UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

School of Health Sciences

The Lived Experience of Newly Qualified Midwives

by

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ABSTRACT

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After completing a three year midwifery degree course at university newly qualified midwives are expected to function fully as autonomous and accountable practitioners. This interpretive phenomenological investigation explored the lived experiences of twelve participants throughout their first twelve months post registration. Data were collected using semi-structured interviews at three points in time: the point of registration, four and twelve months post registration. Analysis and interpretation of these data were achieved using van Manen's methodological structure combined with an interpretive phenomenological approach.

The findings revealed two final interpretive themes that described the meaning of 'becoming a midwife'. These were 'Fairy tale midwifery: fact or fiction' and 'Submissive empowerment: between a rock and a hard place'. The first incorporated the two super-ordinate themes false promises and reality shock; the second incorporated four super-ordinate themes beyond competence, part of the club, self doubt and struggling.

This study has contributed to existing knowledge by way of highlighting the 'crisis of reality shock' that these newly qualified midwives experience surrounding the change of responsibility upon qualification. When participants experience the 'real' world as a newly qualified midwife, they may have to undertake work that previously they did not want to do and could opt out of as a student. The newly qualified midwives did not perceive themselves to have autonomy and by virtue, responsibility. Lack of autonomy and the ability to undertake decisions can lead to high levels of anxiety in the newly qualified midwife. Despite this, they prefer to work on the delivery suite where they have instant access to support and advice compared to being on their own in what they perceive to be a chaotic community setting.

It may be that transition is an emotional challenge and like birth, the reality is that preparation might help, but that the 'reality' can only be experienced.

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Declaration of Authorship

I, *Ellen Kitson-Reynolds*, declare that the thesis entitled:

The Lived Experience of Newly Qualified Midwives

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission

Signed: ……..

Date:…….

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Midwifery Definitions

Terminology	Definition
Bank Midwife/Contract	Midwives work on a temporary basis to cover a shift at a given time. Midwives employed by the same National Health Service (NHS) Trust may take on extra work or overtime whereas others may work part-time hours on a bank or a permanent contract (Shawn of The Norwich Birth Group, 2007). All practising midwives are trained and have met requirements to practise including submitting an 'Intention to Practice' (ITP) ((NMC) Nursing and Midwifery Council, 2004a).
Case-Loading Midwife	Local case-loading midwives cover the 24/7 period for all women booked under their care typically within small teams. These teams are meant to be self sufficient and hence not require input from main stream staffing. Each whole time equivalent midwife's case will hold 35-40 women a year (Walsh, 2008).
Cohort tutor	The cohort tutor may be called the academic tutor or the cohort lead depending on education institution. This person has a predominantly pastoral responsibility to the cohort.
Community Midwife	*'Midwives work in the community and in stand-alone birth centres as well as in hospitals. Typically a midwife will work in partnership with women and their families to give support, care and advice during pregnancy, labour and the postnatal period. In the United Kingdom (UK) Midwives work both alone and with a range of other health professionals as best meets the need of the women and families that they care for'* (NMC, 2009b).
Core Midwife	A core midwife works in one area typically within the hospital environment. This midwife develops a skills base in this area and acts as a reference for other midwives when working in this environment (Beake and Bick, 2005).

Direct entry	Direct entry implies that students undertaking the three year midwifery training programme have no other nursing professional qualification (NMC, 2009a).
High risk midwifery	High risk midwifery is the care of women through high risk pregnancy, birth and the postnatal period. A woman is deemed high risk when some condition puts the mother or fetus/baby or both at higher than normal risk of complications during or after the pregnancy and birth (Biro et al., 2003)
Integrated Midwife	Integrated midwives undertake all aspects of midwifery related care in both the community and hospital settings. They provide care for women within a locality with the aim to provide 24/7 cover in teams for the women in their care (Hunter and Ackerman, 2003).
Lead Midwife for Education (LME)	The LME is an experienced practising midwife teacher who leads the delivery and management of midwifery education programmes. They are responsible for ensuring high quality and standards are met within the educational programmes. The LME informs the NMC if student midwives are of good character, and good health in order to gain entry onto the professional register at the end of their midwifery training (NMC, 2009a).
Low risk midwifery	Low risk midwifery is the care of women through normal pregnancy, birth and the postnatal period. A woman is deemed to be low risk when she has no risk factors identified during the antenatal or intrapartum period (Biro et al., 2003)

Midwifery Award Leader	For the purposes of this research study the Midwifery Award Leader is the programme lead for the pre-registration Bachelor of Midwifery (Hons) degree within a university institution. This person has a responsibility to monitor quality of education delivery. In some universities this person may be referred to as programme lead. In some cases the Midwifery Award Leader may also be the LME.
Student Midwife	Indicates a person who is undertaking a pre-registration midwifery education training programme with academic qualification (NMC, 2009a)
Supervisor of Midwives (SOM)	A SOM means a person appointed by a Local Supervising Authority (LSA) to exercise supervision over midwives practising in its area in accordance with rule 11(1) of the Midwives Rules and Standards (NMC, 2004a). Supervision is a unique role within the NHS. It is not the same as clinical supervision in that SOMs are not employed (by the NHS Trust or LSA) in that role, but undertake this role in a voluntary capacity. SOMs are answerable to the LSA Midwifery Officer who directly liaises with the NMC.
University educated (jointly between University and local NHS Trust)	University educated implies that the students within this study will have undertaken a three year Bachelor of Midwifery (Honours) degree within a large south coast university which is affiliated to a large teaching hospital also within the south coast of England. The students will have both a degree and have achieved the minimum requirements for entry onto the 'Midwives part of the register'.

Abbreviations

Abbreviation	Meaning
CASP	Critical Appraisal Skills Programme
CTG	Cardiotocograph
DH	Department of Health
ENB	English National Board
ERI	Employment Research Institute
EU	European Union
HCC	Health Care Commission
HEI	Higher Education Institution
ICM	International Confederation of Midwives
IPA	Interpretive Phenomenological Analysis
ITP	Intention to Practice
LSA	Local Supervising Authority
LSAMO	Local Supervising Authority Midwifery Officer
MCA	Maternity Care Assistant
MSW	Maternity Support Worker
NHS	National Health Service
NMC	Nursing and Midwifery Council
ONS	Office for National Statistics
QAA for HE	Quality Assurance Agency for Higher Education
RCM	Royal College of Midwives
SHA/SHAs	Strategic Health Authority/Authorities
SOM	Supervisor of Midwives
UK	United Kingdom
WHAG	What Happens After Graduation
WTE	Whole Time Equivalent

Caveat

For the purpose of this thesis, to ensure anonymity for the participants of this study all referents to my place of employment and roles will be removed. It is acknowledged that this may result in a loss of transparency for the reader.

Chapter 1: Introduction and Background

1.0 Introduction

This research study arose from personal experience of working with student midwives in their senior period and with newly qualified midwives. It became apparent that there is disparity between the student midwife role, the newly qualified midwife role and the expectations within the midwifery profession. According to the Nursing and Midwifery Council (NMC) newly qualified midwives are expected to function as fully autonomous practitioners (NMC, 2004c; p548) from the date of registration. Good practice ensures that newly qualified midwives are offered preceptorship[1] programmes to aid their transition to their new role[2] (Department of Health (DH), 2010b, NMC, 2008a, NMC, 2004a, NMC, 2004b). At the point of registration the newly qualified midwife is expected to be competent in 'normal' low risk midwifery care provision (NMC, 2009a) and begin to develop competency in caring for the high risk woman. Given this, the newly qualified midwife is expected to be able to undertake a full case-load and perform holistic care whilst remaining autonomous and responsible for his or her own actions (NMC, 2004a). From experience, senior midwives appear to expect newly qualified midwives to be able to function competently within a high risk delivery suite within a few weeks of qualification. This reality can result in a life-style shock (Clark and Holmes, 2007, Kramer, 1974, Newton and McKenna, 2007). The role change from being the protected to becoming the protector can be profound (Keogh, 2003) for some individuals. Midwifery managers have indicated that newly qualified midwives show a lack of appreciation for the real demands of the qualified role (Hobbs, 2003). Taking this into consideration, I decided to study this further.

[1] Preceptorship is a '*process that enables newly qualified practitioners, the preceptee, to have a specified, formal, supported period during which they can continue to develop their confidence to practise.*' (Steele, 2008; p41-42). This is where planned help and support is given over a period of time, typically four to six months and is considered to be good practice (NMC, 2006).

[2] The Preceptorship Framework document published March this year (DH, 2010) will not be considered further in chapter 1 as it was not used for background information to contextualise the study.

1.1 Study Aim

This chapter provides an orientation to my study, which comprises a phenomenological investigation of the lived experiences of newly qualified midwives from the point of entering onto the 'Midwives part' of the NMC professional register to one year post registration. This study has come from my personal and professional journey through life and my passion for ensuring that high standards through professional practice are available for all.

1.2 Rationale for Undertaking This Study

Through my previous experience, as a midwifery manager, of interviewing senior students and newly qualified midwives for their first post it became apparent that the candidates believed that they could dictate their hours and working conditions once employed. It was perplexing as to why after three years of training in a National Health Service (NHS) establishment, some candidates had little concept of the need to provide a 24/7 service. One explanation might be that for three years the students are affiliated to the university and are supernumery in a non-rostered status, which encourages student experience. They experience flexibility in their study and working parameters and to some extent are protected from the full realities of working in full-time employment independent of university life. Whilst it is recognised that these views have directly emanated from my experiences, it is the perspective of the newly qualified midwives that I am interested in.

