomously but others did not. It is this latter group who lacked autonomy that will be examined first.

Relying on doctors

Midwives as 'practitioners in their own right' are not something that students always observe in clinical practice (Davies 1988, Chamberlain 1993, Emmons 1993, Begley 1997), a view supported by students' data collected in this study. When midwives were observed to rigidly follow rules the use of professional judgement was, according to students noticeably absent from the midwife's practice. Students observed these midwives frequently referring to doctors at the slightest sign of any problems:

> **Elena**
>
> They're still guided by somebody, and if there's any problem they obviously call an obstetrician who makes a decision anyway. I thought they were supposed to be independent practitioners.

Rather than acting as autonomous practitioners prescriptive midwives were 'with doctor' fulfilling the role of obstetric nurse or handmaiden to the doctor. An apparent contradiction appeared to emerge from my data. Novices have been shown to follow rules (Dreyfus & Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984) but prescriptive midwives who followed them were, according to students, experienced midwives who had often practised for twenty or more years. A model of skill acquisition developed by Dreyfus & Dreyfus (1980b) will be used to help explain this contradiction. The model reveals the stages individuals encounter as they develop the ability to make decisions using professional judgement. This process of development is associated with progression from novice to expert. The examples Dreyfus & Dreyfus (1980b) use to illustrate their model of skill acquisition are based on chess players and pilots. Benner (1984) used this model as the basis for her research which explored expertise in nursing. These researchers revealed that novices, lacking in experience relied on rules to inform their practice. Initially practice is therefore inflexible. My interpretation that prescriptive midwives practised in the manner expected of a novice needs to be viewed with caution. Analysis of the model of skill acquisition and its application to the way midwives followed the rules suggests such a view is too simplistic.

According to Rolfe (1999) the experienced practitioner, progressively acquires knowledge from practising in the clinical setting for many years. Benner (1984) does not believe that experience can necessarily be equated with years but acknowledges that it is associated with learning something new and therefore developing expertise. Prescriptive midwives were known to have confined their practice to a single area of expertise such as the antenatal clinic or labour ward. They were able to do this because of the fragmented way in which the maternity services were organised. Midwives working in these areas demonstrated those skills that were required specifically for the care of pregnant women and those who were in labour. Experience was therefore confined to one aspect of midwifery care and what experience was gained may well have been repeated many times over. Following the rules meant their practise was based on traditional knowledge, doing as they always had done. Arguably they were not learning anything new.

Benner's use of the Dreyfus model of skill acquisition does not take into account that giving midwifery care based on rules devised by doctors might suggest that midwives were collaborating in the care of clients with other professionals as they are required to do (UKCC 1992). Benner (1984) also ignores statutory obligations which mean that even when a practitioner can be classified as an expert some rules will have to be followed. One of these rules is the legal requirement for the midwife to notify an appropriate practitioner in the event of deviations from the normal in mother and baby (UKCC 1998). According to students midwives who rigidly followed the rules gave no thought to their actions. Thought or cognition is, however a cerebral activity and unless articulated is not visible to the human eye. To assume such a process did not take place may be inappropriate. They may have lacked expert knowledge associated with an education but they did have knowledge derived from experience. Black (1967) suggests that if a rule is to be followed it must be understood. Professional judgement has to be used to make a decision about whether it is appropriate to use the rule. Lacking in any knowledge novices will have to rely on others to determine which rule they follow. Prescriptive midwives were observed by students to make this decision

themselves. By making a decision about when to apply the rule practitioners determine their own practice rather than allowing the rules to dictate their actions. It could be argued then that these midwives were autonomous but the limited way in which they interpreted and used the rules restricted their own practice.

Prescriptive midwives also followed written guidelines. Practice based on these is associated with progression from novice to advanced beginner. This occurs when the practitioner has gained some experience of practice (Dreyfus & Dreyfus (1979a, 1979b, 1980a, 1980b, Benner 1984). These guidelines represent aspects of a situation which recur in other situations. Each aspect is recognised but accorded equal weighting or importance. Priorities at this stage cannot be determined. Although the definition of a guideline used here differs slightly from the definition provided on page 70 the principle is nevertheless the same. Prescriptive midwives with their status as sister were usually in charge of the clinical setting. This responsibility involved the use of management skills which included delegating the care of women to available midwives in the setting, co-ordinating the workload, ensuring staff had their meal breaks and so on. Prescriptive midwives could clearly prioritise when an emergency situation arose. According to students they determined who would do what and were invaluable in controlling events. When it came to organising the ward this was a very different matter:

> Whoever's on, I mean in charge (of the ward) sets the scene for the rest of the (work) shift. If one midwife's on you know it'll be all right and no matter how busy you know you'll enjoy it. Another midwife and you know as soon as she comes through the door that's it. Long face, no smile, don't want to be here and it will be so disorganised no one will know who's supposed to be doing what.

Focusing on an emergency situation requires a series of actions performed in a sequence and could therefore be interpreted as a rule to follow. Co-ordinating the workload in a ward is far more complex requiring management skills in which it is possible many of these midwives had

never received training. Adapting rules requires the midwife to go beyond the decision to follow a certain rule because the circumstances stipulate its use.

The autonomous midwife

Adapting the rules requires a judgement to be made and flexible midwives who demonstrated this quality were perceived to be autonomous:

Ruth

They're the ones who stand up and say I'll take this woman on for midwifery (care) only. This one can have a home delivery. This is no problem. They make the decisions and that's what I thought they were supposed to do.

Letitia

There'll be another midwife who'll say, 'well if you feel you need it (pethidine) we've got the narcan' so there's definitely two ...(types of midwife).

Midwives who were willing to practise autonomously accepted the responsibilities associated with this. They were willing to make the decision for example to give intramuscular pethidine to a woman in situations which prescriptive midwives felt unable to do so. Pethidine administered to women in labour acts as an analgesic. The criteria for its administration are covered by a standing order signed by Consultant Obstetricians and the Head of Midwifery Services. Pethidine has the potential to act as a neonatal respiratory depressant if administered to the mother within three hours of birth. The unpredictable nature of labour means that no matter how experienced the midwife, sometimes this drug is given within this time span. Neonatal narcan administered to the baby after birth acts as an antidote. Decision making involves taking risks (Orme & Maggs 1993) It was evident to students that role models who adapted the rules had the confidence to take the risks associated with decision making when it was in the interests of the mother to do so. Initiative and discretion were used to determine when to administer this drug. When taking risks midwives demonstrated to students that were

prepared to 'watch and wait' rather than immediately seek the aid of a doctor and, by doing so, were able to acknowledge that the parameters of normality were unclear and midwifery practice was not an exact science.

Professional judgement requires the midwife to review the knowledge she has of all relevant aspects of the situation and choose the action which will achieve the goal (Price 1995). Incorporated within professional judgement are the decisions which midwives make as they fulfil their professional role and also the process involved in making those decisions. Knowing what data to collect, its significance and establishing whether that data fits patterns of existing knowledge are all part of that process (Gordon 1987). Professional judgement is therefore associated with knowledge and experience gained over a period of time in which the practitioner progresses from novice to expert (Dreyfus & Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984). Integral to professional judgement is the concept of accountability. Midwives must be able to justify their actions (UKCC 1998, 1996, 1992). These concern the care they give and any omissions to that care (UKCC 1992). It is the professional knowledge, judgement and skills which are used to make decisions that enable the midwife to provide an account of her actions (UKCC 1996). Crucial to any judgement is the wellbeing of clients (UKCC 1992, 1996, 1998).

Once again an inconsistency emerged from the data. Practitioners who use professional judgement are experts (Dreyfus & Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984) but flexible midwives were perceived to lack experience. Although established in their role they had usually only been qualified for 5-6 years. To become experts they would first have to achieve competency and proficiency. Competency is required to adapt rules (Blau 1963). Competence in giving care is associated with the ability to deliberately plan actions. This is the third stage of the model of skill acquisiton (Dreyfus & Dreyfus 1980b, Benner 1984). The situation is analysed and decisions are begun to be made about what aspects are, or are not, relevant and important in the current situation. If prescriptive midwives do not adapt the rules this might suggest they lacked competence. Fraser et al (1997) and Hindley (1999), however, all comment on the lack of consensus about how competence is defined.

Prescriptive midwives possessed the necessary psychomotor skills which enabled them to offer the medical model of care, and entry of their name onto the professional register was an indication that their practise was safe. Based on this definition prescriptive midwives were competent practitioners.

With further experience proficiency is achieved. At this stage the situation is perceived as a whole rather than made up of individual aspects. Maxims are principles which may have different meanings in different situations. They guide practice but are only understood by those who already have a good knowledge and understanding of the situation (Polanyi 1962). Analysis of the situation does, however, remain an important feature of decision making. When proficient, practitioners have numerous situations (Dreyfus & Dreyfus 1979a, 1980a, 1980b, Benner 1984) or a 'repertoire of cases' (Schön 1983) stored in their long term memory which are compared and contrasted with the current situation. Midwife 16's decision to permit the woman to push because the birth was imminent (see page 80-81) could only be based on knowledge and perception of the whole situation. This requires the midwife to be either a proficient or expert practitioner. (Dreyfus & Dreyfus 1980b). Eraut (1994) makes a distinction when he suggests that the competent practitioner, although unable to perceive the situation as a whole, is proficient when performing skills, a view which Benner (1984:27) alludes to. Midwives who 'cut corners' which was associated with completing skills to meet physical needs could therefore be interpreted to be competent or proficient but could also have achieved the level of an expert.

Expertise is associated with an intuitive response. Often referred to as a gut feeling (Carper 1978, Benner 1984) conscious thought is not a characteristic of this level of expertise (Dreyfus &Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984, Eraut 1994, Rolfe 1998). It is the use of tacit knowledge, that is knowledge which cannot be articulated (Polanyi 1962) which informs decision making and this can account for an individual's inability to explain the rationale for their actions (Rolfe 1998). According to Magill-Cuerden (1993) this intuition emanates from an integration of knowledge and skills. Based on the Dreyfus's model expert practitioners

no longer require rules, guidelines or maxims to help them make decisions and analysis of the situation only occurs if the intuitive response is considered inappropriate. Ultimately action can be faster than thought (Dreyfus & Dreyfus 1979a).

Dreyfus & Dreyfus (1979b) and Benner (1984) equate a lack of conscious thought with dropping the rules. Dreyfus & Dreyfus (1979b) suggest dropping the rules is not simply a case of the rules being consciously forgotten and subconsciously used, because expert performance bears no resemblance to the performance of a novice. If forced to revert back to rule governed behaviour expert performance deteriorates to a level below that expected of the novice. This may be because such an exercise requires individuals to consciously think about what they do. According to Schön (1983) thinking and doing are complementary. It is the interaction of each, which enhances performance. While this may be true of expert practitioners choosing their next skilled action, the complexity of thinking required of the expert to return to practice based on rules may indeed be detrimental to performance. The practitioner must think about how the skill is to be performed, recall the rules and compare these with their intuitive performance. In other words the practitioner must unlearn their previous skilled performance and relearn, while the novice has only to learn the skill for the first time.

Rolfe (1998) provides an alternative perspective when he makes a distinction between psychomotor skills in which expertise is achieved through repetition, and skills associated with high levels of cognitive ability. When undertaking a technical move in a game of chess the expert cogitates on the situation which suggests the rules are not dropped, whereas driving a car becomes automatic. There are therefore different levels of expertise in psychomotor skills and cognitive ability which the Dreyfus brothers failed to recognise (Rolfe 1998). Bending the rules is therefore associated with expertise and enhances performance. However, what may sometimes be perceived as dropping rules may be viewed as interpreting them. Judges of the law are known to assess situations and then apply the relevant rule. The rule therefore has to be interpreted for it to be appropriately applied (Manning 1971). In this instance cognition is a

conscious act. Alternatively the process of cognition may not be a conscious one but needs to be made explicit if students are to learn how to make decisions and also become experts.

To make decisions based on intuition the practitioner must be an expert. To be an expert means they have knowledge and experience associated with at least five years practice (Benner 1984). Benner (1984) suggests that proficiency is associated with three to five years of practice with the same patient group. Using this time scale students' suggestions that flexible midwives were inexperienced appears to be correct. However, it is questionable whether, according to this model they could even be classified as proficient. These role models usually had a variety of clinical experiences gained from moving or rotating at regular short intervals from one clinical area to another. The purpose of this 'rotation' was to enable midwives to consolidate what they had learned during their pre-registration midwifery programme. The provision of this fragmented care would limit opportunities to become proficient or expert in any one area or in all aspects of the midwife's role. Lacking experience, they were mostly graded as staff midwives.

Dreyfus' model implies that novices lack intuition and only experts can possess such a quality. When exploring the therapeutic relationship in midwifery practice Siddique (1999) acknowledged the midwife's ability to intuitively recognise when labour was progressing normally or becoming abnormal. Following the rules would suggest that midwives who interpreted the rules and used them in this way lacked intuition but Zeta dispelled this notion:

> She (the midwife) could see a problem occurring long before it ever occurred, even signs of something coming.

Zeta was the seventeenth student I interviewed. Analysis of data collected from all previous and subsequent interviews failed to reveal any other reference to the issue of intuition. Reliance of these midwives on the rules probably gave them little opportunity to demonstrate this quality and this could account for why most students failed to observe it. It is important to

note that although anticipating an outcome before it happened there was no evidence in my data to suggest the midwife intuitively made decisions based on 'gut feelings'. The findings of this study cannot say that midwives who rigidly followed rules lacked intuition. It was beyond the scope of this study to explore the issue but when I encountered the work of Cioffi & Markham (1997) and Cioffi (1998) I returned again to my data. When midwife 16 was asked how she knew a woman would manage to push her baby out when she had said 'we weren't really getting anywhere', she responded, 'well if it had been an OP (occipito posterior position) there's a chance she wouldn't, but in this instance I knew it was (an) OA (occipito anterior position)'. This suggested that some midwives use heuristics to help them make decisions. Heuristics are principles that simplify and facilitate the decision making process (Cioffi & Markham 1997, Cioffi 1998). The statement made by midwife 16 could be classified as a 'production rule'. Such a rule should state a condition or prerequisite for a specific outcome. If complete, this rule would read, if the fetal position is OA the outcome is likely to be a vaginal delivery. The outcome is, however, unstated but any midwife who knew the context in which this was said would be able to complete the rule. Cioffi (1998) suggests such rules are intuitive rather than explicit. They are acquired through experience in clinical practice although the knowledge is originally derived from textbooks. It is the interaction of knowledge gained from these books and clinical experience which enables the rules to be formulated and their meanings to be understood. Use of these rules might therefore be associated with midwives like midwife 16 who had a number of year's experience practising in the clinical setting.

Dreyfus & Dreyfus (1979b) argue that the acquisition of professional judgement is associated with dropping or suspending the rules on occasions rather than bending them, a view which is supported by Benner (1984). If students are to become autonomous practitioners and safe in their practice they need to be aware of the distinction between rule bending behaviour or interpreting rules, dropping the rules and the consequences of such action. The latter could be interpreted to mean breaking the rules which has negative connotations. It could be argued that disregarding written rules was not an option for midwives or indeed the

students who worked with them because of the potential harm to mothers and babies and the subsequent risk of litigation and investigation into misconduct (UKCC 1998). Yet it was shown in the previous chapter that midwives did break the rules when they inaccurately recorded the onset of the second stage of labour.

Students are not always involved in the decision making process and this does not promote confidence in newly qualified midwives (Chamberlain 1993, Begley (1997). The decisions that midwives make, and how they came to make those decisions is important. If students are to become autonomous practitioners they need to know how to make decisions. When acting as role models it is possible their actions will be observed and emulated by students. Midwives therefore need to develop their ability to articulate the knowledge that informs their practice.

The influence of rules on maternity care

Analysis of data revealed that the way in which midwives practised inevitably influenced the maternity care women received. When midwives rigidly followed rules they dictated 'what should or shouldn't happen'. Because these midwives prescribed care and were so inflexible I named them prescriptive midwives. Flexibility can be defined as the ability to adapt to prevailing circumstances. Midwives who adapted the rules provided individualised care and for this reason I called them flexible midwives. The care women received depended on whether they were being looked after by a prescriptive or flexible midwife.

Prescriptive midwives

These midwives were noted by students to share the philosophy of the medical profession that childbirth is only normal in retrospect and therefore practised the medical model of care that was described in the introduction to this study. Prescriptive midwives provided the same routine care for all women irrespective of their needs. Once behaviour has become routine the opportunity for flexibility is removed and familiarity means alternatives are not sought (Bandura 1977). It is worth acknowledging that rituals do have advantages. Chapman (1983) suggests they can have social meaning. They can enable individuals to learn

specific skills or the rules of practice and maintain the smooth functioning of a hospital ward. Rituals may therefore be particularly important when many staff such as junior midwives did not work permanently in any one clinical setting. Rituals may also be a valuable means of passing on professional skills and culture (Bradby 1990). It is important to remember that the maternity services and the professionals providing the service were experiencing uncertainty due to National Health Service (NHS) reforms and pressure to adopt alternative approaches to care (Davies 1988, DOH 1993). Ritualistic behaviour in these circumstances may have been a strategy to reduce anxiety (Menzies 1970) and help them cope with uncertainty (Helman 1990). Chapman (1983) argues that although the way in which care is organised within the institution may reduce anxiety, it is that anxiety which is responsible for the way the service is organised.

Rules are devised to protect the public and to ensure all clients receive the same high standard of care. It was apparent to students though that this routine care often failed to meet the needs of women and this is supported by the literature (Oakley 1980, 1993, DOH 1993):

> **Letitia**
>
> I've (the midwife) told her (the woman) that she can't have pethidine yet because she's not 5 centimetres (cervical dilatation) yet, and she doesn't need it. Then you'll (the student) go in, and the woman will say, oh I want pain relief.

My own knowledge of the rules suggests withholding pethidine from a woman in labour until her cervix is 5cms dilated is an unwritten rule and a routine practice for one particular midwife. Following the rules implies the midwife knows what care is best for the woman. In this instance the belief does not coincide with that of the woman whose own expertise is not acknowledged and her needs not met. There is evidence in the literature that professionals do not always know what care is best for women (Chalmer et al 1989). Pubic shaving (Romney 1980), giving enemas (Romney & Gordon 1981) and performing episiotomies (Sleep 1984) once ritualistically performed are all well known examples of practices which have been discontinued in response to research evidence which suggests

they are harmful. Practitioners can only act on available evidence. What is perceived to be best care will therefore change over time. It is acknowledged that in the hospital setting research findings are not always incorporated into the care given to pregnant women (Garforth & Garcia 1987, Chalmers et al 1989). This finding has been revealed in my own study (see page 72). Contrary to the view that rules facilitate the provision of quality care rigidly following them means harm may be done and practice cannot be justified. Midwives are denied the opportunity to be flexible and focus care on the needs of women even if they should want to.

It was evident from students' comments that midwives' belief that they knew what care was best, meant women had no choice in their care they received. This was evident in the previous quote of Letitia and reinforced by Rachel:

> **Rachel**
> With a lot of the midwives, particularly my mentor who was... it was a case of 'you're having a baby. I know what I'm doing, you need me to do what I'm doing, do what you're told when I tell you and everything will go safely'. So there's not a lot of 'how did you (the woman) feel you wanted this to go'.

The Department of Health (DOH 1993) believes that women's autonomy should be respected but prescriptive midwives lacking in autonomy themselves denied clients their own autonomy. Information given to women by these midwives was, according to students, restricted and biased in favour of the medical model of care from which the rules were derived. This strategy may have consciously or unconsciously been designed to encourage women to accept care prescribed for them. Restriction of information was also demonstrated in Kirkham's (1987) qualitative research study which explored communication between women in labour and the midwives who cared for them. This may have been due to discomfort associated with implementing policies with which midwives were unhappy. That midwives believed they knew what care was best for women may also account for this behaviour. The tone of voice (conveyed in Rachel's quote) with which women were told what care they would

receive, did not go unnoticed by students, and students' observations were of women being manipulated and intimidated into receiving the medical model of care. Flint (1995) has referred to women emotionally blackmailed into receiving types of care such as hospital birth which they do not want. It is thought that the use of such tactics promotes feelings of irresponsibility in the women if they do not comply with professionals' advice. Without the informed consent of women, midwives were observed by students to coerce women into accepting care they might not otherwise have agreed to. Students observed the reactions of women to their prescriptive carers and it was evident to them that these women, many of whom were experiencing childbirth for the first time, fitted in by unquestioningly accepting the care they received even when it did not meet their needs. This may have been because they believed the health professionals knew what care was best for them (Bluff 1993, Bluff & Holloway 1994). In this way midwives who were themselves women, dominated women and controlled their birth experience.

According to students coercing women into having forms of care they did not want affected the relationship between women and the midwives who cared for them. The medical model of care is associated with the concept of paternalism (Gillon 1985). In this relationship the doctor often acts as a parent who has authority over the child, the patient. In this study some midwives who acted as role models were noted for their maternalistic attitude towards the women they cared for, and this was clearly visible to students who had themselves been on the receiving end of this type of relationship. By following rules midwives exerted authority over them and were seen to be perpetuating what Szasz & Hollender (1956) describe as the activity/passivity relationship. Such a relationship in which the midwife actively gives physical care and makes decisions about that care while the woman passively receives the care that is given, promotes dependency of women on their midwife and reinforces the concept of 'they know best'. However, in the best relationship there is a close bond between mother and child. In the presence of unconditional love the child is nurtured and given the opportunity to grow and develop into a well adjusted, independent adult with a positive self-concept. Role models who were prescriptive did not, however, act as nurturing parents. This was

evident by the midwives' failure to establish a relationship with the women and participate emotionally in their experience of childbirth. Students suggested that lacking in any ability to empathise, these midwives remained detached from the women. It is recognised that adherence to rules promotes detachment rather than personal involvement in situations (Weber 1947, Dreyfus & Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984). Perceived as technicians the relationship between midwives and the women they cared for was, by students' standards, impersonal and failed to acknowledge the women as individuals with feelings and emotions:

Anne

They're so distanced from them. I feel that if you're in there all the time you get to know them (the women). You know you shouldn't like, you shouldn't be (popping in), I know you have to do obs (observations of physical condition) half hourly but that doesn't mean you can go out for twenty eight minutes and come in for two and go out again.

Rachel

They have no real feeling for the women, um, and I don't know how they can do their job really. If she was looking after me I don't think I'd feel that she was taking part in my experience anything other than as a technician... They don't seem to develop any sort of relationship with that person. They're very upright and perfunctory. Does her job. Doesn't sit and chat to them particularly, none of that. It's a case of she's having a baby, she will have a baby, and what goes on between, you know, being pregnant and being a mother has got, well, not much to do with it at all, and you know we'll get a baby out of it and that seems to be the aim rather than to have any sort of, you know, a positive experience.

This emotional distance and the failure to establish a close relationship with women are features of what McCrea et al (1998) call the 'cold professional' approach. Stapleton (1997) in a study which explored how

midwives and clients interpreted the meaning of 'choice' and 'risk' suggested that the hospital environment and its hierarchical structure were responsible for the lack of feeling in the relationship between midwife and woman. When behaviour is determined by rules there is no regard for the feelings of colleagues or individuals (Weber 1947). The type of relationship midwives were observed to have with their clients also provided further evidence of the influence of the medical model of care on the midwife. Medicine focuses on the body and how it functions. When the mind is separated from the body, the body becomes a machine. According to Vuori & Rimpela (1981) views of the body as a machine appear to have originated from Descartes but have been retained within the medical model of care. The desire to cure the sick body has resulted in a model of care that places greater emphasis on achieving measurable outcomes rather than on the process of birth. This may account for students' observations that some midwives were concerned only with the mother and baby as an end product, placing little importance on the women's experience of birth. According to students, the lack of feeling, detachment and the failure to remain with women in labour meant that some midwives did not meet the emotional needs of women. Popping 'in and out' merely to carry out observations which provide vital feedback on the physical status of mother and fetus provided no opportunity to establish a relationship between the midwife and the women. It must be stated, however, that although many midwives did not themselves provide this emotional support, it would be wrong to assume that women never received support of this nature. Midwives were observed by students to delegate the task of providing support to women in labour to the student midwives. In an ethnographic study of midwives in the hospital setting, Hunt & Symonds (1995) observed that sisters in their study did not consider emotional support 'real work'. Completing administrative tasks and presence at the birth of the woman's baby does not, however, provide opportunity for development of a relationship and involvement in the process of birth. When the issue of what happens in the absence of students to provide emotional support was raised, students commented that women were left with their partners. The Audit Commission (1997) confirmed this when they reported that one in four women were left alone

during labour. The reason given for this was the inadequate number of midwives available at times when the labour ward was at its busiest.

A picture emerged from students of prescriptive role models who outwardly appeared to be uncaring. Roles are associated with specific behaviours (Ruddock 1969, Biddle & Thomas 1979), and midwives are expected to demonstrate care for other people. The behaviour of these prescriptive midwives was therefore contrary to the role of midwives and did not meet the expectations of students:

Anne

No I think you're quite naive when you start the course. You think if they're midwives they must be nice people. They must like looking after people, don't you. You presume stupidly that they're all nice and want to care about people but then you realise and think my god these people! I know you get that in any job but some of the things they say, you think, well, they don't like people.

Prescriptive midwives were not necessarily uncaring. It may simply be a reflection of the medical model of care to which they adhered and the influence of the environment in which they practised which both Merton (1949) and Goffman (1961) suggest can dehumanise the individual. The loss of ability to care may also occur when people become 'stuck in a rut', doing what is perceived to be a job that requires no thought (Goffman 1961).

Associated with this apparent lack of caring was the lack of action when the well being of clients was at risk. An advocate in relation to maternity care is an individual who speaks up on behalf of a pregnant woman about aspects of her care and challenges practice to meet her needs (DOH 1993). These midwives did not question practice they participated in when to students it was clearly detrimental to the client:

Elena

I mean we've got a reg (Registrar) on delivery suite who did a ventouse (instrumental vaginal delivery) which was so disgusting. I mean she got the suction cap there (indicates forehead directly above left eye) and this baby had a huge like haematoma there, I think that's the right word, like a huge bloody bruise as big as the suction cap and the midwife who watched it actually thought that she's doing that wrong, but didn't say anything because the woman who was doing it was a registrar and she was a midwife, but she knew that what she was doing was wrong, and she didn't say anything afterwards either. What they did was moan and moan about it, and the parents were horrified at the baby's face. It just missed her eyes by that much (indicates level of eyebrow). But nobody really said anything.

Kelsey

There's been a lady I had who stayed at home until she was 9 centimetres (cervical dilatation) because she's had a previous ventouse and caesarian and she wanted a normal delivery so she tried to stay at home until as late as possible, came in screaming in the ambulance and tried to give birth in the car park. Came in, had fetal distress. Doctor came flying in with the ventouse machine and the tube was blocked, the manufacturers I don't know what they'd done but it was blocked so she tried three sets of tubing but it hadn't worked and she (doctor) promptly kicked the ventouse machine across the floor, started screaming and swearing about no wonder people died in hospital and it was incompetence, swearing, shouting and the poor father was standing in the corner and everyone had forgotten about him and he was just like in tears. So I grabbed his arm and said come and hold her hand, because I didn't want him to see this gore and things so he would be fainting. And the parents had to listen to this doctor screaming and shouting about how rubbishy the equipment was and she couldn't work under these conditions. And then she finally had

> a forceps and the baby out she threw the forceps across the room. They bounced across the delivery trolley and bounced off and flew just missing this medical student's head and (laughs) almost decapitated him (laughs). So they do get a bit...

When I asked Kelsey what the midwife did while all this was going on her response was:

> She stood in the corner. It was just oo doctor on the warpath, stay out of the way and they do tend to do that.

Midwives are accountable for their practice and this includes any omissions in midwifery care. Reluctance to verbalise their concerns and take action such as calling for a more experienced doctor could be interpreted as failure to act in the well-being of clients which clearly contravenes the Code of Professional Conduct (UKCC 1992). This is an issue that will be returned to in chapter six.

Hospital environments are known to be bureaucratic although they do not entirely fulfil Weber's definition of the ideal type (Etzioni 1964). Rules are a feature of bureaucracies. The way in which a bureaucracy functions is governed by rules that determine the behaviour of those who work within it (Weber 1947, Etzioni 1969). The characteristics of prescriptive midwives which also emerged from data collected from students and confirmed by midwife participants are all features of the model of care they practised and the hospital environment in which they practised.

Handy (1993) suggests that where the work is routinised, rules and regulations work well. This does, however, raise the issue of who benefits from the rules. Rules can be perceived as rational if they enable the goals of the organisation to be achieved (Sims et al 1994, Weber 1947). According to Weber (1947) they also provide the means by which the organisation's workload can be efficiently and effectively controlled. This might work in business organisations dealing with products rather than people. However, the goal of the maternity services and midwives working within it, is to ensure the safe delivery of mother and baby and

ideally provide a fulfilling experience of childbirth. Emphasis was placed on the product rather than the process of birth although in the above instance the safety of a baby could have been compromised. Prescriptive midwives did get through the workload. On the ante and postnatal wards this was often achieved by the end of the morning when there was the whole day in which to achieve it. When midwives rigidly followed the rules the interests of the organisation were thus seen by students to take precedence over those of mothers and babies. 'This displacement of goals' (Merton 1949, Etzioni 1964) is associated with the 'bureaucratic virtuosos' who knows all the rules (Merton 1949:198). The 'displacement of goals by someone who knows all the rules implies a conflict between fulfilment of the midwife's professional role and the hospital environment. Rules appeared to have become 'symbolic' rituals rather than serving a specific purpose (Merton 1949). Arguably prescriptive midwives did know the rules but the displacement of goals was associated with a failure to distinguish between those that they had to apply to their practice and those they did not. Viewed from this perspective it was not the bureaucracy that restricted practice but prescriptive midwives' own lack of knowledge and cognition. Students' perceptions were of midwives for whom midwifery had become 'just a job'. If the rules had been appropriately applied in practice, students' observations of these role models might have been very different.

Flexible midwives

When midwives adapted rules they used the rules to facilitate the midwifery care they gave to women. The purpose of the rules was not according to students to get through the work but as Kelsey commented:

> They (midwives) don't set out to flaunt the rules or to go outside the policies, they actually set out to give individualised care to women.

Flexible midwives had greater insight into the rules. They knew the difference between the written and unwritten rules and unlike their prescriptive colleagues had not displaced the goals. It will be remembered that these midwives practised in the community setting which was less

restricted but adapted to the rules of the hospital when they entered this environment. Adapting the rules enabled midwives to be flexible and meet the needs of women. In doing so they provided the woman-centred model of care. They were also committed to providing all care that was needed for women who were classified as 'low risk', acting as an advocate for the women to ensure they achieved what they wanted:

Ruth

> They (flexible midwives) do all of the care themselves. They see the whole woman from start to finish. They see the social circumstances, the psychological needs and they are the ones who generally give the holistic care from start to finish. They'll stand up to the GP and say 'there's no reason for her to have a consultant. There's no reason for you to write to the hospital lets leave the hospital, she just wants us and so they are more confident and um to stand on their own.

The attitude and approach to care adopted by flexible midwives was in direct contrast to that provided by prescriptive midwives. That these role models cared about the women was obvious to students who witnessed their interactions with the women and their involvement in the process of birth. They were perceived to make the women feel 'special', and it is the emotional involvement of the midwife which McCrea & Crute (1991) suggest creates this feeling. These were the midwives who demonstrated to students that they wanted the women to be autonomous and in control of their own experience of childbirth:

Kelsey

> She always left them feeling good about themselves and I think that is such a gift to be able to do. To be able to make people feel good about themselves. And particularly in pregnancy. So much of the way we care for women takes away their, that feeling about themselves, that sense of control that she used to be able to be, actually give them the feeling that they had complete control and that they were brilliant parents, or they were going to be brilliant parents, and that they were doing

really well in pregnancy you know. That sort of thing, that ability even when there was not such good news she still managed to leave them feeling in control. The decisions were theirs. That they were capable of making those decisions.

Ruth

They don't (junior midwives) want to control, they want to give the women control, their choice. If you want to get in the pool get in the pool whatever.

By providing women with an opportunity to be in control of their own birth experience, these midwives were seen to provide women with individualised midwifery care that fulfilled their needs. They were observed to respect women, taking time to sit with them, listening, talking to them and responding to individual needs. Through this interaction a relationship based on trust and friendship was established and emotional support provided. When in labour, women were not left alone unless it was appropriate. However, it must be remembered that community midwives were more likely to be flexible. In the community setting care is provided on a one to one basis, and it could be argued that these midwives had time for this interaction which their hospital counterparts who were sometimes looking after three women in labour, did not have.

By involving women in the decision making process role models that were perceived by students to be flexible gave women the opportunity to be partners in care. In doing so they were recognising that women had their own expertise, were autonomous and had an understanding of what they thought was best for them. Offering emotional support, making the woman feel special and the partnership in care which flexible midwives achieved are all features of what McCrea et al (1998) called the 'warm professional'. The type of relationship these midwives had with women was more equal. It is questionable whether women can have an equal relationship with their midwife when the possession of knowledge is balanced in favour of the midwife. Flexible midwives were, however, noted for keeping themselves up to date on practice issues by referring to the literature. This commitment to life long learning was also apparent to

students by the way in which these midwives were seen to attend continuing educational courses over and above those that met the statutory requirements. The information flexible midwives acquired was passed on to the women they cared for. According to students it was also used to justify their practice. In this way flexible midwives shared their knowledge with the women and in doing so appeared to achieve the mutually participative relationship described by Szasz & Hollender (1956) in which clients are able to make their own decisions. Students perceived the relationship between midwife and woman to be pivotal to the care received. The characteristics of flexible midwives and the care they offered to women suggested that these midwives fulfilled the real meaning of the word midwife to be 'with woman'.

Few midwives had the characteristics of either flexible or prescriptive midwives suggesting a continuum which would explain the behaviour of all midwives.

The Practice Continuum

Practitioners have to apply models of care to clients so that these models cease to be abstract concepts and become reality. People's perception of reality differs hence there are 'multiple realities' and no one model can provide a complete view of care. Students observed that the care women received varied suggesting that the medical and woman-centred models of care could be placed on a continuum which supports the view expressed by Bryar (1995). When I re-interviewed students and they confirmed my analysis of the data it was suggested that only two or three midwives they encountered were either completely prescriptive or completely flexible. Suggestions that there were more than two types of midwife could not be verbalised by students or midwives but students did acknowledge that the midwives with whom they worked were all different. Prescriptive and flexible midwives could therefore be classified as 'ideal types'. An 'ideal type' is an abstract concept consisting of key characteristics which are features of real cases (Weber 1947). Placement of midwives on the models of care continuum and the environment in which they practised may account for the variations in practice and the degree of autonomy which students witnessed. Students observed role models that demonstrated some

flexible characteristics but still determined options for care and restricted women's choice. For example, it was suggested that some midwives still believed they knew what care was best for the women and got annoyed on the rare occasion a woman refused an aspect of care:

Elena

Um, yes, but their interpretation of what's best for the woman may vary dramatically. I mean, for some it will be, what's best for the woman is as pain free a labour as possible. For others with a much more radical approach its got to be much more spiritual so the prescriptive and the flexible would, it's they know best, and I think it's almost that as well at the flexible end to be honest unless you make the flexible end the radical end because they do like act as though they know best and may be in a lot of situations they do.

Elena's reference to the term 'radical' can be related to the independent midwives who are often called radical midwives, a name they gave themselves when they opted out of the NHS to go back to their origins and practise autonomously. It might therefore be assumed that these midwives were very flexible. It was however, beyond the scope of this study to interview radical midwives to ascertain the extent of their flexibility. The small numbers of such midwives in the geographical area of this study might also have compromised confidentiality and their anonymity.

Implicit within the medical model of care is the traditional practice of confining the labouring woman to bed and giving birth in the semi recumbent position. Evidence of flexible characteristics was sometimes limited to bending these unwritten rules and allowing women to mobilise and adopt alternative positions:

Elena

They only really give tiny options. I mean the options getting off the bed. They're very small options within the way you could practise midwifery. I mean they give them some options like the position for delivery which is important. Like they'll

say 'why don't you try a different position?' But they don't like (women) eating (in labour) and like where pain relief is concerned they're all, without any exceptions very keen on pain relief, I suppose literally to relieve the pain. Why be in pain when you don't have to be. So I've never heard a midwife say 'why don't you think about it before you have that?' As long as they're 4cm (cervical dilatation) or 2 (centimetres cervical dilatation) whatever, then they'll (the women) have it (pain relief). So they will give them some option but only within a small area. It's usually a time thing (timing of the onset of the second stage of labour). That's what they bend the rules with most of all. It's the time but really that's all they bend the rules with. They're all really quite similar.

Anne also noted this similarity when she commented 'they even say the same things'. Although most students suggested that prescriptive midwives were in a minority, the overall impression was one of students predominantly working with prescriptive role models unless they were in the community setting. Despite the variations in practice students most frequently talked about midwives with prescriptive features. In this, the impact of their experience in the labour ward cannot be underestimated. Prescriptive midwives were particularly notable for their presence in the labour ward where, as senior staff, many of them were witnessed working together as they provided the permanent core staff. Students always returned to this clinical setting for a second and in some cases a third allocation. From the students' perspective it would appear that in terms of professional practice the culture of midwifery had, in the past, been responsible for the production of midwives providing the same care for everyone. Younger midwives however, demonstrated a shift in this culture away from the medical model of care to one that focused on the needs of women.

Summary

Students claimed that some midwives rigidly followed the written and unwritten rules of practice. These midwives I called prescriptive. The characteristics of these role models reflected the medical model of care

and the institution in which they worked. The rules they followed determined the role they fulfilled which was that of an obstetric nurse. Lacking in autonomy these midwives were observed to subordinate themselves to doctors. When midwives were perceived to bend the rules, they were flexible in the provision of midwifery care and met the individual needs of women. They provided a woman-centred model of care and in doing so demonstrated that midwives could practise autonomously. These midwives I called flexible. The following chapter provides an account of the conflict students witnessed when these two types of midwife practised together in the hospital setting.

Chapter Six

Role Conflict

Introduction

Analysis of data presented in the previous chapter has demonstrated that students worked alongside role models with very different professional identities. These identities reflected the philosophies on which midwives based their midwifery care and the environment in which they worked. Each represented a different culture. Culture incorporates the attitudes, values, beliefs, behaviour, habits and all other aspects of life within a community (Symonds & Hunt 1996). The culture therefore defines the norms or rules which determine how individuals will behave and when learnt is passed from one generation to the next.

Role theory suggests that roles are associated with certain expectations (Ruddock 1969). Such expectations or norms are the means by which the behaviour of group members may be judged. The role of the midwife is associated with a number of functions or activities (UKCC 1998) and the expectations of the midwife's role include how the functions of the role are fulfilled. Fulfilment of the role is open to interpretation by persons occupying the role. When members of the role set have differing expectations of how the role will be fulfilled, conflict is likely to occur (Ruddock 1969, Kramer 1974, Biddle & Thomas 1979, Handy 1993) unless individuals identify effective ways of coping (Turner 1962). Prescriptive and flexible midwives had very different interpretations of their role. Rules which are shared are believed to be necessary to maintain social order and avoid conflict (Douglas 1970). Flexible midwives did not, however, share prescriptive midwives' belief in the unwritten rules. This chapter reveals the conflict which students frequently witnessed between their prescriptive and flexible role models when they worked in the same hospital setting and how flexible midwives coped with it. Central to this conflict was the autonomy which flexible midwives sought and the restrictions prescriptive midwives attempted to impose on them.

The culture in which students were learning the role of the midwife was still one in which the medical model was perceived to predominate. The

functionalist view of society suggests performance is judged on the basis of shared values (Parsons 1951). Students' flexible role models did not, however, share the same values and beliefs as those that were prescriptive. To practise in a manner which is contrary to the expectations of those in authority is considered deviant behaviour (Merton 1949, Becker 1963, Ruddock 1969, Biddle & Thomas 1979). Merton (1949) and Becker (1963) take the view that it is the act or behaviour rather than the individual that is deviant but it is only deviant because of the rules which are formulated and imposed by other individuals (Becker 1963). In this study it was the person or midwife who was labelled deviant. Rather than being accepted for what they are and how they practise, such individuals may be stigmatised (Goffman 1963) and branded as troublemakers (Merton 1949). Once labelled in this way there is potential for the label to be retained and everyday living or work may become difficult because of the administration of sanctions. During the process of primary socialisation the administration of rewards and punishments enables individuals to learn the rules and how to behave. In doing so they learn how to fit in with society. Viewed from this perspective, rules imply that there is either a right or wrong way of doing something. This supports a definition offered by Emmett (1966:12) which states that 'a rule is a directive that acts of a certain kind should or should not be done on certain occasions by a person, a certain kind of person or anyone'. Prescriptive midwives judged the behaviour of their flexible colleagues against their own norms of practice. In doing so, they used the rules of the hospital to determine the right or wrong way for others to behave.

'Getting into trouble'

Midwives who were prescriptive at the extreme end of the prescriptive-flexible continuum were noted by students to have 'strong' personalities. By this students meant they were dominant and assertive. This was demonstrated by the way in which these midwives exercised authority over their less experienced colleagues and indeed the women they cared for. In this study, when junior or flexible midwives practised, and even dressed in a way that failed to meet the expectations of their prescriptive colleagues, they were perceived by students to be 'in trouble' because they did not fit in and accordingly were criticised. Griffith (1996), Davies

(1988), Montgomery (1997), Cavanagh & Snape (1997) and Begley (1997) have also shown that midwives are criticised when they are perceived to break the rules. The destructive way in which students observed their flexible role models being criticised caused embarrassment, distress and anger to students and apparently to the midwives who were submitted to this punishment. Flexible midwives were usually criticised in front of everyone and in this way were intimidated:

Anne

It's very embarrassing. For us it's embarrassing. But because you're a student everyone's used to getting told off in front of everyone. If you're actually a midwife told off in front of everyone it's embarrassing especially when you've got a student. It happened with my mentor and the sister was really having a go at her and I thought how embarrassing. She (the mentor) was furious. She was absolutely furious. She was really embarrassed at the time.

This intimidation of midwives by midwives with more clinical experience demonstrated a lack of empathy for how junior midwives might feel and was consistent with their behaviour towards the women they cared for. Prescriptive midwives enforced the rules by criticising other midwives when they failed to meet expectations. In doing so, prescriptive midwives manipulated the behaviour of their junior or flexible colleagues to ensure they fitted in and conformed to their own way of practise. What students witnessed was 'bullying' (Lyons et al 1995) of junior or flexible midwives by prescriptive midwives in a more senior position in the midwifery hierarchy. It is important to differentiate between 'bullying' and being 'told off' or criticised. It is justifiable for a role model to constructively criticise an individual's practice when it is incorrect or inappropriate, particularly when that care may be detrimental to the well being of mothers and babies. Bullying however, was not associated with incorrect or unsafe practise. Lyons et al (1995) view bullying from the perspective of behaviours adopted by bullies while Randall (1997) prefers to define bullying as the intention to deliberately cause harm, an issue which will be addressed later. 'Bullying' has been an emotive issue in primary (Smith &

Madsen 1999) and secondary school education (Cartwright 1995) for a number of years and is also an issue of continuing concern in the workplace (Overell 1995, Coles 1998). The Royal College of Midwives (RCM 1996:3) defines bullying as 'persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress'. A national survey undertaken by the Royal College of Midwives (RCM 1996) revealed that 43% of midwives had experienced bullying and for 31% of these it was an ongoing problem.