In recognition of the need to balance work and life, the NHS has adopted the 'work/life balance' (Wise, 2005, Employment Research Institute (ERI), 2005) philosophy and the 'Improving Working Lives' (DH, 2000) publication documents this for its employees. The work force of the NHS comprises a significant proportion of women (Lane, 2004, Pudney and Shields, 1999), who may have young families or who are carers for family members (Rands, 1999, Coyle, 2003). According to the 2007-8 annual statistics 89.29% of NMC registrants are female (NMC, 2008b) and as of the 30 September 2009, 89.4% of female qualified nursing, midwifery and health visiting staff work within NHS Hospital and Community Health Services (NHS: The Information Centre for Health and Social

Care, 2010). However compassionate the NHS is towards its employees, it is still a business and has targets, deadlines and public expectations and demands to meet 24 hours, seven days a week, 365 days a year. A flexible conditions/hours philosophy is not realistic for the newly qualified midwife.

Now more than ever, the NHS has to adopt a more efficient service delivery model (DH/NHS Finance Performance and Operations, 2009) with competent (Carlisle et al., 1999), confident, reliable practitioners and administrative staff (Mallik and Aylott, 2005). Hence, both local and national alterations to recent working environments due to changes in service delivery, NHS Trust financial deficits, recruitment freezes, sickness, maternity leave and demographic and social demands, can prove stressful for any practitioner. The level of the newly qualified midwives' responsibility changes upon qualification/registration. Issues of increasing service demands, reduced staffing figures and reduced 'protected' preceptorship time may exacerbate the potential stress for newly qualified practitioners (Maben and Macleod-Clark, 1996); who are gaining confidence and competence with the uncertainty that their new profession brings. Perhaps this has come to the fore with the greater realisations for the need to improve in performance generally within the NHS. This may be linked to reducing staffing levels, a reduction in midwifery numbers and/or reports such as the Health Care Commission (HCC) (2008a) outlining poor standards etc. It is not clear if this is a new concept and/or whether it was an issue previously when, prior to the year 2000, midwifery education was provided fully within the NHS and students did not have some degree of protection from being a full-time university student. Society appears to have greater expectations of health care provision and of professional conduct (Tudor-Hart, 1998, Emmerson et al., 2000) as do professionals which has a direct impact on the working life of a newly qualified midwife. Hence, the above considerations have caused many local practitioners and managers to question whether individuals should be '*protected*', from the realities of being qualified, whilst in their student role (Clark and Holmes, 2007); thus making transition[3] to '*midwifehood*' much harder. This study aims to explore these aspects from the newly qualified midwife's perspective.

[3] For the purpose of this study the term 'transition' refers to 'becoming a midwife'.

1.3 Midwifery in Context

Key factors that impact upon transition have been identified in order to contextualise this research study to the current midwifery profession (box 1.1) and will be discussed briefly in the forthcoming section.

Box 1.1: Factors impacting upon transition

Becoming a midwife	The United Kingdom (UK) Setting and Training Demography National Policy NHS Culture Birth Rate Low and High Risk Environments Midwifery Autonomy

1.3.1 The UK Setting and Training

Over 90 member states have registered midwifery practice with the International Confederation of Midwives (ICM) with the united purpose '*to secure women's right and access to midwifery care*' (ICM, 2010). Midwifery is not governed or always practised to a set standard across the globe. Neither is health care financed or available equitably internationally. Midwifery practiced within the UK is regulated by the NMC as set out in the Nursing and Midwifery Order, 2001 (NMC, 2002) and midwives currently uphold practises referred to in the 'Rules and Standards' (NMC, 2004a) and 'The Code' (NMC, 2008a).

Midwifery education during the first half of the twentieth century was via a direct entry route until post second world war, when the vast majority of midwives had achieved registered general nurse status prior to their midwifery training (Cowell and Wainright, 1981). Midwifery education at the turn of the century was different to midwifery

education today therefore the focus for this research study is the modern era. Midwifery education underwent a major change from 1989 when the first diploma and degree courses for pre-registration students began (Fraser et al., 1998). Prior to this, traditionally entry was via an 18-month midwifery programme for registered nurses (Fraser, 1996). These students were included as part of the workforce and were paid a salary whilst on programme. During 1990 the first of the modern three year pre-registration programmes commenced at 14 pilot sites (Fraser et al., 1998). Before they were evaluated other establishments also had validated curricula to provide similar programmes of education. The English National Board (ENB) published an outcome evaluation of the effectiveness of pre-registration midwifery education programmes conducted by Fraser et al (1998). This research and related publications (Fraser, 1996, Fraser, 1998, Fraser, 1999a, Fraser, 1999b, Fraser, 2000a, Fraser, 2000b, Fraser, 2000c, Fraser, 2006) have considered whether newly qualified midwives are fit for purpose after completion of an effective midwifery education programme (these are discussed further in chapter 6) as well as, for example, developing an assessment of competence.

All midwives commencing training from September 2008 are educated to degree-level ((RCM) Royal College of Midwives, 2009a); prior to this date some institutions offered diploma-level entry programmes. Training[4] is predominantly through direct entry, 156 week programmes with few universities offering 78-week pre-registration shortened programmes. This means that practising midwives possess certificate level training or above; they may be dual registrants or direct entry registered.

The NMC (2009a; p15) state that direct midwifery training '*should be no less than three years*' or 156 weeks equivalent for a full-time commitment. The practice to theory ratio is stated as being no less that 50% of clinical practice with a minimum of 40% theory. Education must be provided via university institutions (NMC, 2009a; p18). For those prospective students currently on the 'Nurses part' of the professional register, full-time courses must not be less than 18 months or equivalent to 78 weeks. The same boundaries apply as to 156 week programmes. For the purpose of this study, I am interested in the

[4] For the purpose of this study the terms 'training' and 'education' are used inter-changeably.

direct entry 156 week degree educated student midwives. This is because they had not received prior exposure to the realities of working within the NHS as a NMC registered practitioner.

1.3.2 Registrant Demography

The latest NMC statistical analysis of the register for the period 1st April 2007 to 31st March 2008 (NMC, 2008b) shows the total number of midwives on the register to be 35,305 (132 male and 35,169 female), all having submitted an intention to practice (ITP) form. Completing the ITP form is an annual statutory requirement for midwives to show their ITP as a midwife in a particular Local Supervisory Authority (LSA). There are currently ten LSAs within England. This mechanism contributes to the monitoring and achievement of safe standards and fitness to practice of all practising midwives (Duerden, 2000). It is a matter of regret that the NMC no longer provides statistics[5] (NMC, 2010, NMC, 2008b) for the numbers of part-time and full-time midwives and that the statistics for ages of registrants, for example, have been combined with the nursing figures so that it is impossible to establish key information related to the midwifery profession. A concern is that the midwifery profession possess fewer whole time equivalent practising midwives than the nursing profession. By having the statistics combined with nursing there is a loss of identity and hence, this undermines the concept that midwifery is an independent profession. In relation to this project, the number of midwives, and proportion that are part-time, has the potential to influence the practice experience of newly qualified midwives. It is because of this that the NHS Hospital and Community Health Services for England (NHS: The Information Centre for Health and Social Care, 2010) and the NMC 2005 statistics have been scrutinised to provide background for this thesis.

As of 30 September 2009 maternity services[6] in England consisted of 26,408 (20,201 whole time equivalent (WTE)) registered midwives working in maternity services and 43

[5] The NMC has provided a statement on their website explaining that for the period 2008/9 no statistical data will be available due to reconsideration as to how they will collect and present it in the future (NMC, 2010).

[6] The NHS: The Information Centre for Health and Social Care (2010) considers midwives within NHS Hospital and Community Health Services in England. Midwives can and do work independently therefore

(35 WTE) in education [total 26,451 (20,236 WTE)] (NHS: The Information Centre for Health and Social Care, 2010; p4-5). 24,270 (19,461 WTE) registered midwives working in maternity services and 43 (35 WTE) in education [24,313 (19,496 WTE)] were not working as 'bank' or 'agency' staff (NHS: The Information Centre for Health and Social Care, 2010; p6-7). Despite the provision of WTE midwife numbers, the NHS: The Information Centre for Health and Social Care do not specify how many midwives work part-time hours. However, in 2005 the NMC showed that the number of part-time workers was at its highest for the recorded twelve years preceding. This could be for a number of reasons such as retirement (where midwives retire and return to work as a midwife on a part-time basis), work life balance, time for other activities i.e. hobbies, other jobs, studying etc. Considering the age range of the practising midwives, the highest proportion was between 45-55 years (NMC, 2005) implying that midwives' numbers will reduce further within the next ten years due to retirement. The HCC (2008b; p 58) has stated that the mean proportion of staff aged 50 years across all NHS Trusts in England in 2007, was 28% with a range of 0 to 94%. They also remind readers that midwives can currently retire at 55 years of age. This loss of expertise compounded by the fact that there are increasing work pressures with reducing experienced midwives to support newly qualified midwives, may make the transition from student midwife to registered midwife harder.