Data collected from midwife participants with flexible characteristics confirmed students' accounts of them being intimidated. It was apparent that such incidences were never forgotten:

Midwife 15

I have actually attempted to speak my mind and be very honest, and it was a nightmare. It was with one particular person and it was probably two or three years ago when it was the norm that anyone (woman) entering the (hospital) doors in established labour was ARM'd (had her membranes ruptured) at the first opportunity. I said I couldn't see any indication for doing it what so ever and talked about research and the reason, and er I was splattered in front of (everyone) and I hadn't been noisy about it. I had just said 'there's no reason to do it, the (fetal heart) trace is fine, I've gone through all my bits and pieces'. I was told it was the policy but it was never actually written down as policy, and I asked her (senior midwife) to show me where it was written, and this was at the point when my head left my shoulders (laughs). After that she didn't speak to me. This midwife wouldn't actually speak to me. She stopped speaking to me which is very difficult in the work environment. She'd ask the others to tell me to admit a lady and if I went to update her on something that was important, something like (laughs) going to (the operating) theatre she just wouldn't even

acknowledge me. I didn't have a weekend off for eight weeks. I'd work four or five earlies (early work shifts) in a row. I'd get dreadful women to look after, I mean hard cases, and I was then the victim of the bullying and it really shocked me how much power people had and although other people noticed that I was being picked on just by one person nobody else would actually say anything. They'd all come to me and say what a shame and you know this shouldn't be happening but nobody came with me and said what are you doing. This went on for about eighteen months. And it really shocked me that someone could have that much influence on my working life. And sometime during this 18 months I actually left the delivery suite and worked in another area and when I needed to contact them I still had all this grief and um, however much you believe in being honest and sticking to your principles it's very difficult to do that when you realise what you're up against because these people do have power. They have power of the off duty. They have power of who they allocate you to (look after) and um... I had a terrible time and after that I became less brave then because my life was suffering. I mean maybe if someone else had stood up at that time things might be different. Everyone turns their backs and it's like it's not them. I know it's not ideal but I haven't got the courage to take on these people single-handed.

Hard cases correspond to what Hunt & Symonds (1995:136) call 'terrible cases' often involving numerous medical interventions and all the additional work that was associated with them. Although students' data referred to these prescriptive midwives as though they were authoritarian parents, it is interesting to note that the behaviour of the midwife in the above quote resembles that of a child who by refusing to talk to someone sends them 'to Coventry'. Randall (1997) notes that this is a more abstruse approach to bullying usually adopted by females. Lyons et al (1995) and Randall (1997) acknowledge that bullying frequently occurs in the absence of witnesses. In my study bullying was clearly visible.

Punishing others when they do not follow the rules may be an attempt to maintain what Strauss et al (1982) refer to as the 'sentimental order' of the ward; in other words, the atmosphere of the ward which is influenced by the interpersonal relationships and group dynamics of those who work within it. The functionalist perspective of sociology suggests that order is maintained by stratification (Parsons 1951) or, in this case the existence of a midwifery hierarchy. According to students these midwives were usually fulfilling the role of a midwifery sister. Their position in the hierarchy therefore gave them the authority or opportunity to give orders to those who were in a subordinate position to them. What students witnessed was therefore the power of prescriptive midwives.

Power is the ability to influence the behaviour of others (French & Raven 1968, Hugman 1991, Handy 1993) and when related to status and position is known as legitimate (French & Raven 1968), positional (Handy 1993) or legal power (Weber 1947, Handy 1993). It is possible that by openly intimidating junior midwives the power of prescriptive midwives was increased because of information passed from one individual to another (Randall 1997). Jahoda (1959) suggests that criticising individuals is a way of coping with anxiety generated by being unable to predict how others who do not share their views will behave. The way in which prescriptive midwives persistently criticised and intimidated colleagues and the women they cared for could, however, be interpreted as an abuse of their authority and provided evidence of what French & Raven (1968) call coercive power. Bullying and the administration of punishment acted as a form of coercion designed consciously or unconsciously to ensure other midwives conformed to expectations. It was their positional power and authority which provided prescriptive midwives with the opportunity to use coercive power. This abuse of power is itself a sign of bullying (Lyons et al 1995, RCM 1996, Randall 1997). It is possible that the bullying was designed to maintain their position of authority (Randall 1997) which was evident from students' belief of the need for these role models to feel in control:

Kelsey

I do think sometimes they are as they are because they need to assert themselves. They need to feel in control and they need to feel the boss because that gives them um a sense of person a sense of being somebody, a sense of authority. So they reinforce the rules because um they are the boss. That's what the rules say so they are going to be the boss and tell people.

Ruth

I think there is an element of power, definitely. I can't explain it any more than that, that that is what they've got to have. Um ... this control they need to feel they are in control and they create a hierarchy themselves within their own profession and it's so sad but it's there. I can't explain it other than feel it. It's there.

Midwife 15 challenged this power but the intimidation and humiliation experienced when she lacked the support of like-minded colleagues, only served to reinforce a sense of powerlessness. A lack of support for those being bullied therefore enabled this bullying to continue and the two types of midwife were perceived by students as two separate groups who did not work well together. Bullying is frequently associated with individuals who possess a disproportionate amount of power (Lyons et al 1995, Randall 1997). Ironically it is possible that if flexible midwives had only supported each other they might have discovered that prescriptive midwives, like the nurse-midwives in Emmons (1993) study would have had to make some adjustment to their behaviour when working in their presence.

Criticism was also covert. Prescriptive midwives talked behind the backs of their flexible colleagues and these conversations were overheard by students:

Ruth

They're talking about people failing. People not being able to do things. People's inability to make decisions. Inability to cope with the pressures of the place um...they talk about how

> many hours someone's worked. Whether they're coping with it or not. Just finding fault. No support. No come on in and have a cup of tea you must have been up all day and what a shame you were called out tonight but never mind. Have a cup of tea and see what we can sort out. No help none what so ever.

Kirkham (1999, 2000) using data from a study which explored the issue of supervision of midwives in England, revealed this lack of support within the midwifery culture. She suggests that the role of caring for women and midwives' own expectation that they should make sacrifices when fulfilling their role did not prepare them for supporting each other and, there was a lack of role models to demonstrate how this could be achieved.

In the absence of data from prescriptive midwives one can only speculate why some midwives acted as bullies and others did not. Hadikin & O'Driscoll (2000) offer a number of theories in an attempt to explain such behaviour. According to the RCM (1996) changes in the way midwifery care is organised is the major cause of bullying. This does not explain why some midwives do not become bullies. Having come through the same system however, I know that these midwives were very likely to have themselves been bullied not only in the hospital setting where they practised midwifery but also as they progressed in their nursing careers. Salvage (1985) refers to student's perceptions of some senior nurses as 'monsters', 'dragons' and 'battleaxes' who, as a result of their own experiences, seek to ensure that others suffer in the same way that they did. This supports the findings of Turnball (1995b) that victims are at increased risk of themselves adopting such behaviours. According to Miller & Dollard (1962) the behaviourist approach to learning ensures that behaviours become a part of the culture. New generations therefore do not require punishments. In addition rewards act as reinforcement (Bandura 1969, 1977, 1986) and it could be argued that bullying was rewarded by achieving a higher status. Most midwives who were observed to intimidate others had achieved the status of a midwifery sister. Comments from students suggested that clinical managers demonstrated a management style which also supported a punitive

environment. Indeed 41% of respondents in the RCM national survey (RCM 1996) quoted managers as the source of bullying. That bullying was frequently seen implies that it was condoned by those above them in the hierarchy.

Students did not witness any of their prescriptive role models being criticised. Conditioned to conform to the rules of practice may have meant that the behaviour of prescriptive midwives was now such that they no longer needed to be criticised. Nevertheless the concerns these midwives had about litigation or potential criticism from doctors if a deviation in the mother or baby's condition occurred, were frequently voiced to students. The constant recording of every event was also clearly visible:

Zeta

She was always quoting to you, it's her head on the chopping block if something goes wrong, it's her head on the chopping block, and she wasn't going to bend the rules as it were for the woman if it then turned round, that then she (the woman) had a post partum haemorrhage, blood all over the place and the doctor turned round and said bla, bla bla. I mean your necks on the line. From what I've gathered there's a lot of litigation involved as well because is it, they've got 21 years in which they (the client) can come back if they (the baby) are brain damaged at birth and a lot of the midwives out there are frightened of the way, the documentation and doing everything correctly, of informing everybody. They write down meticulously that midwife in charge of labour ward was informed, the bleep holder on postnatal unit was informed, the doctor was rung, doctors rung again and rung for the third time. I've never come across anything like that you know.

Although constant record keeping appeared to students to border on paranoia, it has to be remembered that the women's notes or record of all maternity care, are legal documents and there is a legal requirement for midwives to keep records (UKCC 1998). Care given or action taken, if not recorded, is considered as not given in a court of law. Had students

had more knowledge and experience they might have viewed as justified the conscientious way in which these midwives kept records.

In chapter four the difficulties of interpreting rules, the dilemmas this created and the threat to some midwives professional practice was highlighted. Students in a study by Emmons (1993) perceived midwives to be afraid of making decisions because they were afraid of criticism from their clinical managers. Being prescriptive may then be a response to a management culture which criticises and blames practitioners when something goes wrong. My own experiences in clinical practice support this view. In chapter four when exploring the issue of breaking the legal rules and Trust policies the examples used to illustrate this concept imply a lack of support from managers or supervisors. It is, for example questionable that the case against Chris Warren should ever have been brought against her (see page 92). That the second midwife could not arrive in time to be present at the birth because it occurred too quickly is hardly a cause for blame. A Supervisor of Midwife's reaction to a water birth (see page 92) was to pull out the plug (Anderson 1994). As the water pool had no plug this indicated a lack of knowledge and was not helpful. If midwives are to be blamed and then not supported it is hardly surprising that prescriptive midwives were afraid of litigation.

The conflict flexible midwives experienced was associated with practising a model of care which conflicted with the values and beliefs of prescriptive midwives. Although concerned about litigation they did not allow their fears to undermine or restrict their practice. Prescriptive midwives appeared to be concerned with the potential conflict associated with practising in a way that did not conform to the expectations of others. Ruth's comment that 'I'm not sure they even know what is normal' supported my belief that these midwives were experiencing role ambiguity (Biddle & Thomas 1979, Handy 1993) or role insufficiency (Meleis 1975). The inability to define 'normal' created a lack of clarity about how the role should be fulfilled. Because no midwife I interviewed admitted to being prescriptive at the extreme end of the practice continuum I was unable to confirm my interpretation.

All midwives then encountered conflict. A number of strategies were adopted by midwives to enable them to cope with this conflict. All of these involved avoiding conflict rather than confronting it.

Avoiding conflict

The strategies midwives adopted to avoid conflict varied according to whether the midwife was prescriptive or flexible.

Following the rules

When midwives followed the rules I suggested in chapter five that they restricted their own practice. From students' perspective they lacked autonomy. Student's observations were of prescriptive midwives who lacked the confidence to take risks that might have exposed them to the criticism of their peers or other health professionals:

> **Letitia**
>
> Say if a woman is quite near to delivery (of her baby) she'll (the midwife) say 'oh no you can't have the pethidine because it will get through to your baby and I'm telling you I'm not willing to give it'.

Despite the availability of neonatal narcan which can be given to the baby to counteract the adverse effects of pethidine it was evident to students that prescriptive midwives were not prepared to take the risk involved with the administration of pethidine to some women in labour. According to Morgan (1986) if errors are made when rules are broken, blame can be placed on someone. Abiding by the rules however, means the chances of making errors and the subsequent consequences can be avoided (Davies 1976):

> **Elena**
>
> It does mean you don't have to take that responsibility because you can say well the procedures say that I should rupture membranes at 4cms (dilatation) so that's why I did it.

Following the rules was viewed as a means of avoiding litigation yet some of the rules prescriptive midwives followed did not enable them to justify their practise. Such rules will not protect the midwife from litigation. Far from avoiding conflict there was the potential to invite it. The fear of litigation these midwives had may be viewed as out of proportion with reality. Midwives are rarely sued by their clients. This may be because of the existence of vicarious liability which means the Trust or employing authority accepts responsibility for errors and it is they rather than the midwife who is taken to Court.

When rules were followed my interpretation suggests that prescriptive midwives were able to 'fit in' with the doctors with whom they worked and the organisation in which the rules were formulated. In this way conflict could be avoided. Accustomed to a certain way of practice these midwives created an impression that they did not want to be autonomous:

Elena

I don't know whether a lot of them want to be (independent) anyway. I think the responsibility is a bit too much.

Students believed that lacking in confidence in their own ability these midwives needed to follow the written and unwritten rules to provide them with the confidence and security to practise:

Kelsey

It's almost ... it's as though your security is in feeling that you know exactly where you stand because the rules say you can or you can't, and you don't have to make a decision because the rules say this is what you should do.

In the seminal work on bureaucracy by Weber (1947), he suggests people within an organisation can come to rely or depend on the sense of security that the organisation provides. By identifying with the rules and regulations of the organisation midwives were perceived by students to have become 'institutionalised' or dependent upon them. A consequence of this was a lack of thought required to practice:

Faith

I think it's because, well my theory is that they are institutionalized and that they're used to following rules and it's actually easier to work within the parameters of a set of rules so you don't think quite as much as you would do if it was your responsibility.

It was noted in the previous chapter that prescriptive midwives had often confined their practice to a single area of expertise such as the labour ward sometimes for as many as twenty years. Some of these midwives may therefore have had limited opportunities to make decisions because they had only ever practised the medical model of care in the hospital environment. 'Specialisation' (Etzioni 1964:42) can result in the monotonous fulfilment of the same role and prescriptive midwives who practised as they had always done were observed by students such as Imelda to be 'fixed in their ways' or 'stuck in a rut'. The role of being a midwife had, according to students, become 'just a job'.

Students observed that midwives' excuse for remaining in a 'rut' was that their expertise would be lost if they moved to another area of clinical practice. This clearly contradicts the idea that midwives should be able to work in any setting where women require midwifery care (UKCC 1998). According to students prescriptive midwives shared the attitudes, values and beliefs of doctors. If these midwives genuinely accepted these attitudes, values and beliefs on which they based their practice, they correspond to those midwives Emmons (1993) called 'nurse-midwives'. They also share some of the features of nurses whom Kramer (1974) labelled 'rutters'.

By following rules prescriptive midwives could avoid autonomy and the uncertainties associated with the ambiguity of defining 'normal' midwifery rather than determining their own role. While midwives believe factors such as workload (Robinson et al 1983, Pope et al 1996), staffing levels (Brooks et al 1987, Emmons 1993) and financial resources (Pope et al 1996) influence their ability to be autonomous the findings of

my study reveal it is the fear of litigation and the need to avoid conflict. Lack of support from their own clinical colleagues is also influential. A punitive environment maintained by managers also suggests a lack of support from clinical managers has adverse effects on the ability to be autonomous and this is supported by Brooks et al (1987). Lack of confidence, knowledge and skills (Emmons 1993, Pope et al 1993) are also important.

In situations where conflict arises the midwife must be able to justify her actions (UKCC 1996) and it has been shown that prescriptive midwives lacked the knowledge which would enable them to do this. Avoidance of autonomy was also indicated by their reluctance to encompass change which involved new ways of practising. Women's roles are changing (Oakley 1993). The midwife's role is also changing yet prescriptive midwives were resistant to this change in their role. Students believed these midwives lack of confidence contributed to their fear of change:

Rachel

> They're confident in the skills they have to do because they're doing it all the time but I don't think they're very confident in the skills they were taught twenty odd years ago and haven't practised since. A lot of them as well are very um settled in their area and don't want to have to move.

When the midwife lacks confidence and the knowledge to justify actions change can also act as a threat to self-esteem. Responding or reacting to rules does not prepare individuals to be proactive in making changes and determining their own future. It may be that these midwives were unable to cope with change because they lacked the relevant skills. A practitioner who has expertise associated with practising in the same area for many years reverts to a novice when entering a new clinical setting (Benner 1984). It is possible that depression or apathy which can be associated with reaching a plateau in one's career (Rapoport & Rapoport 1980) may also be a contributing factor. The way in which prescriptive midwives practised contrasts with the view of Bandura (1977) that a passive response to external controls will result in a change of behaviour as the

environment changes. Prescriptive midwives did not change their practice in response to changes in the midwifery culture. This might be because it was the midwifery culture that was changing and there was some resistance from doctors who retained the medical model possibly because the control they exerted would inevitably be lost.

The findings of my study are congruent with the functionalist perspective of socialisation which believes roles are enacted by individuals by following directions read from a script (Parsons 1951). To some extent prescriptive midwives wrote their own script because it was they who were responsible for the unwritten rules associated with the hospital in which they practised. Prior to their updating, however, some of these rules were formal written rules mainly influenced by doctors. Prescriptive midwives were therefore also following an old script written by doctors.

It is possible that some of these midwives had tried to be flexible and given up but as older women it is likely that many of them had never had the opportunity to be flexible. Now that this opportunity was available the conflicts associated with ambiguity of the role and the risk of litigation may have meant it was easier to avoid the dilemmas associated with becoming an autonomous practitioner. Afraid to practise they imposed rules on others so that they gave up the struggle to practice flexibly.

Giving up

Some midwives in the hospital setting were perceived by students to have retained their desire to be flexible in the care they provided but had given up the struggle and practised the medical model of care because of the attitudes they encountered from their prescriptive colleagues:

Maureen

Quite a lot of the qualified staff feel threatened by the sisters and don't practise they way they choose to because if they do, I mean one of the sisters thought delivering on all fours was absolutely disgusting. Now with attitudes like that you can't really put your own practice...

Emmons (1993) acknowledges that only a few midwives who have the characteristics of my prescriptive midwives genuinely support the attitudes, values and beliefs of this culture. Some flexible midwives submitted to the positional power of their prescriptive colleagues and conformed to expectations. In doing so they allowed prescriptive midwives to act as their role models. According to Emmons (1993) these midwives whom she called 'survivors' have given up the struggle to maintain their own identity and will continue practising in this way until they retire. Compliance as a means of coping with conflict has been acknowledged by other researchers (Lacey 1977, Emmons 1993). According to Turner (1962) adopting the role as it is interpreted by others is a means of effectively coping with conflict. Ruddock (1969) argues that individuals lack security if they do not have their own identity. Conforming to a particular role is a means of surviving and ultimately what was once valued ceases to have meaning. These midwives were not, however, perceived by students to be happy in their work, and it could be argued they were not coping effectively. It is possible that this may be because by giving up and succumbing to the power of prescriptive midwives they had as it was shown in the previous chapter 'displaced the goals'.

By manipulating a child's behaviour parents act in the interests of the child and enable it to fit into, and, be accepted by society. In this way the individual may ultimately achieve their full potential (Maslow 1968). While this may be viewed as a positive form of manipulation prescriptive role models were viewed by students to manipulate the behaviour of their colleagues in a destructive manner. Students did not consider this to be in the interests of the midwives on the receiving end of such behaviour. By restricting the practise of others, these prescriptive midwives ensured flexible midwives did not have the opportunity to fulfil their potential and were observed to act in their own interests rather than in the interests of those they worked with.

Giving up and conforming to the expectations of prescriptive midwives, midwives who once wanted to be flexible practised the medical model of care interpreting the role in the same way as prescriptive midwives. If all

individuals behave in the same way this suggests that rules maintain order within the organisation which Manning (1971) acknowledges to be the view of those who study organisations. Hence conflict can be avoided. Following rules and giving up were passive ways of avoiding conflict. Some midwives had not given up but rather than confront conflict tried to avoid contact with prescriptive midwives.

Staying out of sight

By avoiding contact with prescriptive midwives conflict could not occur. Just as following the rules and giving up were passive means of avoiding conflict so too was staying out of sight:

> **Ruth**
>
> What happens with junior midwives for example is they will stay out of sight. They deliberately stay away. They stay out of the way. And what they're doing is they're not, the only way they're learning is by trial and error. Like I don't want to go in there. They think I don't want to go and ask because I don't want them to think I don't know, so they don't go and ask so it's a trial and error situation which, I don't think they would ever do something that wasn't safe. They should feel so supported.

This strategy was considered by students to be detrimental to flexible midwives who were usually lacking in experience. Because prescriptive midwives were unapproachable junior midwives did not seek help and were left on their own to learn by a process of trial and error. Flexible midwives did, however, develop active strategies for coping with conflict and these involved being deceptive or evasive.

Being Evasive

There should be scope within the rules to provide care that meets individual needs. Within the ambiguities of the role, bending rules is a means of survival (Hugman 1991). Being evasive enabled flexible midwives to bend the rules and practice autonomously in the presence of their prescriptive colleagues while at the same time avoiding conflict in the absence of any support from other midwives. Flexible midwives were

sometimes observed manipulating the truth to cover up their decisions. It will be remembered that in chapter four it was noted that midwives sometimes bent or broke the written and unwritten rules of the institution in which they practised. By giving an inaccurate time for the onset of the second stage of labour to allow the woman to push for longer the midwife does not reveal the truth. Hutchinson (1990) openly refers to this as 'lying'. She revealed this behaviour in nurses when they informed a doctor that symptoms were worse than they really were to get the doctor to respond positively to their request to see a patient. Hutchinson (1990) refers to rule bending behaviour as 'responsible subversion'. Nurses she interviewed about the way in which they bent the rules for the benefit of their patients revealed that these nurses believed themselves to be responsible, but to achieve the best care for their patients they had to practice subversively to avoid conflict with their colleagues. Being subversive involved evaluating the situation, predicting the potential outcomes of bending the rules and protecting themselves from the consequences of the action taken. Nurses were clear they would not be subversive unless they could justify their actions. A reason perhaps why prescriptive midwives were notable for not bending rules. They could not justify to students why they did something and were also afraid of the consequences. 'Covering' up their actions (Hutchinson 1990) included 'redefining' their behaviour so, for example, the woman's membranes were said to have ruptured spontaneously rather than the nurse-midwife carrying out the procedure. Colluding with the practitioner in charge of the ward area was another strategy although this was not evident in my study. Hutchinson (1990) did not label telling untruths as 'covering' but arguably it was. Withholding some information when updating the midwife in charge of the labour ward of the progress of the women for whom they were caring provided another means of covering up decisions. It is possible that if midwives were familiar with what the rules actually stated manipulating the truth would be unnecessary. The opportunity for not telling the truth and withholding information was possible because these midwives were perceived to practise 'behind closed doors'. In this way midwives who might not agree with what they were doing could not witness their practice. This was particularly easy to do in the labour ward where women each had their own room:

Rachel

I mean it's not done on a very, openly, but it is done definitely very secretively you know, they keep the door shut and nobody needs to know, which is wrong because it's not changing the system but it works on an individual woman probably or basis. Maybe it will change but at the moment...

Practising behind closed doors enabled flexible midwives to present an appearance of conforming to the attitudes, values and beliefs of their prescriptive colleagues and in doing so avoid criticism. Such behaviour may be easier to understand when using the analogy of the parent-child relationship. Senior midwives acted as authoritarian parents. In the presence of such parents children usually do as they are told because of the fear of 'getting into trouble' (Gross 1989). Out of sight of parents, children, or in this case less experienced midwives are known to cheat because the risk of getting into trouble is reduced (Gross 1989). If actions are not witnessed they also cannot be prevented (Hugman 1991).

Griffith (1996) refers to lying as 'cheating' and Kirkham (1987) has also used this expression to mean rule bending. When students observed this and other tactics they too referred to their role models as 'cheating' or being 'crafty'. 'Cheating' implies that these role models were acting dishonestly and in doing so were deceiving others. For this reason I was unhappy with the term. Cheating would be morally wrong if it jeopardised the well being of mother and baby. Such behaviour, however, may be considered acceptable when the motive is taken into consideration. If done in the interests of the women the motive might be considered a good one. In a quantitative study by Grover (1993) practitioners who analysed rules when deciding what action to take experienced less anxiety associated with professional conflict and were less likely to lie about their behaviour than colleagues who relied on rules. The research was based on responses to vignettes and the author acknowledges a number of limitations to the study. These included the difficulties associated with deciding how to act in a situation which in reality did not exist and an inability to alter the situation by their own behaviour. In my study it was prescriptive midwives' reaction to flexible midwives that created conflict.

The power of these midwives meant that it was flexible midwives who, unable to resolve the conflict, sought strategies for avoiding it. Grover (1993) argues that 'lying' impacts on the quality of care clients receive and when it is done in the interests of these clients such behaviour may be ethical. However when behaviour is concealed significant changes in practice cannot be made (Kirkham & Stapleton 2000).

If 'cheating' was based merely on the midwives' desire to practise flexibly the motive might be that of self-interest and therefore questionable. It is possible that if midwives were familiar with what the rules actually stated manipulating the truth would be unnecessary. Midwives acknowledged cheating or practising behind closed doors as a means of avoiding what I call the social control exerted by prescriptive midwives. But in manipulating the truth it could be argued that flexible midwives acknowledged the positional and coercive power of prescriptive midwives but felt powerless to challenge it. Midwife 15 (see p128) was unwilling to continue with such deceptions and did challenge this power but the intimidation and humiliation experienced when she lacked support of like minded colleagues, only served to reinforce this sense of powerlessness.

The strategies which have been explored enabled flexible midwives to cope with conflict by avoiding it. Bending the rules was associated with an inner tension and laughing as a means of coping emerged from the data.

Laughing

When values are shared practitioners are less likely to lie to each other about their behaviour (Grover 1993). Midwives towards the more flexible end of the continuum admitted they were honest with each other and discussed quite openly, even humorously, how they bent the rules.

Midwife 15

We are very honest with each other. It's (bending the rules) discussed quite openly, even humorously (laughs) and its quite

> openly acknowledged amongst ourselves. What else can you do but laugh, cry I suppose (laughs)?

It has been shown that flexible midwives were unable to support each other when they experienced conflict with their prescriptive colleagues. Laughing, however, was a means of relieving the tension associated with constantly 'cheating' or bending the rules when working in the same setting as prescriptive midwives. Kramer (1974) identified stages practitioners pass through as they come to terms with cognitive dissonance. These include mastering skills, gaining acceptance of colleagues and experiencing feelings of anger and frustration. Flexible midwives' sense of humour and ability to survive or practise in an environment associated with two differing cultures suggested that these midwives had come to terms with the conflict and achieved 'biculturism' (Kramer 1974) or the ability to practise within two cultures while retaining the values of the woman-centred model of care.

A consequence of avoiding autonomy and giving up the struggle was the subordination of midwives to doctors. Practising deceptively enabled flexible midwives to practise autonomously but in doing so they subordinated themselves to prescriptive midwives.

Subordination of midwives

Kirkham (1997a) believes internalisation of the attitudes, values and beliefs of midwives like the prescriptive midwives in this study has resulted in acceptance of a subordinate role. Students recognised this subordination when they rarely saw midwives speaking out or intervening in any way. Rather than act as advocates for women, students observed midwives remaining silent and fitting in with their medical colleagues even when the actions of these colleagues was arguably not in the best interests of mother or baby (see pages 108-109). Elena had heard of midwives questioning senior house officers. These doctors were recognised as having considerably less knowledge and experience than many of the midwives in clinical practice and were lowest in the medical hierarchy. The higher the status of the health professional with whom the

midwives worked, the less likely these midwives were perceived to question practice in which they participated:

> **Elena**
> I've never ever seen a midwife question an obstetrician. I've heard of them questioning an SHO (Senior House Officer). Nobody took the registrar to task so, which just seems a bit strange really. I suppose it's got to be the hierarchy.

Advocacy can be viewed as an aspect of support for women. When midwives themselves did not feel supported it may not be surprising that they remained silent. It was suggested in the previous chapter that by remaining silent a midwife may be contravening the Code of Professional Conduct and from the student's account the midwife and others who may have experienced similar scenarios experienced conflict when they did not speak out. Porter (1991) called subordination associated with this unquestioning adherence to the rules of practice 'unproblematic subordination' although she acknowledges that sometimes it is clearly appropriate to accept an order. 'Unproblematic subordination' discourages practitioners from empathising with their clients (Menzies 1961). Buckenham & Mcgrath (1983:57) agree that the hierarchy is partly responsible for practitioners' failing to challenge the actions of their colleagues but also suggest intervention is not perceived as an option because of the sense of responsibility to another member of the health care team. Kirkham (1987) noted the inhibitory effect the presence of senior staff had on the flow of information between women and midwives and that the labour ward was perceived to be the 'doctor's territory'. Challenging is less likely to occur when individuals are on someone else's territory. The effect of the hierarchy and the resultant power was therefore clearly visible to students, and midwives were perceived to know their place in it. Even on rare occasions when students did witness midwives questioning care that doctors, including consultants, prescribed for them these role models appeared to be powerless in the presence of others above them in the hierarchy. Kirkham (1999, 2000) has also identified this powerlessness.

The way in which prescriptive midwives were observed to subordinate themselves to doctors suggested to students that these midwives lacked confidence in their own ability to make decisions and did not value the individual contribution they could make to the care of women. This is suggestive of low self-esteem. Self-esteem refers to the judgement an individual makes about her or his own worth and is expressed in the form of a positive or negative attitude towards the self (Coopersmith 1981). Silence and passivity are sometimes associated with low self-esteem (Coopersmith 1981). This may well be true when some midwives had given up trying to practice in the way they wanted to. Freire (1993) has also noted this silence to be associated with individuals who are dominated by others.

When self-esteem is low, individuals have a greater need to feel in control of events (Breakwell 1986). This supports the belief of Beniot (1989) that midwives in the bureaucratic environment want to be in control. A belief that their practice was controlled by doctors may have led to the adoption of an external locus of control (Rotter 1966) resulting in what Seligman (1975) refers to as 'learned helplessness'. In other words midwives may have accepted that rather than controlling the way in which they practiced, their practice was controlled by others resulting in a sense of powerlessness to change. Emmons (1993) believes that when midwives have a conception of the self as helpless and powerless they do not think for themselves. They accept the pressure to conform. She argues that these midwives fail to understand that their reality is socially constructed or in other words that they can influence events and they therefore end up in a downward spiral of despair. The concept of 'learned helplessness' supports students' perceptions that some midwives were choosing to be subservient and controlling their own behaviour. The lack of caring and commitment of these midwives noted in the previous chapter are features of 'burnout' when the practitioner emotionally has nothing left to give clients and derives no satisfaction from the job (Kramer 1974, Sandall 1997), all of which are suggestive of role strain (Handy 1993).

It is possible that prescriptive midwives' lack of confidence and avoidance of autonomy which resulted in their continued subordination

was only one symptom suggestive of low self-esteem. Prescriptive midwives were perceived by students to feel devalued. Although no midwife admitted to being prescriptive, midwives participating in this study who had flexible characteristics agreed with students' perceptions because this mirrored their own feelings. A number of reasons contributed to this including the grading structure for payment of staff, limited resources, heavy workload and, in one maternity unit, payment of car parking fees. Emmons (1993) believes a lack of self esteem undermines midwives' ability to practise autonomously. Factors which undermine self-esteem therefore also undermine ability to practise autonomously. It is possible that constant change and the commitment to fulfil the recommendations of *Changing Childbirth* (DOH 1993) also contributed to their feelings of lack of worth although according to students they saw little evidence of any changes.

The findings of my study clearly show that the model of care midwives adopted influenced not only their relationship with other midwives but also the relationship they had with doctors. Power is crucial to self-esteem (May 1972). Authoritarianism may therefore have been a strategy for maintaining self-esteem. When individuals perceive their control to be threatened they may go to considerable lengths to retain that control (Breakwell 1986). Coercing women into having forms of care they did not want may have been one attempt by prescriptive midwives to retain some control over their own situation. The women they cared for sometimes threatened this control. The irritation of the midwife recognised by Letitia in the next quote may be an indication that the midwife disliked the challenge to her authority:

> Um ...you might see the midwife coming out of the delivery room and go to the desk and say 'oh that woman, she's so demanding, she won't take any notice of what I'm saying.

Students' perceptions were of prescriptive midwives who wanted to maintain their position and this may be linked to feelings of insecurity (Lyons et al 1995). When prescriptive midwives did not fulfil the scope of the midwife's role, practising alongside those who did also acted as a

potential threat to their position and identity. By criticising others, conformity is encouraged and the identity of the person who does this is maintained (Breakwell 1986). Just as prescriptive midwives dominated the women they cared for so too they dominated flexible midwives. Although junior midwives were perceived to be embarrassed and upset when criticised in front of everyone they were rarely witnessed to challenge the authority of their senior colleagues. According to Anne:

> They don't say anything. I think they're too embarrassed and anyway you can't have a stand up fight in the middle of the ward can you?

When conflict is overt social order breaks down. Emphasis was therefore placed on fitting in and maintaining a peaceful or relatively harmonious atmosphere in the clinical setting. Only rarely did someone speak out, and the data revealed only one example. It is worth noting that the student who gave me this example and other students who knew about it were very impressed at the courage shown by this midwife. By remaining silent flexible midwives passively accepted the positional power of their prescriptive colleagues. In doing so they were dominated by these midwives whose silence they emulated. In this way some midwives dominated other midwives who were also women. It was the influence of prescriptive midwives which encouraged conformity of other midwives to the same way of practice, even if they did not subscribe to the same attitudes, values and beliefs. Emmons (1993) highlights the predominant midwifery culture as one that supports the socialisation of midwives into the obstetric nurse role. Although students perceived only two or three midwives to be placed at the extreme prescriptive end of the practice continuum it was their positional power and attitude to others which created an impression of the medical model of care as the predominant culture. Hence the predominant culture and prescriptive midwives who suppressed creativity and attempted to ensure the culture remained unchanged.

The issue of gender may provide further understanding of why midwives placed themselves in a subordinate position to doctors and why flexible

midwives subordinated themselves to prescriptive midwives. Midwifery is a predominantly female profession. Women in past generations were socialised into passively accepting their feminine role, which was perceived to be maintaining the home and giving birth to children. They were considered to be nurturers and carers of the family (Symonds & Hunt 1996) but little value was placed on this domestic role evidenced by the lack of monetary reward. In this position women were viewed to be subordinate to men. It is important to acknowledge that some women may enjoy their role in the home and would not view themselves as subordinate to their partner. This subordination is reinforced by the stereotype of women whose characteristics imply weakness. Women are considered to be 'emotional, irrational and dependent' (Webb 1985) a stark contrast to the masculine role in which men are considered to be bread winners of the family, strong, powerful and with authority to make decisions (Symonds & Hunt 1996). Webb (1985), a feminist argues that this patriarchy is depicted in doctors' attitudes to women's illness such as that associated with their reproductive system. The cause of this illness is viewed as a mental rather than a physical aberration. Hunt & Symonds (1995) acknowledge that midwives practice in a culture where doctors who are usually men dominate, and women unquestioningly submit to this domination. Webb (1985) uses the work of Douglas (1970) to help explain the behaviour of nurses in her qualitative study which sought to explore nurses 'attitudes and opinions' of caring for women undergoing a hysterectomy. This work can equally be used to gain an understanding of the behaviour of midwives with whom students worked. In Webb's study nurses like midwives in my study did not act as advocates for women. Subordinate to doctors, nurses' attempts to maintain self-esteem were characterised by attempts to upgrade their own status and position while undermining that of others. They did this by distancing themselves from the women and their low status. The lack of emotional involvement and this distancing was shown in the previous chapter to be characteristics of prescriptive midwives. Labelling individuals as deviant is another way of maintaining position (Douglas 1970) as prescriptive midwives have been shown to do. The nurses in Webb's study were, however, able to empathise with the women when the care of a doctor was not good. In doing so their subordinate position as women and nurses was emphasised

and they felt powerless to intervene. The ideas of Douglas (1970) do account for the silence of flexible midwives. They may also account for the silence of prescriptive midwives who in trying to upgrade their own status sided with the doctor.

Autonomy versus bureaucracy

In chapter five the concept of the hospital as a bureaucratic organisation was introduced. The bureaucracy is made up of people and it is the people who make the rules and people who impose them. Etzioni (1969) has acknowledged the apparent incompatibility between the autonomous practitioner and the control exerted by the rules of the bureaucracy. Because of the consequences of overtly practising a woman-centred approach to care and the lack of support from colleagues when found doing so, the bureaucracy was, as Blau (1963) suggests, an environment which promoted the bending of rules. Control of those above the practitioner in the hierarchy is resisted by bending and breaking the rules (Hugman 1991). In reality the rules students encountered were open to interpretation and many had changed in response to current evidence. Few of these rules restricted the midwife's practice. Midwives could therefore be flexible without breaking any rules. It is not the bureaucracy which restricted practise but prescriptive midwives because they followed everything as rules including outdated unwritten rules. It was implied in the previous chapter that there was a conflict between fulfilment of the midwife's professional role and the hospital environment. This was associated with the 'displacement of goals' when the interests of the organisation were seen to take precedence over those of mothers and babies when midwives followed the rules. Prescriptive midwives created this conflict themselves and not the bureaucracy.

When doctors formulate the rules their power and position is also maintained. A change in the midwife's role to autonomy means that power is threatened. There was, however, no evidence in my study of doctors restricting midwives practice. Junior students in a study by Davies (1988) believed that midwives' lack of autonomy was due to the control exerted by doctors on their practice. This was not, however, supported by junior

students participating in this study. They believed that midwives could be in control of their own practise. Elena commented that:

> The doctors don't interfere unless they're asked to. The doctor won't come in and say let me see these notes, why haven't I been called. They don't like come and check in the room so it's kind of just what they (midwives) do. Contractions going off, synto (syntocinon, an oxytocic drug which stimulates uterine activity) goes up.

> Um... I suppose there's more people watching what they do, even if you're a sister you can have obstetricians there. But then they don't pay that much attention, they tend to leave the midwives to do as they see fit.

It is important to point out that students did not always work in an environment associated with conflict. In the absence of many of the rules in the community setting flexible care in this environment was generally viewed as acceptable practice. In this setting students' perceptions were of midwives with shared beliefs. Community midwives also practised on their own and rarely had opportunities for witnessing the practice of others. Conflict was not therefore an issue.

Summary

When both types of midwife practised in the hospital setting students observed prescriptive midwives using the power of their position to try and control the way in which flexible midwives practised. The control exerted by prescriptive midwives might result in an assumption that attitudes and values amongst those in a work area are harmonious. In reality this was just a veneer, and conflict quietly simmered beneath the surface. Midwives coped with conflict by fitting in and avoiding it. Some complied with pressure to conform to the prescriptive midwife's way of practice. Midwives who had not succumbed to this pressure adopted deceptive strategies that enabled them to maintain the peace and practise autonomously. The influence of prescriptive and flexible midwives on the role students learn will be considered in the next chapter.

Chapter Seven

Learning to be Autonomous

Introduction

The process by which individuals learn the ways of a social group and how to function in it, is known as socialisation (Merton 1949, Elkin 1960). When students entered the clinical setting they learned the role of the midwife. In the previous chapter it was revealed that this environment was associated with opposing cultures and students witnessed the conflict associated with practise based on two very different sets of attitudes, values and beliefs. Students were therefore exposed to two interpretations of the role. Which role they learned depended on which midwife they worked with. To meet the expectation of the profession that they become autonomous practitioners who are able to provide woman-centred care students had a need to learn how to bend the rules. It is important to reiterate that students' perceptions were that they had to bend the rules to become flexible. In reality to give individualised care they had to learn to interpret the rules and make decisions relating to the care of individual women.

Learning to be autonomous

The findings of my study support the view of Benner (1984) and Dreyfus & Dreyfus (1979a, 1979b, 1980a, 1980b) that novices must first learn the rules of practice before professional judgement can be used to interpret them when making decisions related to midwifery care.

Learning the rules

Students learned the rules from midwives who so rigidly followed them. Prescriptive midwives had specific ways of doing things. Their expectation that students would observe practice and perform skills in exactly the same way made it easy for students to learn the rules if they had continuity of mentor:

Zeta

It's funny though there are some midwives out there who like things done just so and you've got to learn the way they do it, you know the way they set out the delivery pack for a delivery, god help you if you don't get it right (laughs). It's laughable really because at the end of the day what difference does it make where you have your instruments, where you have your bowls. But for some midwives it does matter. I suppose it's just out of habit, it's practice, and that's the way they work. You learn by observing and then you just do it the way they want it.

Anne

I think you start off with just imitation really. In the first year you tend to just copy what people say, you don't actually learn, say if you haven't actually done the theory like breast feeding I always knew they'd say 'feed the baby more often if it's jaundiced' but I didn't know why. But I used to say it because I'd heard someone else say it (laughs).

In response to learning the rules in this way, students imitated their role models and learned how to perform the practical skills essential for giving care to women. The way in which students imitated the practice of these role models corresponds to what Miller & Dollard (1962) refer to as matched dependent behaviour. Lacking in their own knowledge and expertise students responded only to the stimulus of the role model. Midwife 2 readily acknowledged this behaviour in junior students:

> I know that I say things like darling a lot (laughs) and I here them say give a little push darling. I can hear myself saying it and they'll pick up your way very quickly.

Learning by observation aptly fits Kemper's (1986) definition of a role model defined in chapter one, and has been acknowledged by some nursing students as an important influence on their learning (Coles et al 1981, Burnard 1992, Baillie 1993, Davies 1993, White et al 1993, Cahill 1996). Although Kemper's definition of role modelling does not allow for

any verbalisation by the role model, according to students they did receive instructions from some midwives and were able to listen and learn from what was said to women receiving care.

Prescriptive midwives sometimes forgot that students with professional experience of nursing already knew what some of the rules were. Students were insulted on occasions when they were, for example, asked if they could take a woman's blood pressure. There were, however, exceptions and senior students with no nursing experience also experienced this:

> **Susan**
>
> Yes especially with midwives you don't work with very often, they'll treat you like a first year and say 'can you do blood pressures?' Can you do this? And you think, oh I've been doing it for three years.

In these situations role models taught students the rules associated with how to do the job when students already knew them, rather than focusing on knowledge they lacked such as the implication of blood pressure recordings on the pregnant woman and the evidence to support practice. The failure of these midwives to get to know students and determine their prior knowledge and experience suggests they did not acknowledge the identity of the students with whom they worked.

Learning the rules was not always easy for students. It was noted in chapter five that prescriptive midwives had a superficial relationship with the women for whom they cared. Their emotional detachment and their attitude which emphasised to students that midwifery was 'just a job' did not promote the development of a rapport between midwife and student. These midwives did not interact with students and information which might have helped students to learn the rules was not volunteered.

In the hospital environment continuity of role model or mentor was the exception rather than the rule. Factors such as sickness, annual leave and night duty often disrupted the mentorship process. This lack of continuity created confusion for students. Ruddock (1969) suggests roles are

associated with certain expectations. When rules are recorded in writing these expectations are made clear. The expectation is that everyone will behave in a similar manner and for this reason it has been suggested that rules enable the behaviour of others to be interpreted and predicted (Argyle 1967). However, the role of the midwife appeared to change each time students worked with a different prescriptive midwife. Students observed different role models each with their own style of practice and what appeared to be their own set of rules and their own expectations of students. Information given to students by one role model was often in direct conflict with that given by another role model. Like the student midwives in a study by Chamberlain (1993) what was acceptable practice when working with one midwife was not acceptable with another. Contrary to the view expressed by Argyle (1967) junior students found themselves in a position where whatever they did they could not predict how their role model practised and they were in a 'no win' situation at a time when they were not competent to make their own decisions:

Kelsey

It does seem very unclear. One (midwife) will say 'yes you can check the drugs' and another will say 'no you can't'. One will say 'you can give vitamin K' and another will say 'you can't' um, you know, what can we do and what can't we do. It was one of the things we found most stressful on the course as a whole, that is practical and theory was not knowing where we were going. Not knowing clearly what was expected of us. Um and that goes back to what I said about being on the postnatal wards you know that these things seem so inconsistent about what is expected of us on a postnatal ward. That was a very insecure position and still is in a way.

Mary

I had one (mentor) allocated to me and was never working with her and it was a headache, a real headache because you'd work with one person who'd tell you one thing and then you go in and work with another person and 'no you don't do it like that'. You don't know whether to swap with this other midwife's way

of doing things or whether you stay with the way you were doing it because you know some of the other midwives have done it that way and it's alright. Some will if you work with that midwife again she will expect to have see you swapped to her way of doing things. So you're trying to swap. Was that how she did it? So I'll do it her way this time or was it how it... You end up feeling totally, totally demoralised and confused. I just found it very very unhelpful.

Zeta

I've come across three different ways (to lay up a delivery trolley) and I just felt each time does it really matter.

Meleis (1975) emphasises the importance of role clarification. Students' lack of clarity about what their role entailed created not only confusion and anxiety but also the dilemma of which way to practise in the presence of any one role model. This confusion which was created by contact with so many midwifery role models has also been identified by Walker (1990). Students experienced role insufficiency (Meleis 1975) or role ambiguity (Handy 1993). One can only wonder at how much mental effort students wasted on deciding what a particular role model might want of them rather than considering the implications of the women's care. If each midwife had her own personal set of rules which were imposed on others, it is not surprising that students were confused. It is interesting to note that although students' perceptions were of role models who were rigid in the care they gave to women my own perception is of each role model with her own set of rules. This provided additional evidence to suggest that contrary to students' perceptions prescriptive midwives did interpret the rules but in different ways from each other. It is possible that initially they may have used their judgement in the interpretation of the rules but subsequently become rigid in their implementation of them. When there is a lack of interaction between role model and learner the role model may not consciously be aware of transmitting the role. Odling et al (1990) believe this lack of awareness is associated with role ambiguity and a lack of knowledge that the role can be deliberately transmitted to another individual. The expectation that they would conform did, however, convey

to students that prescriptive midwives were aware of being role models and the approach to learning they adopted was a deliberate technique for transmitting the role.

Students who had no nursing experience often found it difficult to learn some rules of practice because it was taken for granted that they had already learned them. The expectations of these role models were therefore sometimes unrealistic. Students were expected to be able to record women's blood pressure, take out a venflon cannula and put up a 'drip' (intravenous infusion). Although these are not exclusively nursing skills, many of the midwives who mentored students participating in this study, were more used to working with students who were already registered general nurses:

> **Letitia**
> I think yes a lot of them expect you to know a lot of things that you've never been told. In the hospital after you're first 6 months a lot of them don't know where you're... They don't know what year you are. It's very difficult. Some of them thought you knew more than others and some of them thought you knew less and it was difficult to strike a balance with a lot of them. Maybe I just assumed when I started they'd realise I was a novice and treat me as such but they forget you're not nurse trained. They have an expectancy of you and then realise no she's not nurse trained. She doesn't know the aseptic technique she's got to learn. Even though they realise you are direct entry they sometimes don't think before they speak um but then they realise after they say 'of course you're not nurse trained I forget'.

Students undertaking the three or four year midwifery programme often commented that although these role models knew they had no previous nursing experience, they forgot this and made comments which they later realised to be inappropriate. Students could not realistically be expected to carry out nursing procedures such as aseptic techniques when only a short

while into a midwifery programme and had never been shown how to do so.

If students are to adapt the rules of practice it would seem logical to suppose that they would need to work with flexible midwives in order to do so. The lack of clarity associated with practising in this way was, however, difficult for junior students to manage. According to Black (1967) a rule cannot be broken or adapted unless there is an initial understanding of the essence of the rule and its purpose. Lacking knowledge of basic rules or principles, students felt ill equipped to cope with the variations of practice associated with individualised client care:

Rachel

It's a case of some people (midwives) want to do this and some people (midwives) want to do that, depending on what the woman's doing, and this that and the other which is important but not easy to take on board when you can't remember, when you're struggling with the basic principles of what you're supposed to be doing in the first place.

By bending the rules, flexible role models revealed to students the grey areas of practice which demonstrated that midwifery was not an exact science. Confusion was created because role models when discussing situations with students would make suggestions 'well we could do this but in this case we could do this or that'. The confusion students experienced was compounded when flexible midwives practised in a way which did not correspond to what they verbalised to students. The message that Letitia and others received was 'do as I say not as I do':

Letitia

I mean the community midwife I'm out with at the moment, jokes. She says 'oh well I do it like this but don't do it this way because it's not the right way (laughs) but I can get away with it from experience'. She'll sort of joke but then she will always say 'well this isn't the correct way, don't copy me because this is wrong'. So you're never really sure where you stand. It's

> another thing that just adds to the insecurity of it really because it's not black and white why some midwives cut corners and others don't. So you're never really sure where you stand, depending on which midwife you're working with.

It is unlikely that Letitia's role model was practising inappropriately. The findings of this study suggest the midwife was probably using professional judgement to interpret the rules. Telling the student not to copy what she was doing may be an acknowledgement that the midwife was aware of this but without any explanation from her role model, the student was left in a state of confusion. There is a tendency to emulate what is seen rather than relying on what the role model verbalises (Rauen 1974) yet Miller & Dollard (1962) suggest imitation cannot take place if it is not clear what is trying to be achieved. Because of the difficulties students encountered when trying to learn the rules, students sought information that might help them to identify how their role models practised.

Seeking Information

Goffman (1961) acknowledges that individuals need information about those with whom they come in contact so that expectations of behaviour can be identified. In the absence of clear written guidelines students attempted to ascertain what was expected of them and how it could be achieved, by seeking information from the midwives. I initially called this category sussing and sizing which is an expression Davies (1988) used to illustrate the process by which student midwives identified the norms of practice in their mentors. 'Psyching out' (Davis 1975, Olesen & Whittacker 1968) is another term which has been used to describe the same process in the socialisation of student nurses, while student teachers have been shown to observe 'cues' and actively seek information from relevant staff (Lacey 1977). Medical students use this technique to find out what they need to learn from their teachers to get through their examinations (Becker et al 1961).

Students gained information by listening to their role models' conversations. Even fleeting encounters when students overheard a single

conversation or participated in one, provided an insight into some of the midwives' characteristics. Although students might never have witnessed these midwives giving care to women, these conversations provided them with an insight into the midwife's view of care and thus the way she practised.

Observation of their role model's practice provided students with another means of getting to know the midwives. Practice was observed from a distance or, as junior students when working alongside these role models. The latter provided the potential for sussing to be an interactive process. Students quickly realised however, the need to be tactful in their approach. Lacking in confidence or ability to speak out because of the adverse reactions of some of their role models (see chapter six), students did their best to phrase questions in a diplomatic way. Letitia discovered that questions like 'I've learnt this way, which way do you feel is right?' were more helpful than 'why' questions which might be interpreted as confrontational. In this way students could sometimes identify what was expected of them. Faced with mutual difficulties of identifying expectations, students helped each other to fit in and provided support by sharing the knowledge they gained from observing and listening to their role models.

The need to learn rules is not unique to student midwives. Recent studies identify the need for student nurses to also learn the rules (May & Veitch 1998, Holland 1999, Gray & Smith1999). In a well known study of occupational socialisation Melia (1987) found that student nurses quickly learned from their role models the unwritten rules which stated everyone should do their share of the work, work quickly and keep busy rather than sitting talking to patients.

Despite the difficulties they encountered most students participating in this study had the opportunity to learn the rules of practice because they worked with midwives on the prescriptive-flexible continuum and most of their role models therefore possessed some prescriptive characteristics. Students also indicated that they worked with a number of midwives and most had commenced their clinical practice in the community setting

where flexible midwives practised. Knowledge and experience are required if individuals are to become autonomous and accountable for their actions (Price 1995). Having learned the rules of practice and acquired basic midwifery skills, senior students now had sufficient knowledge and experience to enable them to interpret the rules and distinguish between what were, or were not, written rules which had to be adhered to. These students were ready to develop their own style of practice and their own professional identity.

Learning to bend the rules

Learning to bend the rules was possible because flexible midwives provided students with the freedom to practice with less direct supervision. Students were therefore gradually given more independence and autonomy and it is trust which enables practitioners to do this (White et al 1993). It was at this stage of their midwifery programme that Rachel suggested 'having learnt the rules you can apply those principles'.

It was clear from students' accounts that they observed and listened to the communications between their role models and the woman being cared for. When this communication is effective it is known to enhance students' learning (Chamberlain 1993). Interactions with their role model enabled students to learn the views of these midwives. In this way they gained knowledge, and, if options were discussed with the woman, they learned the factors the midwife considered when making her decisions. Learning to bend the rules involved making decisions about what care to give women. These decisions were based on care they had observed their role models give. When bending rules students continued to emulate the practice of their role models. All students learned basic midwifery skills from their role models which enabled them to meet the physical needs of women. When considering practice they would like to emulate it was not these skills that students focused on. Repetition had provided students with an opportunity to become competent in these skills. They now had a need to learn the skills that would enable them to provide individualised care. Even Elena as a junior student with some clinical experience was now able to view the role of the midwife from the perspective of providing this type of care. The skills students sought to emulate were

those for which there were no clear rules and hence their need for role models who were flexible. What students wanted to emulate were these role models' ability to adapt midwifery care, communicate and empathise with clients, meet their psychological needs and help them to feel in control of the process they were experiencing:

Kelsey

I would like to emulate the fact that every time we went to visit somebody when we came out the mother was three steps up the line than she was when we went in. She always left them feeling good about themselves and I think that is such a gift to be able to do. To be able to make people feel good about themselves. And particularly in pregnancy. So much of the way we care for women takes away their, that feeling about themselves, that sense of control that she used to be able to actually give them, the feeling that they had complete control and that they were brilliant parents or they were going to be brilliant parents and that they were doing really well in pregnancy.

Rachel

I think well I like that side of midwifery, they really care, they have a good relationship (with the women) and that's what I like to hopefully try to do in my own practice.

Elena

Oh lots of little things like the way the midwives are with the women as they are delivering. They are usually very supportive. They do what's right for the women.

Students wanted to emulate the woman-centred model of care that met the needs of women. When giving midwifery care senior students imitated the practise of their role models but in responding not only to the stimulus of the role model but also to their own desire to emulate these role models their actions equated with what Miller & Dollard (1962) call copying. Students now had knowledge and experience. Working alongside their

role models enabled them to gain a repertoire of skills and practices from which they could choose when giving care to women:

Rachel

I was lucky I was working with a lot of different midwives. I can see that in that situation there's this, but there's this range of early intervention, late intervention, no intervention, whatever, and then you start picking up what other people do and start saying, well I like this bit it worked in that situation and you start. You're able to pick a bit from person to person and I think you really start learning to be a midwife rather than be a delivery machine which is basically what I was to start with.

Decisions about what practices to emulate or reject were based on whether the student felt comfortable in her work and what the woman wanted. Practises which met the needs of women, students continued to emulate. Students rejected those aspects of midwifery care they considered to be less effective:

Zeta

Different midwives can show you a slightly subtle variation on different things and then you have to work out which way works best for you and if that works best for the mother as well. You're adapting it to the situation that you're in and how you're going to do it. I don't know how I do it really. I try and think what I would want and who I would want to be looked after by and what I would want from them and I try and do that and if I get vibes that that's not what's required then I stop doing that and have a rethink. But generally it's well accepted.

Mary

I'm happy to listen to both ways if they can tell me that their way is better than the other midwives' way. I'm happy to listen and I appreciate the chance to just make my own decision so I would go the way that I feel is most comfortable, that's best for the woman and perhaps I might do some reading up on it as

well (laughs). Yes I would go the way that I feel is the best way for the woman and for me.

Students had to consciously make a decision about what they would do and evaluate the effect of care given, before selecting alternative practices if it was necessary to do so. By trying to perceive the experience from the women's perspective students used their ability to empathise. In doing so, they were able to identify what practice was comfortable and meet the needs of the women. Empathy is an important feature of being a role model (Erickson et al 1983) and suggests that students had already learned this attribute or acquired it in the process of learning the role from their midwifery role models. Mander (1992) identified that midwives in the provision of care they lacked experience in (care of mothers giving up their baby for adoption) imagined the care they would want and then gave care based on this. In this way students tried to give women the care they thought they would want. If this was not effective, they reflected on their practice and then tried another approach. Practice was therefore modified as a result of experience. The law of effect (Thorndike 1966) states that practice rewarded with a successful outcome is more likely to be repeated. Students did have concerns about whether their care would be appropriate because it was important to them to be safe practitioners. This trial and error approach to learning enabled students to modify the role and in this way they created the role to meet their own needs and those of the women for whom they cared. A number of studies have suggested that midwifery students learn by a process of trial and error (McCrea et al 1994, Davies 1988, Chamberlain 1993, Begley 1997). McCrea et al (1994) did not elaborate on the meaning of this process but implied that due to a lack of staff, students were left on their own to give care to women with no guidance or supervision. This approach to learning where students are 'thrown in at the deep end' was not evident in my study but was recognised by Davies (1988), Chamberlain (1993) and Begley (1997) in their midwifery studies which explored the education or training of student midwives undertaking the eighteen-month shortened course. This situation may have occurred because students participating in those studies spent more time in the clinical setting and were therefore a part of the work force. It came as a surprise to me that students participating in

my study offered no evidence of being left on their own to learn. Prescriptive midwives were noted for their detachment from the women and the women's experience of birth. This resulted in them entering the delivery room to do the woman's observations but often leaving students on their own, unsupported, to provide emotional support. In retrospect this is an issue which could have been explored further as it is not uncommon for students to refer to learning by trial and error when discussing issues in the classroom.

Senior students had clear ideas about what they did or did not want to emulate. This distinction was less clear for junior students and what to emulate sometimes created dilemmas:

> **Belinda**
>
> One of the sisters was looking after um a young lady in labour getting to the second stage, and we were trying to encourage her to push, and she only had gas and air and she was coping really well and the midwife she was sort of (saying) 'come on you can do it' and I was sort of trying to give her encouragement and make her feel good about herself, and this other midwife kept saying you're not doing a thing, you're wasting it all. She (the woman) was saying 'it's hard work' and she (midwife) 'said of course it's bloody hard work why do you think they call it labour'. And I'm like ugh, can't say things like that. I was really shocked. You can't say things like that especially as she was doing all right. You can't tell them they're all hopeless. I was shocked. I've never seen an approach like that before but it worked. It worked. So I don't know whether to tell the women they're doing ok and they're doing it right or tell them they're not doing it right.

Although shocked at the way this prescriptive midwife communicated with the woman Belinda was faced with a dilemma. The way in which the prescriptive midwife communicated with the woman had the desired result. In other words the woman pushed her baby out. However, Belinda also acknowledged that the woman was doing well when just being

encouraged. Belinda was a junior student with limited experience. As a novice still learning the rules, when faced with a grey area of practice and unable to make her own decision, she needed a role model to clearly state 'this is what you do'.

No students suggested they learned how to make decisions from their role models. The influence of their role models was, however, apparent. Decisions involving what care to give meant that students emulated their role models practice because they wanted to. It was evident that students recognised each midwife's own unique style of practice. While the disadvantages of working with a number of midwives outweighed the benefits for junior students, as senior students it appeared to be beneficial because they witnessed a wide range of practice. According to Bandura (1977, 1986) it is rare for an individual to adopt all the attributes or exclusively emulate the behaviour of one role model. Some students stated that they would like to emulate certain midwives but the numerous variations in practice meant that there was no one role model on which to base their own practice; this is affirmed by Stolurow (1992) with reference to teachers. Like student nurses (Campbell et al 1994) and medical students (Shuval & Adler 1980), student midwives chose positive aspects of practice from a number of midwives to incorporate into their own practice. Students developed their own style of practice and thus modelled themselves on an abstract model. In this way students were able to experiment with imitation, as perceived by Schön (1983), incorporating into their practice what they perceived to be key components of a skill but maintaining their own style of practice rather than attempting to replicate exactly what their role models did. When aspects of practice from a number of role models are combined, an original form of practice or identity is acquired (Bandura 1977, 1986). From the initial observation and imitation new practices originate from old ones. Midwife 2 expressed this progress in students' development when she said:

> After a while when they're more sure of themselves and they've seen lots of people (midwives) and they're much more confident in their own methods they are just themselves basically they are themselves. They'll adjust how detailed they

are, how they document, just how they approach the woman and then they'll develop there own way, that's how I see it evolving.

In chapter four it was identified that flexible midwives used heuristics to facilitate the process of decision making. There was no evidence to suggest that students, through observing their role models, emulated this practice. Cioffi (1997) suggests heuristics are tacit knowledge. This type of knowledge is associated with the intuitive responses of an expert practitioner (Dreyfus and Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984). Students participating is this study were learning to become competent practitioners and arguably could not be expected to have achieved this level in their decision making skills. It was noted that textbook knowledge contributed to the formulation of production rules and students might therefore be expected to know, and at least use some of the rules. Nevertheless, clinical experience is required (Cioffi 1998) with the opportunity to apply knowledge to practice. It is through repeated exposure in the clinical setting that the conditions and outcomes of these rules begins to make sense. Of this, students had limited experience. When working with prescriptive midwives students did not have the opportunity to apply their knowledge in practice and in adhering rigidly to rules may have been denied the opportunity of witnessing the use of production rules. In a recent study which explores the socialisation of Project 2000 student nurses (Gray & Smith 1999), it is acknowledged that some students do develop intuition towards the end of the second year of their course. However, this intuition was limited to recognising something was about to occur and not related to decision making.

So far it has been shown that students used trial and error as a basis for making decisions. Flexible role models actively facilitated decision-making and rule bending behaviour by encouraging students to reflect on their practice.

Learning to reflect on practice

There are numerous definitions of reflection. Jarvis (1988) defines reflection as 'the skill of looking back upon an action, critically analysing

the situation and making a judgement, thus learning by the experience'. This corresponds to what Schön (1987) referred to as reflection 'on' action. Learning takes place as a result of viewing situations and events retrospectively. In contrast to this, reflection 'in' action emphasises the thought processes and learning as the situation unfolds (Schön 1983, Schön 1987). Reflection requires critical thinking which according to Burnard (1990b) is the ability to identify options, make judgements, be creative and consider new ideas. According to the UKCC (1987) this ability is a crucial characteristic of the effective practitioner. By critically analysing their practice and the consequences of their actions, practitioners can, through a process of reflection, identify knowledge that informs their practice. Experts have been shown to make decisions based on intuition (Dreyfus & Dreyfus 1979a, 1979b, 1980a, 1980b, Benner 1984). Benner (1984) questions whether decisions made in clinical practice, believed to be based on intuition, are, in reality, based on knowledge which individuals are unable to articulate. Polanyi (1962) refers to this as tacit knowledge. Reflecting 'on' action enables this knowledge or 'knowing in action' to be uncovered (Schön 1983, Schön 1987). In this way reflection contributes to learning, informs future practice and promotes personal and professional development.

Students' accounts of flexible midwives provided no evidence to suggest these role models used reflection to inform their practice. This was indirectly revealed when it became apparent that they helped students to develop this skill. Midwives, by asking students questions after events had occurred such as helping a woman to give birth stimulated them to critically analyse the care they had given and the decisions they, or their role model had made. In this way they were able to consider whether they would make the same, or a different decision in similar situations. The extent to which students were encouraged to reflect and the benefits gained, varied depending on the midwife with whom the student worked, her ability to reflect, willingness to be honest about her own practice and the time available in which to do it. According to students, flexible midwives were perceived to welcome questions and to be open minded about their own practice. This suggests that unlike their prescriptive colleagues they did not believe they knew what care was best for women.

They also welcomed students' views and asked for them. This confidence suggested to students that flexible midwives did not feel threatened when their practice was questioned, or when students practised in a different way. In this way midwives also learned from students. Learning was therefore a two way process which Freire (1993) and Rogers & Freiberg (1994) believe to be of mutual benefit for the growth of individuals. Flexible midwives facilitated student learning rather than teaching or instructing them in what they should do. By encouraging students participation these midwives supported the view of Betz (1975) and Bidwell & Brasler (1989) that role modelling is an active process rather than the passive one portrayed by prescriptive midwives in which imitation was all that was required. Ideally all aspects of the event would be reflected upon although this did not always appear to be the case:

Letitia

> Well a few weeks ago I took a delivery (helped a woman give birth), um ...the midwife who was with me at the delivery suggested that I write and reflect on how I feel I did in the delivery, what I felt that my weak points were and what I felt that her weak points were as a mentor. So I found that really helpful. Just sort of went straight home wrote a few pages and it really did help and I came back and gave it to her and we discussed it. It was very good. It was helpful.

Letitia was encouraged to focus her reflections on areas of weaknesses and this more aptly supports definitions that suggest the process of reflection is triggered by an area of concern (Boyd & Fales 1983). It is possible that Letitia in writing her reflections did consider all aspects of care that was given. Reflecting 'on' action (Schön 1983) may, however, mean that some aspects of the event are forgotten. Memories may also be inaccurate or, indeed selective if the event is perceived to be a source of threat. The above quote suggests that weaknesses were focused on to the exclusion of strengths which are of equal importance. Johns (1995) believes that self-awareness is increased through reflection and particularly supports the benefit of keeping a diary for this purpose. Paradoxically I would argue that without self-awareness it is difficult for reflection to take place.

Prescriptive midwives at the extreme end of the continuum according to students did not encourage reflection. It was shown in chapter five that these midwives lacked self-awareness. They did not question or evaluate their own practise or appear motivated to do so. These skills are all pre-requisites for reflecting on practice (Goff 1995). Lacking the necessary skills to reflect on their practice it is perhaps not surprising that these midwives perpetuated the ritualistic routines which were noted in chapter five to be a common feature of prescriptive midwives' practice.

Prior to commencement of this study I had always perceived reflection 'on' and 'in' action to be separate entities. The findings of this study, however, suggest that the distinction can sometimes be blurred. Under the guidance of a midwife, students were asked to articulate findings of examinations such as vaginal examinations and then asked what they would do next. This might be viewed as reflection 'on' action. However, questions were often asked of the student as she was performing the skill because knowledge influenced decisions regarding whether the membranes should or should not be ruptured and what form of analgesia was appropriate to offer the woman at this stage of her labour. A vaginal examination is also an ongoing aspect of care during labour. It could therefore be argued that reflection on this examination was 'in' action. The distinction for students was probably unimportant. They were challenged to think and make their own decisions. The process of reflection suggests that even as senior students they sometimes found this difficult and anxiety provoking depending on which midwife they worked with:

Faith

Sometimes I find it very difficult especially if you're actually in a situation in a room with a woman and a mentor and they say 'right what are you going to do next?' If I'm put on the spot I find it very difficult and I can't always think what I'd do next, but you do learn and yes, I do find theory is actually applied to the practice of midwifery.

Schön (1983, 1987) perceived reflection to be an individual process but this has the potential to pose problems for future practice. Practising within the constraints of the maternity units in which so many midwives and students work, individuals are unlikely to effect change unless they have the support of their colleagues. Change is therefore more likely to take place if reflection is a group as well as an individual process. Price (1995) emphasises the importance of reflection for midwifery practice. She believes expertise in decision-making is developed through reflection and reflection 'in action' can take place over a period of time. Expertise is therefore more likely to be developed when continuity of carer is provided and women cared for throughout their pregnancy. Warwick (1995) suggests this combination of reflection and 'holistic care' increases the midwife's confidence. The emphasis on developing new ways of organising midwifery care which includes midwives having their own caseloads therefore seems to be appropriate. Students working with these midwives would, like clients, have the benefit of continuity of carer/mentor. Students however, lacking in knowledge and experience needed the process of reflection to be facilitated.

There is an expectation that the midwife will base her practice 'upon sound principles and upon all available knowledge and skill' (UKCC 1998:34). The ability to do this requires an up to date knowledge base which flexible midwives possessed and the skill of applying that knowledge to practice. The quote above, and others, highlighted how flexible midwives used their knowledge and in the process of helping students to reflect encouraged them to become reflective practitioners and knowledgeable 'doers'. By asking students questions and responding to challenges of their own practice students were also developing their ability to become critical thinkers. All of these attributes are important components of autonomy. It is worth acknowledging at this point that a perception may have been created that it was only prescriptive midwives who had power. Their legitimate power associated with their position in the hierarchy enabled them to exert power over flexible midwives. Flexible midwives, however possessed expert and nutrient power (Stevens 1983) associated with the knowledge they used to justify their practice and the help and support they provided for students.

There was some evidence to show that flexible midwives used what Schön (1983) refers to as a 'practicum' which represented an abstract event that the midwife had herself encountered or knew the student might experience at some stage in her course. By questioning the student about how she would act in such a situation the role model prepared students for future events and the decisions they might have to make. This corresponds to what Cioffi (1998) refers to as simulations in which students have to 'think aloud'. Although beneficial, one student looked forward to the day when she qualified as a midwife and would no longer be 'grilled' in these scenarios:

> **Elena**
> I know she does it because she wants to help me but it isn't the same as being in a real situation. All this hypothesising about something you've not encountered, it does help but it's not the real thing. I can't wait till I qualify, at least I won't have think about what would I do if....

Creating a role and professional identity

Flexible midwives provided students with the opportunity and scope to negotiate and create their role in a way in which they perceived to be appropriate. Role making (Conway 1978) results in practitioners each with their own unique style of practice. Students developed their own role by adapting the care they gave to fulfil the individual needs of women, and meet their own need for satisfaction in their work. This supports the view of Ruddock (1969) that roles must incorporate expectations of the role and also needs of the individual. Creating the role therefore involved considering options available, making decisions based on their knowledge and taking risks, because sometimes those decisions resulted in care which did not meet the needs of women. The influence of role models who were themselves prepared to take risks and accept responsibility for their actions inspired students to do the same and in this they were supported.

The opportunity to negotiate and create their own role meant students could begin to develop their own professional identity distinct from that

of their role models. By choosing which aspects of care they would emulate and what they would reject they developed their own combination of characteristics and practice unique to the self. In this way it is possible for creative behaviour to develop (Bandura 1977, Bandura 1986). The self can only develop through interaction with others (Mead 1934, Turner 1962). An understanding of symbols with shared meanings enabled students and midwives to predict and respond to each other's behaviour. Students, as adults, had already experienced the process of developing a self, albeit unconsciously, when developing their own personal identity. Becoming a midwife was a reflection of the same process. In the development of self Mead (1934) an interactionist, focuses on the 'I' as subject and 'me' as object. The individual becomes an object to herself when viewed from the perspective of others. We are able to view ourselves when we take the role of another and view ourselves as object (Mead 1934). The individual is the subject when thinking about the actions of 'me', in other words what I think of myself or do, the initiative aspect of the self. Role models who were flexible in providing students with the opportunity to negotiate, adjusted their role in a process of interaction. Senior students who worked with flexible midwives therefore actively learned how to be midwives by interacting with their mentors which supports Puertz (1985) belief that mentorship is an active form of role modelling. Closely associated with this is the concept of the 'looking glass self' (Cooley 1956). The self is a reflection of how others see us. To interpret the perceptions of others requires self-awareness and this awareness of other's reactions to us facilitates the development of a concept of self. This self-concept is enhanced by comparing the self with others. Although the comparison of self with others is part of the process of acquiring our own identity, as people gain in experience they increasingly develop their own identity because they have a variety of choices. Students compared their performance with that of flexible midwives. Lacking in skills they liked, they sought to emulate these. Those aspects they did not like were rejected. Students adapted their behaviour according to the midwife with whom they worked. The self is dynamic rather than static. Based on interpretations of how others see them individuals make a judgement about themselves which constitutes their self-esteem. The role of midwife and the development of the self or

the individual student therefore evolved mainly from a process of interaction and negotiation with flexible midwives. This supports an interactionist perspective which suggests roles are often unclear. Norms and expectations are interpreted and the role determined by the individual but also in response to others.

Summary

Students learned how to become autonomous practitioners when they worked alongside role models who were flexible. Students first learn the rules of practice and then how to interpret and adapt them. Decisions about appropriate care are based on whether students feel comfortable with the care they give and whether the individual needs of women are met. Students also empathise with women and give care which is based on what they would want if they found themselves in similar circumstances. Decisions about what practice to accept and what to reject was therefore based on a process of trial and error. Reflecting on practice enhanced this process.

Chapter Eight

Fitting In

Introduction

In the previous chapter it was shown how students learned the rules of practice and then how to interpret and use them to give flexible midwifery care. Students therefore had the potential to become increasingly independent with the opportunity of practising autonomously. However, it emerged from students' data that when working with prescriptive midwives the expectation was that their practice would correspond to that of their role models. While learning the rules students were not in a position to be autonomous. They also lacked the necessary knowledge and experience requisite for practising in this way. As senior students they were ready to develop their own style of practice but when ever students worked with these role models it became apparent that their practice was restricted. This was achieved by enforcing the rules.

Enforcing the rules

Junior students were particularly unfamiliar with the clinical environment and had yet to learn the rules of practice which governed the way their teachers practised. They therefore experienced difficulty knowing how to behave. When expectations could not be met or students challenged these role models, they did not fit in and, like flexible midwives, experienced conflict. To over come this conflict prescriptive midwives attempted to enforce the rules.

When enforcing the rules prescriptive midwives acted as authoritarian parents. Such actions can safeguard the interests and well being of the child. Fulfilment of this role by some midwives however, meant that students like their flexible role models were bullied. They were also punished in a number of ways and this did not appear to be in the interests of students. Authoritarian parents are recognised for controlling behaviour by enforcing rules formulated by those in authority. Conflict or a lack of obedience to the parent is associated with punishment (Baumrind 1971, Gross 1989). According to students, prescriptive midwives who took on

parent roles intimidated and punished students, treating them as children if they failed to fit in and conform to expectations. In doing so they acted as critical parents.

Historically children have always been punished (Macoby 1980). It was suggested that these prescriptive role models were themselves socialised into the role of the midwife by punitive midwives who acted as their parents, and my own experience as a midwife would support this. Similarly it is possible these older midwives, in their personal lives had authoritarian parents and were brought up in a more rigid environment. It has already been noted that as victims of punishment they themselves may be more likely to punish others. Although intimidation acted as a form of punishment it is appropriate to acknowledge that individuals can be authoritarian without resorting to the use of such tactics. Students spoke of being constantly 'picked on' for every little thing they did which failed to meet expectations. Often criticism was for what students perceived to be issues of little consequence. Zeta, Kelsey and Letitia spoke of how some of their peers had their hands slapped either literally or metaphorically:

Zeta

One of the girls did a delivery with her (the midwife) and....she just hated the way that she ... (midwife) shouts at you non stop for the first few (deliveries) slaps your hands. She basically humiliates you first of all, the way you're doing the delivery. If she doesn't like what you're doing, she humiliates you, it's awful.

Kelsey

They make you feel about that big (indicates with finger and thumb an inch apart) (laughs). One of my other friends (in the same cohort), a sister said to her 'if it wasn't for the fact that you girls are so nice you'd be useless' in front of another woman. They do think we're useless.

Kelsey was a student with no nursing experience and according to these students some midwives perceived them to be useless because they

initially lacked what were considered to be basic nursing skills. Lacking these skills students were therefore unable to help the midwife fulfil her role. While the experience of being humiliated was sometimes confined to the birthing room Susan's experience was much more public:

Susan

Before we went off shift the sister grabbed hold of me in the middle of the ward saying how bad I was. 'I'm (sister) liable for everything that you do and I (student) should know my own strengths and weaknesses' and all this, and that's the sister. Instead of dragging you away into the office or something they do it in front of everyone and then you feel an idiot. That just did it for me, I was going to leave (laughs).

In the same way that they destructively humiliated junior midwives, prescriptive midwives criticised students in front of everybody. Frequent references were made to being humiliated or made to feel 'small', 'stupid' or to feel like an 'idiot'. Other studies reveal student midwives experienced this humiliation (Davies 1988, Montgomery 1997, Cavanagh & Snape 1997, Begley 1997) as do student nurses (Jacobsen 1966, Kotzabaaski 1997, Nolan 1998). Likewise medical students have been humiliated by doctors when participating on the 'ward round' (Becker et al 1961, Atkinson 1981).

Criticism of students was also known to be covert or 'behind their backs'. Students had over heard conversations between prescriptive midwives who criticised flexible midwives in their absence providing no opportunity for them to defend themselves. In these conversations students were also criticised:

Katrina

I don't know. They don't let on to your face but what they said behind our backs well... we heard what they used to talk about everyone down there.

Students who challenged practise or were timid and quiet were particularly vulnerable to this criticism. Such 'gossip' caused considerable stress to those students who heard it. This overt and covert criticism was very destructive. Some students were very junior and had yet to develop confidence in their own abilities. Other students with more experience also experienced doubts and needed constant reassurance that what they were doing was safe. Instead, particularly early in the course, what little confidence students had was effectively destroyed and self esteem undermined. Prescriptive midwives behaved in a manner which corresponded to the 'toxic' mentor Darling (1985) named the 'destructor'. This clearly demonstrated their lack of unconditional regard for students which Erickson et al (1983) believe to be essential in role modelling. Midwives have the skills which students need to learn. They are the 'gatekeepers' (Yearley 1999) providing students with access to those skills. These 'gatekeepers' also provide access to the resources to facilitate this learning. When students were criticised by their role models they quickly recognised they wouldn't get the experience and teaching they needed:

Belinda

They don't like you (if you rub them up the wrong way) (laughs). They don't want to work with you...One of the second year student midwives, she's very much into research says, and she's really for it, and if the midwife does something she doesn't entirely agree with, she'll be ...'the latest research says you shouldn't do that or you should do this or what have you', and all the midwives like... fight over whose going to get lumbered with this particular student because they don't want to work with her. She puts their backs up. She'll argue everything. I mean fair enough for her she's standing up for what she believes in but it makes it awkward for her to learn when no one's prepared to teach her.

Zeta

If you rub somebody up the wrong way, that's it, you can kiss good bye to your teaching and any kind of experience that you might get in with, all sorts of things.

Miranda

They won't get as many deliveries as they need for their clinical experience and they tend not to get the cases that come in, and it's...so you need to be in a position to be strong before you can speak out or get on very well with your mentor which can't happen if you don't have the same one all the time.

The possibility of receiving a poor assessment of clinical performance from their role models also appeared to be a potential punishment. Students wanted to complete their midwifery programme and qualify as midwives. To do this they had to pass not only the theoretical component of the course but also practical assessments in the clinical setting. Students understandably wanted and needed a good evaluation at the end of each clinical allocation and this should be based on their performance and whether they achieved the prescribed standard. Prescriptive midwives, however, were recognised for judging students on the basis of their personality and whether they followed the rules and fitted in with those with whom they worked:

Susan

Just a couple of weeks ago I overheard a midwife talking about one of our group (of students). There's lots of midwives say 'oh she's wonderful' and a lot of other people because she's got a strong personality they're saying 'oh she's incompetent and couldn't do the job properly'.

Field (1997) suggests bullying is a means of hiding incompetence. It would be inappropriate to suggest prescriptive midwives were incompetent. The care they gave to women, however, was limited to one model of midwifery care which often failed to meet individual needs. By exposing others as incompetent it is possible these prescriptive role

models attempted to cover up their own inadequacies and maintain their feelings of self worth. The issue may, however, be more complex. Rowntree (1987) suggests that assessing students is also an opportunity to get to know the person. Emmons (1993) found that when midwives encountered new students they interacted with them in an attempt to gain information. According to students, prescriptive midwives made no attempt to do this. The failure to assess performance may have been a means of avoiding the interaction associated with getting to know the student. Assessment of students requires judgements to be made, but without an understanding of the student those judgements are likely to be influenced by expectations (Downey 1977). Analysis of student data suggested prescriptive midwives were concerned with the product rather than the process and this corresponded with their philosophy of childbirth. An alternative perspective suggests that these role models were noted for giving no thought to what they did and this may have been extended to the process of assessment. In making judgements about performance, assessors also identify whether standards are maintained (Rowntree 1987). It could be argued that by focusing on whether students fit in rather than on their performance, these role models avoided analysing their own practice which might have revealed to them that their own standards were questionable.

To be classified as incompetent is likely to influence subsequent opportunities for employment. Students did have concerns about this, particularly in the present climate of uncertainty. Those anxieties were on occasions reinforced by the midwives with whom they worked:

Elena

> Its pretty difficult because we want jobs in the unit and I've already been told by one of the community midwives you know, for my own good don't make trouble because they'll remember when you come for a job. And so it's hard, I mean it is hard to question things that you're not happy with.

Students' fears of a poor evaluation and the inevitable anxiety it generates are not uncommon (Melia 1987, White et al 1993, Cahill 1996, Begley

1997, May & Veitch 1998). Students participating in this study provided no evidence that the student referred to above, or any other student, did receive a poor assessment. However, while undertaking this study a student for whom I had responsibility was referred in a clinical assessment. When allocated for remedial help to work alongside a role model who was flexible this student was found to be competent but lacking in confidence to make her own decisions. Like the findings of Cahill (1996) a poor evaluation was related to personal qualities of the student and did not constitute failure in terms of their clinical performance.

Following the rules meant that prescriptive midwives acted as critical parents and this occasionally meant the relationship with the student completely broke down. This could also be interpreted as a punishment for students failing to replicate their role model's practice. The ultimate punishment a parent can administer to a child is the withdrawal of love. In the context of this study love can be interpreted as a commitment to students' personal and professional growth. When that commitment is removed the student or child is rejected:

> **Miranda**
>
> She just didn't want to know about her. As far as she was concerned she'd written her off completely. Totally, utterly, she had no intelligence, she had no interest in midwifery, wasn't impressed at all. And she just formed that assumption on the one fact that she couldn't do an admission (of a woman in labour). Her whole attitude changed. She was cold, she was frosty, she wouldn't speak to her, she wouldn't ask her to do anything even if we were really busy.

Just as it was shown in chapter six midwife 15 was bullied and 'sent to Coventry' so students perceived themselves to be treated in the same way by prescriptive midwives. I have previously suggested that prescriptive midwives may have lacked self-esteem. According to Baumrind (1971) parents who lack self-esteem are more likely to reject their children. The influence of rules on these role models affected their approach to learning

and their relationship with students. It will come as no surprise to learn that these role models were perceived by students to be unapproachable. If students only worked with a midwife for one or two days the only experience was a humiliating one and remembrance of an 'awful' midwife. This supports the findings of Begley (1997), Barclay (1984) and Montgomery (1998) that a bad day is about the midwife with whom students work and nothing to do with the workload. Similar findings have also been found in nursing (Cahill 1996, Nolan 1998). A number of midwives acquired an unenviable reputation in this way. Older, more mature students like Matilda who had their own children were sometimes able to philosophically acknowledge that the role model herself had a problem in the way she behaved. Marie-Anne, a young but senior student who had developed some confidence was also able to recognise this. Nevertheless, such intimidation was destructive, and junior students in particular found it difficult to cope with and took criticism personally.

Senior students wanted to become flexible and autonomous practitioners but prescriptive midwives restricted their practice by continuing to impose the written and unwritten rules. According to students these midwives were reluctant to relinquish their responsibility:

Mary

They really know their job...that they are unable to relinquish responsibility, well they don't, no mentor relinquishes responsibility but they are unable to just stand back and see how the student does. They can't just wait that second longer to see if what she's doing is right. I don't mean in an emergency situation, then you expect them to be in there and you just stand back. I mean in ordinary talking in postnatal when you go in to talk to the women they won't give you the chance if you're going to say something about breast feeding. They are in there saying it before you've got the chance. They need to just stand back. They, I don't know whether they've just don't like having people in the room with them. Whether they, I don't know whether they feel threatened by a student being there. Whether they're frightened because they are responsible for us that they

daren't let us do anything (laughs) because you know it is down to them.

Imelda

I'm a third year now yet you still get the midwives who are really cautious about letting you do anything really, they're on your back all the time but most of them (the midwives) are very good.

The constant criticism students experienced from these midwives implies a lack of trust and this lack of trust in the relationship between role model and student was also evidenced by the unwillingness of prescriptive midwives to reduce the amount of direct supervision. If those above them in the midwifery hierarchy did not trust them, or when they perceived that they were not trusted, they are unlikely to trust others. This lack of trust was suggested by Ruth:

> Maybe when you're in charge you've got to be able to trust the midwives you send out to give care. Maybe there's a point there. Maybe they don't trust them or maybe they feel that if they've got control of each domain then they've overall got control and they can cope with their day's work better. It's a question of letting go. Maybe they can't do that.

By imposing rules on others prescriptive midwives could maintain control of the environment. To give students the freedom in which to develop their own practice would mean a loss of this control. It is also possible that prescriptive midwives' lack of trust in others was associated with a lack of trust in themselves, and this may be because they lacked self esteem (Pask 1995). According to Mary 'they have no faith in you at all. They are so frightened that your practice will reflect back on them'. This might suggest that these role models were also afraid to relinquish responsibility because if they did and the student then did something wrong the midwife would take the blame.

Hinde (1979) acknowledges that as the child or individual grows, relationships with others are adjusted and this supports the belief of Earnshaw (1995) that the relationship between mentor and student is dynamic. Relationships with prescriptive midwives, however, remained static. The inability of these midwives to provide senior students with opportunities to develop their independence resulted in the same frustration experienced by student midwives in Chamberlain's (1993) study. Students suggested that these midwives lacked confidence in themselves to allow students some independence. This is not surprising when they themselves lacked independence because they rigidly followed rules. Just as these role models were unwilling to take risks associated with decision making, so too were they afraid to take the risks associated with trusting students to practise independently. Senior students considered that they had sufficient knowledge and experience to know what they could or could not do. They felt able to recognise their limitations and call for help when it was needed. These students were therefore ready to accept more responsibility but were not permitted to do so. They now had opinions about how and what care should be given, and wanted the opportunity to develop their own style of practice. Students' opinions were not however sought and prescriptive midwives continued to dictate what care should be given. This may have been because these role models had a need to be in control and recognition of students' professional identity would reduce that control.