There was a drive from the government in 2008, to recruit 'return to practice' midwives back to the profession with a 'golden handshake' of approximately £3,000 (Martin, 2008). It is unclear how successful this has been, but could be a factor in increasing practising numbers in future reports. Anecdotally, some NHS Trusts are missing their targets for recruiting return to practice midwives with the implication being that they lose money for the places. Strategic Health Authorities (SHAs) had increased the numbers of training places for student midwives to address and meet the requirements of the future demands of maternity services which was supported by the HCC (2008b). The increasing student numbers (and return to practice midwives) requiring support within the clinical

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may not be included within these statistics whereas the NMC (2005) statistical data provides figures of midwives on the professional register who are eligible to practice. These midwives may not actually be practicing therefore these data may also be skewed.

arena combined with the increase of senior experienced midwives retiring has the potential to add to the pressures exerted on newly qualified midwives.

The number of newly qualified midwives accepted on to the NMC register between 31st March 2007 and 1st April 2008 was 1,312 (Colbert, 2008). This does not differentiate between direct entry students and those undertaking a shortened programme for entry on to a second part of the register. Neither does it identify how many students commence a three year undergraduate midwifery programme and how many decide to leave the programme for whatever reason. Student midwives are not given an NMC number as they are not required to be entered onto a register whilst a student. Questions arise from the increasing numbers as it is unclear if midwives are no longer leaving the profession or if more midwives successfully are passing their entry courses and entering the profession.

1.3.3 National Policy

With the 60th anniversary of the NHS, Lord Darzi (2008) provided a report of the NHS looking at '*high quality care for all*.' He aspired to valuing the work undertaken by NHS employees (p8) by providing a:

> '*threefold increase in investment in nurse and midwife preceptorship with a view to offering protected time for all newly qualified nurses and midwives to learn from their more senior colleagues during their first year'*

It is not stated within his report how this 'protected' time might be achieved or how much time is required for an 'average' midwife to develop. Individual NHS Trusts and SHAs are tasked to respond to the Darzi (2008) report with a view to taking ownership for their own efforts to improve the quality of service provision. By implication this must mean that midwives are fit for practice and purpose. Anecdotally, the Darzi (2008) report has become influential in policy-development at local and regional level and may also be key within the DH publications such as '*Delivering High Quality Midwifery Care'* (DH, 2009) and the NHS Operational Framework for 2010/11 (DH/NHS Finance Performance and Operations, 2009). The report (Darzi, 2008), commissioned by the government, appears to be based upon many audits conducted within the NHS and seems to be the

foundation from which the analysis is provided by one eminent individual. This analysis may not reflect the broader views or remain pertinent at the rate that the NHS is changing. The findings from this study might guide the development of a preceptorship package for midwives

There have been many reports commissioned over the years that have failed to deliver what they recommended within the time scales promised i.e. The Changing Childbirth Report (DH, 1993); The National Service Framework for Children, Young People and Maternity Services' (DH, 2004b) and 'Maternity Matters' (DH, 2007). A small 'off the record poll' undertaken by the RCM (2010c) asked fifty midwives if they thought '*Maternity Matters has made a real difference to women and their babies*?' (RCM, 2010c; p7). The vast majority (76%) stated that the policy had not made a difference due to lack of available resources leading to the increase of unrealistic expectations and dissatisfaction reported by women. It reports one midwife as saying that the reality is that midwives deal with more women who have more complex needs when there are not the skilled midwives to undertake this workload safely. Whilst this poll cannot be accepted as rigorous evidence, it does highlight an aspect of how midwives 'feel' about policy as delivered at floor level.

The Changing Childbirth report (DH, 1993) was perceived to be a powerful report at its conception, the reality is that after seventeen years this five year plan has still not completely been achieved. Its aim was to instigate a positive change for many women by implementing and affirming '*the three C's'*: choice, control and continuity. From experience, lip service is still paid to the three 'C's' in many NHS maternity services with the inference being that '*yes you can have choice, but only if it's what we say you can have'*. There have been changes in maternity services that have positively benefited women such as having a named midwife and/or a small team of midwives providing care; carrying hand held antenatal records and having some degree of autonomy and empowerment over choices of care provision; there remains the fact that financial constraints within NHS Trusts means that aspects of service provision have been withdrawn or minimised (RCM, 2009b, Shaw, 2007). From experience, on qualification

some newly qualified midwives passionately aspire to achieving the goal of providing continuity of carer during both the antenatal and postnatal periods and for there to be one-to-one care in labour as set out in 'The Changing Childbirth Report' (DH, 1993). They are taught that they have the remit of being the change agents of the future (DH, 2009, NMC, 2006). However, for those that try to implement new ideas for practice or a new piece of evidence, they feel that they are either restricted by the constraints of the service or castigated by their colleagues eventually becoming too exhausted to try to assert change. The recently published 'Report by the Prime Minister's Commission' (Keen, 2010) reiterates these outlined concepts[7]. Again, these perceptions come largely from my experiences therefore this study aims to explore the experiences of newly qualified midwives.

'The National Service Framework for Children, Young People and Maternity Services' (DH, 2004b) ten year plan dedicated one standard (number 11) to maternity services which sets out to improve postnatal care for women. Changes to the 'Midwives Rules and Standards' (NMC, 2004a) at this time lifted the restriction of discharging the postnatal client by the twenty-eighth day to when appropriate, after the tenth day post-partum. The aim here was to forge greater liaisons with health visitors and community health sectors. Whilst these inter-professional relationships are building, the reality is that mainstream services are so stretched due to service demands, changing priorities, numbers of available midwives and increasing clientele that anecdotally, for local NHS Trusts there is an obligatory unwritten rule of 'three postnatal visits' for each client; some of which are telephone advice only. The women that require extra visits are given them, but the risk is for those women who do not realise when extra input is required, e.g. the jaundiced baby who is not feeding well and when the parent's state that they have a quiet baby. There are implications of babies being re-admitted to hospital in need of phototherapy treatment which may have been unnecessary if an appropriate assessment had been carried out earlier. This has a financial cost to the NHS and also to family

[7] Whilst it is recognised that the 'Front Line Care' report (Keen, 2010) is a recently published document that lays out the foundation for nursing and midwifery, it will not be considered further in chapter 1 as it was not used as background information to contextualise the study.

wellbeing (DH/NHS Finance Performance and Operations, 2009). For the newly qualified midwife, there may be conflict between personal values and ideals of what they perceive midwifery practice to be and what the reality is (Kramer, 1974) leading to disillusionment. Student midwives are taught to use current evidence and policy (NMC, 2008a, NMC, 2009a). There is potential for the newly qualified midwife to experience a practice-policy divide which may lead to uncertainty or confusion within their own interpretation of practice. Therefore, this study aims to elicit the experience of newly qualified midwives.

In 2007 the then health minister Patricia Hewitt, presented a speech at the RCM conference and announced that by 2009 all women will be able to give birth at a place of their choice with the person of their choice being with them (Directgov, 2007, Morgan and Kirby, 2007, Shaw, 2007). The reality is yet to be achieved for mainstream services. Nationally, birth centres such as the Albany (RCM, 2010b) and the option of a home birth have been greatly reduced due to cost and resources. Birth centres need to be used to capacity for them to remain viable commodities; whilst no-one wants to see their birth centres close, if they are not used they are not cost effective. It is right and proper that they close under these circumstances, with the allocated funds being redistributed into the NHS to be used more effectively. Whilst this is controversial, from a business perspective, funding has to be considered appropriate. By reducing service options not only do the client choices suffer, but there is potential for newly qualified midwives to miss consolidating or learning low risk midwifery skills. This could impact on future practises and become a self perpetuating cycle leading to overall loss of skills for generations of midwives to come. More importantly though is that more women will birth in the main maternity units, placing greater strain on the service provision and resources thus increasing work pressures. Although staff may be re-deployed to the main maternity units, the reality may be that they continue to provide antenatal, intrapartum and postnatal care within the community and not necessarily within the busy hospital delivery suites.

1.3.4 NHS Culture

The HCC (2008a) published its third review on maternity services in England. The HCC was superseded by the Care Quality Commission on 1st April 2009 however, this HCC report remains, at present, the most current. This review was the first as a '*national* [performance] *benchmarking study*' ranking each NHS Trust as either: least well performing; fair performing; better performing or best performing. Issues of low staffing levels have been prevalent in those NHS Trusts highlighted as 'least well performing' along with mobility and mix of the population. The HCC has published individual reports for the 148 Trusts assessed so that each can devise their own strategy and business plan for improving client care. The SHAs are named as being responsible for monitoring the action plan(s). It could be viewed that the Strategic Health Authority (SHA) could provide a strategic view on current maternity services, but equally the SHAs are away from the frontline, hence may have lost touch with the realities. For individual maternity services the issues of staffing and skill mix continue to offer regular challenges which, leads to greater responsibility for newly qualified midwives who are already trying to adjust to the changes in their responsibility. The HCC (2008b; p 54) confirm that staffing and skill mix continues to be a concern for professional organisations particularly where increasing birth rates are recorded. Anecdotally, within the NHS Trust nearest to where the research took place, currently 75% of the midwifery workforce comprises midwives who have been qualified less than two years and of the 25% more experienced midwives, a high number are due to retire within the next few years. This has implications for supporting newly qualified midwives through their preceptorship programmes when the preceptors may still be learning and developing their own skills for competent practise.