Kelsey

I do think sometimes these midwives are as they are because they need to assert themselves. They need to feel in control and they need to feel the boss because that gives them um a sense of person a sense of being somebody, a sense of authority. So they reinforce the rules because um they are the boss. That's what the rules say so they are going to be the boss and tell people.

Senior students did not want to be treated as children but so long as role models act as parents, students have to behave like children unless they rebel. Students could not afford to rebel because of the potential

consequences and therefore adopted strategies of action which focused on avoiding conflict.

Avoiding conflict

Students wanted to become autonomous midwives competent in giving woman-centred care. To learn this role they had to work alongside flexible midwives. Conflict could therefore be avoided if students chose their own role model or mentor rather than waiting to be delegated one who might be prescriptive.

Choosing their role model

Which role model an individual chooses is influenced by the stage at which practitioners have achieved in their professional career (Dalme 1983, Dotan et al 1986, Green 1988). Junior students were not usually in a position to choose their role model. It was in the latter half of their midwifery programme that increasing confidence and the ability to be assertive enabled some students to choose their role model. Tosteson (1979:693) states 'when I ask an educated person, 'what was the most significant experience in your education?' I almost never get back an idea but almost always a person'. This statement suggests that individuals are influenced by other people and those people are remembered because of the impact they have on the person who has observed them. Students remembered certain midwives because of their characteristics and their approach to caring for women:

Rachel

There are a few that are constantly like it. Never smile, always miserable and make everyone else miserable and I don't understand how they can get up and come to work in the morning if they couldn't see the point in that. It's just a job and they don't seem to care. I don't want to be like that.

Catherine

You remember the ones who care, really make women feel special. That's so important.

When choice is an option senior practitioners are most frequently chosen (Kramer 1974, Dotan et al 1986, Green 1988). Students did not choose one midwife on whom to model themselves but they did want to emulate flexible midwives. It was acknowledged in chapter five that these midwives were usually less experienced and junior to prescriptive midwives. The choice of flexible midwife suggests that like nurses in a study by Kramer (1974) student midwives chose role models who were prepared to take risks, act autonomously and be innovative. Students' desire to practise in a similar way to their flexible role models corresponds to the view of Bandura & Walters (1963) that learning a role from a role model is not just about imitating an individual but also a process by which the observer identifies with and tries to become like the role model:

> **Elena**
> Um... I was out with a community midwife who I mean it's very interesting because she practised quite like I'd like to practise, very laid back. If it was what the woman wanted that's what she got, there wasn't any hassle.

Similarities between role model and learner promote attraction to the role model (Bandura 1977, Bandura 1986). This attraction may be associated with shared values and beliefs (Shuval & Adler 1980). Balance theory (Heider 1958) acknowledges our dislike of dissonance and suggests that to achieve balance or harmony we tend to like individuals who share the same attitudes and beliefs. Individuals' desire to be liked is more likely to be reciprocated by those who are similar to ourselves (Festinger 1957). This is supported by the findings of my study and reinforces the findings of Emmons (1993). Students chose a midwife who shared their philosophy and provided them with an opportunity and support to create the role as they interpreted it. Students therefore chose flexible midwives to be their role models because they possessed the characteristics they admired and those characteristics that were influential in terms of developing their role. Students admired their flexible role models who were willing to actively give of their time to help them. With their friendly personalities and their obvious attempts at getting to know students these midwives demonstrated their respect for individual students and commitment to their

personal development. They were approachable and students enjoyed working with them. According to Darling (1984) these criteria of 'attraction', 'action' and 'effect' are essential in any relationship but were noticeable absent in the relationship between prescriptive midwives and students.

Students provided each other with information which helped them to choose their role model. Opportunities for sharing information occurred in the clinical setting because often more than one student was allocated to any one clinical setting. Students in the same 'set' or cohort informed their peers of what they felt would be helpful information. Likewise senior students informed more junior ones. This grapevine or 'folk - lore system' as Wyatt (1978) called it also operated in the classroom. Students had one study day per week or a number of study block weeks where there was ample opportunity to share experiences, information and feelings. The experiences students shared with each other included accounts which illustrated the overt criticism they received. Students provided examples of their peers' experiences rather than their own. The message which passed from one student to another was that students who stepped 'over the line' by practising in a way that was unacceptable to the midwives, would experience problems. Students learned from the grapevine which midwives were prescriptive or flexible, which midwives were good to work with and from whom they would learn, or which midwives to be cautious of, or even avoid if possible. It was also noted and passed on, that certain midwives were 'difficult' with some students and yet not with others. This supports the findings of Davies (1988) that the reputation of some qualified staff was passed to other students and this information was used to enable students to fit in.

The expectation that senior students would continue to conform did not help them to learn the autonomous role. The attitudes, values and beliefs of these role models was not cognisant with those of students. Students did not like these role models and as a senior student Ruth commented 'you need them (prescriptive midwives) like you need a hole in the head'. However, choosing their role model was not always an option:

Marie-Anne

I said to myself forget it I'm not going to work with this midwife again and when the students were going with the midwives the sister said ok er this girl (student) will go with this midwife and er would you (names midwife) like to take (names herself) with you. I was so scared I didn't want to go with her but I don't know how but all the time I ended up with her (laughs).

Unable to choose their mentor students had to develop strategies which enabled them to work alongside the midwife and avoid conflict. Prescriptive midwives in enforcing the rules left no doubt in students' minds that they had to follow the rules and in doing so they took on the role of an obstetric nurse.

Taking on the role of an obstetric nurse

To avoid conflict, students when in the presence of prescriptive midwives conformed or emulated these role models' practice. When doing so they took on the role as it was prescribed for them. The role which was prescribed was that of an obstetric nurse or handmaiden to the doctor. Like their counterparts in nursing (Smith 1992), students were aware that conforming to expectations enabled their role models to 'shape' or 'mould' them into what they wanted them to be:

Catherine

I suppose it's because you're so new and the first time. I don't know, they're there to kind of mould you and to take care of you and I suppose that's how it is and you copy like a child would. They kind of mould you to how they want you.

Catherine was a junior student and in telling her what to do there is a perception that the midwife is caring for her. The continued expectation that everyone would behave in the same way rather than becoming independent is, however, cause for concern. The belief that everyone should behave in exactly the same way is how role taking has sometimes been interpreted. This may have been because of the terminology used by

Mead (Miller 1981). Miller (1981) suggests that role taking is based on the premise that gestures or symbols result in what Mead refers to as the 'same response'. It is difficult to accept that Mead, an interactionist, meant exactly the same behaviour. Miller (1981) however, questions the meaning of 'same' and believes that Mead would agree with his interpretation that it is an internal cognitive process which results in shared meaning. The anticipated behaviour is the same but how it is carried out is likely to be different. Indeed it is questionable whether any individual could perform a skill in exactly the same way as someone else.

Some of the skills students had to learn were complex. Bandura (1977) acknowledges that errors in skill learning will initially occur, so it is unlikely that students were able to replicate with precision every action of their role models. This may be why students, no matter how hard they tried, still perceived themselves to be criticised. Working with a number of midwives each with their own way of practice meant that students did not have the opportunity to achieve perfection with any one midwife. According to Schön (1983), imitation of role models provides opportunities for students to experiment. He argues that what the learner perceives to be key components of a skill is incorporated into their performance. This implies that minor details are omitted. Key components may vary from one learner to another and the performance of each individual will therefore be unique. This corresponds to the view expressed by Mead (1934) that it is possible to take on the role of 'generalised other' in which behaviours from a number of people are incorporated into one's own behaviour. Shibutani (1962) believes 'generalised other' refers to a perspective rather than specific people. Prescriptive midwives acted as a reference group for students. Reference groups provide a perspective for an individual which is used to guide their actions (Shibutani 1962). Because students worked with so many midwives, learning the rules and taking on the role could never be an exact process. Nevertheless students' perceptions were of prescriptive role models who expected replication in detail of everything they did. To help them take on the role as it was prescribed students used the grapevine to learn what practises their role models expected:

Anne

By your third year you know through your friends and students what midwives do what, who likes what. You say 'oh my mentor's so and so' and they'll 'she likes, well she really likes you to flex the (baby's) head or she really likes you to do that. Whatever you do, don't'... well (shrugs shoulders) it could be anything, it depends on the midwife.

This sharing of information has been called 'information gossip' (Fine & Rosnow 1978). 'Morality' gossip that is thought to influence other people's behaviour is viewed by these authors as a separate entity. I would argue however, that in the context of this study, conversations between students were both 'information' and 'morality' gossip because they influenced students' to adapt their behaviour to enable them to fit in and avoid conflict with their role models. Emmons (1993) also identified the grapevine as an important strategy for helping student midwives survive their course. Although gossip is sometimes perceived to have negative connotations, in this sense it was constructive, because it helped students' socialise into the role they were expected to take on. Students then, actively participated in their socialisation process seeking information and adjusting their behaviour according to the circumstances. Students therefore have an influence on the socialisation of their peers (Oleson & Whitaker 1968, Melia 1987, Davies 1988)

By taking on this prescriptive role students had the potential to be competent in midwifery practice at the point of registration. Their competence, however, lay in the provision of a medical model of care, routine practice which Begley (1997) discovered did not facilitate student midwives' learning and following written and unwritten rules of the institution. Competence according to Fraser et al (1997) is the ability to be an autonomous practitioner with the appropriate skills who is able to provide individualised care based on a sound knowledge base. Prescriptive midwives therefore inhibited the development of students who were not given the opportunity to develop beyond the level of competence of their role models. Unable or lacking in confidence to make decisions, students remained dependent on their role models. Burnard's

(1990a) concern that the mentorship relationship would promote conformity in practice and continued dependence on the mentor are reinforced by the findings of this study. Learning was inhibited and students remained dependant on their role models because these role models were inflexible. This finding reflects those of student nurses learning in the clinical setting (Campbell et al 1994). Persistent supervision when it is no longer necessary has previously been noted by student midwives (Pope 1986, Chamberlain 1993, McCrea et al 1994) and student nurses (Ogier 1989) to cause frustration and dissatisfaction.

Bandura (1969, 1977, 1986) acknowledges that the role model that has high status is more likely to be emulated. Competence (Miller & Dollard 1962, Bandura 1977) and power are also believed to be influential (Bandura 1969, 1977). Prescriptive midwives had achieved the status of sister:

> **Maureen**
>
> Usually the sisters and the ones who are higher up because the young ones and the ones who have just qualified seem normal (laughs), just down to earth and they don't I suppose don't convey power. Power is what the sisters convey and they make you feel quite frightened. It happened the other day. For example if they're sitting in delivery suite and they were chatting and if you go up to ask them something it's like quite off putting because they carry on talking, they don't realise you're there or they tend not to look, choose not to look.

These role models were known to be competent at the clinical skills they performed. Their influence was based on their positional power which placed them above flexible midwives and students in the midwifery hierarchy and their coercive and manipulative power. According to Hughes & Hardy (1984) failure to acknowledge the individual identity of students and provide them with the opportunity for autonomy is all part of a manipulative process. Black (1967) argues that rules cannot be followed if there is a belief that they do not achieve their purpose. Instead senior students in this study were, as Black (1967) suggests, obeying a command

from someone in a position of authority rather than making a reasoned judgement about the appropriateness of the use of the rule. Kramer (1974) associates role taking with identification with the role model in other words the individual wants to act in the same way as the role model. In this study students demonstrated what Miller & Dollard (1962) refer to as matched dependent behaviour imitating practice because they had to rather than because they wanted to. This type of behaviour also occurs when the role model is older (Miller & Dollard 1962) as prescriptive midwives often were. Students then followed the rules but not because they believed them to be correct, which Weber (1947) considered to be the reason for such obedience.

By complying with expectations students could avoid conflict and the punishments associated with it and gain the rewards (Kelman 1967).

Seeking rewards

Noticeably absent from the behavioural approach to learning that midwives adopted with other midwives was the absence of any rewards. But, as Peters & Waterman (1982) have noted, positive reinforcement is frequently not valued by those who are in a position to influence others. It was possible for students having experienced humiliation to gain rewards if they worked with prescriptive midwives long enough to learn the rules and emulate their practice.

While criticism and intimidation of students by their prescriptive role models acted as deterrents for certain behaviours or variations in practice, rewards for behaviour that was considered acceptable, acted as positive reinforcement ensuring that behaviour was repeated. Like children, students emulated behaviour which was associated with rewards rather than those behaviours which were associated with punishments. Reward came in the form of praise and the clinical experience students needed:

> **Zeta**
>
> You learn it. That is the way you do it with her (the midwife) and perfect the art and then comes the praise and you can't do any wrong in her eyes. You have to get through that initial kind

of initiation in order to actually qualify as a person in her eyes and then that's it. You have free run of any thing that's she's got going, she'll let you do anything which she has to do.

Giddens (1997) suggests that rewards and punishment may be less influential than the desire to gain acceptance and avoid humiliation or rejection. Bandura (1969, 1977) has shown that behaviour is more likely to be emulated when role models are seen to be punished for their actions. Students wanted to be accepted but the findings of this study make it difficult to determine whether one was more influential than the other. Students wanted to avoid being humiliated and therefore did as they were told. They also needed the rewards which would help them achieve their goal to become a midwife. In taking on the role as it was prescribed for them students had to present an image which supported their belief in this approach to care.

Putting on a front

To increase their chances of being rewarded students sometimes simulated or pretended to play a part and follow the rules thus meeting expectations:

Anne

You're so good at pretending to flex the head it's untrue, and we can all practise. It's an art at making your fingers do something when they're not. I mean that's terrible isn't it that we're still doing that (laughs). We can all do that really well (laughs).

Ruddock (1969) suggests that most roles enable individuals to express their true self. In other words they can act according to their own emotions, wishes, values and beliefs. He does, however, concur with Rogers & Freiberg (1994) that individuals cannot be authentic when responding to the expectations of others or trying to please them. When Goffman (1959) discusses the presentation of self, he speaks of the 'dramaturgical perspective'. Just as actors on the stage put on a performance to fulfil the role they occupy so too did students in this study.

In the same way that actors consciously play the role, students were consciously aware of playing a part. They, like the student nurses in a study by Olesen & Whittacker (1968) and student midwives (Davies 1988), put on an 'act' or 'front' and presented an image which they thought would be acceptable to the midwives with whom they worked. The reference group made up of individuals upon whom students can compare their own performance therefore act as an audience (Shibutani 1962). Lowe (1972) suggests a loss of spontaneity may be associated with putting on this act. According to Hinde (1979) the audience may see through such acts; however, there was nothing to suggest this was so. Students then adjusted their role to correspond to that of their prescriptive role models but these role models did not reciprocate with a change in their own role. Prescriptive midwives adjusted their behaviour only in terms of offering rewards when expectations were met and administering punishments when they were not. This apparent failure to make any adjustment to their role might suggest a lack of awareness or recognition of students' cues. By putting on a front, it is likely that students' cues were not visible and prescriptive midwives were therefore not given the opportunity to respond.

Conflict associated with having to practice in a different way and cope with constant criticism was stressful. An additional dimension of putting on a front was the decision students' consciously made to hide their feelings:

Zeta

I learnt to cope with it. I didn't cry once. That was one thing I was determined not to do on that placement but I just then became within myself and just used to sit back and keep quiet.

Katrina

I just let it roll off my back. If you let yourself get offended by it you wouldn't stop crying every day.

It was evident from what students said that they had not achieved the biculturalism or ability to adapt to two opposing cultures which flexible

midwives demonstrated by their sense of humour (see page 137). Hochschild (1983) identified this control of emotions and presentation of self to the public which suggested that despite internal negative feelings, overtly all was well. Hochschild (1983) called this emotional labour. Smith (1992), in a study of nurses' socialisation into the nursing profession, also identified this phenomenon and called it 'the emotional labour of nursing'. This 'front' acted as a protective mechanism or survival strategy and was designed to ensure that students did not do anything that prescriptive midwives might consider to be unacceptable. 'Putting on a front' could be interpreted as an unwritten rule and is still believed by some midwives to be accepted practice (McCrea & Crute 1991). Alternatively it may be a strategy to reduce anxiety which is perfected over repeated exposure to a stressful environment.

The self is dynamic and the extent to which students put on this act varied depending on the midwife with whom they worked. Letitia implied that once comfortable in the presence of the midwife the need to put on a front was no longer necessary. It later became apparent however, that this 'front' remained throughout the students' midwifery programme. This was because students continued to work with prescriptive midwives. A consequence of taking on the role of an obstetric nurse was that students also took on the role of being subordinate.

Taking on the subordinate role

It has previously been shown that the role of obstetric nurse results in a subordinate role to doctors. In taking on this role students subordinated themselves to their prescriptive role models:

Ruth

I mean I am subservient definitely subservient with my mentor depending on her personality. But if she's a... I mean I am a dominant personality when I think of the sort of person I am outside of here and the sort of things I have done and then I look at myself and think, my God what are you doing making this tea. What are you doing saying 'ok this is fine'. Why aren't you arguing, why aren't you challenging but you don't. You

> think I'm here to learn let them teach me. I'll just stay quietly and let them teach me and I'll come out at the other end of it. I don't want to make any waves because I don't want any hassle and that's how you feel. That's what you do.

Students recognised their place in the hierarchy as 'bottom of the pile' and like their role models accepted a subordinate position to those in authority. Students consciously accepted this subordinate role although they were not happy to do so. An additional aspect of putting on a front was keeping quiet. As Lynne said 'I've learned to keep my mouth shut'. Saying nothing created an impression that students agreed with prescriptive midwives and their approach to care. It was also a means of avoiding criticism which Emmons (1993) and Davies (1988) acknowledged in their studies. The effort of trying to conform to expectations, cope with punishment and put on a 'front' in the presence of prescriptive midwives and practice a different model of care when working with flexible midwives was too much for some students.

Giving up

Two students who participated in this study intimated they had 'given up' the struggle to practice flexibly. Enforcing the rules meant that prescriptive midwives imposed their own values and beliefs on students and conditioned them to behave in a specific way and therefore controlled their behaviour. Rules are known to be a form of social control (Salaman & Thompson 1980). Whether intended or not, the authoritarian approach to learning acted as a form of professional control. This implies that students passively accepted their socialisation into a role and is congruent with the functionalist perspective of socialisation. It is possible that undermining the confidence of students may have made them more vulnerable to being controlled. It is important to point out though that students were aware that their behaviour was being manipulated. Hughes & Harding (1984) suggest manipulation of behaviour can result not only in demoralisation but also helplessness and powerlessness which, it was shown in chapter six, also appeared to be attributes of prescriptive midwives. Demoralisation was demonstrated by students giving up the

struggle to practice differently when in the presence of prescriptive midwives:

Mary

I'm just not practising what I believe. I still believe what I used to believe but I wouldn't... I was so challenging, and now I'm not doing that. Now it just seems that you give up. I always said I'd never give up challenging and questioning, but you do. You get tired of it everyday don't you, so you stop being starry eyed.

Arguably prescriptive midwives were only able to exert their positional power and authority over students because students accepted the need to conform in order to avoid criticism and gain rewards. The way in which this power was used was abused. Consciously or unconsciously it produced the same effects in students. It ensured students fitted in. Learning the role of a social group and adopting similar behaviour implies that individuals can fit in and be accepted by the group. Students wanted to fit in and be accepted by their role models. Avoiding conflict enabled them to do this.

Fitting In

'Fitting in' is a well recognised phenomenon which student midwives (Davies 1988, Walker 1990, Chamberlain 1993, Emmons 1993, Hunt & Symonds 1995, Yearley 1999, Currie 1999), student nurses (Oleson & Whittacker 1968, Davis 1975, Melia 1984, Nolan 1998, May & Veitch 1998, Holland 1999, Gray & Smith 1999), health visiting students (Dingwall 1977, Mackenzie 1992), medical students (Becker et al 1961, Atkinson 1981) and student teachers (Lacey 1977, Rogers & Freiberg 1994) are familiar with. In my study taking on the role as it was prescribed enabled students to meet the expectations of their role models. Strategies such as carrying out nursing observations (Davies 1988, Chamberlain 1994, Emmons 1993), keeping a low profile (Emmons 1993) and running errands for midwives and doctors (Chamberlain 1993) also help students who are qualified nurses to fit in. This raises the issue of what students with no nursing experience do to help them fit in. A small study by

Yearley (1999:629) identified that very early on in their midwifery programme students concentrated on 'looking busy' by reading their books when there was little clinical work to do, making tea and utilising their interpersonal skills to develop good relationships with the midwives with whom they worked. In my study these students like those who had experience of nursing took on the role as it was prescribed for them but until they were able to do this they also focused on developing good relationships with their role models. This did not emerge spontaneously from the data but in response to a specific question relating to this issue.

By fitting in and conforming to expectations students can be accepted, survive, gain good evaluations and succeed in their chosen career. Katrina was rather dramatic when she suggested she fitted in with prescriptive midwives because 'I want to live' (laughs). Consciously aware of the attempts to shape or mould their behaviour so that it corresponded to that of their role models, students deliberately formulated their own unwritten rule:

> If you want to gain clinical experience, receive teaching and a good assessment of performance, you have to fit in with the midwives with whom you work and stay out of trouble.

Students, then, consciously fitted in and met the expectations of their prescriptive role models. In doing so it was apparent that when working alongside these midwives learning in the clinical setting had greater impact on students than learning in the classroom. Fitting in not only helped students to survive but was also a means of protecting clients:

Rachel

I think it's protecting myself really. I don't want to go into a situation where I'm still a learner and become something that the midwife doesn't practice in that way you know and then you know there's a clash of personalities. It's not fair on the woman.

Ruth

You don't want hassle particularly when you're in a room with somebody whose having a baby or you're on a ward where people are already stressed because it's antenatal and they don't want to be there. So you don't make any waves because you don't want the atmosphere... It's not fair to the women that you're with.

By consciously adopting strategies to help them fit in, students actively participated in their socialisation process retaining some degree of autonomy but what they learned was how to become an obstetric nurse. My interpretation of the data also supports the belief that some midwives encouraged students to fit in with prescriptive midwives. Letitia's midwife for example (see page 154) did not practise what she preached. In telling the student not to copy her practice it is possible she may have wanted the student to know what the rules were because of prescriptive midwives' expectations that they would fit in. An explicit example was provided by Elena whose role model suggested that if she did not do as she was told Elena might not get a job when she qualified as a midwife. One midwife informed another that Lynne was asking questions in a manner that was not acceptable to everyone. The outcome of this conversation was that Lynne was encouraged to keep quiet and hence fit in:

Lynne

The senior sister in charge said that 'oh I've been told by somebody that you're being a bit aggressive in the way that you've been asking the questions' (laughs) and I said 'well if that's how I come across I'm sorry, but I was just, it's just the way I am. The fact that I want to learn things and I want a decent answer to my questions and when you don't get them you keep probing because that's the way I am and I'm never satisfied with 'well that's the way I was taught' kind of thing. I want to know why and then I was told that 'ok you can find out these things but watch who you're asking and be careful about what you're saying'. And I talked to my mentor about it and

she said 'well', she said, 'well you're got to watch about what you say to certain people because certain people don't like to be questioned about everything they do, and um, the fact that um, you know um, just learn to keep your mouth shut sometimes' (laughs).

Although data collection was not directed to focus specifically upon clients, students observed the reactions of women to their prescriptive carers and it was evident to them that these women, many of whom were experiencing childbirth for the first time, fitted in by accepting the care they received. By dictating the care of women, prescriptive midwives failed to inform them of available options and placed women in a position of having to fit in and meet the expectations of these midwives. By fitting in women become 'good patients' (Kirkham 1987). Mentally ill (Goffman 1961a), medical (Waterworth & Luker 1990) and elderly patients (Warren 1995) have been noted to adopt similar strategies enabling them to fit in with their care givers in order to 'stay out of trouble'.

I have revealed how prescriptive midwives fitted in and met the expectations of doctors and in doing so permitted themselves to be dominated. Some midwives met the expectations of prescriptive midwives and allowed themselves to be dominated by midwives and doctors. Even when flexible midwives practised evasively they maintained a subordinate position to midwives and doctors. Women receiving midwifery care complied with the midwives who cared for them and students conformed to the expectations of prescriptive midwives. Fitting in then ensures the subordinate role is perpetuated and this has implications for the future role of the midwife.

The future role of the midwife

Students learned the role of the midwife in a setting characterised by two cultures each with their own philosophy and approach to midwifery care. Which role students learned depended on whether they worked with prescriptive or flexible midwives. This raises the issue of which role students will implement when their name is entered on the professional register.

When working in the presence of prescriptive midwives students complied with expectations because of the power of these midwives. Taking on the role could be viewed as a passive means of coping with conflict but it is important to point out that students consciously made a decision to emulate these role models. In this way they could avoid punishment and gain the rewards associated with practising in the same way. The findings obtained from a quantitative study undertaken by Kelman (1967) are still relevant today. When individuals identify with a role model they emulate practice (Kelman 1967, Kramer 1974). Kramer suggests this identification is associated with emulating a desired role model. Based on this assumption students did not identify with their prescriptive role models and role taking could not be interpreted as a means by which identification with role models is achieved. Kelman (1967), however, identified that acceptance of the influence of the role model seen when behaviour is emulated can take place even if individuals do not believe in the behaviour. The influence of the role model is accepted because it enables a relationship to be established and maintained. So long as students emulated these role model's practice the relationship was at least overtly a good one. According to Kelman (1967) identification can then take place in role taking or role making. Kelman's distinction between compliance and identification does, however, lack clarity. Conformity enables punishment to be avoided and rewards to be gained. Gaining the rewards facilitates a good relationship and hence identification.

Bandura (1977) believes successful socialisation takes place when reinforcements are replaced by an individual's internal controls. This implies acceptance of the role models' values and beliefs and hence their internalisation. Once internalised, rules are likely to be followed even when the need to do so no longer exists (Etzioni 1964). When students gave up the struggle and conformed to expectations reinforcements were no longer necessary but the potential threat of sanctions administered by their role models continued to act as an external control. Turner (1962) points out that taking on a role does not necessarily mean internalising it. He also makes a distinction between fulfilling the role but rejecting the attitudes. Students did not perceive the behaviour of prescriptive role

models to be a part of their own self-concept. Although overtly their behaviour reflected that of prescriptive midwives students did not identify with them and did not emulate their critical attitude. Students maintained their caring approach. This may have been because as adults they had already internalised the ethic to care. This 'active rejection' of the attitudes of their role models meant that students did not identify with them (Shuval & Adler 1980) and, as Kramer (1974) suggests, they were able to preserve their own identity.

When students give up and continue to practice like prescriptive midwives there is the potential for the medical model to be perpetuated. Students suggested that only two or three midwives were prescriptive but the data has suggested they lack confidence and self esteem and promote the same characteristics in some students. The lack of confidence which students believed to be a characteristic of prescriptive midwives was also a characteristic of two students as they neared the end of their midwifery programme. Self-efficacy refers to the belief an individual has in their ability to perform a specific behaviour (Bandura 1977, 1986, 1997). It was this lack of confidence that undermined these students' belief in their ability to fulfil the role which met women's needs:

Faith

No I don't really feel as if I do (have the confidence) at the moment but I can see that it's very easy to get sucked in and just keep the peace, and just keep everything going along nice and smoothly. I think it is difficult in a big organisation. You've got to have policies such as third stage management. I mean if I let someone in my position eat in labour and then they needed a (caesarian) section I wouldn't have enough experience, enough confidence to stand up to the anaesthetist who's saying why did you let her eat and now she's got to have an anaesthetic.

When self-esteem is low individuals lack confidence and it has been suggested that such individuals are more likely to imitate behaviour (Bandura 1977). In the latter few weeks of their midwifery programme no

students who were interviewed had accepted the attitudes, values and beliefs of prescriptive midwives and hence internalisation had not taken place (Kelman 1967, Kramer 1974, Shuval & Adler 1980). There remains, however, the potential for internalisation. An environment in which individuals are constantly criticised does not encourage risk taking (Kelly 1992) or development of the role. Rowntree (1987) makes the distinction between accepting values and beliefs because individuals agree with them or being unaware that they have accepted them. Green (1988), in a study which explored the relationships between role models and role perceptions of new graduate students, found that within three months of qualifying as a nurse, the professional role learned in the classroom had been replaced by the bureaucratic version, the reality of the clinical setting. Kramer (1974) also identified the importance of adopting this role as a survival strategy. This rejection of the values of the midwifery school is, according to Kramer (1974), part of the process of dealing with reality shock associated with having to practise in a different way from that which was expected and probably occurs because other qualified staff seem to be rewarded for adopting the bureaucratic values. They then act as role models transmitting practice to the next generation. My own experience suggests that the influence of prescriptive role models is such that newly qualified midwives very quickly internalise the values of these role models and accept them as their own without realising they have done so. The process of socialisation into the obstetric nurse role and a subservient role to doctors is then successful. Indoctrination takes place when individuals are closed to other beliefs and ways of behaving (Jarvis 1983). Kirkham (1987) has suggested that midwives in the past have been indoctrinated and the way in which prescriptive midwives were observed by students to accept only one perspective of giving care to women supports this. Indoctrination may be a deliberate intent to mould individuals or can take place if individuals are not encouraged to explore alternatives (Jarvis 1983). Prescriptive midwives, according to students, would not consider any other way of practising nor did they permit those who were subordinate to them to practise in any way other than their own.

Students worked alongside both flexible and prescriptive midwives. Their desire to emulate their flexible role models might suggest that they had

internalised the attitudes, values and beliefs of the woman-centred model of care. In reality all students participating in this study who had experience of nursing admitted beginning their midwifery programme with a belief in individualised care. Mature students with no prior experience of health care also shared this belief. Only those students entering their midwifery programme straight from school were initially uncertain and this may be because of their lack of familiarity with the maternity services and models of care. However, they very quickly accepted the woman-centred approach to care.

Students felt that role models who were flexible prepared them for being autonomous practitioners. Nevertheless in the hospital environment although only a few were extremely prescriptive these midwives tried to impose the rules. Once again it was confidence or lack of this crucial characteristic that was likely to determine how students practised in the future. Anne acknowledged that in the hospital environment she would lack the confidence to be overtly flexible when she qualified as a midwife and like her role models she too would be deceptive:

Anne

Yes I think I probably would (lie). Yes I definitely would (lie) if it gave the women a little more time (to push), yes I would. I'd love to have the courage of my convictions and say this woman's been fully (cervix fully dilated) for an hour and a half but she's pushing well, and the baby's fine we're going to carry on, but I know that at the moment that wouldn't be accepted. If I could work in a unit where that was accepted, that would be wonderful. I don't think I could change that yet (laughs).

Through a process of observation and interaction with their flexible role models students learned how they could manipulate their own behaviour when they qualified as a midwife so that they too could covertly practise in accordance with their own values and beliefs. Lacking in confidence there is, however, no guarantee that prescriptive values and beliefs will not be internalised unless newly qualified midwives have a flexible preceptor. Being deceptive implies perpetuating a culture in which

midwives continue to be subordinate but students acknowledged that midwives could sometimes openly practise the woman-centred model of care. This depended on the type of midwife who was in charge of the clinical setting and suggests that the culture within which midwifery is practised is changing.

Summary

Students learned the role of the midwife in an environment associated with two different cultures. When students worked with flexible midwives they were given the freedom in which to learn how to be autonomous practitioners. Prescriptive midwives did not want to be autonomous and by enforcing rules ensured students did not threaten their position of authority. When students worked with prescriptive midwives, they learned the role of an obstetric nurse. Conformity to this role meant students were able to fit in and meet the expectations of these role models, but their professional growth and development was inhibited. Students wanted to become autonomous practitioners and when able to do so chose role models who were able to facilitate this process. From these role models students learned how to practise deceptively when in the presence of prescriptive midwives. Confidence was a crucial determinant of how students perceived they would practise when their name was entered onto the professional register. In the next chapter the efficacy of these role models will be examined.

Chapter Nine

The Efficacy of Role Models

Introduction

In this chapter the issue of whether prescriptive and flexible midwives were effective or ineffective role models will be explored both in terms of the end product or midwife produced and the process by which students learned the role of the midwife. Midwives who acted as role models for students were also their teachers. The end product envisaged by teachers is likely to influence the process by which students are socialised into the role. The process students' experience may in turn reflect the role model's own experience of learning to be a midwife and the values and beliefs they have internalised. The approach to teaching and learning they adopted and the outcome they sought revealed that when viewed from the students' perspective the issue of whether their role models were effective or ineffective was not clear cut.

Prescriptive midwives as teachers

The process by which students learn from their role models has already been revealed. Junior students had a need to learn the rules of practice. Prescriptive midwives taught them these rules and clear ways of performing skills. Many students compared this stage of their education with their experience of learning how to drive a car. Students recognised that first they had to learn the basic skills and rules associated with road safety and only then would they be able to develop their own style of driving:

Rachel

When you're learning to drive its absolutely high way code stuff. You drive like this and you turn like that and you park like this. Um, I really feel that my first allocation down there (labour ward) was basically learning to drive um, that she taught me how to drive. She (the midwife) taught me how to deliver a baby and she taught me what to do. If this scenario

> happens you do this, this and this. If this happens you do this. All these things. And from that point of view she (the midwife) was excellent. I knew what the basic principles were. I knew in this situation I do this and I do that.

According to students, the rules appeared to be associated with a series of steps performed in a specific sequence which, once learnt, provided a base on which to practise. The way in which they did this closely corresponded to what Gagne (1977:91) referred to as 'chaining'. Students learned responses to a series of stimuli which were performed in a specific sequence. When each component of the skill was linked together the chain was completed. When students had continuity of role model or mentor they quickly learned what was expected of them and became conditioned to respond in an appropriate manner, 'this is what you do in this situation'. For junior students these role models were effective at helping them learn the rules. However, the expectation that skills would be performed in a certain way sometimes meant that in Susan's words, 'silly things' had to be adhered to like, for example, standing on the right hand side of the baby's cot and not the left to do a thorough examination of the baby, or standing at the top of the cot and not the bottom. While it could be argued that in emergency situations performing a series of steps in a specific sequence might be in the interests of clients in other situations the sequence may be of little importance. Performing skills in a specific way also meant that students like their role models did not have to give thought to what they did. Learning took place by rote. Rote learning has been referred to as the 'banking concept of education' because information is deposited in the individual's memory and withdrawn when required (Freire 1993:53). Ausubel (1968) and Rogers & Freiberg (1994) place rote learning at the extreme of one end of a continuum with meaningful learning at the other extreme end. Rote learning can be meaningful when it is related to existing knowledge and used in new ways (Ausubel 1968, Peters 1973, Rogers & Freiberg 1994). But it has been shown that these midwives relied on traditional knowledge doing as they always had done. Lacking current evidence prescriptive midwives did not facilitate learning. Learning was a one way process (Jarvis 1983), students learning only how to perform practical skills while their role models learned nothing new.

It was identified in chapter seven that some prescriptive midwives clearly expected students to learn by a process of observation and imitation with no interaction between them and the student. According to Freire (1993) a passive approach to learning is an appropriate approach for individuals who act as oppressors to adopt, because their own wellbeing relies on others conforming. Chamberlain (1993) also uncovered this passive approach to learning. This is not to say that passive learning is always inappropriate. Students were not always working alongside their role models but sometimes observing them from a distance. Inevitably interaction did not take place but there was the potential for students to learn by comparing their own performance with that of their role models. When working alongside the role model this approach was not, however, conducive to learning. Several students including Belinda commented 'I can't learn just by watching' and 'to learn I need to be doing'. Rogers & Freiberg (1994) in their book 'Freedom to Learn' support the view that significant learning takes place by 'doing' or in this case participating in care. In reality students did participate in giving care to women but minimal interaction with their role models perhaps created for students a sense of non-involvement in their learning process. Students' learning was also undermined by prescriptive midwives because they were unwilling to listen and dismissive of questions or requests for help:

Kelsey

One of the midwives I've been working with actually feels, when I ask questions she's defensive and so the response in me has been to stop asking her questions because I don't like, I don't like peoples' disapproval, I don't like feeling someone dislikes me and therefore to feel um ...that they feel threatened by my asking questions.

When challenged by students, prescriptive midwives presumably had to review their conception of their role and their conception of themselves. According to students, questions were generally perceived by these teachers as criticism of themselves and were therefore taken personally. The defensive reactions inhibited any further attempts by students to ask

more questions. Unable to accept criticism, these midwives nevertheless criticised students. Prescriptive midwives as authoritarian parents have already been acknowledged. By intimidating students they also acted as critical parents. Scared of their role models students learned through fear:

Rachel

I'm sure she'd be horrified if she knew I was scared of her um... and maybe scared is too strong a word but I certainly was on edge an awful lot of the time um... which I don't think was her intention at all. I don't think she set out to terrify me (laughs) but um I think it's, she's a very strong personality and I just had to learn.

Letitia

The midwives I'm talking about I'd actually be scared to approach, well not scared but I would rather approach a different midwife if I had a question I wanted to ask, say if I was doing a monitoring on somebody and I was unsure of the (fetal) trace then I would rather approach someone else than them because they might just look at me and say 'well you can see what's wrong with this trace' or 'shouldn't you know that by now?' um... so you'd obviously go to another midwife who was more approachable.

What students needed was constructive feedback on their performance which, according to Fretwell (1982) and Rowntree (1987) is essential for professional development. It also promotes confidence in students (Yearley 1999) and can increase an individual's belief in the self to achieve a desired outcome (Bandura 1997). The lack of interaction with the role model and intimidation experienced meant feedback was inadequate but when received by students was destructive. Rewards were to be had but were not always forth coming:

Faith

She was very quick to tell you where you went wrong and slow to tell you where you'd done well'.

Students felt nervous of these midwives and if they wanted advice would avoid role models that humiliated them. Ogier (1989) observed in her study of student nurses that there was the potential to give less than optimal care when students were reluctant to seek support. Opportunities for learning were also missed when they were inadequately supported:

Faith

> Um well yes, I guess a good one is doing a VE (vaginal examination) on a, not as a junior, as a senior when I went back again (to labour ward) not being certain of what I was getting so ringing for the sister who I was working with who rushed in, wasn't at all pleased that I'd asked her to check it, did a very rough cursory VE, shouted her findings at me and ran out. Which wasn't fair on me and certainly wasn't fair on the woman. It made me feel awful and it made the woman feel awful.

When learning opportunities were missed there was scope for students to make mistakes. Students did not perceive this to be a good way of learning and were always concerned that their practice should be safe. When prescriptive midwives were accountable for what students did it is surprising that they placed students in a position where mistakes might be made.

The adoption of a behaviourist approach to learning may be easy to understand when one considers that it ignores the cognitive influence on learning and focuses on behaviour. This is analogous to the mind body separation associated with the medical model of care they implemented. Nevertheless their ability to teach psychomotor skills meant that prescriptive midwives, despite their negative characteristics, were often perceived by junior students to be good teachers provided they had sufficient time to teach:

Miranda

Some of these prescriptive midwives I found were the best teachers because they want you to know how to do everything. They will go through things very thoroughly with you so long as they have the time. I mean you might only learn there is one set way to do this but they at least do go through things so you know where you are and what to do, and once you've learned that you can see there are other ways to do it. So they're very keen to show there's the right way.

Viewed from my own perspective prescriptive midwives could not be described as good teachers. Although these midwives helped students to learn the rules the approach they adopted suggests learning is the acquisition of psychomotor skills and teaching a didactic process. Prescriptive midwives therefore adopted a pedagogical approach to teaching which views learners as children and focuses on the belief that learners lack experience and need to be directed (Knowles 1990, 1996). The approach is therefore teacher centred. The way in which students were expected to learn and the characteristics of these midwives as teachers hindered learning rather than promoting it. Treated as children students' confidence and self-esteem were undermined. It was evident from what students said that prescriptive midwives influenced their perception of working in the clinical setting. A number of conversations focused on what made a 'bad day' at work. It was never the workload or the type of work encountered but always the role models that were particularly remembered, because of the way in which they treated students. This reinforces the findings of Barclay (1984), Emmons (1993), Begley (1997) and Montgomery (1998). Although prescriptive role models could be encountered in any setting, they were particularly concentrated on the labour ward where two or three might be on duty at any one time. These midwives set the scene for the whole work shift. Smith (1992) acknowledged that it was the ward sister who influenced the atmosphere of the ward, and this reinforced the findings of Fretwell (1982), Orton (1981) and Ogier (1989) who all explored the learning environment for students nurses. Working with these role models sadly coloured students' whole perception of socialisation into midwifery and

also adversely affected their attitude towards returning to the labour ward for further experience.

Most students acknowledged the positive aspect of their learning experiences and recognised that they provided an opportunity to learn how they would or would not want to practice. Even negative experiences were, in their view, opportunities for learning:

Matilda

Oh yes, negative at the time but I think it's all relevant. You can always draw on it even if it's, oh I'm never going to be like that. I wouldn't ever do that. But I think it's always, it can always be positive although at the time it can be absolutely, you know, tearing your hair out over it. I've certainly worked with several people that I don't want to emulate (laughs) and worked with people that I definitely would want to emulate. But it's good to see what you don't want to do because it gives you situations where you would act differently.

Imelda

I think we need negative models so you can learn how not to be. It's nice when you've got a role model that you really admire and you'd like to be but it's also really nice when you meet someone who is just not. I think you learn just as much from people who are crabby. So there's a positive side to it (laughs).

Parathian & Taylor (1993) in a study of the effects of role modelling when giving bad news were able to show that negative role modelling could be positive when the situation was discussed. Similarly Nelms et al (1993) revealed that student nurses were able to recognise the benefits of such role models. Belinda, in the presence of two role models with different ways of practising had experienced difficulties in trying to decide which practice it was appropriate to emulate (see pages 160-161). The behaviour of one of these role models clearly shocked her. She did discuss this with her peers but equally inexperienced they had not been able to help her

resolve this dilemma. Discussion had not taken place with another midwife or with a midwife teacher.

In the environment created by prescriptive midwives students did not feel valued. Although some midwives provided instructions when they demonstrated practical skills, the lack of interaction with students meant they did not get to know students and little attempt was made to identify their learning needs. Indeed students commented 'they don't bother to find out'. This was apparent when students recognised that the way in which they learned changed as they progressed through their midwifery programme but was not recognised by prescriptive midwives:

> **Letitia**
> I think my learning has changed. To begin with I think I learned from observation and just repetition really. Things like aseptic technique I had to go through again and again before it got to me. But I've conquered all that now. And I think now I tend to learn by reflection so I hope I've got the basis now.

It is difficult to see how prescriptive midwives could facilitate reflection. They did not question or evaluate their own practice or appear motivated to do so all of which are pre-requisites for reflecting on practice (Goff 1995). The disregard for students demonstrated a lack of respect not only for them as individuals but also for the knowledge and experience they had gained to date. It also ignored the influence of prior knowledge on learning (Ausubel 1968, Rogers & Freiberg 1994, Knowles 1990, 1996).