For issues of safety, the priority area within the maternity services is intrapartum care. The HCC (2008b) has identified that the ratio of midwives to births varies across England from more than 40 midwives per thousand births to fewer than 25 per thousand (median is 31 per thousand births). Babies do not wait until optimum staffing levels and skill mix has been achieved. From experience, community/case-loading/integrated midwives[8] are

[8] Integrated team midwives work autonomously within the remit of low risk (normality) midwifery providing antenatal, intrapartum and postpartum care to both mother and baby. This takes place within the community and hospital/birth centre settings. These midwifery teams also provide care for high risk

frequently called to cover unit staffing deficits and ensure that labouring client care is not compromised. When this occurs, clients within, for example, the community setting have their appointments cancelled and rescheduled adding to the midwife's workload the next day. The implications for this are that there is a reduced contact time for those clients as more midwifery aspects have to be covered within the working day leading potentially to greater stress for the newly qualified. It also means there is less time for mentoring or preceptorship.

The HCC (2008b) recommends that NHS Trusts urgently review their staffing figures and alter them accordingly. 'Birth Rate Plus' (Ball and Washbrook, 1996) is a tool that can identify staffing ratios for the type of service provision planned. This is calculated on birth numbers. For many NHS Trusts who have used the tool, this has been a paper exercise to add to the business plan(s) without the extra financial requirements being provided to implement changes (RCM, 2009b). As a Supervisor of Midwives (SOM), I am privy to the information of maternity temporary closures to new admissions including labouring women within the LSA. These units close typically due to unsafe staffing levels or no beds for labouring clients to occupy. One way in which financial and resource crippled services are managing this issue, is to train maternity care assistants (MCA) to a national vocational qualification level three or maternity support workers (MSW) (DH/NHS Finance Performance and Operations, 2009) to undertake tasks that a midwife traditionally performed. The midwife remains responsible for the MCA/MSW's actions and in effect becomes the manager of client care. The consequences for the newly qualified midwife include not having the opportunity to practise and consolidate basic midwifery skills, thus potentially (over time) losing the 'art' of practising midwifery; and assuming responsibility for other team members' work when they are trying to develop confidence in their own change of responsibility and workloads.

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women under the care of their team in partnership with the obstetric team. Case-loads per midwife are much higher than case-load held midwives. Unlike case-load held midwives, integrated team midwives cover the whole maternity services as priority dictates.

1.3.5 Birth Rate

The number of live births in England and Wales increased for the seventh successive year in 2008 to 708,711 ((ONS) Office for National Statistics, 2009) compared to 690,013 in 2007 and 669,601 in 2006 (ONS, 2008). There was a continued rise in the proportion of births to mothers born outside of the UK (23 percent in 2007 compared to 22 per cent in 2006). In 1997, 13 percent of births were to non-UK born mothers (ONS, 2008). This has direct impact on the allocation of resources (RCM, 2009b) where, for example, non-English speaking clients often require additional expenditure such as longer appointments and interpreters. They are also predisposed to increased risk of co-morbidities and health issues (Lewis, 2007). Due to these issues, often newly qualified midwives misjudge the time required to perform their daily workloads which is an added strain to the transition period. Handling these professional challenges impacts upon both professional and personal lives where individuals often work well past their allocated shift time.

1.3.6 Low and High Risk Environments

The role of the midwife in the UK is expanding covering both high and low risk midwifery care provision, with midwives developing specialist roles in areas of interest or consultancy and/or education (DH, 2009) to name but a few. Midwives may be employed by the NHS or practice independently. They may work solely within hospital units[9] or within case-load[10] or community settings (Walsh, 2008).

The maternity services' workforce comprise midwives working predominantly within the community (providing ante and post natal care), within the hospital (for ante and post natal care) and within hospital birthing environments (intrapartum care). However, as the HCC (2008b) highlight, many maternity units have enhanced services to encompass a more integrated and holistic philosophy of care. Although this way of working aims to promote woman centeredness, the newly qualified midwife has to cope with consolidating

[9] Hospital midwives undertake high and low risk midwifery care within a main maternity hospital setting. They do not typically provide any community related care.

[10] Case-load schemes share a core philosophy where there is importance placed upon the '*relationship between women and a small number of carers who deliver care through out antenatal, intrapartum and postnatal spheres of care*' (Walsh, 2008; p 178). They typically provide care for both high and low risk women. Local teams cover the 24/7 period for all women booked under their care between them. These teams are meant to be self sufficient and hence not require input from main stream staffing. However this is not always feasible at local level.

skills in all aspects of care, all at once. Some units continue to provide a more traditional rotational post where midwives spend a given number of months in each of the main areas in the hospital i.e. antenatal ward, postnatal ward and delivery suite. Midwives are able to consolidate their training and skills within these environments, but may not achieve the continuity of care and carer that the integrated approach could offer (Biro et al., 2003) hence there may not be the satisfaction that such integrated care offers both woman and midwife.

At the point of registration newly qualified midwives are to be '*competent and confident in supporting women in normal childbirth*' (NMC, 2009a; p17). Normal childbirth means low risk. Low risk includes caring for women, for example, at home, in birthing centres and/or main maternity units which have a low risk of complications throughout their antenatal, intrapartum and postpartum periods. The NMC have developed guidelines (NMC, 2007) concerning case-load held experiences within graduate midwifery education programmes (Walsh, 2008). Individual education establishments provide varying interpretations on this guidance through their curricula design and structured midwifery practice in both high and low risk midwifery care. Traditional ways of working may conflict with quality of care, accountability and evidence based practice. Case-loading therefore, potentially develops expectations of one way of working which may not be the reality for many newly qualified midwives in their first workplace. This in turn may affect satisfaction within midwifery and impact upon the retention of midwives. Consolidation is an issue as case-load practises ensure that midwives experience all aspects of midwifery in a multitude of arenas, but over a longer time frame.

The DH (2009; p23) has devoted much of the *'Delivering High Quality Midwifery Care'* publication to '*Education for Tomorrow's Midwives*'. Effort is afforded to ensuring education meets the current and future demands of maternity services with clinical skills resources, assessment tools, exposure to an array of settings and care models, fast track routes to make midwifery '*attractive'* (resulting in Masters-level qualifications) developed to ensure newly qualified midwives can competently carry out their roles. They also acknowledge the need for support initially and assert the importance of

effective and defined preceptorship packages for all. One could then question if preceptorship periods ought to be longer in duration because of this, but the uncertainly lies with how long they would be. This may be dependant upon individual experience and learning needs. The reality however, is that the newly qualified midwife may be consolidating training within main busy maternity units that include high risk clients as opposed to consolidating 'normal, low risk' midwifery skills for which they have been trained to.

1.3.7 Midwife Autonomy

Autonomy is complex to define briefly however, Keenan (1999; p 561) states that it is:

> *'… the exercise of considered independent judgement to effect a desirable outcome.'*

Linked closely with autonomy is accountability (Savage and Moore, 2004). Statutory regulations within the 'Midwives' Rules and Standards' (NMC, 2004a; p17) assert that a midwife is accountable for his or her own practise and that this accountability cannot be '*taken from you by another registered practitioner, nor can you give that accountability to another registered practitioner.'* This is within the sphere of 'normality' implying low risk contexts. However, accountability is something that practitioners converse about without really understanding its implications (Dewar, 2010). Having accountability means one is answerable to their acts and omissions:

> *'…the fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results, income and expenditures for which one has authority.' (Lewis and Batey, 1982; p 10)*

The word autonomy comes from the Greek and means 'self governing'. Griffith et al (2010) refers to autonomy as the capability of a person to make an informed decision about his or her future without coercion. Self-governing in this case is about the individual's right to be able to take control of themselves and the outcomes that befit their personal values and belief systems (Beauchamp and Childress, 2001). As Autonomy is

about self-rule, self-support, liberty, freedom and power (Marshall and Kirkwood, 2000, Kramer and Schmalenberg, 2003) midwife autonomy by virtue concerns the right to self-govern and make decisions about one's own clinical practice (Marshall, 2005). Despite this, Pollard's (2006) qualitative study consider what midwives understand autonomy to be and then asks the participants to consider if they perceive themselves and their colleagues as being autonomous. It is unsurprising that findings from the 27 participants indicate that they had little understanding of the implications of autonomy especially on the control of their own practice. Participants portrayed mixed views about their perception of exercising autonomy within practice with those being 'pre-registration midwives' having less of a barrier to it. It could be perceived that those who had trained as nurses prior to their post registration midwifery education had become entrenched within the philosophies of nursing finding it more challenging to a change in 'mindset' to a midwifery philosophy of autonomy.

These considerations have led many (Marshall, 2005, Marshall and Kirkwood, 2000, Beauchamp and Childress, 2001, Pollard, 2006) to question if midwives are truly autonomous when they are employed within a large organisation such as the NHS. Such organisations reduce the freedom that individual professionals had, leading to midwife autonomy being solely in relation to that which she holds authority from, for example, expert knowledge and experience (Marshall, 2005) Midwives have the right to accept or decline advice from other registered practitioners, but ultimately that midwife holds accountability for the care of the client from the point of registration. The NMC (2009a; p17) assert that student midwives are to be '*working towards autonomous practice at the point of registration*'. Therefore, with registration comes change in responsibility and accountability. It is unsurprising that newly qualified midwives risk anxiety and reduced confidence in their ability during the initial stages of their first post.

When working within high risk situations or environments the midwife works in partnership with the obstetric team, where they are the managers of care. The midwife remains autonomous in her own right as she remains accountable and responsible for the safety of her client (NMC, 2004a).

1.4 Research Areas of Interest and Anticipated Benefits of This Study

Whilst it is possible to surmise the challenges of transition based on analysis of current policy and practice (section 1.3) this study seeks to better understand what it is like for newly qualified midwives passing from '*studenthood'* to '*midwifehood'*. One can question whether the realities of working as a newly qualified midwife have been realised throughout the students' training programme, and if not, when this reality occurs. The main research area of interest considers how newly qualified midwives experience working in that role with inference to whether current preparation has equipped them with the knowledge and skills to perform.

At the outset of the study it was clear that the benefits of conducting this research cover both education and clinical practice. An understanding of what newly qualified midwives experience during their first year post registration are used in curricula development and future planning of maternity services. This would mean that future midwife preparation is suitable for the ever-expanding and changing role of the midwife. Having an insight into what it is like for a newly qualified midwife will identify where support mechanisms can be developed and executed more effectively. It might also provide insight for issues related to recruitment and retention of midwives. The proposal of Darzi's (2008) preceptorship plans might, together with the findings from this study, help to create an environment within which preceptorship is more valued and the programmes more tailored to midwives' needs.

I anticipate that findings related to professional issues will guide the local SOM team development in minimizing risk in relation to support and professional development. To effectively and proactively support and develop a midwife is to ensure public protection is at the fore (NMC, 2004a). At local level, it is anticipated that findings from this study will be utilised to support senior student midwives as they embark on their journey to 'becoming' that midwife they have aspired to be.

1.5 Introduction to Content of Thesis

This chapter has provided the rationale for and general policy context within which this study has been undertaken. Chapter two provides the outcome from a preliminary review of the literature, as is appropriate for the phenomenological methodology, in order to provide context and credence[11] for the study. Chapter three provides readers with the principal research question; the methodological consideration; the study design and timeline. Chapter four presents the audit trail of how the data were managed and how interpretive themes emerged. These themes have been considered in chapter five where participant experiences have been used to explicate the findings. Chapter six presents the findings from chapter five in relation to the current literature in the form of a synthesis. Chapter seven provides the conclusion to the study; incorporating its strengths and limitations and draws implications for practice. A reflexive overview of the process of this research is also located within this chapter. The contribution to existing knowledge is also presented.

1.6 Synopsis of Chapter

This chapter has situated this research project within a general policy background highlighting the challenges and opportunities for newly qualified midwives within a healthcare setting. This has been achieved through introducing the thesis and study, providing the reasons for the study and considering them in the context of the UK and national policy. Study areas of interest have been articulated along with how findings may be used to inform both theory and practice.

As a result, this phenomenological study is designed in order to gain an understanding of the experiences of newly qualified midwives during their first twelve months after registration.

[11] Credence in this case means credibility for the undertaking of this phenomenological study, based on the results of the preliminary review.

Chapter 2: Contextualisation of the Research Problem

2.0 Introduction and Purpose

In preparation for any research project, a review of the research is required in order to consider if there is any prior available knowledge and to establish what new knowledge the researcher seeks to obtain and contribute to the arena (Moustakas, 1994, Flick, 2006). This study takes a phenomenological approach. Phenomenological methodologies recommend that an in-depth literature review is not conducted at the start of the project, as it may cloud the interpretation of the data collected (Jenkins et al., 2003, Spiegelberg, 1965). An initial literature review is required however, to highlight the context within which the study is being conducted (Flick, 2006) therefore, a preliminary review of the literature is presented below. This was useful in providing initial background to this study without unduly influencing the direction or outcomes. Chapter one has considered evidence surrounding experience, policy and contexts; this chapter considers the research evidence. Data are discussed, analysed and commented upon during the preliminary literature review (Jenkins et al., 2003) to enable an appropriately focused topic that will contribute to practice and/or education. As is consistent with principles of phenomenological research, once themes generated from the current research study have been collated, a critical analysis of the literature is conducted to support or refute the findings. This was undertaken towards the end of the study to reduce potential data contamination (Spiegelberg, 1965) and therefore, is integrated within the synthesis of findings chapter (Chapter 6).

2.1 Literature Selection

Electronic literature searches of health and social care databases commenced in 2005 to prepare for the study and for ethics. The question posed to guide each search was:

What is the current evidence surrounding transition from: student to health care professional; student midwife to midwife; student nurse to nurse?

Sources were identified for computer searches so all relevant articles could be included for consideration (Greenhalgh, 1997; p 9). Ayres (1995) provides an overview of literature sources which includes direct access to journals via local libraries and databases, but as Cluett (2006) highlights, not all databases maintain a full index of published articles hence, a significant number of current and relevant literature is at risk of being omitted. Obscure journals and article reference lists contain articles which may be of interest; these sources were identified. The health and social care databases and specialist library catalogue used (box 2.1) were chosen as it was deemed that they would elicit articles appropriate to healthcare in general as well as the midwifery aspects themselves.

Box 2.1: Databases searched for the literature review.

British Nursing Index
EMBASE
Medline
CINAHL (Citation Index for Nursing and Allied Health Literature)
OVID
Journals @ OVID full Text
MIDIRS
Pub Med
Copac National, Academic, and Specialist Library Catalogue

Search parameters were specified at the onset of the literature review which included *'…key words by which the relevant studies or materials might be indexed'* (Renfrew et al., 1998; p 143). By using truncation ($), the allowance for different endings of a word have been included (University of Southampton, 2005). Boolean operators (AND and OR) were also implemented to enhance and refine the search (Cluett, 2006; p 45). The key words for both searches are in box 2.2.

Box 2.2: Keywords for the review of literature.

Assess$
Clinical experience
Expectations
Expectations and reality
Experience$
First post
First six months
Job satisfaction
Lived experience$
Newly qualified midwives
Newly qualifie$
Perceive$
Perception$
Preceptorship
Research$
Role$
Student midwives
Transition

$ = truncation for search purposes

Selection criteria were adopted due to the vast quantity of data generated. These necessitated clear parameters which can be identified in box 2.3 in order to begin to reduce the identified papers to a manageable amount.

Box 2.3: Primary inclusion/exclusion criteria.

Primary inclusion/exclusion criteria
Limit to articles written in English
Published within the last 10 years
Seminal texts
Limit to UK and European Union (EU) countries
Primary research articles
All experiences of roles
All health professions

Various reasons supported the selection of these criteria for instance many states within, for example, America do not permit midwifery practise (as interpreted within the UK), but have obstetric nurses who follow a paternalistic philosophy to care (Davis-Floyd, 1993). Obstetricians are the leads for care. Interpretation of American literature would not be generalizable to UK practices for the purpose of this study. Similarly, for example,

Dutch (Amelink-Verburg et al., 2008) midwives appear to practise more freely (possibly more radically in part) and although in the UK, the aspiration is to develop similar practices with the associated positive outcomes, the profession is governed differently and health care is funded and delivered differently through the NHS. Whilst these differences are acknowledged as potentially adding theoretical wealth to the experiences of newly qualified midwives, the focus for this study is UK trained and practising midwives who work within the constraints of the NHS. However, both UK and European midwives must work to EU directives therefore literature pertaining to the UK and EU countries will be utilised predominantly within this study in view of these points. On reviewing the literature for inclusion, one author appeared to be referred to in the literature reviews related to midwifery training. The work of Begley appears to be seminal therefore it has been included within this review of the literature. This is despite the fact that she has researched midwifery within the Republic of Ireland where the training of midwives is different. The implications of this are considered within the critique below.

Limiting articles to publication in the last ten years meant that some seminal texts had been omitted from the primary search. Reading the literature reviews from the located papers highlighted these key seminal texts that would have otherwise been missed. The seminal texts appeared to form the foundations to the majority of located papers. Therefore both a serendipitous search and a repeat of the electronic search without a date restriction were also carried out (box 2.4). This revealed more papers including the seminal texts for consideration.

Box 2.4: Secondary inclusion/exclusion criteria.

Secondary inclusion/exclusion criteria
Limit to articles written in English
No date restriction
Seminal texts
Limit to UK and EU countries
Primary research articles
All experiences of roles
All health professions

2.2 Review of Selected Literature

A review of the current literature demonstrated a paucity of papers concerned with the focus of this research project[12]. Of the studies initially identified, the majority were nursing papers (Myrick and Younge, 2004, Maben and Macleod-Clark, 1996, Jackson, 2005a, Ewens et al., 2001, Fagerberg, 2004) with only two researchers working within midwifery (Begley, 2001a, Begley, 2001b, Begley, 2002, Montgomery et al., 2004).

None of the papers identified a direct link with the expectations of becoming a qualified practitioner and/or the reality of experiences of qualifying and working as a health care professional. The review yielded research papers concerning the preceptorship of newly qualified and employed practitioners, but only for those within the NHS environment. Preceptorship has a wide coverage (Mamchur and Myrick, 2003, Myrick and Younge, 2004, Hobbs and Green, 2003, Steele, 2008) and has been adopted and developed within clinical practice to enhance 'fitness for first' post (Coles et al., 2005) along with fitness for purpose (Ewens et al., 2001). Although the main focus of this research project was not to consider whether newly qualified midwives are/are not fit/ready for practice, it was anticipated that the outcomes would impact on future research which may incorporate these issues (Quality Assurance Agency for Higher Education (QAA for HE), 2005).