When students worked with prescriptive midwives they received a training. According to students prescriptive midwives had undergone training although it was not unknown for a few midwives who had undergone a degree course to possess the teaching characteristics and role of prescriptive midwives. It is therefore likely that these midwives emulated the approach to learning and teaching that they themselves had experienced. This view would support the findings of Chamberlain (1993) that midwives approach to teaching is based on how they themselves were taught. Training is made up of a number of components.

Pedagogy is recognised as being the traditional approach to teaching in nursing (Mason 1982, Hurst 1985) and midwifery (Turnball 1986). Learning by rote is the beginning of a training (Peters 1973) and a characteristic of pedagogy. The authoritarian approach to learning is also associated with training (Hurst 1985).

An alternative perspective might suggest that this approach was deliberately adopted. Teaching implies deliberately guiding the learning process (Ausubel 1968, Jarvis 1983). By determining what and how students would learn, the way in which students practised was controlled by their role models. This control was reinforced by the authoritarian approach to learning. An underlying assumption of pedagogy is that learners will remain dependent (Knowles 1990, 1996) and this is likely to promote subordination. Rote was limited to helping students learn skills and was not used to promote understanding, critical thinking or creativity. Training therefore provides the means of ensuring subordination. Students' experience could not therefore be classified as an educational process (Jarvis 1983). Training therefore controls behaviour and contributes to the theory practice gap known to exist in midwifery (Davies 1988, Emmons 1993, Chamberlain 1993). I doubt that prescriptive midwives considered what they were doing although consciously they were almost certainly aware of the threat woman-centred care posed to their own way of practising and the influence of this on their status as a sister. Hurst (1985) suggests that the status of the teacher can be maintained by controlling what is learned and limiting questions which might reveal a lack of knowledge and reduce the practitioners' credibility. In this way the status of the midwife is also maintained. Whether the approach to teaching and learning was consciously or unconsciously adopted it could be argued that prescriptive midwives abused their power by undermining the confidence of students and inhibiting their learning.

It could be argued that the ability of prescriptive midwives to help students learn the rules and conform to expectations meant that they were effective teachers. However, the learning and teaching strategies they adopted were inappropriate and remained unchanged throughout the midwifery programme. They did not provide students with opportunities

to develop beyond the level of their role model. Learning can be defined as a change in behaviour (Knowles 1990) which Gagne (1985) suggests has only taken place if the new behaviour persists over a period of time. Jarvis (1987) criticises this perspective of learning because it focuses on the outcome or product without any consideration for the process of learning. Prescriptive midwives were only concerned with an outcome for students to become an obstetric nurse. Some midwife teachers believe that midwives who act as mentors but do not fulfil the full scope of the midwife's role and lack autonomy are poor role models (Emmons 1993). Viewed from the perspective of the UKCC (1986) and DOH (1993) a role model who ensures students learn to become an obstetric nurse and perpetuate a culture of midwifery which does not meet professional expectations or the needs of women is not an appropriate role model. Students did not want to emulate these role models and did not internalise their attitudes, values and beliefs. Students only emulated practice in the presence of these role models. How they will practice in the future as newly qualified midwives is not known. The influence of these role models will, however, be limited if students emulate flexible midwives in the absence of prescriptive midwives. Irby (1986) suggests the poor role model is a problem associated with clinical teaching. When the dilemmas arising in clinical practice are not discussed and the needs of clients not fulfilled the student is not provided with a good example to follow. The characteristics prescriptive midwives displayed are not unique and can be found in literature which explores the learning environment (Fretwell 1982, Ogier 1989, Orton 1981, Orton et al 1993), attributes of the effective and ineffective teacher (Jacobson 1966, Marson 1982), mentoring (Cahill 1996, Earnshaw 1995, Gray & Smith 2000), socialisation (Campbell et al 1994, Nolan 1998), quality of nursing care (Redfern & Norman 1999) and role models (Stiehl 1977, Lublin 1992, Davies 1993). The findings of my study also support those of Morgan & Knox (1987), Nehring et al (1990) and Kotzabassaki (1997) that the 'worst' teachers can also be the 'worst' role models. Flaws in the process of clinical teaching suggested by Irby (1986) which include poor feedback, inappropriate role models and inadequate problem solving are also borne out by this study although contrary to Irby's view expectations are made clear by these midwives. Students were quick to acknowledge

that there were factors which might contribute to the approach of these role models:

> **Katrina**
> I don't know, I really don't know. I think it's just a load of women working together. I think they're stressed, they're overworked, they're underpaid... It just made it very difficult to learn in that environment. You felt that you were coming into a, I mean it was a stressed environment.

Despite the constraints on their role models students nevertheless did not like the 'rigid, authoritarian' approach to teaching and learning and this is a view supported by other student midwives (Barclay et al 1984).

Flexible midwives as teachers

Midwives who had flexible characteristics provided a very different learning environment for students. According to students these midwives had usually had an education and adopted a very different approach to teaching and learning. Many of these midwives had, however, received post registration education as opposed to pre-registration education. Just as flexible midwives interacted with clients so they also interacted with students. Flexible midwives got to know students and prior experience was acknowledged and valued. Opinions were sought and learning was a two way process. As students progressed through their midwifery programme their motivation for learning the role and their need for knowledge and skills to enable them to fulfil the role were recognised. So too was their increasing need for independence. In this way students were treated as adults and flexible midwives adopted what Knowles (1996:83) refers to as the andragogical approach or 'the art and science of helping adults to learn'. Learning from these midwives was not, however, easy for junior students. The difficulties they encountered when trying to learn the rules from flexible midwives was considered in chapter ten. The andragogical approach to teaching focuses on helping learners to solve problems (Knowles 1990, 1996). It acknowledges that adults are independent and take responsibility for their own learning but does not recognise that adults may also be novices who may initially not know

what their learning needs are and may be dependent on others to fulfil their needs. Junior students lacked knowledge and experience which would enable them to analyse the situation and use their own judgement. Flexible role models took their own knowledge for granted and did not facilitate students in first learning the practical skills:

Zeta

They (senior students) were talking about one sister who was brilliant, you know sister so and so she's really good and um they were going, the (junior) student midwives were saying well yes she is very good but I need to learn the basic skills, and she's a very holistic approach is what they were getting at. She practises holistically and that's very well and fine and good but the (junior) student midwives felt that they needed the experience of someone who doesn't practise in quite the same way so they could recognise the signs rather than going out on a limb and practising on their own as it were because basically they do.

It could be argued that flexible midwives were not effective teachers for junior students because they did not help them to learn the rules. Students believed flexible midwives empathised with them because they remembered what it was like to be a student but in considering the whole picture had clearly forgotten what it was like to be a novice. Interaction, however, meant that senior students were able to be creative in developing their role by a process of trial and error with the continuing support of their flexible role models. Learning by trial and error is associated with no thought or connection between one behaviour and the next (Schön 1987). Like the stimulus-response approach to learning adopted by prescriptive midwives this is a behaviourist approach to learning. Rules or principles are neither understood nor applied to find a solution (Ausubel 1968). Jarvis (1987) disputes the notion that this approach to learning does not result in learning and suggests learning is demonstrated through recognising when attempts are incorrect. This requires cognition which is not acknowledged in the behavioural approach to learning. Students had to retrieve behaviour or practices they had witnessed from their long-term

memory. Recognising when attempts are incorrect requires knowledge and understanding. According to Jarvis (1983, 1988) education is more than learning a skill it is also about understanding. An account of the way in which this understanding was facilitated was given by Letitia:

> Well she doesn't make you feel small and she explains the trace without making you feel silly but at the same time will give you an open ended question. Will ask you what you feel about the trace first and then she'll tell you your weaknesses but not in such a direct way as to make you feel small. She'll say well you didn't mention this but there is this here as well, which is a lot better.

Some midwives particularly those who were newly qualified were considered by students to be very good at teaching because they could remember details and they therefore answered questions very well. Education is also believed to be associated with discriminating between what is of value and what is not. The process flexible midwives adopted which enabled students to apply their knowledge to practice, uncover learning from practice and choose what they wanted to emulate supports their learning process as an education rather than training. When discussing this stage of their education students once again made comparisons with learning how to drive a car:

> **Rachel**
> And then you pass your test and you spend time after that developing how you drive, not the mechanism of you know clutch, change gear and all this manoeuvre, but you develop a style of your own.

According to Jarvis (1983) teaching is associated with interaction between teacher and learner. Knowledge is transmitted and interaction enables the learner to question the teacher and therefore gain understanding. Rather than viewing learning as a means of acquiring skills and shaping and controlling students' behaviour, flexible midwives adopted a humanistic approach to learning which bore resemblance to that discussed by Rogers

& Freiberg (1994). The focus of this approach is on the student with the teacher acting as a facilitator. Crucial to learning was the quality of the relationship between flexible midwives and students and the amount of support they received:

> **Kelsey**
>
> If you've got a good relationship, if you get on well with somebody and you feel comfortable, um you feel happy, you're enjoying your job, you feel at ease and you work well.

Essential to this relationship is genuineness, trust, acceptance and empathic understanding (Rogers & Freiberg 1994) all of which were features in the relationship between flexible midwives and students. Students reported that flexible midwives accepted them and in doing so offered what Rogers & Freiberg (1994) refer to as unconditional positive regard. Rogers & Freiberg (1994), Knowles (1990, 1996) and Freire (1993) believe the process of learning to be more important than the product. By facilitating personal growth, individuals can strive for self-actualisation (Maslow 1970) and achieve their full potential. Flexible midwives encouraged students to question and challenge practice, learn from reflection and consider alternatives all of which are features of critical thinking (Brookfield 1987). In this way flexible midwives reinforced the education students received in the classroom. Arguably the product of midwifery education is as important as the process by which students learn. However, if the process promotes personal and professional growth and is influenced by positive role models, practitioners who emerge at the end of the midwifery programme should be as good as the process they experienced. Flexible midwives were therefore good teachers for senior students. What students became was based on an abstract rather than a concrete model

According to Rauen (1974) a good role model is a practitioner who can meet objectives as well as the expectations of a role. Women want a live healthy baby with a positive birth experience (DOH 1993, Hutton 1994). Through the provision of a woman-centred model of care flexible midwives usually met these expectations and those of the

UKCC (1986) to be competent, autonomous, knowledgeable and reflective practitioners. Based on these criteria flexible midwives are arguably effective role models for all student midwives. When working with flexible midwives students were encouraged to develop their own style of practice and reflect on their own and that of the role model. No apparent attempts were made by flexible midwives to deliberately influence students. The positive characteristics observed by students support those found in other studies which explore the learning environment (Fretwell 1982, Ogier 1989, Orton 1981), attributes of the effective and ineffective teacher (Jacobson 1966, Marson 1982), mentoring (Cahill 1996, Earnshaw 1995, Gray & Smith 2000), socialisation (Campbell et al 1994, Nolan 1998), quality of nursing care (Redfern & Norman 1999) and role models (Stiehl 1977, Gerber 1979, Gerber 1982, Dotan et al 1986, Lublin & Driver 1986, Irby et al 1987, Lublin 1992, Davies 1993) My findings also confirm those of Morgan & Knox (1987), Nehring et al (1990) and Kotzabassaki (1997) that the 'best' teachers are also the 'best' role models.

There was evidence to suggest that the good teacher can sometimes become a poor teacher for senior students. When the midwife's confidence is undermined some of the prescriptive midwives' teaching characteristics are adopted. I had only one example of this and the student who informed me was so concerned that the midwife might be identified that I have chosen not to include her quotes about this scenario within this thesis. Nevertheless in a situation where the midwife questioned her own practise and blamed herself for an adverse outcome for mother and baby confidence was undermined and the relationship between teacher/role model and learner was detrimentally affected. The midwife did not want to talk about the event, questions were dismissed and the student missed a valuable opportunity to learn from the role model's experience. The student did not reject this midwife as a role model but diplomatically sought ways to regain the interactive relationship.

Power and influence

Students indicated that given a choice they would reject the practice of prescriptive midwives. They wanted to emulate their role models who

were flexible even in their absence. Anderson (1984:176) acknowledges a difference between influence and power. 'Influence is the ability to bring about certain kinds of results; power is the ability to do so despite direct opposition'. Throughout this study the power of prescriptive midwives has been clearly evident. Students emulated their practice to avoid conflict and gain the rewards of doing so. The power of prescriptive midwives was, however, limited to restricting students' practice when in their presence. In contrast flexible midwives influenced students by the example they set. Midwives recognised that by setting an example they were role models for students although how they taught the role to students was not always clear to them:

Midwife 7

Um... well I think every midwife is a role model whether they like it or not. They set an example for students.

Midwife 1

I can't say that I actually teach them what the role of the midwife is. I hope I do it by example and as a role model, I don't actually think about this very much but when I have a student I take her through the care of a woman in labour that's what happens in the labour ward. I'll teach them. But I don't know how I actually teach them about the role of the midwife. I just teach them by example.

Midwife 3

You don't think about what students think about you. I don't sort of consciously try to have a particular effect on them.

The effect midwives had on students was sometimes recognised and in the following quote one midwife acknowledged that with more experience the student developed her own style:

Midwife 2

I know that I say things like darling a lot (laughs) and I here them say give a little push darling. I can hear myself saying it

> and they'll picked up your way very quickly I am, but then after a while when they're more sure of themselves and they've seen lots of people and they're much more confident in their own methods they are just themselves basically they are themselves.

Some midwives were therefore aware of being role models but did not consciously set out to influence students. This is not to say flexible midwives lacked power but the power they possessed contributed to their influence. Flexible midwives possessed expert power based on their knowledge and nutrient power (Stevens 1983) based on their concern for the well being of students. This power was used constructively to promote personal and professional development while prescriptive midwives abused their power undermining the confidence of students and inhibiting their learning. Failure to internalise the role as it was determined by prescriptive midwives could suggest their power was limited to the short term. In the past their power has determined how most midwives practice in the hospital setting and internalisation of the obstetric nurse role has perpetuated the role. Likewise the subordinate role to doctors has also been perpetuated. The culture is changing and prescriptive midwives are a minority. Confidence is associated with the anticipation of practising the autonomous role suggesting the influence of flexible midwives may be enduring.

Education versus training

The move away from the concept of training to giving students an education might be seen to imply that training is inappropriate. Skills are, however, also associated with education. Training is, then, a component of education but can also be distinct and separate from it. When students received training they learned the rules but had no understanding of why they were doing what they did and their experience could not therefore be classified as an educational process (Jarvis 1983). Students expect their role models to apply principles to their practice (Howie 1988). When what was taught in the classroom was not implemented in practice this was clearly not achieved. These findings support the view expressed by Howie (1988) and confirmed by Burnard (1992) and Emmons (1993) that the influence of the clinical setting is greater than that of the classroom.

Education provides individuals with the knowledge and understanding to enable them to justify their actions (Peters 1973, Jarvis 1983). In my study this approach did not, however, help students learn the rules. When students received an education in the classroom in conjunction with an education that flexible midwives provided in the clinical setting, they had the potential to become autonomous, reflective practitioners who are able to integrate knowledge with practice to provide a midwifery service that meets the needs of women. This suggests that with an education midwives can be liberated from the control and domination associated with training and the role of the obstetric nurse. Indeed Freire (1993) believes that the active participation of individuals in the learning process prevents education from becoming a means of social control. Implicit within the concept of self-direction is autonomy. Able to think for themselves individuals retain their humanity. Jamieson (1994) argues that education can empower midwives. Expert power derived from education enables midwives to find, evaluate, articulate and use evidence to support practice for the benefit of clients. In this way tradition can be challenged. The skills acquired through education enable the practitioner to become a life longer learner. Confidence and self esteem associated with competence in these skills will enable the midwife to help women develop these attributes so that they themselves are empowered not only during childbirth but also in their future years as parents (Page 1995). Midwives who are empowered and in control of their own practice are then in a position to empower women and give them control of their own birth experience. Hanson (1996), however, believes that andragogy too is a form of social control. She argues that predetermined outcomes and the content of the curriculum limit autonomy in what is learned. Student midwives have specific experience that they must achieve during their educational programme. The curriculum specifies pre-determined outcomes and skills that must be achieved to a certain level. Arguably education does then act as a form of control but it is difficult to perceive how the curriculum could ever be completely free of this control when the well-being of mothers and babies is paramount and student learning is aimed at enabling women's needs to be met. Students retain their autonomy, however,

because they have a partnership with the flexible role model and this enables them to identify what skills and knowledge they need to learn during a specific allocation. Finkel & Arney (1995) focus on the paradox of education. Achieving autonomy is also to recognise that individuals operate within a society or group which restricts that freedom. There is then a balance between autonomy and authority which flexible midwives appeared to achieve. What is important is that the role model can recognise the value of training and education and integrate both approaches. The change in how students needed to learn was not, however, recognised by either prescriptive or flexible midwives. Prescriptive midwives adopted the pedagogical and authoritarian approach to learning and teaching throughout students' programme while flexible midwives approached learning from an andragogical and humanistic perspective which supports education. The distinction between pedagogy and andragogy was made by Knowles (1996) and implies there is one approach for children and another for adults. My own experience suggests that this is what midwives who participate in the ENB 997 Teaching and Assessing Course for Midwives in Clinical Practice are taught. This distinction is unhelpful (Watkins & Mortimore 1999). There are a range of approaches which cater for lower and higher levels of learning which are suitable for children and adults but individual needs have to be recognised. Students needed a training to learn the rules and an education to develop the cognitive and expressive skills to support their practice.

Jarvis (1983) acknowledges that individuals are socialised into a role but believes that socialisation and education are two different processes. Students learned the knowledge, practical skills, attitudes, values and beliefs associated with two very different cultures. Learning how to fit in cannot, however, be regarded as an educational process. Indeed, this is not included as an outcome of the midwifery curriculum and could therefore be described as the hidden curriculum. Jarvis (1983) also makes a distinction between learning the role from the teacher and being influenced by the teacher. The two, he argues are often perceived to be synonymous. In helping students to learn the role, the role model

is an educator but being influenced by the teacher is not an educational process.

Summary

When midwives adopt a pedagogical and behaviourist approach to learning, learning is perceived to be a passive process with little interaction between role model and learner. Prescriptive midwives teach students the rules of practice. However, the learning and teaching strategies they adopt are inappropriate. They particularly inhibit senior students' learning and the outcome of the process is conformity to the role of an obstetric nurse. Prescriptive midwives are therefore inappropriate teachers and role models for students. Midwives who perceive learning to be an interactive process adopt an andragogical, humanistic and cognitive approach to teaching and learning. In doing so, they do not help students to learn the formal rules but do facilitate their growth and development into autonomous practitioners with their own unique identity. They are therefore appropriate teachers for senior students and effective role models for all students.

Chapter 10

Conclusion and Implications

Introduction

The purpose of this study was to develop a theory, which would explain the meaning and process of learning the role of the midwife from midwives who acted as students' role models. The grounded theory approach to collecting and analysing data facilitated the emergence of both midwife and students' perspectives providing depth and detail of a phenomenon that has not previously been examined. This is my contribution to knowledge. Students' conception of their role is based on their experiences of working in the clinical setting. What emerges is an explication of the conditions under which students learn two very different roles, that of obstetric nurse or that of autonomous midwife. The interaction between students and their role models is made explicit, as are the strategies which students adopt to help them learn these roles and the consequences of doing so. The implications of this for learning and teaching are also considered. What emerged was a number of important theoretical ideas rather than a single theory. These ideas which are listed below focus on the rules of practice and will be described throughout this final chapter.

1. When midwives rigidly follow written and unwritten rules they prescribe midwifery care which corresponds to the medical model. In doing so they act as obstetric nurses or handmaidens to the doctor.

2. When everything is interpreted as rules to be followed prescriptive midwives appear to be uncaring and detached from the experience of childbirth. The individual needs of women are not met and the relationship between midwife and client is superficial.

3. Midwives who rigidly follow the rules inhibit the growth and development of students providing them with few opportunities to achieve beyond the level of their role model.

4. Midwives are flexible when they interpret the rules for the benefit of women and provide a woman-centred model of care. These midwives therefore act as autonomous practitioners.

5. When rules are interpreted and adapted to meet the needs of women, flexible midwives demonstrate involvement in women's experiences and are empathic, supportive and caring.

6. Midwives who use professional judgement to interpret the rules provide an environment in which senior students can become autonomous practitioners.

7. When midwives demonstrate the role of autonomous practitioner, practise a woman-centred model of care and meet the learning needs of students, they are appropriate role models and teachers.

8. When practitioners who hold opposing attitudes, values and beliefs practice together there is conflict in the clinical setting. Conflict can be avoided when flexible midwives adopt strategies that involve becoming prescriptive or practising by subterfuge.

Diagram 1 illustrates the relationship between these ideas and is presented on page 220.

The issue of generalisability of findings was considered in chapter three. It is, however, important to state here that the theoretical sampling technique appropriate in this research means findings cannot be generalised to the total population of student midwives but many of the ideas, which emerged, are supported by other studies.

When working in the clinical setting, students observed and participated in giving midwifery care to clients. Students made explicit their experiences of practising alongside midwives whom I called flexible and prescriptive, and clearly made a distinction between the two very different roles, which they took on. I have used 'prescriptive' and 'flexible' midwife as labels to make a distinction between the models of care these midwives practised.

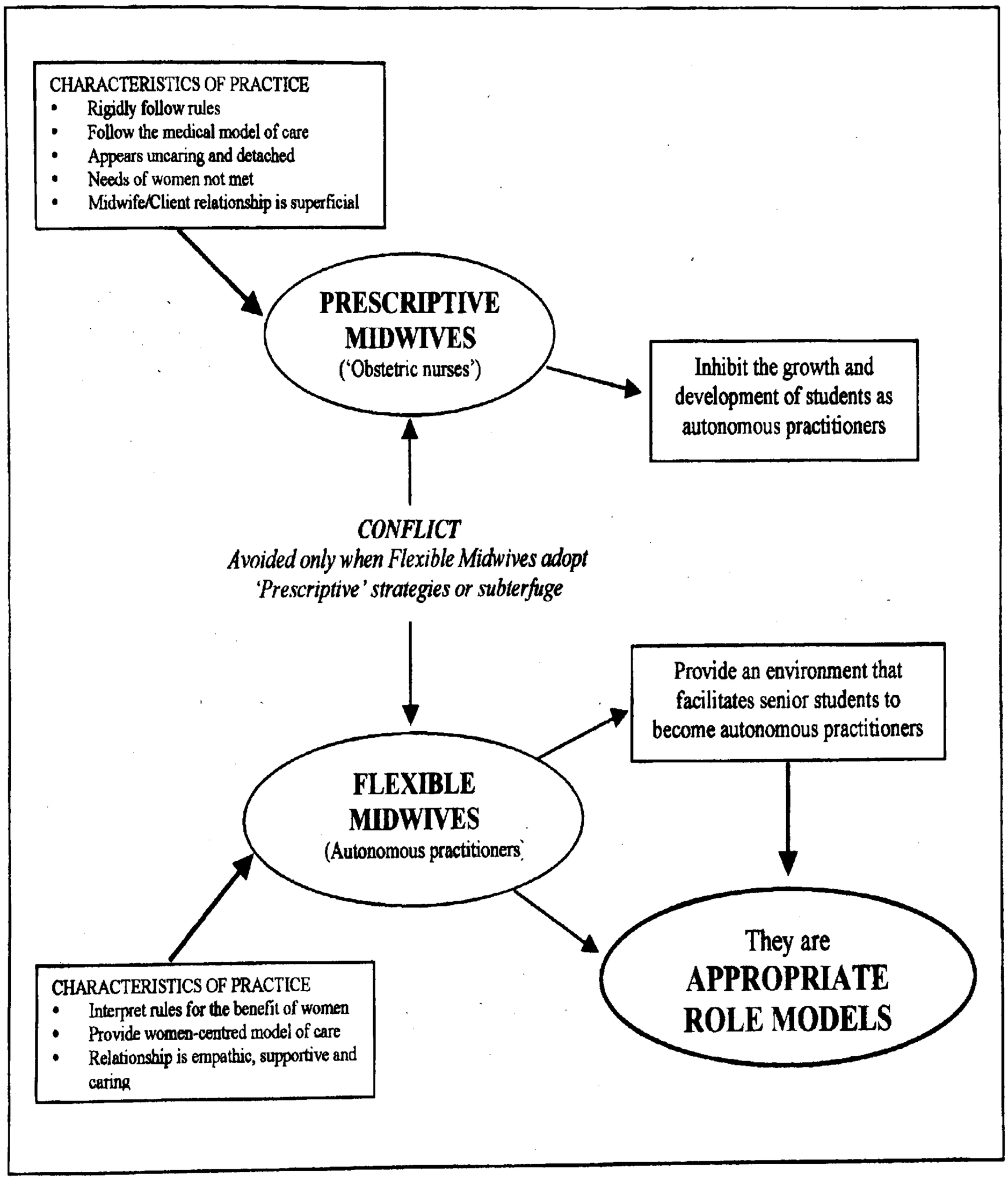

Diagram 1 to illustrate the relationship between the eight theoretical ideas

The distinction between these models of care, and the midwives who implement them, are important because it influences students' perceptions of their role models, how they make sense of the role and how they manage their experiences of learning in the clinical setting.

Prescriptive midwives

When midwives rigidly follow written and unwritten rules, this inhibits their ability to practice autonomously. Many of the rules emphasise the medical model of care upon which these midwives base their practice. Prescriptive midwives are usually to be found working in the hospital setting. Hospitals are known to be bureaucracies and in this setting midwives work alongside doctors whom have most influence in formulating the rules. It is here that women classified as 'high risk' are cared for and the rules for these women have been applied to everyone. Policies, which determine the care women classified as 'low risk' should receive, do not provide the opportunity for midwives to make their own decisions about the care that they give. Although a decision must be made about which rule to follow, doctors determine practice because it is they who are influential in devising the rules. The data therefore suggests that midwives take doctors as their role models. When midwives do not use their cognitive abilities to interpret rules but rigidly follow them, their role is determined for them and their behaviour controlled. They therefore depend on doctors and lack autonomy and do not act as role models for the decision making process. Rather than fulfilling the meaning of the word midwife, being 'with woman', prescriptive midwives are 'with doctor'. Analysis of data uncovers that when rules determine practice, midwives are dominated by doctors and fulfil a subordinate role. The role these midwives fulfil is that of obstetric nurse. Midwives therefore 'fit in' with doctors and the institution in which they work. Students do not, however, believe that doctors dominate midwives, rather that the behaviour of these midwives places them in a subordinate position.

When written and unwritten rules are so closely adhered to, there is no opportunity to be flexible. Rules are enforced. According to students, prescriptive midwives dictate the care women will receive. This results in a relationship in which midwives give care that women passively accept

without question. Information is restricted to midwifery care that supports the rules, and students' perceptions are of women manipulated and coerced into receiving care they might not otherwise accept. The same routine care is offered to all women irrespective of their needs. Midwives with prescriptive characteristics therefore control women's experience of childbirth by rigidly following the rules. My interpretation of the data suggests that a consequence of this is the domination of women by women. Midwives who lack autonomy deny women their own autonomy and women conform to expectations. When the needs of women are not considered, midwives cannot be advocates for them and there is a lack of empathy. When everything is interpreted as rules to be followed prescriptive midwives appear to be uncaring and detached from the experience of childbirth. The individual needs of women are not met. The data suggest that the goals of the organisation have taken precedence over those of the women for whom midwives provide care.

Many of the rules of the bureaucracy support the medical model of care. This model is associated with the separation of mind and body and hence a failure to consider psychological needs. Concern lies with the outcome of a healthy mother and baby and not on the experience of birth. The lack of emotional involvement in the process of birth means the midwife/client relationship is superficial. Bureaucracies are associated with rules designed to achieve efficiency and focus on outcome rather than process. This is supported by students' observations that midwives get through the workload by following rules. Students suggest that for these midwives the role has become 'just a job' and they sometimes question why these midwives continue to practise. The characteristics of the prescriptive midwife, and the way in which she practises, are therefore a reflection of the hospital in which she works and the medical model of care which she practises.

The findings of this study identified a limited number of policies that restrict the midwife's practice. One of these is an admission CTG for all women entering the labour ward even though many of them are classified as 'low risk'. However, prescriptive midwives place equal weight on all rules and make no distinction between policies, protocols, procedures,

guidelines and unwritten rules. They therefore restrict their own practice as well as that of other midwives far more than any policies do. The study shows that prescriptive midwives lack knowledge of up to date evidence that would support their practice and, as some policies have not been revised, practice is based on traditional knowledge. When learning is viewed as the acquisition of new behaviours, change is inherent in learning. Viewed from this perspective prescriptive midwives have ceased to learn. My interpretation suggests that unquestioning acceptance of rules by midwives who do not up-date their knowledge base means that they cannot justify their actions to students.

All students thought that midwives who rigidly follow the written and unwritten rules lack confidence in themselves. The findings of this study suggest that prescriptive midwives need the security of following the rules to minimise their fear of litigation and give them the confidence to practice. In this way they are also able to overcome the ambiguity associated with what is 'normal' midwifery practice. The literature suggests that lack of confidence can be linked to lack of self-esteem, an external locus of control, learned helplessness and a reluctance to participate or initiate change. When the status quo is maintained a model of care no longer considered appropriate is perpetuated.

Implications for practice

When prescriptive midwives rigidly follow rules, their practice is determined for them. Students perceive that these midwives rely on rules because they lack confidence to practice in any other way. Further research would provide an opportunity to confirm or refute this. I would suggest that rules should facilitate order but not control practice. Midwives need to be involved in the development of policies which influence their practice, particularly those related to normal pregnancy, labour and the postnatal period. Involvement in development of protocols for the care of women classified, as 'high risk' is also important. In this way midwives can be autonomous and collaborate with doctors rather than following prescriptions for care. Policies, protocols, procedures and guidelines should be clearly labelled to avoid confusion and regularly updated. An absence of policies and the provision of only guidelines to

support evidence-based practice would encourage midwives to be autonomous. Further research would be needed to identify whether midwives were practising within these guidelines or resorting to unwritten rules to support their practice. Midwives are striving to provide more midwifery care in the community setting for those women classified as 'low risk. As the pace of this innovation increases, more midwives will give care in a setting where many of the rules so rigidly implemented do not apply.

The adverse characteristics of the medical model and of the bureaucracy which prescriptive midwives adopt are not only inappropriate but also unnecessary. Midwives need to be able to identify and meet the needs of women. It is unacceptable to coerce or bully women into accepting care they do not want. When obstetric interventions are necessary a woman-centred approach can still be provided with midwives being 'with woman', treating women as equals and making them feel special. Options can be given, providing women with opportunities to be actively involved in decisions about their care. In this way women can be humanely cared for.

Implications for learning and teaching

Learning the role from a role model is an important component of students' education. Bandura's perspective of social learning theory suggests that individuals learn by observation and imitation. For learning to take place attention must be given to the behaviours that are being modelled. These behaviours must be retained in the memory and retrieved when required. Repetition enhances this process. The ability to reproduce the behaviour is also necessary although it is unlikely that any behaviour will be replicated exactly. Incentives and motivation influence whether behaviours are emulated. Rewards and punishment may therefore influence whether behaviour is followed. When individuals observe the consequences of others' action vicarious learning takes place, in this way they can anticipate the consequences of their own behaviour.

It emerged from the data that learning the role in this way can be a passive or active process. The amount of interaction that takes place between role

model and learner is reflected in the type of midwife students perceive them to be and is influential in what and how students learn the role of the midwife.

Prescriptive midwives: implications for learning and teaching

All students learn by observing and imitating their role models' behaviour. Contrary to the ideas of social learning theory, it emerged from the data that when working with prescriptive midwives all students are expected to passively learn by observation and imitation although some instruction may be given. Prescriptive midwives are classified as mentors for students but despite the suggestion that mentorship can be a means by which students are actively helped to learn, interaction between role model and learner is not expected nor encouraged by the role model. When there is little interaction between teacher and student the superficial relationship prescriptive midwives have with clients is also reflected in their relationship with students. No attempt is made by prescriptive midwives to get to know students, questions are not encouraged, and any attempts by students to ask questions are dismissed. This lack of interest does not make students feel valued or respected. It is important to interact with students and treat them as equals rather than expect the learning process to be a passive one.

Lack of interaction is associated with a didactic approach to teaching. By dictating care students can give to women, prescriptive midwives dictate what students will learn. This pedagogical or teacher-centred approach to teaching means that students are treated as children. This is not to say that pedagogy is never appropriate for adults. Prescriptive midwives teach a clear way of performing skills, providing clarity of the role, which in reality does not exist. Junior students believe these midwives are good teachers, because they help them to learn the rules of practice. Many of these are unwritten rules. Analysis of data reveals that students pay attention to these rules and retain them in their memory for a number of reasons. Learning the rules enables students to 'fit in' with their prescriptive role models and conform to their way of practice. Students want to practise safely and the rules provide a basis on which future practice can be developed. In addition decisions cannot be made until the

rules have been learned. Nevertheless, as senior students the relevance of many rules is questioned. Continuity of mentor provides students with the opportunity to practise and develop their skills and anticipate when it is appropriate to reproduce them. This continuity cannot, however, be guaranteed and, when students work with a number of midwives each with their own set of rules, learning the rules is not easy. When rules and guidance are not forthcoming all students experience anxiety.

When students follow the rules they learn by rote. Unlike their role models, senior students possess up to date knowledge of current evidence to support practice but are not given the opportunity to use it to support their own practice. Traditional knowledge is an important source of knowledge in the absence of evidence but in the presence of these role models students do not learn to integrate theory with practice or uncover theory embedded in practice. What is taught in the classroom is therefore not reinforced in the clinical setting. This highlights a continuing gap between theory and practice. Learning takes place when information is used in new ways. Midwives who rigidly follow the rules inhibit the growth and development of students providing them with few opportunities to achieve beyond the level of their role model. All students are aware that prescriptive clinical teachers mould them to practice in a specific way. One student perceived this to be helpful when she lacked knowledge and experience. As senior students direct supervision restricts the way in which they can practise. Senior students cannot learn to make decisions so long as they have to rigidly follow rules. The findings of this study demonstrate that when students work alongside prescriptive midwives the approach to learning and teaching focuses on controlling behaviour. My interpretation of the data reveals that these midwives abuse the power of their position by failing to provide an environment conducive to learning.

A variation within the concept of 'fitting in' was found in those students undertaking a long midwifery programme compared to those undertaking an eighteen-month programme. These students revealed that prescriptive midwives took it for granted that junior students with no nursing experience could perform nursing skills which realistically they could not

be expected to achieve early on in their programme. Fitting in is therefore difficult. When asked, students commented that they focus on developing their relationship with their teachers because they lack these skills. Students do not develop the confidence to practise in alternative ways when attention is focused on meeting the expectations of their role models.

Motivation for emulating practice is based on gaining the rewards of clinical teaching, experience and a good assessment of performance. In this way students can fit in with their role models and maximise their chances of achieving their desired goal to become a midwife. The decision to emulate prescriptive midwives in their presence suggests that learning a role from a role model is not simply something that happens because students work alongside them. The social environment, cognition and behavioural factors are all influential. Through a process of interaction individuals create their own social environment and are also shaped by it as they interpret and respond to the behaviour of others. This interaction enables individuals to have some control over their own behaviour.

Examples have been provided to show that when unable to emulate their role model's practice students are humiliated in front of everyone. A culture associated with a punitive environment and the need to conform to expectations continues to prevail. A behaviourist approach to learning is adopted which reinforces the concept of students as children. It is the influence of personality attributes which is greatest and a 'bad day' for students is not related to aspects of care but to the midwife with whom they work. Midwives who humiliate students are unapproachable and, when it is possible to do so, students will avoid them. There is then the potential to make mistakes because they are inadequately supervised. This raises a question about whether the strategies prescriptive midwives adopt to help students learn are appropriate.

When students work with prescriptive midwives they learn to follow the written and unwritten rules of practice. The role which students learn is that of an 'obstetric nurse'. Lacking in their own professional identity students cannot act autonomously. Like their role models, they learn to control women's experience of childbirth and subordinate women. Social

learning theory suggests that role modelling is more than imitation. It encompasses the process by which one person tries to become like another. The role model is of higher status and the learner usually shares the same values and beliefs. None of the students in this study seemed to share the attitudes, values and beliefs of prescriptive midwives but the power of their position in the hierarchy means they can impose their values and beliefs on students. The literature suggests the influence of role models is apparent when individuals emulate and display some of the role models' characteristics. Students emulate the practice of prescriptive midwives because they have to rather than because they want to. The apparent lack of caring, inability to empathise and establish a rapport with women are also characteristics that students participating in this study do not want to emulate. Their attitudes do not, therefore, reflect those of their role models. Students reject some of the attributes of prescriptive midwives but do not always have a choice of mentor so cannot ignore the role model.

Role modelling is not an appropriate way for students to learn from prescriptive midwives. Students do learn the rules of practice but this approach to learning transmits an outmoded culture of medicalisation, poor relationships with clients and inappropriate care to the next generation of midwives. When inadequate attention is paid to role modelling there is the potential for inappropriate behaviours to be learnt. The strategies these midwives adopt for learning and teaching mean these midwives are also inappropriate teachers for students. Students should not have to emulate practice to 'fit in' and gain rewards from their role models. When this is the expectation, there should be a clear distinction between the roles of mentor and assessor but it is questionable whether these prescriptive midwives should fulfil either role. When learning is a passive process, education acts as a form of professional control stifling the use of professional judgement and innovations in practice. Criteria for selection of mentors need to be determined so that students only work with good role models. Evidence from my study could be used for this purpose. When staff shortages exist this may not always be easy to achieve.

Flexible midwives

Students and midwives perceive that some midwives bend the rules. My interpretation of the data reveals that midwives are flexible in giving care when they use professional judgement within the scope of the rules and interpret guidelines and procedures rather than viewing them as rigid prescriptions for practice. Because these midwives are able to adapt the provision of midwifery care, I called them flexible. They make a distinction between formal written rules and unwritten rules. In doing so these midwives provide a woman-centred model of care that meets the individual needs of women.

Midwives who adapt the rules give care based on a philosophy that childbirth is a normal physiological process requiring a doctor's intervention only in the event of deviation from the normal. When midwives are flexible they provide individualised care which meets the needs of women. Knowledge is shared with women, thus empowering them to make their own decisions if they wish to do so. In this way flexible midwives and women work together in partnership and women's autonomy is respected. Women have choice in the care they receive and when necessary midwives act as their advocate. When rules are interpreted and adapted to meet the needs of women, flexible midwives demonstrate involvement in women's experiences and are empathic, supportive and caring. They are 'with woman'. Students observe what I call a mutual/participative relationship in which the women are made to feel 'special'.

When rules are interpreted midwives make decisions about what care is appropriate. The use of professional judgement therefore enables midwives to act autonomously. Flexible midwives do not rely on doctors to make decisions for them. Knowledge is necessary to determine the way in which rules can be used and to facilitate decision making. Taking risks is part of the decision making process and requires confidence. According to students in my study, flexible midwives possess a knowledge base that is up to date. When this knowledge is applied in practice, actions can be justified.

Flexible midwives: implications for learning and teaching.

When students work with flexible midwives, learning is an active process. From these role models students learn how to become autonomous practitioners. My study reveals that the relationship these midwives have with their clients is also reflected in their relationship with students. Clinical teachers who interact with students as flexible midwives do get to know them, their personal life and past experiences. When prior knowledge and experience are recognised and opinions and views shared students feel valued respected and treated as equals. Midwives learn from students and learning is therefore viewed as a two way process. Students also have the opportunity of acting as role models for the midwives with whom they work. Respect for students is demonstrated when midwives take an interest in students and give of their time, encouraging and responding positively to questions rather than viewing them as threatening. The relationship between role model and learner is then crucial to the learning environment these midwives create for students. Students need to learn the role of the midwife in an environment that is constructive and supportive. Midwives who are open minded, approachable and friendly establish an environment in which learning can take place.

Flexible midwives do not always teach students the rules, nor do they demonstrate clarity of role. When continuity of mentor is achieved, there is still no guarantee that students will learn the rules. According to students they learn that there are many different ways of performing skills, and the course of action depends on the woman and her individual circumstances. Familiar with using their professional judgement, flexible midwives sometimes appear to have lost sight of what it is like to be a novice and students experience confusion and initially difficulties in learning the role. Lacking knowledge of the basic rules students feel ill prepared to cope with the variations in practice. Flexible midwives are therefore inappropriate teachers for junior students, but students do have a vision of the practitioner they want to become. Continuity of mentor is less important for senior students. These students benefit from working

with a number of midwives because they are ready to choose those aspects of practice they want to emulate.

Trust is an important ingredient in the relationship between teacher and learner. When the midwife has confidence in herself, she trusts students providing opportunities for them to perform their role under indirect supervision. This gives students the freedom and encouragement to make their own decisions. With increasing knowledge, experience and a supportive role model, students are able to choose those aspects of practice they wish to emulate and reject those they do not. A process of trial and error helps students determine what practice they feel comfortable with and what meets women's needs. They reject practice that is not effective for women or that they disapprove of. Motivation is therefore based on the desire to become flexible. Students emulate practice from a number of midwives. Practice therefore derives from a group of abstract traits rather than a particular person.

Theory can be applied to practice when teachers articulate the reasoning behind their actions. When they encourage reflection on practice, students also gain knowledge that is imbedded in practice and identify new ways of practising. When the education provided in the classroom is reinforced in the clinical setting the theory/practice gap is reduced. This increases students' confidence and gives them the opportunity to develop beyond the level of their role model. My study shows that, when role models adopt a humanistic, andragogical and cognitive approach to learning and teaching, an environment is created in which personal and professional growth is encouraged. Students are treated as adults.

When learning is an active process, flexible midwives provide opportunities for students to be creative and determine their own role within safe practice boundaries. This suggests that to help others gain autonomy and apply professional knowledge to practice and learn from practice, practitioners must themselves possess these attributes and skills. Midwives who use professional judgement to interpret the rules provide an environment in which senior students can become autonomous practitioners. Students learn the woman-centred approach to care. Crucial

to giving care are the communication skills enabling students to establish a rapport with women and maintain a relationship in which women are given choice and control of the care they receive. Students also learn how to empathise with women and support them throughout their experience of childbirth. The relationship flexible midwives develop with their clients is one in which women have the potential to achieve fulfilment in childbirth. It emerged from the data that when midwives demonstrate the role of autonomous practitioner, practise a woman-centred model of care and meet the learning needs of students, they are appropriate role models and teachers. Role models who are flexible are therefore particularly appropriate for senior students. Students share the values and beliefs of flexible midwives and it is these midwives whom they choose to be their mentor and role model if they have a choice.

It is acceptance of the attitudes, values and beliefs of flexible midwives together with the knowledge and skills, which contribute to the development of a unique identity and a change in midwifery culture. In this way the role of the autonomous practitioner is transmitted to the next generation of midwives. It is in the latter rather than the early stages of development that students develop this identity. As students become more experienced flexible midwives also help them to increase their level of competence. Students want to become like their flexible role models, which reinforces the belief that role modelling is more than imitation. It is also the process by which an individual identifies with and becomes like another. Role models who demonstrate the qualities learners want to acquire are sought out while others are ignored or rejected. Students look forward with optimism to their practice as qualified midwives when they work with flexible midwives. They have confidence and self-esteem, although they still lack sufficient confidence to openly practise a woman-centred approach to care unless the midwife in charge of the ward is herself flexible.

To prepare students for their future role as midwifery practitioners and appropriate role models for practice, an active approach to learning needs to be emphasised. Midwives need to recognise the different approaches to teaching and learning and when they are appropriate to use. My study has

shown that neither type of midwife recognises that at different stages of development, different approaches to learning and teaching are necessary. Midwives who are flexible in their practice are not necessarily flexible in their choice of teaching and learning strategies. Approaches to learning which facilitate the skills of enquiry and decision making will enhance learning of the midwife's role. A didactic approach, which provides opportunities for students to respond and interact with the teacher, helps students to learn the rules of practice.

The practice continuum

The two models of care and hence the two very different roles which have been identified are akin to Weber's notion of 'ideal' types. An 'ideal' type is an abstract based on essential features derived from real cases. Neither prescriptive nor flexible midwives possessed all the essential characteristics but could be placed somewhere along a continuum. The variations in practice which students witness reveal that some midwives are flexible or prescriptive in some situations but not in others.

Accounts of students' experiences with midwives who were prescriptive nevertheless dominate the data revealing the impact these midwives have on students despite their small numbers. This may be because several prescriptive midwives always work in the labour ward. One or more might therefore be present on each work shift. All students were also allocated to work in this setting on more than one occasion. The length of time spent in the labour ward therefore often exceeded time spent in other clinical settings.

I would suggest that the amount of autonomy and degree of flexibility midwives demonstrate is influenced by where they are placed on this continuum. Students believe prescriptive midwives lack autonomy while flexible midwives are autonomous practitioners. If autonomy means that individuals make their own decisions then prescriptive midwives like their flexible colleagues are autonomous in a limited analytical sense because they have to decide which rule is appropriate to use in the situation they encounter. Flexible midwives are more likely to question why the rule is relevant. The failure of prescriptive midwives to distinguish between

formal written and unwritten rules does, however, mean they restrict their own practice and create an impression that they lack autonomy.

Tensions between roles

In revealing their experiences of learning the role of midwife, it became apparent that students witness tension between prescriptive and flexible midwives when they practise in the same setting. The philosophy on which midwives base their practice determines their attitudes, values and beliefs and their professional identity. When practitioners who hold opposing attitudes, values and beliefs practice together there is conflict in the clinical setting.

The characteristics of the two types of midwife and the tensions that exist can be explained by the two models of care and the context in which care is given. Most midwives have traditionally practised in the hospital setting and it is here that conflict occurs. Prescriptive midwives occupy senior positions in the midwifery hierarchy. When rules exist there is an expectation that everyone will follow them. As the study shows, intimidating flexible midwives and students who want to provide woman-centred care is a means by which prescriptive midwives ensure those who do not share their values and beliefs are subordinated to them and conform to their own way of practice. The hospital setting is therefore not conducive to woman-centred care which flexible midwives and students want to practise.

It is possible that observation would have enhanced this study. What people do in the context in which interactions take place would then be seen. Arguably I have presented only a superficial view of bullying. To understand its different dimensions such behaviour needs to be observed and this provides scope for further research. This might reveal for example whether midwives intimidate doctors and vice versa. What people say they do does not necessarily correspond to their actual behaviour. Although no midwife participating in my study admitted to intimidating others, there is always the possibility that they unconsciously do this or are aware of doing so but do not admit to such behaviour.

Conflict can be avoided between prescriptive and flexible midwives when flexible midwives adopt strategies that involve becoming prescriptive or practising by subterfuge. This raises a question about why flexible midwives concede to the pressure of their prescriptive colleagues and not prescriptive midwives who change their practise. As a coping strategy practising prescriptively does not seem to be effective. By allowing prescriptive midwives to manipulate their behaviour and submitting to persistent criticism, some midwives reinforce the positional power of these prescriptive midwives and their own subordinate position. When flexible midwives withhold the truth and some information, practise 'behind closed doors', remain silent and 'stay out of sight', they construct their behaviour to give an appearance of conforming to prescriptive midwives' expectations. In this way they can maintain their professional integrity by practising a woman-centred model of care. An assumption that midwives cannot be autonomous in the hospital setting is not supported by the findings of my study. Covert practice is a cause for concern. Several students observed midwives contravening a statutory requirement to maintain accurate records although they do not admit to this. When midwives have to covertly practise a woman-centred model of care, it is the environment or institution that promotes such behaviour. The majority of midwives participating in this study confirmed students' observations. What students did not see and some midwives acknowledged was the discussion and laughter, which relieved some of the tension associated with practising autonomously in the presence of prescriptive midwives. When certain midwives are in charge of the ward some midwives can now openly practise the woman-centred model of care.

Flexible midwives are often encountered in the community where they collaborate with other health professionals but usually practise on their own or with students. Students do not encounter conflict in this setting. Here many of the rules associated with the institution lack relevance and are not applied in practice. Unnecessary medical interventions are not carried out. Flexible midwives do not control women's experience of childbirth but promote their own autonomy and that of their clients. These midwives are not subordinate to doctors and likewise do not subordinate the women in their care. When these midwives work in the hospital

setting, they use the formal rules of this setting to inform their practice but are able to distinguish between these and the protocols, procedures, guidelines and unwritten rules of the institution.

Students learn the role of the midwife in an environment where midwives interpret their roles and practise in a very different way. Learning to cope with the tensions that exist between prescriptive and flexible midwives as they work alongside each other is all part of the everyday life of being a student. In addition students experience anxiety when they do not share the attitudes, values and beliefs of their clinical teachers. To overcome this, they actively contribute to their own process of socialisation by seeking information, which enables them to learn about their role models' practice. Constant criticism is destructive and undermines confidence and self-esteem. Ultimately students give in and conform to those who try to manipulate their behaviour. Students continue to learn their place in the hierarchy accepting a subordinate position to prescriptive midwives just as these professionals accept a subordinate position to doctors. They become cynical, disillusioned and reluctant to use their initiative. Students are therefore socialised to fit into a culture associated with the medical model of care even though they question its relevance for women classified as 'low risk'. Fitting in with their teachers is actively facilitated when students remain silent, hide their feelings and pretend to conform. In this way students create a good impression.

If students are to become the autonomous practitioners of the future they must learn the strategies that enable flexible midwives to avoid conflict and practise the woman-centred model of care. My study demonstrates the importance of this. Students learn these strategies as they observe the flexible midwife's practice. Working with flexible midwives enables students to develop the confidence to adopt these strategies. This suggests that role models that are flexible or have some flexible characteristics are influential in the long term. Midwives have power, but expert power associated with current knowledge is more influential than power associated with position in the hierarchy. The use of punishment as an instrument of control is therefore only effective in the presence of role models that administer them. Learning how to avoid conflict will,

however, perpetuate the subordination of flexible midwives to their prescriptive colleagues. Midwives need to work together in collaboration rather than in opposition providing support for each other, in this way the impact of prescriptive midwives at the extreme end of the continuum would be diminished. A reduction in the number of hierarchical layers in the institution might reduce opportunities to subordinate and intimidate individuals.

Diagram 2 presented on page 238 incorporates students' and midwives' perspective of role modelling within the eight theoretical ideas previously discussed.

Implications for the future role

Midwives are aware of being role models, although they do not consciously think of themselves in this way all the time. Many of them are also aware of the effect they have on students when they work alongside them. What happens to students after their name is entered on the professional register has not been addressed by my study. Interviews of students at a number of intervals following qualification might have identified the long-term influence of prescriptive and flexible role models on future practitioners, and whether the effect of these role models on others is temporary or permanent.

Students cannot internalise the values and beliefs of two opposing models of midwifery care. Many students participating in this study entered their midwifery programme with values and beliefs that corresponded to the woman-centred approach to care. Students who commenced their programme direct from school acknowledged they could not initially articulate their beliefs but quickly came to accept those associated with a woman-centred model of care. Emulation of practice does not therefore necessarily indicate internalisation of values and beliefs. Senior students reject the midwifery culture associated with the medical model of care and only tolerate it when working with prescriptive midwives. When students have confidence in their own abilities, they believe they will practice flexibly when their name is entered on the professional register. This suggests that the administration of reinforcements to students is limited to

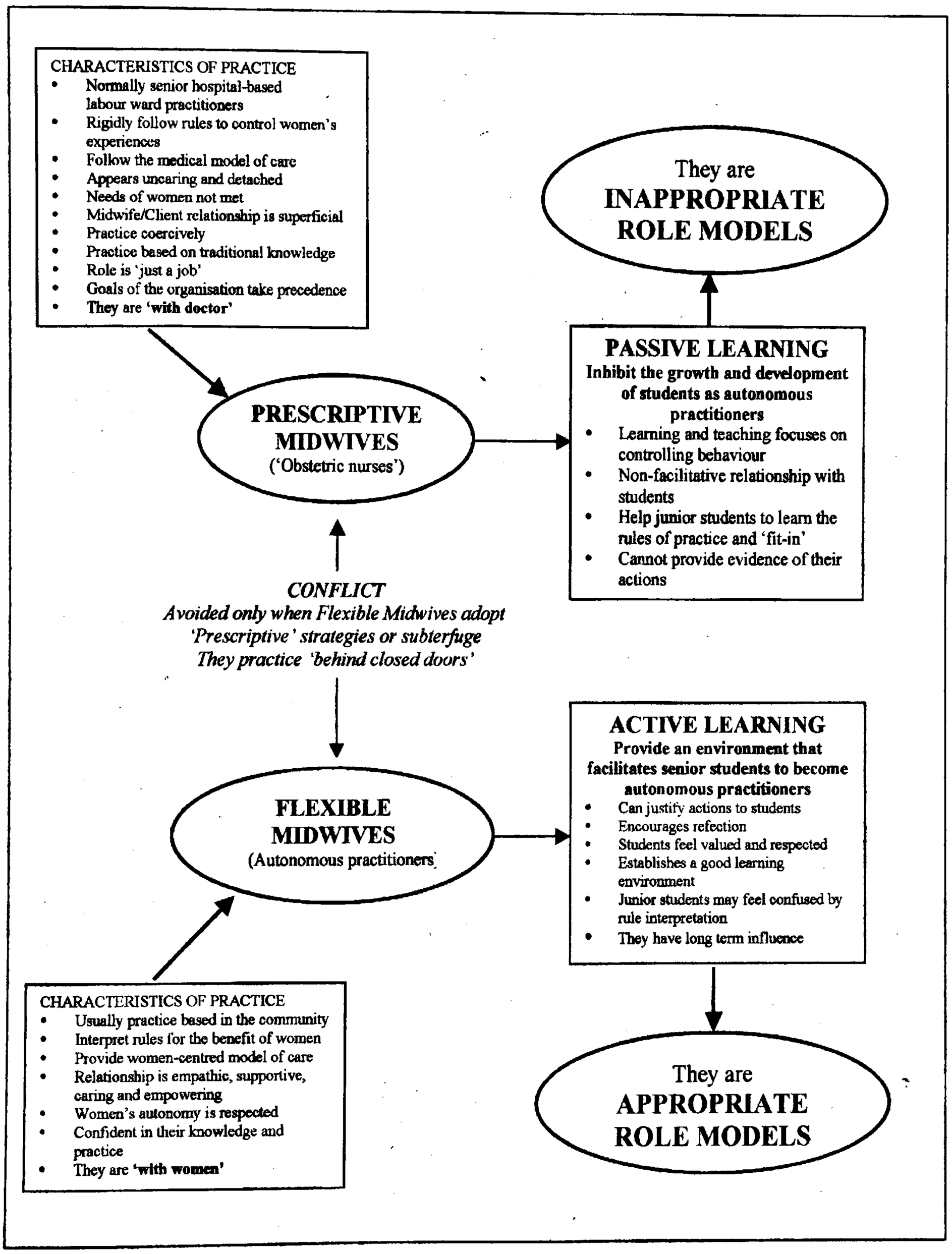

Diagram 2 to illustrate the relationship between the eight theoretical ideas and the other perspectives of the students and midwives.

the short term. It is encouraging to note that all students participating in a degree course felt they would practise flexibly. Support of newly qualified midwives by midwives who practise the autonomous role will be essential to ensure that they maintain their professional values and beliefs and do not ultimately internalise the values of the bureaucratic model. A lack of confidence is associated with students' belief that they will continue to rely on rules when their name is entered on the professional register. If students internalise the values of prescriptive midwives they too will ultimately become prescriptive. This lack of confidence can be illustrated particularly with two students who had undertaken an eighteen-month midwifery programme leading to a diploma in higher education. No conclusions can be drawn from this but further research to establish whether or not confidence is associated with the level of education students receive, has implications for future approval of educational programmes.

There is an expectation that all midwives will practise autonomously. If prescriptive midwives are to become flexible they will need support as they make the transition from obstetric nurse to autonomous midwifery practitioner. Anxiety is associated with change. Grief may be experienced as they give up their old role and experience its loss. Given that new patterns of care are being introduced based on the woman-centred model of care, midwives who lack the knowledge and skills to practise autonomously will need help to identify their learning needs. Study days and courses to meet those needs will need to be provided. Help will be required to enable prescriptive midwives to develop self-awareness and the skills of reflection, critical analysis, decision making and communication. In response to education they may move away from mechanistic midwifery care based on rules. Support in the clinical setting will be essential if these midwives are to become confident in a different way of practising and not revert back to their old ways. In this way they may regain their humanity and provide an environment that is conducive to women having a positive experience of childbirth to student learning. If these midwives can become autonomous/flexible this would prevent much of the conflict in the clinical setting. However there will always be variations of interpretation within the autonomous role and hence the

potential for conflict. Viewed from a positive perspective this conflict can be a stimulus for change. In this way the role will continue to be dynamic.

Students will one day themselves be role models. How individual skills and the complexity of the role are learned from role models needs to be made explicit for students. Opportunities need to be created for discussing the attributes of appropriate or inappropriate role models. This could be related to practice scenarios which students have experienced or role-play to demonstrate how a variety of situations can be effectively managed. Course curricula also need to reflect changes in clinical practice and enable students to develop the attitudes, knowledge, skills, values and beliefs associated with the appropriate role model and teacher. This means midwifery teachers must keep up to date on all aspects of clinical practice, the politics which influence the provision of maternity care and the changes in practice which occur.

Summary

Eight theoretical ideas emerged from the data rather than a single theory. These ideas focus on the rules of practice and influence what students learn and how they will practise when their name is entered on the professional register.

Students learn from their role models the skills they themselves lack. Observation and imitation are therefore crucial components in the education of student midwives. In accordance with Bandura's view of social learning theory, social, cognitive and behavioural factors are all influential in the role modelling process. When learning is interpreted as a passive process a behaviourist and pedagogical approach to learning and teaching ensures perpetuation of the obstetric nurse role. Midwives who are prescriptive are therefore inappropriate role models and teachers. Role modelling serves as a vehicle for transmitting new behaviour when learning is perceived to be an active process. When learning is active, a humanistic, andragogical and cognitive approach to learning and teaching is adopted. This does not help students to learn the rules of practice, therefore flexible midwives are not appropriate teachers for junior students. Senior students are, however, given the freedom to determine

their own role. Practice from a number of role models is emulated. In this way each midwife acquires a unique identity. Students are prepared for the autonomous role of the midwife, which involves taking risks and being accountable for actions. Flexible midwives are therefore appropriate teachers for senior students. They are also good role models for all students. This is because they demonstrate the role of the midwife that meets the expectations of the UKCC. They also meet the expectations of all professionals who really care for their clients, want them to maintain their own autonomy and have a fulfilling experience of childbirth.

Chapter Eleven

Reflections

Introduction

Reality is socially constructed. Individuals interpret and give meaning to events based on the context in which they occur and their understanding which is influenced by experience. The researcher is therefore an integral part of the research process and cannot be separated from it. Reflexivity refers to the process of looking back on the self (Mead 1934). This facilitates a conscious awareness of how the researcher's participation in the study may have influenced any or all aspects of the research process, and how in turn the researcher may have been affected by the research. This process facilitates new learning about the self as it was, and a new perspective of self as a result of learning throughout the research process. This awareness of 'self' is also necessary if the perspective of another is to be understood (Hutchinson 1986).

My own background

My career began as a nurse at the end of the 1960's. I received training which emphasised the skills required to give care to patients. A pedagogical approach to teaching and learning was adopted. Teachers determined what I would learn and much of my learning was by rote with little understanding of why I practised in the way I did. An authoritarian style of management was common, creating a punitive environment. There was an expectation that practitioners would practise in a certain way and this was unquestioningly accepted. The model of care I took with me to midwifery practice was the medical model. When I first qualified as a midwife this model of care was the childbirth culture. I perceived women to be patients and called them that. I knew no other way of giving care and unquestioningly conformed like all other midwives to this prescriptive model. In doing so I adopted Porter's (1991) 'unproblematic subordination' and acted as an obstetric nurse subordinate to doctors. All midwives appeared to share the same values and beliefs which corresponded to those of the medical profession. Punishments were administered but my assumptions were of doing something incorrectly, although I do not remember what. Now I realise I too, was often bullied

although I had never called it that. This was because I practised in a different way while still adhering to the medical model of care.

I was unable to make a distinction between policies, protocols, procedures, guidelines because no one had defined them, and lacking in self direction I made no effort to find out for myself. In retrospect I realise that when I had gained some practical experience I was flexible and did sometimes bend the rules. I believe I had the personal qualities of the flexible midwife and in caring for women would, for example, omit a ritual blood pressure recording because the woman was sleeping. I also remember shutting the delivery room door and allowing women to push beyond the one hour rule. Shutting the door was because of feelings of guilt for what I perceived to be breaking the rules and concern about what my colleagues would say. I failed to make any distinction between breaking or bending the rules. My instincts, or the progress of labour suggested with additional time a forceps delivery was unnecessary and painful. For an additional ten to fifteen minutes I called no doctor. To practice in this way was relatively easy to do. Having become a sister just one year after qualifying as a midwife my position in the midwifery hierarchy meant that when on duty I was frequently in charge of the clinical setting. When a distinction is made between policies, protocols, procedures and guidelines I am now acutely aware that I broke many rules but even though I was consciously aware of what I was doing I do not remember experiencing any dilemma. Professional issues were not, however, something that was included in the curriculum. I practiced in ignorance and unwittingly placed myself in a very vulnerable position. I was never negligent because I was always careful to ensure the well-being of mother and baby but unlike M16, with no knowledge of the research process, or any evidence to support my practice, the justification for my actions would, at the very least, have been difficult. If anything had gone wrong resulting in harm to mother or baby the Health Authority would be unlikely to accept vicarious liability. In a Court of Law decisions or judgements are based on what is acceptable practice (Montgomery 1997). I did not know whether other midwives 'cheated'. If they did it is questionable whether they would have admitted to doing so, bearing in mind the punitive environment in which we practised.

I remember a number of midwives who were influential in the way I practised. What I particularly liked in others was an ability to remain calm in any situation and instil confidence in others. These role models could also perform skills to a level of expertise that I had yet to achieve and could articulate and demonstrate these skills so that I could learn. This meant that the role models I perceived to be positive ones had the skills and expertise that I myself lacked.

A role model for students

The findings of this study have stimulated me to consider what I was like as a role model when practising as a full time midwife in the clinical setting. I always worked in the hospital setting. Although I would not have placed myself at the extreme prescriptive end of the continuum I certainly had prescriptive characteristics. At times I am sure I was authoritarian. I was, however, also flexible in that I had the confidence to let students develop their own style of practice within the principle of the rules. I did not expect students to emulate everything I did so long as I thought their practice was safe, but it is possible that the way in which I communicated to them reinforced the rules. My practice was frequently based on routine with little thought but was happy for students to challenge me because I then had to think, learn and grow. I would like to think that I was a good role model but it will be left to those who worked with me to make their own judgements.

In my present capacity as a teacher I am also a role model for students. Fitting in was a key concept to emerge from my study. Reflecting on this made it explicit to me how I had fitted in when working full time as a clinical midwife. Practising in the labour ward recently in my present position as a teacher I was also reminded of how I fit in. I am very aware of what are called the Delivery Suite Guidelines and Operational Policy. The very title of this document creates confusion and when opened, the contents fail to provide clarity. Words like 'must' and 'should' which can be interpreted as an obligation or duty, clearly suggest how the midwife is expected to practice. Such terminology is a contradiction of the word guideline and supports policy. If the policy is to obtain an admission CTG

this must be done. There is, however, no research evidence to demonstrate the necessity for this if women are classified as 'low risk'. I find myself placed in a situation where as a teacher I emphasise adhering to rules, inform what evidence is available but communicate in such a way that women have agreed to an aspect of care based on the rule and this is not providing the unbiased information recommended by the Department of Health (1993) or acting as an effective role model for students. It has become clear that I and other midwives must be proactive in initiating changes to this and other policies and make clear the distinction between what is policy and what is a guideline. This has already begun with a change from the original requirement for continuous monitoring throughout labour. After a period of time further changes will be made so that this CTG will no longer be expected as a routine. As a teacher who is also a role model for students I can tell students this. In the meantime I am reinforcing the theory/practice gap which creates enormous discomfort and compromises my integrity.

Learning from the research process

At the time this study was undertaken I was employed as a midwife teacher/teaching fellow by an established University in the south of England. First and foremost I perceived myself to be a practising midwife then a teacher. Approximately four fifths of my work time is spent in the education department, the remaining fifth in clinical practice although this does vary considerably according to my workload. Because of this I was arguably both an 'insider' and an 'outsider' to the phenomenon under study. May (1991) notes the difficulty researchers may have in remaining neutral when undertaking a research study. The possibility that my own knowledge and experience as a midwife in clinical practice and a teacher for many years, might adversely influence data collection and analysis therefore had to be considered. As an 'insider' I shared the same language as participants and was also familiar with their culture. This familiarity had the potential to disadvantage me by limiting my understanding of the phenomenon because of being closed to alternative interpretations of the data. Phenomenologists suggest 'bracketing' in other words putting personal and professional experience to one side to avoid influencing the study. The desirability of being able to suspend knowledge (Morse 1994)

was likely to be difficult or even impossible to achieve after nearly thirty years as a midwife. After some initial data collection and analysis for example, I realised that I was making judgements early in each interview about who was, or was not a good participant. A good participant related to my perceptions of quality of data being collected, or the number of concepts referred to by participants and the depth and detail provided. This suggested I had my own preconceived ideas. I quickly learned, however, that such judgements were inappropriate as the process of analysis often revealed different dimensions of concepts which I had not previously considered.

Grounded theorists believe that knowledge and experience can help the researcher to make sense of what is happening and facilitate data collection and analysis (Strauss 1987, Strauss & Corbin 1998), it becomes a resource. My own knowledge enabled me to recognise the written and unwritten rules which midwives were adhering to which someone lacking in that experience might not have been able to do. I was also able to distinguish between practice based on evidence and practice based on tradition. Lacking this knowledge I might not have been so easily able to make this distinction. I therefore had the advantage of being better able to identify with participants and having insights that outsiders would lack.

To make explicit any effect I might have on my study I followed Hutchinson's (1986) suggestion and kept a diary to jot down my thoughts and interactions with both participants and data. The discipline of keeping this diary was something I had to learn. On occasions when I was disorganised I forgot to complete it, or even could not find it. It was my diary that made me acutely aware of my own anger when bullying became a predominant feature of the study and that during data collection I sometimes focused for too long on this concept in the belief that the more data I had the easier it would be to expose this behaviour. Students were only too happy to talk about bullying because it was a major feature of their socialisation into the role of midwife and it is possible they thought my exposure of it would make life easier for them. However, it is equally possible that my exposure of it might have no effect. Students often complain that what they are taught in the classroom does not match what

happens in the clinical setting and all too often teachers have been seen to change nothing. By recognising my own anger I was able to understand why students responded in the way they did. Having experienced bullying myself I could also relate to those students and midwives who were themselves experiencing it. The diary was also valuable in providing me with a record of the audit trail, discussions with colleagues about different aspects of the research study and ideas from study days and the literature.

In retrospect it would have been appropriate to give participants written information about the study before undertaking the first interview. My experiences of interviewing when undertaking a previous study (Bluff 1993, Bluff & Holloway 1994) had taught me that this aspect of the research process was not always easy to do. Listening skills are a vital part of the process and I discovered that sometimes questions I asked were very similar to a previous one. This was partly due to my initial anxiety associated with ensuring the interview went well and concern that I did not ask leading questions which would adversely influence the data collected.

Data collection sometimes went well, on other occasions difficulties were experienced. Clients are particularly vulnerable and there is the potential for a power relationship between the researcher and participants, the advantage lying with the researcher. When three participants failed to turn up for their interview, I discovered it was they who held the power. I was dependent on them for my data and ultimately completion of my study. I was fortunate in that students who did not attend for their interview were, nevertheless, still keen to participate in the study. They had either forgotten about the interview or, on one occasion a student's work shift was changed and she was unable to contact me. Rearranging another date for interview enabled my data to be collected, but it did mean I travelled quite long distances only to be disappointed initially.

Theoretical sensitivity, the ability to understand and give meaning to the data (Glaser 1978, Strauss & Corbin 1998), as I discovered, was not something to which I had an automatic right. On some days I would be 'immersed' in the data. The ideas flowed and the analysis of data rapidly

progressed. On other occasions it became necessary to focus on different aspects of the study because no amount of time and effort created the sensitivity so essential to analysis of the data. The difficulties I experienced may have occurred because sometimes I worked on the study even though I was tired. There were, however, occasions when I was tired but still possessed this sensitivity. Much of the research study had to be completed around my other work. Picking up and putting down the study at odd moments often for short time spans meant that each time I had to reorientate myself, and sometimes for no apparent reason I was unable to do this.

A source of theoretical sensitivity is provided by the literature (Strauss & Corbin 1990, Strauss & Corbin 1998). It was only when I encountered the work of Cioffi & Markham (1997) and Cioffi (1998) that I realised midwives were using heuristics to help them make decisions. My study did not set out to identify how decisions were made. It is important for students to learn how to make decisions because it is crucial to learning how to be an autonomous practitioner. Decision-making is, however, only one aspect of learning from a role model. Asking students and midwives specifically about the decision making process would, however, have provided greater depth of knowledge. I could also have focused more on the issue of learning by trial and error. Although students did not volunteer that they were left to their own devices in the clinical setting as a teacher I am used to hearing students say that they do in fact learn in this way.

Glesne & Peshkin (1992) believe qualitative researchers should be able to accept ambiguity, even enjoy it. This I was never able to achieve and it was a source of constant frustration, even amusement when discussing issues with my supervisor. It was like 'leaping in the dark' taking a step, the consequences of which I could not foresee. I did not know the outcome until I had got there. This could be described as an adventure but, as I already knew, I was not an adventurous person. According to Morse (1993) researchers should not drown in their data. Nevertheless the amount of data I collected often overwhelmed me. Despite detailed memos which acted as a written record of the analytic process, within my

mind it often felt like drowning. The initial excitement of starting the study and being ready to 'go' was often replaced with despair when connections between codes and categories could not be made. Nevertheless I learned to believe in the process and knew that relationships would ultimately become clear, but this did not reduce the anxiety I experienced much of which was associated with the want and need to complete the study and move on to other projects. My need for issues to be 'black and white' and information neatly placed in separate marked boxes led a nursing colleague to suggest that if I could not move away from these boxes it might be useful to leave the lids open. While I could appreciate this imaginative response it did not prove to be helpful. My strategy for coping was to take solitary walks to the sea front, drink coffee in the cafeteria and stare out to sea. This enabled me to empty my mind and provide the space for subsequent insights. It was here that I came to understand and value the benefits of meditation.

Some people have suggested to me that the research process is a lonely one but I can only partially agree with this. No one piece of research is the same and it was therefore not possible to compare my own progress with that of other researchers. I found this frustrating but acknowledged it as a reflection of my own lack of confidence. This was, however, counteracted by all the opportunities I had to share what I was doing with my colleagues. Verbalising my own ideas helped to clarify them and identify any flaws in reasoning. In turn they generously shared their ideas with me often introducing new ideas and extending my thinking.

As I neared completion of the study I re-read Strauss & Corbin (1990, 1998). The examples they gave of questions to ask and the examples of properties and dimensions to facilitate development of a theory were beneficial in helping me to understand the grounded theory approach. The examples appeared too obvious and simplistic however, and did not help me to develop my own categories. Attempts to fit their questions to my data meant forcing the data and inhibiting the emergence of my own story. Ultimately I abandoned any attempts to use their questions but identified no consistent questions that I asked of my own data. Strauss and Corbin (1998) place open, axial and selective coding in sequential order and I

often found this too prescriptive. They suggest that questions posed to participants are designed to enable the relationship between categories and subcategories to be identified and from this the storyline will emerge. In retrospect it became apparent that the questions I asked facilitated development of the core category. A relationship between codes was often identified, but these relationships sometimes changed when the core category emerged. It was only when the core category had emerged that I was able to complete the axial coding.

Role Modelling

Through the completion of my study the process of role modelling has been made explicit. I now recognise it to be a complex process that cannot be encompassed within one definition. Role models help students to learn the role of the midwife but when there is a lack of clarity about the role, what each student learns and ultimately becomes will be unique. There is no one approach to role modelling. Different approaches to learning are adopted by different midwives and a practitioner can be an effective role model on some occasions and an ineffective role model on others. No midwife can be the perfect practitioner. It is important that we recognise our strengths and weaknesses and work in collaboration. One individual's weakness may be another individual's strength. Working as a team with effective communication is therefore important.

I now separate socialisation from the educational process as I recognise they are not synonymous. Socialisation into a role is an active process creatively interpreted but learning the role does not have to be an educational process. Indeed when students worked with prescriptive midwives their experience of learning the role could not be classified as educational. The process can, however, be educational and when senior students work with role models with flexible characteristics they reinforce the education students experience in the classroom. I and my colleagues have often commented in frustration how students behave like children in the classroom. I now realise that it should not come as a surprise. When treated as children in the clinical setting the way in which they behave in the classroom is a continuation of that behaviour and evidence of an inability to adapt to a different environment.

Appendix 1 The Role and Activities of the Midwife

The Midwife's Role:

The midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

Midwives code of practice (UKCC 1998:25 - 26)

Activities of a midwife

- 'The activities of a midwife are defined in the European Union Midwives Directive 80/155/EEC Article 4 as follows:
- to provide sound family planning information and advice
- to diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies
- to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk
- to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
- to care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means
- to conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery
- to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate to take the necessary emergency measures in the doctors absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus
- to examine and care for the new - born infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation
- to care for and monitor the progress of the mother in the post - natal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new - born infant
- to carry out the treatment prescribed by a doctor
- to maintain all necessary records'

Midwives code of practice (UKCC 1998:26)

Appendix 2 Profile of Participants

To preserve anonymity pseudonyms, approximate ages and lengths of experience have been used.

The glossary should be referred to for an understanding of abbreviations

Student Participants

Name	Age/Marital Status	Junior /Senior Student	Experience of Nursing	Course	Clinical Experience
Rebecca	20 –25 years Single	Senior	RGN Certificated Course	18 month certificated	Community TH Antenatal Labour Postnatal Clinics Neonatal Unit GPU
Rachel	20 - 25 years Single	Senior	RGN Certificated Course	18 month Diploma	Community TH Antenatal Labour Postnatal Clinics Neonatal Unit GPU
Faith	35 - 40 years Married Experienced mother	Senior	RGN Certificated Course	18 month Diploma	Community TH Antenatal Labour Postnatal Clinics
Elena	25 - 30 years Single	Junior	None	3 year Diploma	Community MUDGH Labour Postnatal
Zeta	20 - 25 years Single	Junior	RGN Diploma Course	18 month Diploma	Community TH Labour Postnatal
Marie -Anne	20 - 25 years Single	Senior	None	3 year Diploma	Community MUDGH Antenatal Labour postnatal
Belinda	20 - 25 years Single	Junior	None	3 year Diploma	Community MUDGH Labour Postnatal

Kelsey	35- 40 years Married Experienced mother	Junior	RGN Certificated Course	18 month Diploma	Community Antenatal Labour Postnatal TH
Catherine	18 - 20 years Single	Senior	None	3 year Degree	Community Antenatal Labour Postnatal Clinics MUDGH
Letitia	20 - 25 years Single	Senior	None	3 year Diploma	Community MUDGH Antenatal Labour Postnatal MLU
Mary	40 - 45 years Married Experienced mother	Senior	None	3 year Diploma	Community MUDGH Labour Postnatal MLU
Miranda	20 -25 years Single	Junior	None	4 year Degree	Community TH Labour
Katrina	25 - 30 years Single	Junior	None	4 year Degree	Community TH Labour
Lynne	20 - 25 years Single	Senior	None	4 year Degree	Community TH Labour Postnatal
Maureen	18 - 20 years Single	Senior	None	4 year Degree	Community TH Labour Postnatal
Ruth	35 - 40 years Married Experienced mother	Senior	RGN Certificated Course	18 month Diploma	Community TH Antenatal Labour Postnatal Clinics Neonatal Unit GPU
Imelda	20 -25 years Married	Junior	None	3 year degree	Community MUDGH Postnatal

Susan	20 - 25 years Single	Senior	None	3 year Degree	Community MUDGH Antenatal Labour Postnatal MLU
Anne	20 - 25 years Single	Junior	None	3 year Degree	Community MUDGH postnatal Labour
Matilda	25 - 30 years Married Experienced mother	Junior	RGN Diploma	18 month Diploma	Community TH Antenatal Labour Postnatal Clinics GPU

NB:Community experience includes care of women during pregnancy, labour and the postnatal period although in some instances labouring women were cared for by the community midwife in the hospital setting

Midwife participants

Number	Age/marital Status	Midwifery Course	Length of Midwifery Experience	Area of Practice	Experience of Nursing
1	40 - 45 years Single	One year certificated	10 - 15 years	Labour Ward/TH	RGN Certificated Course
2	30 - 35 years Married	18 month certificated	10 - 15 years	Antenatal MUDGH	RGN Certificated Course
3	20 - 25 years Single	18 month certificated	0 - 5 years	Postnatal/TH Expecting to rotate to all areas	RGN Certificated Course
4	40 - 45 Married Experienced mother	One year certificated	20 - 25 years	Rotating to all areas MUDGH	RGN Certificated Course
5	35 - 40 years Married Experienced mother	One year certificated	15 - 20 years	Community	RGN Certificated Course
6	40 - 45 years Married Experienced mother	18 month certificated	10 - 15 years	MLU	RGN Certificated Course

7	25 - 30 years Single	18 month certificated	0 - 5 years	MLU	RGN Certificated Course
8	40 - 45 years Married Experienced mother	One year certificated	20 - 25 years	MLU	RGN Certificated Course
9	30 - 35 years Married	18 month certificated	5 - 10 years	Rotating to all areas MUDGH	RGN 3 year Degree Course
10	35 - 40 years Single	18 month certificated	15 - 20 years	MLU	RGN Certificated Course
11	50 - 55 years Married Experienced mother	One year certificated	20 - 25 years	Community	RGN Certificated Course
12	25 - 30 years Single	3 year Diploma	0 - 5 years	Rotating to all areas/TH	Enrolled Nurse (EN)
13	35 - 40 years Married	18 month certificated	5 - 10 years	Community	RGN Certificated Course
14	25 - 30 years Married	3 year Diploma	0 - 5 years	Rotating to all areas/TH	None
15	35 - 40 years Married	18 month certificated	5 - 10 years	Rotating to All areas/TH	RGN Certificated Course
16	50 -55 years Married Experienced mother	18 month certificated	5 - 10 years	Rotating to All areas/TH	RGN Certificated Course
17	50 - 55 years Married Experienced mother	One year certificated	20 - 25 years	All areas MUDGH	RGN Certificated Course

Appendix 3

Example of a Student Interview

RB: Thankyou for agreeing to talk to me and for giving your permission to use the tape recorder. I want to reassure you that this interview is confidential and steps will be taken to ensure anonymity is preserved. I have an initial question I want to ask you but subsequent questions will be based on your response. There are no right or wrong answers to questions. I simply want to know your views and I'm not making any judgements. If there are any questions you don't want to answer please say so and I will respect that and if you want to withdraw from the study at any time you are free to do so. Perhaps I could begin by asking you how you think you're learning the role of the midwife in the clinical setting?

Lynne: Well the theory is very different from the clinical, and we did theory for the first two years basically and then we really got into the clinical practice.

RB: When you say theory, what do you mean by that?

Lynne: Um ...well what we learned in the classroom. The difference between the theory and the practical is immense. I mean we went to the clinical area thinking we'd got a decent background of what we were supposed to be doing, and in fact we knew very little and you did feel as if you were thrown in at the deep end. I mean, I don't know about any other courses but for our course we certainly weren't prepared for what happened when we went on our clinical placements. Um ... you learn, I think from the practical. What you learn in the classroom you try out in practise but if the practical overrides what you learned, you go with the practical. It's um much more important. You can't always apply theory to what you do in practice because it doesn't always work that way. And the theory is not individualised to individual care so...

RB: So why do you think there is this gap between what you're taught in the classroom and what you learn in the clinical area?

Lynne: Because what we're taught in school is the ideal way of doing things so we're taught a lot of... I think originally you are taught a lot about the non medicalised, risk care, what the ideal care is, should be, and things like that, and we weren't taught about what it was going to be like in the clinical area and how medicalised it was and how, we sort of question things. 'I thought you weren't supposed to do that' or 'I thought it was better if you did it like this' and it was sort of 'because of the cut backs, because of the lack of staff this is the way it's done'. And we didn't talk about that in the theory, the classroom. So I think that's difficult, to try and um connect the two together. In some cases you can and other cases you can't, but um you learn the ideal in class and you learn realistically what it's like on the wards. But then you can change things a bit. You know in the back of your mind what it should be, and you just have to go with the flow when you're a student. You can't really challenge anything. I have in the past and it hasn't worked (laughs). I've been told off (laughs) because they (teachers) say to us 'ask them

questions', ask them for the reasons why they do what they do, and um, if they've got any research behind the practise that they do'. So you ask the questions and you get told that, maybe it's just me, but I got told that I shouldn't ask so many questions to certain people especially the older midwives. Sometimes they couldn't cope with the fact that I was asking them these questions. It made them uncomfortable.

RB: So who's telling you not to ask questions?

Lynne: The senior sister in charge said that 'oh I've been told by somebody that you're being a bit aggressive in the way that you've been asking the questions' (laughs) and I said 'well if that's how I come across I'm sorry, but I was just, it's just the way I am. The fact that I want to learn things and I want a decent answer to my questions and when you don't get them you keep probing because that's the way I am and I'm never satisfied with 'well that's the way I was taught' kind of thing. I want to know why and then I was told that 'ok you can find out these things but watch who you're asking and be careful about what you're saying'. And I talked to my mentor about it and she said 'well', she said, 'well you're got to watch about what you say to certain people because certain people don't like to be questioned about everything they do, and um, the fact that um, you know um, just learn to keep your mouth shut sometimes' (laughs). But then I think the only way I'm going to learn is by asking questions. But it's amazing the different practises that go on. So many different practises exist. That gets me, really confusing. The fact that some of the older midwives come out with one thing and they tell you off because you're not doing it their way. And then you go onto the next person and they tell you off because you're doing it the way that midwife told you. I think that is the most frustrating thing, because in the end you end up, before you walk in the room 'well how do you do it?' so I don't get told off, because I kept on getting told off for doing the wrong thing.

RB: So what happens when you're told off?

Lynne: Well um it depends. Sometimes you are actually doing it and they say 'oh no you don't do it like that' in front of the woman which I don't think is very good. Other times afterwards you sort of say 'well how did I do, was that ok'. And they say 'well I think maybe you should have done it like that which is obviously better. So, and then sometimes they just go straight up to the senior sister and tell her (laughs).

RB: What the junior midwives?

Lynne: Um well in that circumstance it wasn't actually her at all. It was somebody who was listening to our conversation, who came in on our conversation half way through and didn't really understand what I was saying and the way I was saying it. It wasn't the junior midwife who was saying anything; it was the senior, somebody who was just walking past. One of the sisters that heard what ...but I've learned to keep my mouth shut (laughs).

RB: So now you're keeping your mouth shut?

Lynne: I'm trying (laughs). I'm really enjoying it there (Labour ward) and I think it's really good. Every time I go down there I learn something and the midwives who are really chatty, really put you at your ease, treat you like a human being, it's wonderful. You can learn so much from them, but sometimes the midwives just don't give you the time of day, and they obviously don't want students down there, and they obviously don't want to teach you, and you're obviously just a hindrance to them especially when you're younger and not experienced, and they just don't want to know, and you just feel so awkward and your confidence just goes like really down. But as you get more experienced and you can ask the relevant questions and you tend to get more questions right that they ask you, um.... It's got better as it's (the course) gone along. There's still a couple down there who, that just better off when there's no students down there.

RB: So what is it about these midwives who think you're a hindrance, if you compare them with those who are really nice?

Lynne: I think that they're just, because they a) don't like our course very much. I don't know whether it's, I mean I've talked to other students on different courses and they say well they're the same to all the students, but our course is a bit different and I don't think they like change for a start. They really don't like change, and um I just think that it's, if they, it depends on what students they've had before and if the students haven't really made the effort before, then they've got, oh all the students are like that, sort of opinion and they don't want to know. I don't know, I think it's just personality. I think some people just want to get on with their job and don't want to teach. Some people want to teach. Some people don't. But I think it's personality. There's personality clashes there (Labour ward) as well (laughs).

RB: So what personalities are causing clashes?

Lynne: Um... those...um... I've been told by um my mentor that quite a few of the, well the teaching of a student down there, whose somebody who asks a few questions and wants an answer, because they don't like that. Um, they like the students that just meekly follow around and do the job and get on with it and don't really, and she said it's the same with the junior midwives as well. If you start trying to change practice like you're supposed to and you start questioning what's going on and things like that, then you're labelled a trouble maker from the beginning and you're never given a chance after that, and that's what I've found anyway.

RB: So you've been labelled a troublemaker?

Lynne: Yes by some of them (laughs). But I've got better. I've been told I've got better.

RB: So why have you got better?

Lynne: Because I've had to. I've had to make a really big effort this term to be generally a lot more happy and friendly and get less um ..asking questions and more um..sucking up if that's the right word to use,

(laughs) because that's what you have to do. To get on down there (Labour ward) you have to suck up and I hate it, and I refuse to do it most of the time but sometimes you just have to give in. And most of the midwives have said 'oh yer, yer, you're much better this term, like you've really got on with everyone and you're obviously enjoying it a lot more and you're making the effort. Um.. but then there's still a few that it doesn't matter how good your work is, how well or how hard you're trying, you will not be given a chance. You will never be given a second chance, and that is frustrating because I'm getting really good reports because my work and everything. You know the work I do is fine and I've got really good reports, but um, they don't take it into consideration at all. If they don't like you they don't like you and they're not going to do anything about it because they're the sisters and you're just a student and it doesn't matter does it (laughs).