After sifting the papers, six papers remained (Begley, 2001a, Jackson, 2005a, Montgomery et al., 2004, Fagerberg, 2004, Maben et al., 2006, Maben and Macleod-Clarke, 1998) appropriate for consideration. An amalgamation of the Critical Appraisal Skills Programme (CASP) 'qualitative research', the 'cohort studies' tools (NHS Forth Valley, 2005) and Crombie's (1999) critiquing tools (appendix 1) and the criteria for the evaluation of qualitative research papers (British Association Medical Sociology Group, 1996) (appendix 1) were used to appraise the papers for consideration. These six papers remained rigorous enough to be included after applying these tools. Table 2.1 provides

[12] It is acknowledged that there has been another published paper (van der Putten, 2008) concerning the focus of this research study. This has not been considered within this preliminary review of the literature as the publication occurred after data collection had been completed and not before. It is considered within chapter 6.

an alphabetical ‘at a glance’ summary of each of the papers. The papers are then critiqued below using the midwifery focus papers primarily with the nursing perspective following.

Table 2.1: Six studies included in the preliminary review of literature (in alphabetical order)

Study- full reference	Intervention assessed and number studied	Entry criteria	Outcome measures	Results
Begley, C. (2001a) Giving midwifery care: student midwives' views of their working role. *Midwifery* 17 pp24-34	A longitudinal triangulated mixed method study. This paper presents a phenomenological aspect exploring the opinions, feelings and views of student midwives of their education as they progressed through their 2 year program in Ireland Total number of participants = 125	All student midwives in the first intake of 1995 in every midwifery school in Ireland (7 in total)	To measure self esteem and assertiveness	Eight themes were identified from a first interview and diaries: • It's a whole new ball game • Thrown in the deep end • Them and us • Its all routine • We're workers not learners • Good days and bad days • They all have their moments • Getting the hang of it Four further themes identified from second interview. • Knowing your place • Counting the days • It's a do it yourself course • Gaining confidence and competence

Fagerberg, I (2004) Registered Nurses' work experiences: personal accounts integrated with personal identity. *Journal of Advanced Nursing.* 46(3) pp284-291	A phenomenological hermeneutic approach to understand the meaning of Registered Nurse's narratives of their work experience five years after graduation Total number of participants = 16	Between 1993 and 1996 27 Swedish student nurses participated in a longitudinal study concerning transition into nursing. In 1998 follow up interviews were conducted with 20 RN' and for this study the same 20 RNs were asked to participate further of which 16 volunteered.	A guided interview was conducted by the researcher	Three themes were identified after a second analysis of sub-themes: • The meaning of caring and protection of patients • The meaning of work organisation in nurses' work • The implied meaning of using one's individual attributes in the professional role
Jackson, C. (2005) The experience of a good day: a phenomenological study to explore a good day as experienced by newly qualified, registered nurses. *International Journal of Nursing Studies* 42 pp85-95	A descriptive phenomenological approach to explain newly qualified nurse's experience and description of a good day. Total number of participants = 8	All participants are from the rotational programme that aimed to develop clinical competency and confidence. All were from the surgical wards only	To provide an explanation of a good day experienced by a newly qualified RN and to provide an explanation of how a good day made them feel about nursing	Five main themes were identified: • Doing something well • Good relationships with patients • Feeling that you've achieved something • Getting the work done • You need team work

Maben, J. and Macleod-Clarke, J. (1998) Project 2000 diplomates' perceptions of their experiences of transition from student to staff nurse. *Journal of Clinical Nursing*, 7, 145-153.	A qualitative approach akin to Lincoln and Guba's naturalistic enquiry to describe the experience of transition from student to staff nurse for project 2000 diplomates Total number of participants = 10	A convenience sample drawn from participants completing questionnaires and willing to be interviewed within an earlier large scale study. 5 people from 2 cohorts (January – May 1991) were interviewed December 1994 – January 1995.	To identify the factors which facilitate or inhibit transition.	A key theme has been presented: Emotional highs and lows. 10 themes have been addressed within this. These are: • The lows: role difficulties and problems encountered • Stigma and negative staff attitudes • Resistance to change • The highs: satisfaction and fulfilment • Valued by colleagues • New responsibilities and support: getting to grips with the staff nurse role • Initial skills deficit • Confidence: a contradiction-feeling confident –v- feeling like a 'lemon' • You're on your own: responsibility and accountability • Preceptorship and support: myths and realities

Maben, J., Latter, S. and Macleod-Clarke, J. (2006) The theory-practice gap: impact of professional-bureaucratic work conflict on newly qualified nurses. *Journal of Advanced Nursing,* 55**,** 465-477.	A longitudinal naturalistic enquiry undertaken in the UK into the extent to which the ideals and values of the pre-registration nursing course are adopted by individual newly educated Registered Nurses. Total number of participants = 26	Final year nursing students in three colleges of nursing from 1997 to 2000 completed questionnaires (n=72) and 26 participants undertook in-depth interviews at 4-6 and 11-15 months post qualification.	To indicate the extent to which views on their ideals and values for practice were adopted in practice.	4 key themes are presented in the findings section. These are: • Development of ideals • Reality of implementing ideals in practice • Covert rules • Role models as agents of socialisation and providers of support.
Montgomery, E., McCandlish, R., Martin, A. (2004) What happens after graduation? The WHAG study. A longitudinal cohort study of pre-registration midwifery graduates. *MIDIRS Midwifery Digest*. 14(3) pp422-424	Pilot of a longitudinal cohort survey 24 respondents out of a possible 40 returned postal questionnaires	Midwifery graduates from one university who completed the pre-registration Bachelor of Midwifery 78-week programme in 2000-2002.	• Description of the work experiences, patterns and future plans of surveyed midwifery graduates • Description of rates of and reason of attrition from midwifery • Description of rates of and reasons for continuing in midwifery practice	• 18 (82%) respondents had been in a post requiring midwifery registration • 4 (18%) had never practised as a midwife because of: maternity leave, a desire to travel and return to nursing' the longer out of midwifery the less desire to return to practice as a midwife, dissatisfaction with midwifery program, no support clinically • 16 (73%) intended remaining in midwifery. 3 midwives intend not staying and used midwifery as a stepping stone to other health careers,; one expressed general dissatisfaction with midwifery

As the focus of this study is midwifery, it is appropriate to present the midwifery focussed papers first. The WHAG (What Happens after Graduation) longitudinal cohort survey (Montgomery et al., 2004) undertaken within the UK is presented first followed by Begley's (2001a) Republic of Ireland, EU focussed paper. Both Maben and Macleod-Clarke (1998) and Maben et al (2006) UK focussed nursing papers are presented concurrently followed by Fagerberg's (2004) Swedish study.

The WHAG longitudinal cohort survey (Montgomery et al., 2004) considers midwifery graduates from one University within the south of England who have completed their pre-registration programme and registered as midwives onto the 'Midwives part' of the professional register (NMC, 2004c). The focus of the survey describes the graduates' work patterns after the end of their programme and what influenced their decision to stay or leave the midwifery profession. Montgomery et al's (2004) paper presents the findings of the pilot study which was set up to test the feasibility of undertaking an annual survey of graduating students from one year following graduation. Despite the fact that this is a 'self-stated' 'pilot' and not the completed longitudinal cohort survey, it is the only available evidence that focuses on where newly graduated midwives are employed and indeed if they have remained employed as midwives.

The pilot comprised 40 graduates who had completed the pre-registration Bachelor of Midwifery 78 week (shortened) programme during 2000-2002. These graduates had prior experience within the NHS as qualified nurses so their experiences may be different to those of direct undergraduate student midwives. The 40 graduates were sent a covering letter and postal questionnaire to their last known address. This has ethical considerations as this occurred one year after the completion of their programme and it is not apparent if consent had been obtained to use their addresses for research projects. Many universities routinely however, follow up students' careers with surveys and this might have been a consideration for this pilot. The response rate was 60% (n=24); with two responses returned as '*not known at this address*' (p424).

Montgomery et al (2004) acknowledge limitations of this study and state that due to the small sample size conclusions could not be drawn. Ironically, as it is 'only' a pilot study, one would not expect to see generalised conclusions drawn merely those related to methodological development. They do state however, that it would be feasible to conduct a follow up survey after making minor adjustments to their questionnaire. Their intention, being that enrolment to any future survey would be prospective, was never doubted. There is no in-depth analysis of the lived experiences for participant choice in this area. Whilst this study is not wholly relevant to my study as no direct entry (156 week) students were included, it confirms that it is possible to conduct research to ascertain the experience of newly qualified midwives within the first year of graduating as a midwife. Although not using the design selected for the study, Montgomery et al's (2004) study may prompt further research into the area of retention within the midwifery profession as it highlights a gap in current knowledge.

Begley's work is presented in a number of papers (2001a, 2001b and 2002). Begley's (2001a) focus is student midwives' views of their working role in Republic of Ireland. One must remain mindful that Begley's (2001a) focus lies with that of the student midwife and their experiences whilst in that role. Practice within Republic of Ireland is not regulated by the NMC (NMC, 2004c) however practice is bound by the same EU directives (NMC, 2004c, NMC, 2002, European Communities (EC) Midwives Directives, 2005). Although the transferability to midwifery practice within the United Kingdom could be questioned when practice is governed differently, the reality is that midwifery practice it is likely to be broadly similar.