RB: What are the consequences of not sucking up to them?

Lynne: ...Um I certainly wasn't as happy down there (Labour ward) before I sort of decided I was going to change, but...I was unhappy because um...I don't know, people weren't talking to me because I wasn't talking to them and if a student gets on down there it's because they've had to make the effort in the beginning. The rest of them they don't have to make the effort. They're above you. They don't have to make the effort, and if you want to get on, it's like the junior midwives to the sisters. To get on with them you've got to make the effort. The sisters can just drift along and be hated if they want to because they've got every right to be hated if that's what they want to do (laughs). It sounds horrible doesn't it (laughs) but it's just that it's the way it comes across to us or to me. It's the hierarchy, and if you're at the bottom you have to try really hard, and if you're at the top you really don't have to because you can rely on your experience and the respect that you think you deserve because you're a sister. You should respect people because they're sisters because they have the experience but then...you've got to be a nice person as well.

RB: So do you respect them?

Lynne: I do respect them. I respect all of them but I respect some more than others. Some of them I've got minimal respect for because I don't think that they're very nice people, but then they probably think I'm not a very nice person. But I get on with most people, it's just um ...very frustrating when you try hard and you don't get anywhere. I don't think I'm used to that. I'm not used to being knocked back all the time and being, not being told off, but sort of like, I mean there was a lot of stuff said about me last year when I was down here (Labour ward) about, you know she's miserable, she doesn't make the effort, and yet I was the most enthusiastic person to go down there really because I just wanted to learn, and it was like hitting your head against a brick wall, and eventually when you get told enough times that you are stupid and you really are not doing anything right then you just end up, well I'm not going to say anything. Well that's what it ends up like, and that's why I really didn't get on with it down there (Labour ward) at all last time because everything I did was wrong. I guess a lot of students think like that, but my way of dealing

with it was, right ok then, and didn't say anything, (laughs) but it's changed this time (laughs).

RB: So you say it's changed this time

Lynne: Yes because of me, because I made the effort.

RB: You seem to be saying that initially you didn't fit in

Lynne: Yer, I just didn't fit

RB: So now you're making an effort to adapt to them by keeping quiet

Lynne: I'm still asking them the questions but I'm, I don't know, I'm just trying to keep a low profile and trying to get on with them in a more social context, you know, just like offering to make them coffee, and offering to help when ever you can and never just sitting there doing nothing. They hate it if you sit there doing nothing. So you always have to be doing something. I mean it's worth it. It's been worth it to me because I've learned a lot more and I've got on with a lot more people, and I'm not a complete nobody any more. I actually feel I can do something rather than, oh she's just a hindrance.

RB: Are you saying you weren't getting the experience you needed when you didn't fit in?

Lynne: Mm.... I mean I learnt a bit but I've learned more in the last 6 weeks than I did in the ten weeks I was down there last time. I mean maybe it was because I'm doing more, but I just feel I'm getting on with people um...It is a lot better but you still, it's what they make people in the beginning because there's still comments about me. I walked into a room, the coffee room. There must have been about six or so senior midwives, sisters or senior midwives and um, the conversation just stops when you go in and you know they've been talking about you. Maybe not necessarily about me but about degree students or something like that.

RB: Well my research suggests they talk about everybody

Lynne: Yer but it's really disheartening walking into a room, and I've been stood making coffee and I've heard them, heard my name being said before and you know, I don't know, I guess it must happen to a lot of students but none of the rest of my group have been as um, um... I was going to say picked on. It's not picked on; it's just that I haven't fitted in the most out of all of them. Because even if people haven't fitted in down there they've just kept dumb about it and got on with it, whereas I've sort of kicked up a fuss it's just the way I am.

RB: Have you changed your technique in the way you ask questions?

Lynne: Um yes I've tried to. I still ask loads of questions, and um I always try and say why and things like that, but.. um, it's very difficult to have a discussion with, especially a sister who, they don't really want to have to justify themselves to you, and um I had terrible trouble trying to find out. I knew for a fact that the policy down there was not to guard the

perineum and yet I worked with two sisters who both guarded the perineum and they really told me off, and they told me their reasons for guarding the perineum. They put my hand there and I couldn't move my hand and things like that, and afterwards I was saying 'why' and it was 'it's clinical experience, it's what I've learned through being a midwife'. And I said 'oh well fair enough' and then the next girl I was working with was quite a junior midwife because I said what do you think about this and she said 'oh no you musn't touch it . In some units they don't even put their hands on anyway. They just sort of stand and watch. And I said all right then and then the next person you should guard the perineum. So you end up going round in circles and I know it's sort of learning in a way but there's so much evidence to support not doing it, and yet there are still people doing it so it shows you can't really do individual practice down there till you hit 50. Well you can't really because you don't have the respect. Until you become a sister you really have to follow the rules. Whereas you can become a sister and you can do things the way you want to do them. I think it's really difficult to do your own practise, incredibly difficult and I don't think even if you do your own practise down there you keep quiet about it. Junior midwives I know they do because I've worked with them and they keep quiet about it. Even if they do do things differently then they don't say anything because they know they'll get frowned on.

RB: Do they have any other strategies for practising in the way that they want to?

Lynne: Oh they do little things like, if the lady's (cervix is) fully (dilated) they put 9cms on the board instead of fully because then they've got more than an hour you know, and things like that. It's not that they want to break the rules, it's just because that's the way they've been taught, you know in the classroom, in their own research you know but why should you give them just an hour. Everyone's different. Every woman down there (Labour ward) seems to have to be put in a category and stop watched to do this, that, and the other in a certain time. It's incredible some times. Some people still do such old fashioned things and yet the old fashioned things aren't frowned on as much as the new things are frowned on. You know, you can do something that's twenty years out of date or that research has shown that you really don't have to do that. Whereas you try and do something new and they don't want to know how much research has said it's good. You still, I would say would find it very difficult to implement it unless you kept quiet about it (laughs). Which I don't think is the right way to do things and I think that causes trouble, because you're supposed to tell senior sister what you're doing but if you feel the sister in charge is not going to back up what you're doing or is going to tell you off in front of everyone then you've not going to tell her, in which case the whole system breaks down really.

RB: So how do you cope when these midwives are all telling you something different?

Lynne: Um, you just go along with it because that's all you can do when you're a student and you really don't have any right to practice on your own as a student. You're always practising under someone else's qualification so you have to do as they say, and if you walk in a room and

one person says guard the perineum you have to guard the perineum whether you believe it or not, and the next case if they say don't guard the perineum you don't. So you're own clinical practice won't come into effect until you're qualified anyway. At the moment we're just watching and learning and just doing what they say, um but really it's sort of, it's just keeping your eyes open and evaluating what's going on really and that's really good learning. You're going with different midwives is probably one of the best things that you can do. Frustrating because you see so many different things, but good because you get to know how diverse practise can be and what's good and what's bad. It's pretty vague. Some people, one thing is completely right and they'd die for what they believe in, but to another person it's completely wrong.

RB: So how do you decide what is good practise or what you're going to emulate?

Lynne: I think ...we would go with, our first learning was with the ideal and I think that's always been our, what we should really do, like through research and all that. It's very much a research-based course. So we know what the ideal is but a lot of us have accepted that realistically it's never going to happen like that, and um there's little things that you can do to make it better. Little practises that you can do that er, you think is good practise but I think everyone realises now that you will never get the ideal. The ideal will never happen and I think that's really sad because we were taught that that's the ideal and everyone believed it so much in the first two years. We were so enthusiastic. This is what should happen and it doesn't quite get beaten out of you, but it, really ..real life in the hospital environment it will never happen and um it will change to a certain extent through some people. You can change practise, but it's an uphill struggle and it really is frustrating. I think even to make little changes it would take a lot of hard work.

RB: So how's it going to change?

Lynne: Well the research that's being done now has to be implemented by the students as they're coming up (qualifying) now. When they become midwives they have to implement the research they learned about through their studies recently, and um because midwifery itself is changing rapidly I think that changes are going to happen but there's going to be lot of new people digging their heels in. Especially the older midwives who don't really like change.

RB: You seem to be saying that the younger midwives are telling lies and withholding information and keeping quiet.

Lynne: In a minor way, so they are making small changes already and once it gets to the stage where they feel comfortable going up to a sister and saying 'this is what I'm doing' and sister says 'I agree with you because I agree with what your practice is', then that will be fine, but at the moment they can't because there's always that brick wall between them and us. The hierarchical system doesn't allow you to say well 'I'm a midwife in my own right and this is my practise um..'

RB: So when is the change going to come?

Lynne: I don't know but I think the way we've been taught is um quite good in the fact that we're research based, so we accept changes as we go along, whereas the way the generations before us were taught midwifery is very much text book really, put into practice and then change as you go along. It's not been research based at all. I think some of them (midwives) have adapted as they've gone along and the research has come more and more into it, but some of them haven't um, and.....I think it's difficult. I think there's a generation of midwives who are coming up who will make a few desperate changes as they go along (laughs). Because they'll have to, they're frustrated and they'll just start standing up for themselves which is difficult in a nursing environment. Nurses standing up for themselves is not really the done thing is it? But I think it will be because as the standard of education rises I think that they will feel more confidence to say 'this is what I believe in, and I believe in it so I'm going to say it' whether it's to a senior sister or a doctor or a woman I'm going to say what I believe in. I still think it's going to be an uphill struggle, I really do especially in this kind of hospital.

RB You keep referring to the Labour ward, does it apply to other clinical areas?

Lynne: Not so much. I find that there's a lot of static on the labour ward and people stay in the same place all the time so um, in the postnatal wards, and I haven't been on postnatal yet, but the postnatal wards they seem to um be younger midwives up there. And because they move round, it's much more relaxed as well. There's no emergencies going on all the time. They may have the occasional one but it's much more relaxed. I know it's busy but what they're doing is sort of um...there's less pressure on them and there isn't as much of a hierarchy, and because things keep changing all the time the staff keep changing, they do rotas and all that then there's no one set senior sister who's always there so you can, as they rotate around practises will change as the midwives talk to each other and decide this is what they're going to do in this case and I think that helps. And I think just the fact that the sisters don't rotate downstairs. There isn't a chance for anyone else to take the helm and explore the idea.

RB: Can I come back to some thing you said at the beginning. You had an older sister who was saying junior midwives didn't like students questioning practice. What was the younger midwife's response to your questioning her?

Lynne: Um ..well I think most of the, some of the sisters down there they know me and they think all right. The ones that don't know me, have never had a conversation with me, they tend to hold the opinion that I'm a bit of a trouble maker and as soon as I sat down and talked to the senior sister and started to explain why, I just want to find out what, why, if I come across being slightly aggressive then I'm sorry I'll tone it down a bit I didn't realise sort of thing, she was like oh right well you sound really intelligent, you sound you know. They don't know. They never sort of think to sort of find out what you're like and when I started asking her 'well what do you think about this guarding the perineum thing' she actually talked it through and we had quite a good chat about it and I said

'oh fair enough that's good' and she said 'oh well I'm glad we've had this chat' and now she's says hello to me in the corridor and before I was none existent and things like that But they don't seem to realise that, that just don't seem to give you the time of day unless you actually say to them 'excuse me I've got a personality' they assume you don't and they assume you are what everyone else has told them, and they are such gossips down there, it's incredible. The gossiping that goes on about what each other, all the time.

RB: When you say gossip is it about personal life?

Lynne: Yes, about who you are in your personality and 'oh she's a miserable so and so and things like that. They don't know. They might just be having an off day but they judge their, they base their judgement on your personality from such few things, about what you look like and what you may do on two or three days a week and that's it, their minds are made up. To change them is incredibly difficult and I find that really difficult to make them change their minds. I'm actually a nice person and I'm not a miserable old cow (laughs) this that and the other.

RB: And is this the older midwives?

Lynne: Mainly yer, because I really do enjoy working with the younger midwives because they're a laugh and it is a serious job but to make it fun as well. You can sit in a room and you can have a really good chat and you don't have to talk about midwifery. You can talk about anything and I really love that. I really love talking to the women particularly if they are in really early labour and the partners keep popping out. It's just great because you can really build up a rapport. And when it's busy you can't and things like that, and sometimes when you're with certain sisters you can't really talk to them (the women) because they take over a bit. With the junior midwives they just say 'yer get on with it' because they remember what it was like as a student, but sometimes you feel you can't do that with the sisters there because they're watching what you're doing 'oh you shouldn't be that familiar with the women and things like that because you've got to act at a professional level', and I don't agree because I had such a good time just talking you know. And I don't think you have to be stand offish and I'm above you sort of thing because it really does, I mean you talk to the women about it and they say 'oh no it's much better to be able to talk because we're nervous as it is without having somebody sort of going keep on doing that you've got to do that'. Especially with the invasive procedures we've got to do. It's bad enough when someone walks in through the room and sticks a hand in (VE) if you've got a rapport it's a lot easier. You can at least chat to them and make them feel slightly more at ease, I think anyway.

RB: What does it mean to be a professional midwife?

Lynne: I think we're doing it now in a small way already. Most of us at our level because we're being told to look after women on their own kind of thing, and if there is a problem go and ask. So in that respect we're sort of getting to the stage where you have to um ..being professional is more about knowing what you're doing, picking up the danger signs. Being

able to answer the questions that they ask you, um, and being knowledgeable and um just doing the job without making yourself superior. You have to make them know that you know what you're doing and that if anything arises you have to gain their trust. In that respect that's really important so that you can have a laugh with them, have a joke and get on with them really well but they have to know that if a situation arises you could be able to cope with it. So if they don't believe that they won't believe anything you say. You have to do the (physical) examinations and you have to talk to them about what's happening and you have to explain things to them so they know that you know what you're talking about, but in the other respect once you've got through all that and just doing the occasional paper work and waiting for something to happen stage, then I think you have time to relax and have a good time. So there's two different sides to it. I treat women as I would like to be treated in hospital. I didn't know anything and I was really frightened. I've got some close friends who told me their experiences because they told me things they wouldn't necessarily tell other people and so I was really scared. This woman walked in and shouted at me and simply walked out again. It was really scary. You just think well if someone walked in there (the room) 'it's all right, how you doing' and made it a really nice relaxing thing I just think she would have enjoyed it a whole lot more, or at least she would have felt that she had a friend rather than an enemy and she felt that she could ask a question. That's another thing they never ask questions. It's like the doctors come round and there's four of them and they say 'well do you want to ask any questions dear ' and they say 'not really'. But as soon as they're out of the door she (woman) says 'what the hell were they talking about (laughs). You have to just explain the whole thing again, and it's because they're too scared to ask, because there's four of them in their white coats standing around looking at her lying on the bed, and I just think that's horrendous, I really do. I think it's much nicer to be able to have a nice chat with them. You can't always I know, but it's nice to if you've got the time.

RB: Some students have actually said to me that they don't think this talking behind people's backs is very professional

Lynne: No exactly I don't think it is either. And sometimes you can see it in the coffee room or at the nurses' station, at the desk. They're having a laugh and they're telling jokes and doing things that I'd do in a pub but wouldn't do on duty. I mean I'm a pretty basic person. I'm not snobby or anything. I don't mind people having a laugh but people can still hear behind the screen what's going on and they were telling things really crude jokes and I thought I'm going back in the room (laughs) because I didn't think that was very nice. I think everyone's going to gossip. It doesn't matter what or who you are I just think that's one of lifes things especially if you work for lots of women.

RB: It comes with working with women does it?

Lynne: Mainly yes, I'd say yes (laughs). It's not just the gossiping it's the bitching as well. I mean you can gossip and you can be nice about it, you know just pass comment. But these, they just slate people. They do it to the doctors as well.

RB: Why do you think they do it?

Lynne: I don't know. I don't know whether it's an inferiority complex or just passing the time of day. They always do it because they're in their own little group and it's such a little clique group down there and.....

RB: Do you think they're happy?

Lynne: I think some of them are. I think a lot of them are frustrated but some of them are really miserable. There's one who left recently because she really just didn't like the job. I think some of the junior midwives don't get stuck in a rut. They say it's a lot easy to go with the flow than it is to stand up and be counted and I think that um, you get to a certain stage where you are just going with the flow. Sometimes they realise they are just going with the flow and it's dissatisfying because your work isn't as good as it can be. I don't really know because I don't really have a great relationship with them. I don't know what they think. It's frustrating. All the paper work's frustrating and the fact that you don't get any thanks. The hours are pretty bad and the pays pretty bad (laughs). I think it's brilliant because I'm new and fresh and starting out but I can see how it would get extremely frustrating and I can't see myself working in a hospital environment for much longer. It just grinds you down, all the red tape and the bickering. It's the stuff other than working in the room with the women. Working with the women's fine, that's the good bit about it, but it's the stuff outside the room that wears them down and the under staffing and the fact that you look after three women at once and that I think really gets on their nerves. That annoys them.

RB: So why does it get on their nerves?

Lynne: Well because of the understaffing. They walk on (to the ward) and say 'oh look at the board, oh no, look there's only four midwives on' you know something like that. They just, that's it, that starts them off, and for the rest of the shift they're (laughs) in a foul mood. It's frustrating.

RB: So are they over worked or is that just their perception?

Lynne: I think some of them are, they find it hard to cope and then some of them, little things annoy them. Like the car parking. They get charged for the car parking and they go barmy about it. It's understandable. It's completely understandable why they go barmy about it but I think it's more the little things that get on their nerves than the big thing and the understaffing and the ...things like that.

RB: The students seem to be saying to me that they have a parent/child relationship with their mentor would you agree with that?

Lynne: Um, personally no, but I know a couple of people who have said that and I know one person that has incredible difficulty. The midwives just said to her 'oh I really miss you when you're not here and um, wear your coat and scarf before you go out and really does mother her so much it's ridiculous and it makes her look stupid. It makes the midwife look stupid and everyone is like married, it's just ridiculous. That kind of

relationship is just too much and it gets on my nerves as well. But I'm not kind of child like. But if you suck up you're going to get treated like a child. If you act stupid you're going to get treated like a child.

RB: But you have admitted to me that you're sucking up to some midwives on the Labour ward

Lynne: Yes you have to (laughs), but I still wouldn't accept being treated like a child. I'd rather be treated like someone who is learning. You see if you start treating someone like a child the relationship is very difficult. I don't think you can have confidence in someone if you see them as a child. I think the midwife has to look at you, like ok you're a student and you're still learning, but that you're still going to be at the same level. I mean my mentor's great I can talk to her about anything and we have a laugh about things and she's not my age. She's much older than me, but we have a laugh and we have a normal working relationship.

RB: But if you are told what to do and you have to do it is that not being a child?

Lynne: Well say if you turn round and say 'go and do this, go and do that' then yes it is, but if she sort of says 'oh could you help me out and do this' or you say to her 'do you want me to do this for you' that's a totally different relationship. I think it's just how you act at the beginning. You act as very submissive at the beginning and then you are going to, but I think it's how you act as to how you are going to get treated.

RB: I think it depends on what we mean about this parent/child relationship. It does seem even with you to some extent midwives are saying this is what you're doing and you're saying you have to do it.

Lynne: Yes but you have to because that's the law. That's different because you can't practise on your own. The relationship is still one of student/teacher relationship and you're still beneath them in the respect that you're learning from them, but it depends on the midwife and it depends on the student really and you do get midwives who really talk down to you. You get some midwives who just treat you like normal people who are just learning a job. It really annoys me when they start treating the students like children because they're not children. You know some of them have so much experience in other things and I don't think we should get treated like children at all. Certainly some of the older midwives treat some of the midwives and students as students. I enjoy working with the younger midwives...It's all very individual

RB: It seems as though you have revealed yourself. You haven't fitted in so you've let people know what you're really like, but I just wonder now whether you are actually sucking up to them.

Lynne: I'm not sucking up to them but I'm just trying to fit in a bit more because I'm so different from what they expect me to be, and so I'm thinking well ok I'm never going to suck up in that respect, I'm just going to try and conform a bit more to what they want me to be. I'm not going to be, it's like they kept on telling me that the way I looked was messy, and so I changed that a bit, um just walking in with a smile on my face

rather than walking in looking like I normally do. Like it's a job sort of thing, and making the effort to make conversation. Saying hello to loads of people made a load of difference. And I haven't changed anything else I do; it's just the little things that make so much difference.

RB: So you've actually become a different person?

Lynne: No not at all because I still get told off (laughs).

RB: But you've changed

Lynne: Yes I've changed because I talk to a lot more people now. I talk to people. I haven't changed myself, I just make the effort to talk to people and by talking to them they've realised I'm not this miserable cow they thought I was. I mean I like chatting to them and they say 'oh yes you've some good ideas' and so on and then they change the way they think about me or some of them do. That helps, making the effort to act happy all the time and looking as though I'm busy all the time. Things like that. That's not sucking up. It's making the effort. You have to make the effort.

RB: So you're acting happy but underneath it all are you happy?

Lynne: Yes because like when they react back and they say hello to you it does make a difference. I mean, if I'm not happy, sometimes you're not happy. You walk to the Labour ward and you're miserable because of other things, but then because it's such a weird environment, such a focused environment on what you're doing, you can, not become a different person, you can put on a face. I'm not sucking up.

RB: Do you feel you're putting on a face?

Lynne: No I just feel I'm making a lot more effort. Sometimes I do feel like I'm putting on a face but the majority of the time it's just me making a bit more of an effort. I've just got such an outgoing personality. I just find that sometimes it gets repressed down there rather than.... I mean sometimes you feel you like, you can't say things. Sometimes you feel if you're going to say something you're going to get your head bitten off, or you don't have the right to say something just from the attitude you're given, or that if you join in the conversation you get frowned at because you're still a student and you're not supposed to. And I think that's bad because you should be able to have a personality and still work there.

RB You've been ignored and it's as though you lacked an identity.

Lynne: I think that was like that last year (when a third year student). This year's much better because we're doing the job and we're helping them. We can go in and we're helping them. You know we can go in and we can do an admission. We can do a delivery and we can do the paper work and we can do everything now. Ok we still need help but the basics we can do, so they actually think oh right they can do something now and they give us a little bit more credit. At the beginning it was, I don't know anyone in my group that actually enjoyed it in the first term. Everyone was...we used to get um in report they used to say 'what course are you

on?' 'the degree', 'oh right then you'll need proper supervision won't you' (said with lowered voice). You know constant supervision when it was really derogatory and now because we're doing the work it's better. It's sort of like, oh well you're degree, well that's alright then you can have a woman each, and it has changed, the fact that we've had to prove that we can do it. But at the beginning it was, it was like that.

RB: So is the problem with the course that they don't like it because you come in not able to do anything and you actually hinder them getting them job done?

Lynne: I think the problem is not necessarily with the Labour ward staff. Sometimes there could be more communication between the tutors and the staff and what we were expected to do and how much we could do. Just um things like that. We get caught in the middle because we're taught to go and ask questions so we go and ask questions and they (clinical staff) tell us calm down on the questions, this that and the other. We're not supposed to question everything they do because they don't like it so we end up getting bounced along the floor between the tutors and the Labour ward staff because they say 'oh the tutors upstairs they don't know nothing they don't work on the ward, but they do sometimes (laughs). They really don't like tutors going in and doing a delivery, they really don't like it (laughs). It's not a deliberate brick wall. It's just the odd muttering afterwards. I'm sure some of them don't mind. It's difficult for us to get the clinical practice because we are in the middle of the ideal and the reality and we're trying like to balance both and that's very difficult.

RB: We've covered a lot in our chat and I think it would be helpful to stop now particularly as I said it would take approximately an hour. I'd like to go away and analyse what you've said and then if I have your permission I would like to meet with you again. This would give me the opportunity to tell you my interpretation of what you've said and ask any additional questions that arise. Thank you very much.

Glossary

Activity passivity relationship: a relationship in which the health professional actively makes decisions about the care which will be given while the client is a passive recipient of the care.

Artificial rupture of membranes (ARM): the deliberate rupture of the amniotic sac surrounding the fetus, the purpose of which is to accelerate or induce the onset of labour.

Assessor: a midwife who has the skills necessary for facilitating students' learning, supervising practice and assessing their performance in relation to the learning outcomes of the midwifery programme.

Breech presentation: when the baby's breech or bottom presents first rather than the head.

Bullying: the intimidation of others, the inappropriate use of power to pressurise someone into doing something they would not otherwise choose to do.

Caesarian section: delivery of the baby via an incision into the abdominal wall and uterus.

Cardiotocograph (CTG): an electronic trace of the fetal heart to determine wellbeing

Cervix: the opening to the uterus

Continuity of care: when care is co - ordinated and consistent with the plan that is followed.

Continuity of carer: the provision of care that is given mainly by one midwife.

English National Board (ENB): an independent body which has the responsibility for ensuring that the policies of the United Kingdom Central Council for Nurses, Midwives and Health Visitors related to education and training are carried out in England.

Epidural analgesia: the insertion of local anaesthetic into the epidural space to anaesthetise the spinal nerves which transmit sensory stimuli to the central nervous system which is interpreted as pain.

Episiotomy: an incision to enlarge the vaginal orifice

Flexible midwife:a midwife who provides a woman centred approach to care meeting individual needs.

Forceps delivery: an operative vaginal delivery in which birth is assisted by the application of metal forceps around the baby's head and on which downward traction is applied to facilitate the birth.

General Practitioner (GP): a doctor who usually works within a group practice in the community and who is the first point of contact for medical care

General Practitioner Unit (GPU): a maternity unit in which midwives and/or general practitioners are the professionals leading the maternity care (DOH 1993).

Guidelines: offer practical guidance on the provision of aspects of care.

Haematoma: a collection of blood, which invades the surrounding tissues.

'High risk': a classification that identifies women and their baby's who are at potential risk of complications during childbirth.

Individualised care: care that focuses on the specific needs of the woman

Labour: the process by which the fetus, placenta and membranes are expelled from the genital tract. It is divided into three stages. The first stage is associated with regular uterine contractions to full dilatation of the cervical os. The second stage is from full dilatation of the cervical os to complete expulsion of the baby. The third stage is associated with delivery of the placenta and membranes and the control of blood loss.

'Low risk': a classification that identifies women and their baby's who have no potential factors in their history that might complicate childbirth.

Maternity Unit attached to a District General (MUDGH): a maternity unit incorporated within a District General Hospital that shares the required facilities with other departments or units.

Mentor: a midwife who is selected by students to facilitate, guide, assist and support them in their learning. In this study mentor is used to mean both assessor and mentor as this is how it is interpreted in the clinical setting.

Midwifery Led Unit (MLU): a small maternity unit in which care is provided for women classified as 'low risk' without the support of on site medical staff.

Model of care: an abstract concept that represents the way in which care of clients is organised

Modelling: behaviour that is not a requirement of a role

Mutual participative relationship: a relationship in which the woman and her professional carer are equals

National Health Service (NHS): a national system designed to provide health care to the total population free at the point of contact.

Neonatal narcan: an antidote to maternal pethidine that may be given to a baby if necessary to counteract respiratory depression a side effect of pethidine

Perineum: an anatomical region situated between the vagina and the anus that stretches during childbirth and sometimes tears

Pethidine: an analgesic drug commonly given to women during labour

Policies: statements issued by the Trust that determine a course or principle of action that should be adopted.

Postnatal period: a period of not less than ten days and no more than twenty eight days during which the care of a midwife is requisite.

Postnatal checks: the full examination of mother and baby following birth to monitor progress and wellbeing

Preceptor: an experienced midwife who provides support for a newly qualified midwife

Prescriptive midwife: a midwife who rigidly adheres to rules and provides care based on the medical model which does not meet the needs of all women.

Primigravida: a woman expecting her first baby.

Procedures: documents that provide guidance on how to carry out a specific task or physical skill.

Protocol: a written statement that outlines the medical care women experiencing obstetric complications should receive

Reflection: the skill of learning from experience by critically analysing situations in retrospect or as they occur and making judgement which inform future practice.

Registered General Nurse (RGN): a qualified nurse whose name is entered on Part 10 of the Professional Register.

Registrar: a doctor with many years' experience who is placed above a surgical house officer but below a consultant and senior registrar in the medical hierarchy.

Role: the expectations that individuals and/or society apply to the incumbent of a particular position.

Role making: the ability to be creative and determine your own role.

Role model: an individual who demonstrates behaviour specific to a role.

Role taking: taking on a role as it is prescribed by others.

Sister: a senior midwife who is usually in charge of a ward when on duty.

Staff midwife: a qualified midwife. The amount of experience these midwives have can vary in numbers of years but they have not gained the experience and seniority of sisters.

Sterets: swabs that contain chlorhexidine which are used to clean the stump of the baby's umbilical cord.

Sterzac powder: a powder that is dusted onto the stump of the baby's umbilical cord providing some protection from staphyloccocal infection.

Syntocinon: an oxytocic drug that stimulates the uterus to contract.

Teaching Hospital (TH): a hospital linked to a university that provides education and clinical placements for medical students.

Trust: an organisation that has a legal responsibility to provide health care to people in a predetermined geographical area.

Umbilical cord: the cord which, during fetal life contains blood which carries oxygen and nutrients from the mother to the baby and enables waste products to be returned to the mother for excretion.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC): the professions statutory body that is responsible for registration, education, training and professional conduct.

Venflon cannula: fine plastic tubing which is inserted into a vein to enable fluid to be given intravenously.

Ventouse extraction: a method of facilitating the birth of a baby by attaching a metal or plastic cup to the baby's head. This is achieved by creating suction. The cup is then pulled as the mother pushes with a uterine contraction.

Vulva: The folds of flesh which enclose the openings of the urethra and vagina.

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References

Abraham, C., Shanley, E., 1992. Social Psychology for Nurses, Edward Arnold, London.

Alexander, M.F., 1983. Learning to nurse: integrating theory and practice, Churchill Livingstone, Edinburgh.

Allen, I., Bourke Dowling, S., Williams, S., 1997. A Leading Role for Midwives? Evaluation Of Midwifery Group Practice Development Projects, Policy Studies Institute,

An Bord Altranais, 1994. Guidelines for Midwives, An Bord Altranais, Dublin.

Anderson, B., 1984. The Empirical Study of Power, In: Anderson, R.J., Sharrock, W.W., Applied Sociological Perspectives, George Allen & Unwin, London.

Anderson, T., 1994. Trust betrayed. The disciplining of the East Herts midwives, MIDIRS Midwifery Digest, 4(2): 132-134.

Anderson, R.J., Sharrock, W.W., 1991. Applied Sociological Perspectives, George Allen and Unwin, London.

Anforth, P., 1992. Mentors, not assessors, Nurse Education Today, 12,

299-302.

Archbold, P., 1986. Ethical issues in qualitative research. In:Chenitz, W.C., Swanson, J.M., From Practice to Grounded Theory, Qualitative Research in Nursing, Addison-Wessley, Menlo Park.

Argyle, M., 1967. The Psychology of Interpersonal Behaviour, Penguin Books, London.

Askham, J., Barbour, R., 1996. The negotiated role of the midwife in Scotland, In: Robinson, S., Thomson, A.M., (Eds) Midwives, Research and Childbirth Volume 4, Chapman & Hall, London. Chapter Three, pp 33-59.

Atkinson, P., 1981. The Clinical Experience The Construction and reconstruction of medical reality, Gower, Westmead, England.

Audit Commission, 1997. First Class Delivery: Improving Maternity Services in England and Wales, Audit Commission Publications.

Ausubel, D.P., 1968. Educational Psychology A Cognitive View, Holt, Rinehart and Winston, Inc, New York.

Baillie, L., 1993. Factors affecting student nurses' learning in community placements: a phenomenological study, Journal of Advanced Nursing, 18, 1043-1053.

Bandura, A., Walters, R.H., 1963. Social Learning and Personality Development, Holt, New York.

Bandura, A., 1969. Principles of Behavior Modification, Holt, Rinehart and Winston, INC. New York.

Bandura, A., 1977. Social Learning Theory, Englewood Cliffs, Prentice Hall.

Bandura, A., 1986. Social Foundations of Thought and Action: a social cognitive theory, Englewood Cliffs, NJ: Prentice Hall.

Bandura, A.,1997. Self-Efficacy The Exercise of Control, W.H. Freeman and Company, New York.

Barclay, L., 1984. An enquiry into midwives' perception of their training, The Australian Journal of Advanced Nursing, 1(4): 11-24.

Barker, PJ., 1991. Interview, In: Cormack, DFS., The Research Process in Nursing, Second Edition, London, Blackwell Scientific Publications.

Baumrind, D., 1971. Current Patterns of Parental Authority, Developmental Psychology Monograph, 4(1) Part 2, pp 1-103.

Becker, H.S., 1963. Outsiders Studies in the Sociology of Deviance, Macmillan Publishing Co, Inc.

Becker, H.S., Geer, B., Hughes, E.C., Strauss, A.L., 1961, Boys In White Student Culture In Medical School, University of Chicago Press, Chicago.

Begley, C.M., 1997. Midwives In The Making A Longitudinal Study Of The Experiences Of Student Midwives During Their Two-Year Training In Ireland, Unpublished PhD thesis, King's College, Dublin.

Bellinger, K., Reid, J., Posey, S., 1985. Beliefs Held By Associate Degree Nursing Students About Role Models, Community College Review, 13(2): 32-36.

Bendall, E., 1976. Learning for reality, Journal of Advanced Nursing, 1, 3-9.

Benner, P., 1984. From Novice to Expert Excellence and Power in Clinical Nursing Practice, Addison Wesley, California.

Benoit, C., 1989. The professional socialisation of midwives: Balancing art and science, Sociology of Health & Illness, 11(2): 160-180.

Betz, C. L., 1985. Students in Transition: Imitators of Role Models, Journal of Nurse Education, 24(7): 301-303.

Bewley, C., 1995. Clinical teaching in midwifery - An exploration of meanings, Journal of Nurse Education Today, 15(2): 129-135.

Biddle, B.J., Thomas, E.J., 1979. Role theory: Concepts and research, Huntington NY: Robert, E
Krieger Publishing Co.

Bidwell, A.S., Brasler, M.L., 1989. Role Modeling versus Mentoring in Nursing Education, Image: Journal of Nursing Scholarship, 21(1): 23-25.

Bittner, E., 1973. The concept of organisation, In: Salaman, G., Thompson, K., People and Organisations, Longman, Bristol. Chapter 17, pp 264-276.

Black, M., 1967. Rules And Routines, In Peters, R.S., (Ed) The Concept Of Education, Routledge & Kegan Paul, London, Chapter 6, pp 92-104.

Blau, P.M., 1963, The Dynamics of Bureaucracy, 2nd Edition, University of Chicago Press, Chicago.

Bluff, R., 1993. The Experiences of Women In Labour And Birth, Research Diploma, Bournemouth University.

Bluff, R., Holloway, I., 1994. 'They know best': women's perceptions of midwifery care during labour and childbirth, Midwifery, 10(3): 157-164.

Blumer, H., 1971. Sociological implications of the thoughts of G.H., Mead, In: Cosin, B.R., (eds) School and Society, Open University Press, Milton Keynes, pp 11-17.

Boyd, E.M., Fales, A.W., 1983. Reflective Learning: Key to Learning From Experience, Journal of Humanistic Psychology, 23(2): 99-117.

Bradby, M., 1990. Status passage into nursing: another view of the process of socialisation into nursing, Journal of Advanced Nursing, 15, 1220-1225.

Breakwell, G., 1986. Coping With Threatened Identities, Methuen, London.

Brookfield, S., 1987. Developing Critical Thinkers: Challenging Adults to Explore Alternative Ways of Thinking and Acting, Jossey Bass, New York.

Brooks, F., Long, A., Rathwell, T., 1987. Midwives' Perceptions On The State Of Midwifery, The University of Leeds, Department of Social Policy and Health Service Studies, Nuffield Centre For Health Services Studies, Manpower Planning Advisory Group.

Brown, J., Sime, J., 1981. A Methodology for Accounts. In: Brenner, M., (ed) Social Method and Social Life pp 159-189.

Bryar, R.M., 1995. Theory for Midwifery Practice, Macmillan Press LTD, Houndmills.

Buckingham, J., McGrath, G., 1983. The social reality of nursing, Health Science Press, Sydney Australia.

Burnard, P., 1990(a). Is anyone here a mentor, Nursing Standard, 4(37): 46.

Burnard, P., 1990 (b). Critical awareness in nurse education, Nursing Standard, 4(30): 32-34.

Burnard, P., 1992. Student nurses' perceptions of experiential learning, Nurse Education Today, 12(3): 163-173.

Cahill, H.A., 1996. A qualitative analysis of student nurses' experiences of mentorship, Journal of Advanced Nursing, 24(4): 791-799.

Campbell, I.E., Larrivee, L., Field, P.A., Day, R.A., Reutter, L., 1994. Learning to nurse in the clinical setting, Journal of Advanced Nursing, 20, 1125-1131.

Carper, B.A., 1978. Fundamental Patterns of Knowing in Nursing, ANS/Practice Orientated Theory Part 1, pp 13-21.

Cartwright, N., 1995. Combating bullying in a secondary school in the United Kingdom, Journal for a Just and Caring Education, 1(3): 345-353.

Cavanagh, S.J., Snape, J., 1997. Stress in student midwives: an occupational perspective, British Journal of Midwifery, 5(9): 528-533.

Chalmer, I., Enkin, M., Kierse, M., (Eds) 1989. 'Effective Care in Childbirth', Volume 1 and 11, Oxford, Oxford University Press.

Chamberlain, M., 1993. Factors affecting the acquisition of skills in midwifery students, Unpublished PhD thesis, University of London, London.

Chapman, G.E., 1983. Ritual and rational action in hospitals, Journal of Advanced Nursing, 8, 13-20.

Cioffi, J., 1998. Education for clinical decision making in midwifery practice, Midwifery, 14(1): 14-22.

Cioffi, J., Markham, R., 1997. Clinical decision-making by midwives managing care complexity, Journal of Advanced Nursing, 25, 265-272.

Clarke, R., 1996. Accountability:Frying Pan Or Fire? Modern Midwife, 6(4): 34-35.

Coffey, A., Atkinson, P., 1996. Making Sense Of Qualitative Data Complementary Research Strategies, Sage Publications, Thousand Oaks.

Cohen, H., 1981. The nurse's quest for a professional identity, Menlo Park, CA: Addison-Wesley Publishing Co.

Coles, J., Dobbyn, M., Print, C., 1981. 'Nursing students' perceptions of teaching in the clinical setting', The Australian Nurses Journal, 11(1): 47-49.

Coles, M., 1998. Don't let bullies wreck your life, The Sunday Times, 11 January, p36.

Comaroff, J., 1977. Conflicting Paradigms Of Pregnancy: Managing Ambiguity In Ante-Natal Encounters, In: Davis, A., Horobin, G., Medical Encounters The Experience of Illness and Treatment, Croom Helm, London, Chapter 8, pp 115-134.

Conway, M.E., 1978. 'Theoretical Approaches to the Study of Roles'In: Hardy, M., Conway, M., (eds), Role Theory, Perspectives for Health Professionals, Appleton-Century-Crofts, New York.

Cooley, C.H., 1956, Human Nature and the Social Order, The Free Press of Glencoe, New York.

Coopersmith, S., 1981. The Antecedents of Self-Esteem, Consulting Psychologists Press, Inc, Palo Alto.

Couchman, W., Dawson, J., 1990. Nursing and Health Care Research, Scutari Press, London.

Coutu, W., 1951, Role-Playing VS. Role-Taking: An Appeal For Clarification, American Sociological Review, 16, 180-187.

Currie, S.M., 1999. Aspects of the preparation of student midwives for autonomous practice, Midwifery, 15(4): 283-292.

Dalme, F.C., 1983. Nursing Students and the Development of Professional Identity, In: Chaska, N.L., The Nursing Profession A Time to Speak, McGraw-Hill Book Company, New York.

Darling, L.A.W., 1984. What Do Nurses Want in a Mentor? The Journal of Nursing Administration,

Darling, L.A.W., 1985. What to do about toxic mentors, The Journal of Nursing Administration, 15(5): 43-44.

Davies, F., 1975. Professional socialization as subjective experience: the process of doctrinal conversion among student nurses, In:Cox, C., Mead, A., (eds) A Sociology of Medical Practice, Collier-Macmillan, London, Chapter 6, pp116-131.

Davies, C., 1976. Experience of dependency and control in work: the case of nurses. Journal of Advanced Nursing, 1, 273-282.

Davies, R.M., 1988. The Happy End Of Nursing: An Ethnographic Study Of Initial Encounters In A Midwifery School. Unpublished MSc dissertation, University of Wales, Cardiff.

Davies, E., 1993. Clinical role modelling: uncovering hidden knowledge, Journal of Advanced Nursing, 18, 627-636.

De Maio, J., Parkinson, S., Leshowitz, B., Crosby, J., Thorpe, J.A., 1976. Visual Scanning: Comparisons Between Student and Instructor Pilots, Arizona State University.

Department of Health and Social Security, 1970. Report of the Sub Committee on Domiciliary and Maternity Bed Needs, HMSO, London.

Department of Health and Social Security, The Social Services Committee of the House of Commons, 1980. Perinatal and Neonatal Mortality, Second Report, 1979-1980, HMSO, London.

Department of Health, 1993. Changing Childbirth The Report of the Expert Maternity Group. HMSO, London.

Department of Health, 1996. Promoting Clinical Effectiveness A framework for action in and through the NHS, NHS Executive, London.

Department of Health, 1998a. A First Class Service: Quality in the New NHS, The Stationary Office, London.

Department of Health, 1999. Making a Difference strengthening the nursing, midwifery and health visiting contribution to health and healthcare, DOH, London.

Dingwall, R., 1977. The social organisation of health visitor training, Croom Helm, London.

Donnison, J., 1988. Midwives and Medical Men, Heinneman, London.

Dotan, M., Krulik, T., Bergman R., Eckerling, S., Shatzman, H., 1986. Role models in nursing, Nursing Times, 82(3): 55-57, Occasional Paper.

Douglas, J.D., 1970. Deviance & Respectability The Social Construction of Moral Meanings, Basic Books, Inc, New York.

Downe, S., 1996. Concepts of normality in maternity services: Applications and consequences, In:Frith, L., (ed) Ethics And Midwifery Issues In Contemporary Practice, Butterworth Heinemann, Oxford, Chapter 5, pp 86-103.

Downey, M., 1977. Interpersonal Judgements In Education, Harper &

Row LTD, London.

Dreyfus, H.L., Dreyfus, S.E., 1979a. The Psychic Boom: Flying Beyond The Thought Barrier, Department of Industrial Engineering and Operative Research, University of California, Berkeley.

Dreyfus, S.E., Dreyfus, H.L., 1979b. The Scope, Limits And Training Implications Of Three Models Of Aircraft Pilot Emergency Response Behavior. Operations Research Center, University of California, Berkeley.

Dreyfus, H.L., Dreyfus, S.E., 1980a. Proficient Adaptable Response To Emergencies Caused By Identifiable Malfunctions:Contrasting Training Implications Of Two Proposed Models, Operations Research Center, University of California, Berkeley.

Dreyfus, S.E., Dreyfus, H.L., 1980b. A Five - Stage Model Of The Mental Activities Involved In Directed Skill Acquisition, Operations Research Center, University of California, Berkeley, California.

Earnshaw, G.J., 1995. Mentorship: the students' views, Nurse Education Today, 13, 274-279.

Edgerton, R.B., 1985. Rules, Exceptions, And Social Order, University of California Press, Berkeley.

Elkin, F., 1960. The Child and Society: The Process of Socialisation, Random House, New York.

Emmett, D., 1966. Rules, Roles and Relations, Macmillan, London.

Emmons, E., 1993. A Divided Profession: An Analysis Of The Two Cultures In Midwifery Education And Practice, Unpublished PhD Thesis, University of Surrey, Surrey.

English National Board for Nursing, Midwifery and Health Visiting, 1989, Preparation of Teachers, Practitioner Teachers, Mentors and Supervisors in the Context of Project 2000, ENB, London

English National Board, 1995. Changes in Regulations and Guidelines for the Approval of Institutions and Courses, ENB, London.

English National Board for Nursing, Midwifery and Health Visiting, 1996. Regulations and Guidelines for the Approval of Institutions and Programmes, ENB, London.

English National Board for Nursing, Midwifery and Health Visiting, 1997. Regulations and Guidelines for the Approval of Institutions and Programmes, ENB, London.

English National Board for Nursing, Midwifery and Health Visiting, 1999. Supervision in Action a practical guide for midwives, ENB, London.

Enkin, M., Keirse, M.J.N.C., Neilson, J., Crowther, C., Duley, L., Hodnett, H.E., Hofmeyr, J., 2000. A Guide to Effective Care in Pregnancy and Childbirth, Third Edition, Oxford University Press, Oxford.

Eraut, M., 1994. Developing Professional Knowledge and Competence, The Falmer Press, London.

Erickson, H.C., Tomlin, E.M., Swain, M.A.P., 1983. Modeling and Role-Modeling A Theory and Paradigm For Nursing, Prentice-Hall, INC., Englewood Cliffs, N.J.

Etzioni, A., 1964. Modern Organisations, Prentice-Hall, Inc, Englewood Cliffs

Etzioni, A., (ed) 1969. The Semi-Professions and Their Organization, The Free Press, New York.

Festinger, L., 1957. A Theory of Cognitive Dissonance, Harper, New York.

Fetterman, DL., 1998. Ethnography step by step. Newbury Park, Sage, California.

Ficklin, F.L., Browne, V.L., Powell, R.C., Carter, J.E., 1988. Faculty and House Staff Members as Role Models, Journal of Medical Education, 63, 392-396.

Field, T., 1997. Bully in sight, Nursing Standard, 11(44):18.

Fine, G.A., Rosnow, R.L., 1978. Gossip, Gossipers, Gossiping, Personality and Social Psychology Bulletin, 4(1):161-168.

Finkel, D.L., Arney, W.R., 1995. Educating For Freedom, The Paradox of Pedagogy, Rutgers University Press, New Brunswick.

Fitzpatrick, J.M., While, A.E., Roberts, J.D., 1996, Key influences on the socialisation and practice of students undertaking different pre-registration nurse education programmes in the United Kingdom, International Journal of Nursing Studies, 33(5): 506-518.

Flint, C., 1986 . Sensitive Midwifery, Heinneman, London.

Flint, C., 1995. Communicating Midwifery, Books for Midwives Press, Cheshire.

Flint, C., Poulengeris, P., 1987. The 'Know Your Midwife' Report, London, C Flint, 49 Peckarman's Wood, London SE 26.

Ford, J.S., Reutter, L,I., 1990. Ethical dilemmas associated with small samples, Journal of Advanced Nursing, 15, 187-191.

Ford, P., Walsh, M., 1994. New Rituals for Old Nursing Through the Looking Glass, Butterworth, Heinemann, Oxford.

Fowler, M.D.M., 1988. Ethical Issues In Nursing Research Issues in Qualitative Research, Western Journal of Nursing Research , 10(1): 109-111.

Fraser, D., 1995. Client-centred Care: Fact or Fiction ? Midwives, 108(1,289): 174-177.

Fraser, D., Murphy, R., Worth - Butler, M., 1997. An Outcome Evaluation of the Effectiveness of Pre-Registration Midwifery Programmes of Education, University of Nottingham, ENB, London.

Freidson, E., 1975. Profession of Medicine A study of the sociologyof applied knowledge, Dodd, Mead and Co, New York.

Freire, P., 1993. Pedagogy of the Oppressed, New Revised 20th-Anniversary Edition, Continuum, New York.

French, J.R.P., Raven, B., 1968. The bases of social power In: Cartwright,D., Zander, A., (eds) Group dynamics, Reseach and theory, 3rd Edition, Harper and Row, New York, pp 259-269.

Fretwell, J.E., 1982. Ward Teaching and Learning Sister and the Learning Environment, The Royal College of Nursing of the United Kingdom, London.

Gagne, R.M., 1977. The Conditions of Learning, Third Edition, Holt, Rinehart And Winston, New York.

Garcia, J., Garforth, S., Ayers, S., 1987. The policy and practice in midwifery study: introduction and methods, Midwifery, 3(1): 2-9.

Garcia, J., Garforth, S., 1989. Labour and Delivery Routines in English Consultant Units. Midwifery, 5(4):155-162.

Garcia, J., Garforth, S., 1991. Midwifery policies and policy making, In: Robinson, S., Thomson, A.M., (Eds) Midwives, Research and Childbirth Volume 11, Chapman & Hall, London. Chapter Two, pp 16-47.

Garcia, J., Renfrew, M., Marchant, S., 1994. Postnatal home visiting by midwives, Midwifery, 10(1): 40-43.

Garforth, S., Garcia, J., 1987. Admitting-A Weakness or a Strength? Routine admission of a woman in labour. Midwifery, 3(1): 10-24.

Garforth, S., Garcia, J. 1989. Breastfeeding policies in practice-No wonder they get confused, Midwifery, 5(2): 75-83.

Gerber, L.A., 1979. The Search for Clinical Role Models As a Way of Coping with Clerkship stress, Journal of Medical Education, 54, 659-661.

Gerber, L.A., 1982. Factors Affecting The Choice Of A Psychiatric Career: An Experimental Study, Psychiatric Quarterly, 54(1): 26-32.

Giddens, A., 1997. Sociology, Third Edition, Polity Press, Cambridge.

Gillon, R., 1985. Paternalism and medical ethics, British Medical Journal, 290, 1971-1972.

Glaser,B., & Strauss,A.L., 1967. The Discovery of Grounded Theory Strategies for Qualitative Research, Aldine, Chicago.

Glaser, BG., 1978. Theoretical Sensitivity, CA, Sociology Press, Mill Valley.

Glaser, B., 1992. Basics of grounded theory analysis:Emergence versus forcing, CA:Sociology Press, Mill Valley.

Glesne, C., Peshkin, A., 1992. Becoming Qualitative Researchers An Introduction, Longman, New York.

Goff, A., 1995. Reflection-What Is It? A Literature Review, Assignment-Ongoing Work of Health Care Students, 1(2): 7-14.

Goffman, E., 1959, The Presentation Of Self In Everyday Life, Penguin Books, London.

Goffman, E., 1961. Encounters:two studies in the sociology of interaction, The Bobbs-Merrill Company Inc, Indianapolis.

Goffman, I., 1961a. Asylums, Essays on The Social Situation Of Mental Patients And Other Inmates, Penguin Books, London.

Goffman, E., 1963. Stigma, Prentice Hall Inc, Engelwood Cliffs.

Gordon, M., 1987. Nursing Diagnosis: Process and Application, Second Edition, McGraw-Hill, New York.

Gray, M., Smith, L.N., 1999. The professional socialization of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study, Journal of Advanced Nursing, 29(3): 639-647.

Gray, M.A., Smith, L.N., 2000. The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study, Journal of Advanced Nursing, 32(6): 1542-1549.

Green, G.J., 1988. Relationships Between Role Models And Role Perceptions Of New Graduate Nurses, Nursing Research, 37(4): 245-248.

Green, J., Kitzinger, J., Coupland, V., 1994. Midwives' responsibilities, medical staffing structures and women's choice in childbirth, In: Robinson, S., Thomson, A.M., (Eds) Midwives, Research and Childbirth Volume 3, Chapman & Hall, London Chapter Two, pp 5-29.

Griffith, P., 1996. The Culture of Midwifery Practice: Does It Have a Relationship To Birth Environment? And What Are The The Implications For Midwifery, Proceedings International Confederation of Midwives, 24th Triennial Congress 26-31 May, Oslo.

Gross, J, 1989. Psychology and Parenthood, Open University Press, Milton Keynes.

Grover, S.L., 1993. Why Professionals Lie: The Impact of Professional Role Conflict on Reporting Accuracy, Organizational Behavior And Human Decision Processes, 55, 251-272.

Hadikin, R., O'Driscoll, M., 2000. The Bullying Culture cause effect harm reduction, Books for Midwives, Oxford.

Handy, C.B., 1993. Understanding Organisations, Penguin Books, London.

Hanson, A., 1996. The search for a separate theory of adult learning:does anyone really need andragogy? In:Edwards, R., Hanson, A., Raggatt, P., Adult Learners, Education And Training 1 boundaries of adult learning, Routledge in association with the Open University, London, Chapter 5, pp 99-108.

Hartley, J., 1997. 'Normal pregnanacy and labour': is it limiting midwifry practice? British Journal of Midwifery, 5(12): 773-776.

Heider, F., 1958. The Psychology of Interpersonal Relations, Lawrence Erlbaum Associate Publishers, Hillsdale, New Jersey.

Helman, C.G. 1990. Culture, Health and Illness, Butterworth Heinemann, Oxford.

Henderson, C., 1984. Some facets of social interaction surrounding the midwife's decision to rupture the membrane's, MA Dissertation, University of Warwick.

Henderson, C., 1995. Rhetoric can't hide the reality, British Journal of Midwifery, 3(3): 125-126.

Henty, D., Hartley, J., 1997. Caseload midwifery-a student's perspective, Modern Midwifery, 7(11): 27-29.

Hinde, R.A., 1979. Towards Understanding Relationships, Academic Press, London.

Hindley, J., 1992. Support for Student Midwives, Association of Radical Midwives Midwifery Matters, Issue 53, Summer.

Hindley, C., 1999. An assessment of clinical competency on an undergraduate midwifery programme: midwives' and students' experiences, Journal of Clinical Excellence, 1(3): 157-162.

Hochschild, A.R., 1983. The Managed Heart: Commercialisation of Human Feeling, Berkely, University of California Press.

Holland, K., 1999. A journey to becoming: the student nurse in transition, Journal of Advanced Nursing, 29(1): 229-236.

House of Commons Social Services Committee, 1980. Perinatal and Neonatal Mortality; Second Report from the Social services Committee, 1979-1980 (Chairwoman R. Short), HMSO, London.

House of Commons Health Committee, Second Report on the Maternity Services (Winterton, N) Session 1991-1992, HMSO, London.

House of Commons 1979. Nurses, Midwives and Health Visitors Act, HMSO, London.

House of Commons 1992, Nurses, Midwives and Health Visitors Act 1992, HMSO, London.

Howie, J., 1988. The effective clinical teacher:a role model, The Australian Journal of Advanced Nursing, 5(2): 23-26.

Hughs, L., 1992. Faculty-student interactions and the student-perceived climate for caring, Advanced Nursing Science, 14(3): 60-71.

Hughes, J., Hardy, L.K., 1984. Learning about manipulation, Nurse Education Today, 4(3): 63-65.

Hugman, R., 1991. Power In The Caring Professions, Macmillan, London.

Humphries, J., 1997. Beating the Odds A survivor of midwifery education, Midwifery Matters, Issue 74, Autumn.

Hunt, S., Symonds, A., 1995. The Social Meaning of Midwifery, Macmillan, Houndmills.

Hunter, B., 1998. Independent midwifery-future inspiration or relic of the past? British Journal of Midwifery, 6(2): 85-87.

Hurst, K., 1985. Traditional versus progressive nurse education:a review of the literature, Nurse Education Today, 5, 30 - 36.

Hutchinson, S., 1990. Responsible Subversion:A Study of Rule-bending Among Nurses, Scholarly Inquiry for Nursing Practice, 4(1): 3-17.

Hutchinson, S., 1986. Grounded theory:the method. In:Munhall, PL., Oiler, CJ., (Eds), Nursing Research:A Qualitative Perspective, Appleton-Century-Crofts, Norwalk, Connecticut, Ch 6, pp 111-130.

Hutton, I., 1994. What women want from midwives, British Journal of Midwifery, 2(12): 608-611.

Infante, M.S., Forbes, E.J., Houldin, A.D., Naylor, M.D., Faans, R.N., 1989. A Clinical teaching Project: Examination of a Clinical Teaching Model, Journal of Professional Nursing, 5(3):132-139.

Irby, M., 1986. Clinical Teaching and the Clinical Teacher, Journal of Medical Education, 61(1): 35-45.

Irby, D.M., Gillmore, G.M., Ramsay, P.G., 1987. Factors Affecting Ratings of Clinical Teachers By Medical Students and Residents, Journal of Medical Education, 62(1): 1-7.

Ireland, J., Rennie, A-M., Hundley, V., Fitzmaurice., Graham, W., 2000. Cord-care practice in Scotland, Midwifery, 16, 237-245.

Isherwood, K., 1995. Independent midwifery in the United Kingdom, In: Murphy-Black, T., (ed), Issues in Midwifery, Churchill Livingstone, Edinburgh, Chapter 2, pp 21 - 39.

Jacka, K., Lewin, D., 1987. The Clinical Learning of Student Nurses, NERU Report No 6, Nursing Education Research Unit, King's College, University of London, London.

Jacobson, M.D., 1966, Effective And Ineffective Behavior Of Teachers Of Nursing As Determined By Their Students, Nursing Research, 15(3): 218-224.

Jahoda, M., 1959. 'Conformity and Independence', Human Relations, 12, 99-120.

Jamieson, L., 1994. Midwife empowerment through education, British Journal of Midwifery, 2(2): 47-48.

Jarvis, P., 1983. Professional Education, Croom Helm, Beckenham, Kent.

Jarvis, P., 1987. Adult Learning In The Social Context, Croom Helm, London.

Jarvis, P., 1988. Adult and Continuing Education Theory and Practice, Croom Helm, London.

Johns, C., 1995. The value of reflective practice for nursing, Journal of Clinical Nursing, 4(1): 23-30.

Jung, J., 1986. How Useful Is The Concept Of Role Model?: A Critical Analysis, Journal of Social Behavior and Personality, 1(4): 525-536.

Kelly, B., 1992. The Professional Self-Concepts of Nursing Undergraduates and Their Perceptions of Influential Forces, Journal of Nursing Education, 31(3): 121-125.

Kelman, H., 1967. Compliance, Identification, and Internalization: Three Processess of Attitude Change, In: Fishbein, M., (ed). Readings in Attitude Theory and Measurement, John Wiley & Sons, Inc. New York.

Kemper, TD., 1968. Reference groups, socialisation and achievement. American Social Review,
33, 31-34.

Kent, J., MacKeith, N., Maggs, C., 1994. DIRECT BUT DIFFERENT An Evaluation of the Implementation of Pre-Registration Midwifery Education in England: A Research Project for the Department of Health, Executive Summary, Crown Publication.

Kitzinger, J., Green, J., Coupland, V., 1990. Labour Relations: Midwives and Doctors on the Labour Ward, In:Garcia, J, Kilpatrick, R., Richards, M., The Politics of Maternity care Services for Childbearing Women in Twentieth - Century Britain, Clarendon Press, Oxford, Chapter 8, pp 149-162.

Kirkham, M., 1987. Basic Supportive Care in Labour: Interaction With And Around Women in Labour, Unpublish PhD thesis, University of Manchester, Manchester.

Kirkham, M.J., 1997. Professionalization Past and present:With Woman or With the Powers That Be? In:Kroll,D., (Ed), Midwifery Care for the Future, Bailliere Tindall, London, Chapter 8, pp 164-201.

Kirkham, M., 1999. The culture of midwifery in the National Health Service in England, Journal of Advanced Nursing, 30(3): 732-739.

Kirkham, M., Stapleton, H., 2000. Midwives' support needs as childbirth changes, Journal of Advanced Nursing, 32(2): 465-472.

Knowles M., 1990. The Adult Learner A Neglected Species, Gulf Publishing Company, Houston.

Knowles, M., 1996. Andragogy An emerging technology for adult learning, In: Edwards, R., Hanson, A., Raggatt, P., (eds) 1996. Adult Learners, Education And Training Boundaries of Adult Learning, Routledge, London.

Kotzabassaki, S., Panou, M., Dimou, F., Karabagli, A., Koutsopoulou, B., Ikonomou, U., 1997, Nursing students' and faculty's perceptions of the characteristics of 'best' and 'worst' clinical teachers:a replication study, Journal of Advanced Nursing, 26, 817-824.

Kramer, M., 1968. Role Models, Role Conceptions, And Role Deprivation, Nursing Research, 17(2): 115-120.

Kramer, M., 1974. Reality Shock: why nurses leave nursing. Mosby, St. Louis.

Lacey, C., 1977. The Socialization of Teachers, Methuen, London.

Leininger, MM., 1985. Qualitative Research Methods in Nursing, Grune & Stratton, Orlando.

Lincoln, YS., Guba, EG., 1985. Naturalistic Inquiry, CA, Sage, Newbury Park.

Linton, R., 1969. Status and Role In:Coser, L.A., Rosenberg, B., (eds) Sociological Theory: A Book of Readings, Third Edition, The Macmillan Company Collier-Macmillan Limited, London. Pp 346-351.

Lofland, J., Lofland, L.H., 1984. Analysing Social Settings A Guide to Qualitative Observation and Analysis, Wadsworth Publishing Company, Belmont California.

Lopez, K.A., 1983. Role Modelling Interpersonal Skills With Begining Nursing Students: Gestalt Techniques, Journal of Nursing Education, 22(3): 119-122.

Lowe, G., 1972. The Growth of Personality: From Infancy to Old Age,

Penguin, Harmondsworth.

Lublin, J.R., 1992. Role modelling:a case study in general practice, Medical Education, 26(2): 116-122.

Lublin, J., Driver, B., 1986. The general practitioner as teacher and role model, Australian Family Physician, 15(12): 1582-1584.

Lyons, R., Tivey, H., Ball, C., 1995. BULLYing at work: how to tackle it A Guide for MSF representatives and members, MSF Health and Safety Office, Hertfordshire.

Mackay, L., 1989. Nursing A Problem, Open University Press, Milton Keynes.

MacKeith, N., 1994. A study of students who leave pre-registration midwifery, Nursing Times, 90(39): 40-41.

Mackenzie, A.E., 1992. Learning from experience in the community: an ethnographic study of district nurse students, Journal of Advanced Nursing, 17, 682-691.

Macoby, E.E., 1980. Social Development Psychological Growth and the Parent-Child Relationship, Harcourt Brace Jovanovich Publishers.

Magill-Cuerden, J., 1993. Midwifery Is An Old Craft And A New Science? International Conferderation Of Midwives 23rd International Congress Proceedings, Volume 111, pp 1152-1165.

Mander, R., 1983. Stop and Consider! Student Midwife Wastage in Training. Research and the Midwife Conference Proceedings

Mander, R., 1992, See how they learn:experience as the basis of practice, Nurse Education Today, 12, 11-18.

Manning, P.K., 1971. Talking and Becoming:A View of Organizational Socialization In: Douglas, J.D., Understanding Everyday Life, Routledge & Kegan Paul. Chapter 10, pp 239-256.

March, J.G., 1988. Decisions and Organisations, Basil Blackwell, Oxford.

Marson, S.N., 1982. Ward sister - teacher or facilitator? An investigation into the behavioural characteristics of effective ward teachers, Journal of Advanced Nursing, 7, 347-357.

Maslow, A.H., 1970. Motivation and Personality, Harper and Row, New York.

Maternity Services Advisory Committee., 1982. Maternity Care in Action Part 1 Antenatal Care, HMSO, London.

Maternity Services Advisory Committee., 1984. Maternity Care in Action Part 11, Care During Childbirth, HMSO, London.

Maternity Services Advisory Committee., 1985. Maternity Care in Action Part 111, Care of the Mother and Baby, HMSO, London.

May, R., 1972. Power and Innocence A Search for the Sources of Violence, W.W. Norton & Company, New York.

May, KA., 1991. 'Interview Techniques in Qualitative Research:Concerns and Challenges'. In: Morse, J., (Ed), Qualitative Nursing Research-A Contemporary Dialogue, London, Sage Publications. Ch pp 188-201.

May, N., Veitch, L., 1998. Working to learn and learning to work:placement experience of Project 2000 nursing students in Scotland, Nurse Education Today, 18(8): 630-636.

McCourt, C., Page, L., 1996. Report on the Evaluation of One-to-One Midwifery Practice, Wolfson School of Health Sciences, Thames Valley University, London.

McCrea, H., Crute, V., 1991. 'Midwife/client relationship: Midwives' perspectives', Midwifery, 7(4): 183-192

Mc Crea, H. B., Thompson, K., Carswell, L., Whittington, D., 1994. Student midwives' learning experience on the wards, Journal of Clinical Nursing, 3, 97-102.

McCrea, H., Thompson, K., 1995. Role of midwives in a teaching hospital in the Republic of Ireland, British Journal of Midwifery, 3(9): 494-502.

McCrea, H. B., Wright, M.E., Murphy-Black, T., 1998. Differences in midwives approaches to pain relief in labour, Midwifery, 14(3): 174-180.

Mead, G.H., 1934. Mind, Self and Society, University of Chicago Press, Chicago.

Meleis, A.I., 1975. Role Insufficiency And Role Supplementation: A Conceptual Framework, Nursing Research, 24(4): 264-271.

Melia, K., 1987. Learning and Working The Occupational Socialization of Nurses, Tavistock Press, London.

Menzies, E.P., 1970. The Functioning of Social Systems as a Defence Against Anxiety, Tavistock, London.

Merton, R.K., 1949. Social Theory and Social Structure, The Free Press, New York. Revised and Enlarged Edition.

Miller, D.L., 1981. The Meaning Of Role-Taking, Symbolic Interaction, 4(2): 167-175.

Miller, N.E., Dollard, J., 1962. Social Learning and Imitation, Yale University Press, New Haven.

Minichiello, V., Aroni, R., Timewell, E., Alexander,L., 1990. In-Depth Interviewing, Lincoln School of Health Sciences La Trobe University, Longman Cheshire.

Montgomery, J., 1997. Health Care Law, Oxford University Press, Oxford.

Montgomery, E., 1998. A Phenomenological Enquiry Into Student Attrition Through Dissatisfaction With Midwifery. Unpublished dissertation submitted for Master of Arts Health Professional Educaton, Portsmouth University.

Morgan, G., 1986. Images of Organisations. Sage Publications, Beverley Hills.

Morgan, J., Knox, J.E., 1987. Characteristics of 'best' and 'worst' clinical teachers as perceived by university nursing faculty and students, Journal of Advanced Nursing, 16, pp 331-337.

Morse, J.M., 1993. Drowning in Data, Qualitative Health Research, 3(3): 267-269.

Morse, J.M., 1994. 'Emerging From the Data':The Cognitive Processes of Analysis in Qualitative Inquiry, In: Morse, J.M., (Ed) Critical Issues in Qualitative Research Methods, Sage Publications, Thousand Oaks. Chapter 3, pp 23-43.

Morse, J.M., Field, P.A., 1996. Nursing Research The application of qualitative approaches, Chapman & Hall, London.

Morse., J.M., Johnson, J.L., 1991. Toward a Theory of Illness:The Illness Constellation Model, In:Morse, J.M., Johnson, J.L., (eds) The Illness Experience Dimensions of Suffering, Sage Publications, Newbury Park, Chapter 7, pp 315-342.

Mulholland, L., 1997. Midwife ventouse practitioners, British Journal of Midwifery, 5(5): 255.

Murphy-Black, T., (ed) 1995. Issues in Midwifery, Churchill Livingstone, Edinburgh.

Nehring, V., 1990. Nursing Clinical Teacher Effectiveness Inventory:a replication study of the characteristics of 'best' and 'worst' clinical teachers as perceived by nursing faculty and students, Journal of Advanced Nursing, Vol 15, pp 934-940.

Nelms, T.P., Jones, J.M., Gray, D.P., 1993. Role Modeling: A method for Teaching Caring in Nursing Education, Journal of Nursing Education, 32(1): 18-23.

Ness, M., 1998. Evaluation of Midwifery Services–a personal reflection, British Journal of Midwifery, 6(1): 53-55.

News, 1987. Midwife wins clinical judgement battle, Nursing Times, 83:5, 8.

News, 1999. Nursing Times, 95(17): 6.

NHS Management Executive 1991. Junior Doctors The New Deal Hours of Work in Training:Working Arrangements of Doctors and Dentists in Training. NHS Management Executive, London.

Nicoll, L.H., (ed) 1997. Perspectives on Nursing Theory, Third Edition, Lippincott, Philadelphia.

Nolan, C.A., 1998. Learning on clinical placement: the experience of six Australian student nurses, Nurse Education Today, 18(8): 622-629.

Oakley, A., 1980. Women Confined:Towards a sociology of childbirth, Martin Robertson, Oxford.

Oakley, A., 1993. Essays on Women, Medicine and Health, Edinburgh University Press, Edinburgh.

Odling, G., Ohlsson, M., Danielson, E., 1990. The Nurses Transmissions of the Professional Role to Students in Nursing Education, Scandinavian Journal Caring Science, 4(3): 137-141.

Ogier, M.E., 1989. Working and Learning, Scutari Press, London.

Oleson, V.L., Whittacker, E.W., 1968. The Silent Dialogue A Study in The Social Psychology of Professional Socialization, Jossey-Bass Inc., Publishers, San Francisco.

Orme, L., Maggs, C., 1993. Decision-making in clinical practice:how do expert nurses, midwives and health visitors make decisions, Nurse Education Today, 13(4): 270-276.

Orton, H.D., 1981. Ward Learning Climate, Royal College of Nursing, London.

Orton, H.D., Prowse, J., Millen, C., 1993. Charting the way to Excellence, PAVIC Publications Library & Learning Resources, Sheffield Hallam University.

Overell, S., 1995. BULLYING in the workplace-Great Britain, People Management, 1(19):10-12.

Page, L., 1995. Change and Power in Midwifery, Birth, 22(4): 227-231.

Parathian, A.R., Taylor, F., 1993. Can we insulate trainee nurses from exposure to bad practice? A study of role play in communicating bad news to patients, Journal of Advanced Nursing, 18, 801-807.
Parsons, T., 1951. The Social System, New York, Free Press.

Pask, E.J., 1995. Trust:an essential component of nursing practice-implications for nurse education, Nurse Education Today, 15(3): 190-195.

Patton, M.Q. 1990. Qualitative Evaluation and Research Methods. Second Edition, Sage Publications, Newbury Park.

Pearson, G., 1975. Making Social Workers: Bad Promises and Good Omens, In: Bailey, R., Brake, M., Radical Social Work, Edward Arnold.

Pembury, S.E.M., 1980. The Ward Sister-Key to Nursing : A study of the organisation of individualised nursing. The Royal College of Nursing, of the United Kingdom, London.

Peters, R.S., 1970. Ethics and education, Unwin University Books, London.

Peters, R.S., 1973. What Is An Educational Process, In:Peters, R.S., (Ed) The Concept Of Education, Routledge & Kegan Paul, London.

Peters, T.J., Waterman Jr., R.H., 1982. In Search of Excellence Lessons from America's Best-Run Companies, Harper & Row Publishers, New York.

Polanyi, M., 1962. Personal Knowledge Towards a Post-Critical Philosophy, Routledge & Kegan Paul, London.

Polit, D.F., Hungler, B.P., 1993. Essentials of Nursing Research Methods, Appraisal, and Utilization, J.B. Lippincott Company, Philadelphia.

Pope, R., Cooney, M., Graham, L., Holliday, M., 1996, Identification Of The Changing Educational Needs Of Midwives In Developing New Dimensions Of Care In A Variety Of Settings And The Development Of An Educational Package To Meet These Needs, ENB, London.

Porter, S., 1991. A participant observation study of power relations between nurses and doctors in a general hospital, Journal of Advanced Nursing, 16, 728-735.

Price, A., 1995. Sound choices:Part 1:principles and process, Modern Midwife, June, pp 14 - 18.

Priest, D., 1997. In a Crunch, Ban on Women Bends, (online) http://jobs.washingtonpost.com/wp-srv/national/longterm/armywomen/armywomen.htm

Pritchard, J., 1996. Ethical decision-making and the positive use of codes In: Frith, L., Ethics And Midwifery Issues In Contemporary Practice, Butterworth-Heinemann, Oxford. Chapter 11, pp 189-204.

Proud, J., 1992. Placental grading as a test of fetal wellbeing. In:Robinson, S., Thomson, AM., Midwives, Research and Childbirth Volume 1, London, Chapman & Hall, Chapter 5, pp 95-116.

Puertz, B.E., 1985. Learn The Ropes From A Mentor, Nursing Success Today, 2(6):11-13.

Pulzer, M., 1996. Student midwife placements:community vs. hospital, Modern Midwife, 6(7): 34-35.

Pyles, S.H., Stern, P.N., 1983. Discovery of Nursing Gestalt in Critical Care Nursing:The Importance of the Gray Gorilla Syndrome, Image:The Journal of Nursing Scholarship, XV(2): 51-57.

Quinn, F.M., 1988. The Principles and practice of Nurse Education, Chapman and Hall, London.

Randall, P., 1997. Adult Bullying Perpetrators and Victims, Routledge, London.

Raphael - Leff, J., 1991. The Psychological Process of Childbirth, Chapman & Hall, London.

Rapoport, R., Rapoport, R., 1980. Growing Through Life, Harper & Row Publishers, London.

Rauen, K.C., 1974. The Clinical Instructor As Role Model, The Journal of Nursing Education, 13(3): 33-40.

Redfern, S., Norman, I., 1999. Quality of nursing care perceived by patients and their nurses: an application of the critical incident technique Part 1 and Part 2, Journal of Clinical Nursing, 8(4): 407-421.

Reid, M., 1986. Apprenticeship into midwifery:an American example, Midwifery, 2(3): 126-134.

Reid, T., 1993. Welcome To Change, Nursing Times, 89(51): 52-54.

Robinson, C.A., Thorne, S.E., 1988. Dilemmas of Ethics and Validity in Qualitative Nursing Research. The Canadian Journal of Nursing Research, 20(1): 65-76.

Robinson, S., 1989. The role of the midwife: opportunities and constraints, In: Chalmers,I., Enkin, M., Keirse, M.J.N.C., (Eds) Effective

Care in Childbirth Volume 1, Pregnancy, Oxford University Press, Oxford. Chapter 9, pp 143-161.

Robinson, S., 1990. Maintaining the Independence of the Midwifery Profession:A Continuing Struggle, In:Garcia, J., Kilpatrick, R., Richards, M., The Politics of Maternity Care Services for Childbearing Women in Twentieth Century Britain, Clarendon Press, Oxford, Chapter 4, pp 61-91.

Robinson, S., 1991. Preparation for practice:the educational experiences and career intentions of newly qualified midwives. In:Robinson, S., Thomson, A., Midwives, Research and Childbirth, Vol 2, Chapman and Hall, London. Ch 11, pp 302-345.

Robinson, S., Golden, J., Bradley, S., 1983. A study of the role and responsibilities of the midwife. NERU Report no 1, Nursing Education Research Unit, King's College London University.

Rogers, J.C., 1986. Mentoring for Career Achievement and Advancement. American Journal of Occupational Therapy, 40(2): 79-82.

Rogers, C., Freiberg, H.J., 1994, Freedom to Learn Third Edition, Macmillan College Publishing Company, New York.

Rolfe, G., 1999. Insufficient evidence:the problems of evidence-based nursing, Nurse Education Today, 19(6): 433-442.

Romney, M.L., 1980. Predelivery shaving:an unjustified assault? Journal of Obstetrics and Gynaecology, 1,33-35.

Romney, M.L., Gordon, H., 1981. Is Your Enema really Necessary? British Medical Journal, 282, 1269-1271.

Rotter, J.B., 1966. Gereralised expectancies for internal versus external control of reinforcement, Psychological Monographs: General And Applied, 80(2): 1-27.

Rowntree, D., 1987. Assessing Students: How shall we know them? Kogan Page LTD, London.

Royal College of Midwives, 1996. In Place of Fear Recognising and Confronting The Problem of Bullying in Midwifery, Royal College of Midwives, London.

Ruddock, R., 1969. Roles and Relationships, Routledge and Kegan Paul, London.

Rynne, A., 1998. The nightmare prison of midwife Ann Kelly, cited in MIDIRS Midwifery Digest, 8(4): 433-434.

Salaman, G., Thompson, K., (eds) 1980. Control and Ideology in Organisations, The Open University Press, Milton Keynes.

Salvage, J., 1985. The Politics of Nursing, Heinemann, London.

Salvage, J., 1990. The Theory And Practice Of The 'New Nursing', Nursing Times, 86(4):12-15.

Sandall, J., 1997. Midwives' burnout and continuity of care, British Journal of Midwifery, 5(2): 106-111.

Sandelowski. M., 1986. The problem of rigor in qualitative research, Advances in Nursing Science, 8(3): 27-37.

Saunders, N., Paterson, C.M., Wadsworth, J., 1992. Neonatal and maternal morbidity in relation to the length of the second stage of labour, British Journal of Obstetrics and Gynaecology, 99, pp 381-385.

Schön, D.A., 1983. The Reflective Practitioner How Professionals Think in Action, Basic Books, New York.

Schön, D.A., 1987. Educating the Reflective Practitioner, Jossey-Bass Publishers, San Francisco.

Schwarz, E.W., 1990. The Engineering of Childbirth:A New Obstetric Programme as Reflected in British Obstetric textbooks, 1960 - 1980, In: Garcia, J., Kilpatrick, R., Richards, M., The Politics of Maternity Care Services for Childbearing Women in Twentieth-Century Britain, Clarendon Press, Oxford. Chapter 3, pp 47-60.

Seidman, I.E., 1991. Interviewing Qualitative Research, New York, Teachers College Press.

Seligman, M.E.P., 1975. Helplessness, Freeman, San Francisco.

Shibutani, T., 1962. Reference Groups and Social Control, In:Rose, A.M., Human Behavior and Social Processes An In teractionist Approach, Routledge & Kegan Paul, London. Chaper 7, pp 128-147.

Shuval, J.T., Adler, I., 1980. The Role Of Models In Professional Socialisation, Social Science and Medicine, 14A, 15-22.

Siddique, J., 1999. The therapeutic relationship in midwifery, British Journal of Midwifery, 7(2): 111-114.

Sidebotham, M., 1993. Clinical expertise or academic degrees? British Journal of Midwifery, 1(6): 250-251.

Siegler, M., Reaven, N., Lipinski, R., 1987. Effect of Role - Model Clinicians on Students'Attitudes In a Second-Year Course on Introduction to the Patient, Journal of Medical Education, 62, 935-937.

Sims, D., Fineman, S., Gabriel, Y., 1994. Organizing & Organizations An Introduction, Sage Publications, London.

Sleep, J., 1984. The West Berkshire episiotomy trial, In:Thomson, A., Robinson, S., (eds) Research and The Midwife Proceedings for 1983, Department of Nursing, Manchester University.

Smith, P., 1992. The Emotional Labour of Nursing How nurses care , Macmillan, Houndmills.

Smith, P.K., Madsen, K.C., 1999. Ageism, Bullying, School Children, Educational Research 41(3): 267-286.

Smithers, K., Bircumshaw., 1988. The student experience of undergraduate education:the relationship between academic and clinical learning environments, Nurse Education Today, 8, 347-353.

Spradley, J.P., 1979. The Ethnographic Interview, Harcourt Brace Janovich, Fort Worth.

Stapleton, H., 1997. Choice in the face of uncertainty, In:Kirkham, M.J., Perkins, E.R., (ed). Reflections on Midwifery, Bailliere Tindall, London.

Stern,P.N., 1980. Grounded Theory Methodology. It's Uses and Processes. Image, X11(1):20-23.

Stevens, K.R., 1983. Power and Influence A Source Book for Nurses, John Wiley & Sons, New York.

Stiehl, R.R., 1977. Characteristics Of Role-Models And A Description Of Their Influence On Professional Socialization As Perceived By Students In Two Elementary Education And Nursing Programs. Unpublished PhD thesis, University of South Florida, USA.

Stolurow, L.M., 1972. Model the master teacher or master the teaching model, In:Stones, E., Morris, S., (eds) Teaching Practice:Problems & Perspectives, Methuen, London.

Strauss, A., Fagerhaugh, S., Suezek, B., Weiner, C., 1982. Sentimental work in technological hospitals, Sociology of Health & Illness, 4(3): 254-278.

Strauss, A., Corbin, J., 1990. Basics of Qualitative Research Grounded Theory Procedures and Techniques, Sage Publications, Newbury Park.

Strauss, A., Corbin, J., 1998. Basics of Qualitative Research techniques and Procedures for Developing Grounded Theory, Sage Publications, Thousand Oaks.

Strauss, A., Corbin, J., 1994. Grounded Theory Methodology An Overview, In: Denzin, N.K., Lincoln, Y.S., (Eds) Handbook of Qualitative Research, Sage Publications, London.

Studd, J., 1985, The Management of Labour, Blackwell Scientific,

Oxford.

Swanson, J.M., 1986. The formal qualitative interview for grounded theory. In:Chenitz, W.C., Swanson, J.M., From Practice to Grounded Theory Qualitative Research in Nursing. Addison - Wesley, Menlo Park, California.

Symonds, A., Hunt, S., 1996. The Midwife and Society Perspectives, Policies and Practice, Macmillan Press LTD, Basingstoke.

Szasz, T.S., Hollender, M.H., 1956. A Contribution to the Philosophy of Medicine The Basic Models of the Doctor Patient Relationship, A.M.A., Archives of Internal Medicine, 97, 585-592.

Tew, M., 1995. Safer Childbirth:A Critical History of Maternity Care, Chapman and Hall, London.

Thorndike, E.L., 1966. Human Learning, THE M.I.T. PRESS, Cambridge, Massachusetts.

Timmins, N., 1988. Midwife sacked over home birth wins job appeal, The Independent, 19th October, p5.

Tinsley, V., 1998. Ventouse Extraction – a midwifery skill? Changing Childbirth Update, 11, p15.

Tosteson, D.C., 1979. Learning In Medicine, The New England Journal of Medicine, 301(13): 690-694.

Towler, J., Bramall, J., 1986. Midwives in History and Society, Croom Helm LTD, Beckenham, Kent.

Turnball, C., 1986. Adult learning theory:its applications to the education of midwives, The Australian Journal of Advanced Nursing, 3(4): 51-59.

Turnball, J., 1995b. Hitting Back At The Bullies, Nursing Times, 91(3): 24-27.

Turnball, A., 1995a. No turning back, Modern Midwife, Sept, 5(9): 11.

Turner, R., 1962. Role-Taking:Process Versus Conformity, In:Rose, A.M., (Ed) Human Behaviour and Social Processes An Interactionist Approach, Routledge & Kegan Paul, London. Chapter 2 pp 20-40.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1986. Project 2000:A new preparation for practice, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1992. Code of Professional Conduct, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1994. The future of professional practice-the Council's standards for education and practice following registration, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1996. Guidelines for professional practice, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1998. Midwives rules and code of practice, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1998a. Guidelines for records and record keeping, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1999. Statistical analysis of the UKCC's professional register 1 April 1998 to 31 March 1999, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 2000. Guidelines for the administration of medicines, UKCC, London.

Vuori, H., Rimpela. M., 1981. The Development And Impact of The Medical Model, Perspectives in Biology and Medicine, Winter, pp 217-228.

Waegel, W.B., 1984. How Police Justify The Use of Deadly Force, Social Problems, 32(2): 144-155.

Walker, J., 1976. Midwife or obstetric nurse? Some perceptions of midwives and obstetricians of the role of the midwife, Journal of Advanced Nursing, 1, 129-138.

Walker, P., 1990. Student Placements: The learner's perspective, Nursing, 4(13): 9-14.

Warren, J., 1995. The Emotional Experience of Hospitalisation, Unpublished MPhil thesis, Bournemouth University.

Warwick, C., 1995. Small group practices Part 2:the midwife's perspective, Modern Midwife, November, pp 22-23.

Waterworth, S., Luker, K.A., 1990. Reluctant collaborators:do patients want to be invloved in decisions concerning care? Journal of Advanced Nursing, 15, 971-976.

Watkins, C., Mortimore, P., 1999. Pedagogy What Do We Know? In Mortimore, P., (ed). Understanding Pedagogy and its impact on learning, Paul Chapman Publishing LTD, London.

Webb, C., 1985. Gynaecological nursing: a compromise situation, Journal of Advanced Nursing, 10, 47-54.

Webb, C., 1992. The use of the first person in academic writing:objectivity, language and gatekeeping, Journal of Advanced Nursing, 17, 747-752.

Weber, M., 1947. The Theory of Social and Economic Organizations, translated by Henderson, A.M., Parsons, T., Oxford University Press, New York.

White, E.., Riley, E., Davies, S., Twinn, S., 1993. A detailed study of the relationship between teaching, support, supervision and role modelling in clinical areas, within the context of Project 2000 courses, Kings College, London and University of Manchester.

Whitfield, S., 1983. The Midwifery Process In Action, Midwives Chronicle & Nursing Notes, pp186 - 189.

Wilde, V., 1992. Controversial hypotheses on the relationship between researcher and informant in qualitative research. Journal of Advanced Nursing, 17, 234-242.

Wiseman, R.F., 1994. Role Model behaviors in the Clinical Setting, Journal of Nursing Education, 33(9): 405-410.

World Health Organisation., 1985. Having a Baby in Europe, Public Health in Europe 26, Copenhagen: WHO Regional Office for Europe.

Wraight, A., Ball, J., Secombe, I., 1993. Mapping Team Midwifery, IMS Report Series 242. Institute of Manpower Studies, University of Sussex.

Wyatt, J.F., 1978. Sociological Perspectives on Socialization into a Profession: A Study of Student Nurses and Their Definition of Learning, British Journal of Educational Studies, 26(3): 263 - 276.

Yearley, C., 1999. Pre-registration student midwives: Fitting In, British Journal of Midwifery, 7(10): 627-631.

Zimmerman, D.H., 1971. The Practicalities of Rule Use, In: Douglas, J.D., Understanding Everyday Life, Routledge & Kegan Paul, London, Chapter 9, pp 221-238.