Begley's (2001a) research adopted a mixed methods approach with a predominantly phenomenological approach presented in this paper. Begley (1999) describes the study in full stating that triangulation was used in the study in a number of ways, but no evidence relating to this was located. However, Begley states that this ensures confirmation and completeness of data. One hundred and twenty five participants took part from across the seven midwifery schools in Republic of Ireland and were from the first intake of 1995. Nineteen of these kept unstructured diaries for the first ten weeks of clinical placement;

31 had unstructured interviews at three intervals during their two year course (at four, twelve and twenty months with no rationale provided for these timings) and all 125 received a final questionnaire two to three months prior to the end of their programme whilst in their last study week. This is a two year programme for registered nurses who are not supernumery whilst on programme. Caution has to be applied with transferability as updating of the NMC regulations, and midwifery education and curricula have developed over the past ten years and also this is not a pre-registration programme. The data analysis was undertaken by the researcher alone, leading to potential bias and error in transcribing and analysis of the data. Key findings show the views of the student midwives concerning their working environments; midwifery culture and not having space to learn affect satisfaction. The themes also include 'thrown in at the deep end' and the expectation to 'get on with it'. Begley (2001b and 2002) considers the students' place within the hierarchy of midwifery and also student relationships with qualified midwives and obstetricians again in Republic of Ireland. The findings from the study provide insight into current environments and experiences that student midwives are faced with.

Jackson's (2005a) phenomenological descriptive study concerning the experience that constitutes a good day for a newly qualified registered nurse, adds to the overall picture of what it is like to be a newly qualified practitioner working within an NHS environment. Jackson (2005a) states that the experience and description of a 'good day' impacts upon how individuals feel about their career in nursing in general, their job satisfaction and commonly retention in the profession. Eight newly qualified nurses with less than one year's experience were interviewed individually on two occasions in an informal and unstructured way. There is no information to indicate over what time period these occurred. One group interview was also held in order to clarify the themes generated from the analysis of the transcribed audio taped interviews. Five themes naturally emerged as components of a good day: doing something well; good relationships with patients; feeling you have achieved something; getting the work done and team work. Jackson's (2005a; p 87) interviews commenced with '*can you remember a good day and can you describe it*? This had the potential to consider positive experiences only. My

study aims to seek a balanced view on both the positive and negative lived experiences of participants; not just on one day, but over a much longer time period.

Maben and Macleod-Clark (1998) consider transition from project 2000 student diplomate nurses to staff nurse positions. They examined factors that facilitated and inhibited this transition. This paper presents an extension to Macleod-Clark et al's (1997) final report of a three year study where two of four cohorts at one college qualified within the life of the project (n=62). They were sent postal questionnaires between five and six months post qualifying and were also asked if they would volunteer to be interviewed. From the responses and other criteria (not specified) a sample of ten was identified (five from each cohort) who were then interviewed between December 1994 and January 1995 and the findings presented in Maben and Macleod-Clark (1998). Key findings include role change, nurse culture including attitudes, confidence in own performance, change in accountability and responsibility and the effect of preceptorship packages on transition. Both of these papers appear to be a follow on from a Master's thesis undertaken by Maben (1995). This overarching study compared graduate nurses preparedness to that of traditional style, non-university trained nurses. Many papers have been published from the original thesis by the author and the research supervisor(s). Maben et al (2006) appear to have conducted a similar and more recent study, with the focus being the extent of ideals and values pre-registration adult nurses had adopted once qualified and were practising as registered nurses. The focus for this paper was the practice-theory gap. This longitudinal, naturalistic inquiry followed a group of students from the end of their training to 15 months post qualified (n=72). This covered three colleges of nursing from a period of 1997 to 2000. In-depth interviews were conducted at four and eleven to fifteen months post qualifying with a purposive sample of 26 from a possible sample of 46. Key findings showed that although the newly qualified nurse held strong nursing values, organisational and professional factors '*effectively sabotaged implementation*' (Maben et al., 2006; p 465). Maben et al (2007) follows on from this to highlight ideals, frustration, burnout, disillusionment and the decision to leave nursing. Maben et al (1996), Macleod-Clark et al (1997) and Maben and Macleod-Clark (1998) appear to be seminal pieces and are referred to by many papers in their backgrounds and literature

searches. My project does not consider differences between university and non-university trained midwives, but the findings (such as poor support, covert rules, poor role models, time pressures, staffing shortages and role restrictions, to name but a few) from these papers provide non-degree trained perspectives related to educational and reality advancements.

Fagerberg (2004; p284) used a hermeneutic phenomenological approach to understand '*the meaning of registered nurse's narratives of their work experience five years after graduation*'. This publication highlights a follow on study from a longitudinal group of participants (Fagerberg and Kihlgren, 2001) who were student nurses undergoing transition to nursing five years prior to this study. The study sought to explore the human experience as it is lived by each participant and the methodology chosen proved appropriate to meet these aims. Fagerberg (2004) does not offer any insight into these processes during the paper. Data collection was via interviews which were transcribed by the researcher and there is no presented evidence of independent examination of the transcripts. Fagerberg (2004) does not discuss whether the participants were involved in reading any of the reports or transcripts. The paper contextualises the research and presents the data systematically and concisely. Fagerberg devotes a paragraph to her role, possible bias and influence on the research. Although this paper concerns 16 nurses, from an original group of 27 Swedish nursing students, five years after qualification, issues of transition continue to be explored. It could be questioned if transition is really the issue or whether the focus has altered to 'following' the group journey. However, for the purpose of my study insight into the longer term aspects emanating from training and education and expectations demonstrate how individuals adapt to their role both from an organisational political perspective and a patient care perspective over time.

2.3 Conclusion and Implications for Current Study

None of the chosen papers directly answer the focus of the search question concerning transition for student midwives, although they provide aspects which can be applied. These are what constitutes a good day for nurses (Jackson, 2005a); student midwives' views of progression during their educational programme (Begley, 2001a); where midwives work after graduation (Montgomery et al., 2004), practice-theory gap for nurses

(Maben and Macleod-Clarke, 1998, Maben et al., 2006) and the effectiveness of Swedish nurse training five years after qualification (Fagerberg, 2004). At the time of this review there was no evidence available addressing the issue of what the experience of a newly qualified midwife is; this research project addresses this deficit.

2.4 Synopsis of Chapter

At the commencement of this project there appeared to be paucity in the research of the lived experiences of newly qualified midwives during their first year as practising midwives. This research project aims to elucidate what it is like to experience the first twelve months after first registering and working on the 'Midwives part' two of the NMC register (NMC, 2005).

Chapter 3: Methodology

3.0 Introduction and Study Aim

This chapter details the study aim, research question, methodological considerations, research design, data collection, process of data analysis and ethical considerations. The aim of this study was to explore the lived experience of newly qualified midwives during their first twelve months after registration within a health care environment. The background and preliminary literature review have highlighted a paucity of evidence that considers this focus.

3.1 Research Question

What is the lived experience of newly qualified midwives during the first twelve months post registration?

3.2 Choosing My Methodology

Methodology is the '*philosophical framework, the fundamental assumptions and characteristics*' that determines the view taken toward the knowledge being sought (van Manen, 1990; p27). As I wanted a 'rich description' of individuals' 'lived experience', it was important to consider an overarching approach to research that encompassed both philosophy (epistemology and theory) and methods (data collection and analysis) (Finlay, 2006). Firstly I had to determine my philosophical position. The typology which showed a 'best fit' was the constructivist-interpretivist (meaning and interpretation) paradigm. An interpretive human science approach (van Manen, 1990) was considered to be the most appropriate. The interpretivist epistemology '*draws attention to the way our perceptions and experiences are socially, culturally, historically and linguistically produced*' (Finlay, 2006; p 19). The interpretive human science view considers that a person cannot be understood apart from the world in which they live (van Manen, 1990, Moustakas, 1994, Holloway, 2005) therefore; the interpretivist researcher recognises that they are part of the world they are studying. This is in contrast to the natural science view that supports the exploration of cause and effect and grounds itself in observation and confirmation (and disconfirmation) of theory. The ontology sits within the 'critical

realist' perspective. Critical realists consider meanings to be 'fluid' while accepting that the participants' stories reflect something of their subjective perceptions of their experience (Finlay, 2006; p 20).

The design for this study has been informed through an exploration of the research approaches that are relevant to the understanding of a phenomenon. As the enquiry is about the lived experience, phenomenology appeared to be the obvious choice for the approach to the enquiry. Ethnography, Grounded Theory and Phenomenology were considered with a view to explicate phenomena related to the experience of transition. Ethnography, originating from anthropology (Dykes, 2004), describes a '*culture or group and its members' experiences, beliefs, attitudes and behaviours as well as their location in the culture'* (Holloway, 2005; p 291). It involves extensive fieldwork allowing for direct observations (Moustakas, 1994) where the researcher becomes part of that culture in an attempt to fully understand it (Dykes, 2004; p 25). Grounded Theory is an approach which '*emphasises the systematic discovery of theory from data so that theories remain grounded in observation of the social world rather than being generated in the abstract*' (Robson, 2002; p 548). Phenomenology has been described as a means of '*gaining a deeper understanding of the nature or meaning of our everyday experiences'* (van Manen, 1990; p 90) and as such enabling complex experiences to come alive and be understood (Clark, 2000). The phenomenological research design therefore seemed the most appropriate to use in the present study because I wanted the newly qualified midwife's view of their experience not necessarily a view of how they behaved, how people reacted to them or if they were fit for practice. This approach also befits the philosophical model of care that midwifery beholds e.g. from an autonomous perspective (section 1.3.7), and fits with my values and beliefs. The strengths and weaknesses of this approach in reality are considered in the concluding chapter.

From this point a consideration of the type of phenomenology to be implemented was achieved through an overview of phenomenological approaches. These are considered below. In order to confirm that a phenomenological approach was appropriate for my study, I conducted a review of the literature to ascertain if other researchers had

undertaken similar studies with this approach to glean whether it was possible and consider any pitfalls. Appendix 2 presents a search and summary.

3.2.1 Overview of Phenomenology

Phenomenology has been traced back to Aristotle (Marcelle, 2005), but came into its own in the early 20th century with the philosopher Edmund Husserl renowned as being its 'founder' (Embree, 1997, Kockelmans, 1987). He considers the approach as a 'science of consciousness' with a strong relationship between psychology and phenomenology (Spiegelberg, 1965). He aimed for a description of a pure interpretation of an experience claiming that the task of phenomenology was to study essences. There are many essences such as the essence of 'emotion'. The purpose of Husserlian methodology is to describe the essence of 'behaviour', based on meditative thought and to promote an understanding of human beings wherever they may be found (Omery, 1983).

Husserl also discussed the issue of '*phenomenological reduction'* where one reflects upon the content of the mind to the exclusion of everything else. This in turn has led to the term '*bracketing',* where one places the experiences and contextual relations separate to the phenomenon being studied (Moustakas, 1994). 'Bracketing' is a Husserlian concept which considers a move from 'natural attitude' to one of 'transcendental attitude' through reduction (Husserl, 1962). The researcher reduces the world as it is considered in the 'natural attitude' to a world of pure phenomena (Valle and King, 1978). Parse et al (1985) explains that the researcher is required to clarify his or her experiences, beliefs and position before the data generation phase of the research process occurs in order to 'bracket' them to reduce bias. This has been argued to be a 'final impossibility' (Merleau-Ponty, 1962) because as the researcher progresses he or she will never reach a finite position (Laverty, 2003, Colaizzi, 1978).

In 1927 Martin Heidegger (who had worked as an assistant to Husserl) published his own ideas of phenomenology which were that '*we and our activities are always in the world*' (Woodruff Smith, 2003). Heidegger expanded Husserl's theory (Valle and King, 1978) and articulated that *our* understanding serves as an ontological base for 'being-in-the-

world' (Kockelmans, 1987). Heidegger's expansion of Husserl's approach to 'bracketing' takes a more 'honest' attitude, acknowledging that personal experience will influence interpretation. Experience is shared between both the researcher and participants, with the researcher using his or her own experience to enter the world of others, seeking an interpretation of that experience (Lucock, 1997). It enables investigators to question 'what makes us human' (van Manen, 2002). By being present one becomes the experience. In comparison, Husserl aimed for an isolated theoretical analysis (total bracketing) in order to encounter the phenomenon from as 'fresh-a-perspective' as possible making the interpretation of the true meaning of a phenomenon, he believed, possible (Le Vasseur, 2003). It could be argued that it is difficult to comprehend how one can successfully remove oneself from the situation and then re-insert oneself into it for the purpose of analysis therefore a Heideggarian approach has been adopted. As this is consistent with the relationship/situation of the researcher in this study, 'bracketing' to completely remove the researcher's biases has not been considered.

Heidegger's (1962) philosophy of 'being-in-the-world' how we are, live and believe means that our history will affect how we interpret a phenomenon (Koch, 1999). Human existence is inherently concerned with 'Being', it is the hermeneutics of existing (Kockelmans, 1987). Gadamer's '*philosophical hermeneutics*' elaborated Heidegger's concepts, where he strived to uncover the nature of human understanding (Malpas, 2005). Gadamer (1983) explores this concept further by considering 'fusion of horizons'; if one looks at the horizon from different aspects, such as from the top of different mountains, it will look different. Both Heidegger and Gadamer's concepts appear more plausible than Husserl's concept and were adopted for this phenomenological project.

Both Husserl and Heidegger were German philosophers from a different era to today and hence, the problem with many texts concerning Husserl and Heidegger is that they have been translated into English, which as van Manen (2008) stated, means that the essence of what was said has been lost. It makes reading more complex because the text has lost its original meaning. My interpretation is not only considered from a change in language, but era and societal differences also. After locating a translation of Heidegger's '*The*

Basic Problems of Phenomenology' (Heidegger, 1988) and his seminal piece '*Being and Time*' (Heidegger, 1962), I initially found it difficult to fully appreciate the concepts portrayed and hence consider how I could apply them to my area of interest. Both Husserl and Heidegger had comprehensive training and education as philosophers; the language and concepts therefore were part of 'them' and inseparable from their work. These aspects may not be transparent to individuals from other backgrounds such as healthcare, thus making interpretation difficult. Heidegger's writings also lack detail in relation to the precise steps to undertake in an interpretive phenomenological research study; this type of detail is particularly important for a novice researcher. However I found that van Manen (2002) had developed Heidegger's ideas and presents them on a comprehensive interactive web site in order to assist in understanding the many aspects of this methodology in a logical user friendly way (van Manen, 2002). van Manen's approach is from an educational background, set in a modern era. Although Dutch, he lives in Canada, he writes and converses directly in the English language and his work is readily accessible. These points aid the interpretation of his methodological approach for the novice researcher. Reviewing the web-site led me to consider van Manen's (1990) conceptual framework as a means to guide this research study. This is considered further in section 3.3.

3.3 Selecting the 'Type of Phenomenology'

van Manen's (1997, 1990) perspective of interpretive phenomenology appears to be the most appropriate phenomenological approach for this research study. The researcher's task is to explain the interpretations that have already been made by those who have undergone the experience (Jackson, 2005a) and to describe accurately the experience of the phenomenon under study, being careful neither to generate theories or models, nor to develop general explanations (Field and Morse, 1990). It is a way of thinking about what life experiences are like for people and exposing them to others (Powers and Knapp, 1990). van Manen (1990) states clearly that his book '*Researching Lived Experience'* aims to describe and demonstrate how to use his method from the 'pedagogic' perspective. He explains his focus is via 'meaning' of teaching and parenting and that his work '*attempts to be relevant to researchers in* [for example] *nursing…*' (van Manen,

1990; p 1). van Manen (1990) believes that interpretative phenomenological research weaves itself amongst six research activities. Table 3.1 shows the six methodological themes with my interpretation used for this study.

Table 3.1: van Manen's (1990; p 30) methodological structure of human science research as applied to this research study

Six Methodological Themes	My Interpretation of the Six Methodological Themes
1. Turning to a phenomenon which seriously interests us and commits us to the world	The researcher has to want to 'really' know the meaning of the phenomenon of interest. He or she is committed to deep thinking in order to want to make sense of this aspect of human existence.
2. Investigating experience as we live it rather than as we conceptualize it	The researcher needs to make a renewed contact with the original experience throughout the study.
3. Reflecting on the essential themes which characterize the phenomenon	Phenomenological reflection aims to grasp the essential meaning of something by considering reflections from many perspectives i.e. experience and intelligence, in order to show what one 'really' sees/experiences.
4. Describing the phenomenon through the art of writing and rewriting	The researcher has an obligation for '*bringing to speech'* through writing, the phenomenon being explored
5. Maintaining a strong and oriented [pedagogical] relation to the phenomenon	The researcher is reminded to stay 'strong' to the original phenomenon and not become side tracked with other preoccupations
6. Balancing the research context by considering parts and whole	The researcher needs to stop and consider the parts (themes) in relation to the contribution of the 'total' e.g. the study design.

The words used in each of van Manen's (1990) six themes are complicated to interpret without reading the accompanying explanations. Theme five is made more complicated by the word 'pedagogical' however; van Manen does not always include this word when explaining the theme's meaning in his text. One can surmise that the inclusion of this word is primarily to link to his focus of teaching and parenting. Conversely one could interpret it to mean that one might learn from the work by applying the findings in practical situations. For the purpose of this study the word 'pedagogical' will be bracketed and be replaced with 'becoming a midwife' (section 6.1) prior to the theme's application to better reflect interpretation for my phenomenon under investigation.

To undertake phenomenological research is to '*question what something is 'really' like*' (van Manen, 1990; p 42). Gadamer (1998; p 266) states that '*the essence of the question is the opening up, and keeping open, of possibilities*' which can only be achieved with continuing interest of one's research focus. As van Manen (1990) informs, the research question formulated for phenomenological research must be 'lived' by the investigator. The researcher must really want to know what the answers are in order to appreciate how phenomenology can work with him or her as opposed to what he or she can do with the result. In this case the answer that is being searched for comes from wanting to understand what it is like for a newly qualified midwife experiencing their first twelve months post registration as a midwife. This is with the view to using this understanding to develop and enhance the transition experience of midwives ensuring they are fit for purpose and first post.

3.4 Study Design

The overview of the history of phenomenology not only contributed to the background reading and planning stage of this project, it also enhanced the understanding of how a researcher can design a project and consider the analysis of the data collected. The structure of human science research identified by van Manen (1990) provided a logical approach. However the essential research components of sample selection, data collection and analysis, ethical aspects and establishing rigour were not always explicit. Other frameworks were used to aid these aspects and are discussed further in section 4.2.

The remainder of this chapter details the study design using the six headings from van Manen's (1990; p 30) '*methodological themes'* (table 3.1). As this study's design is to follow van Manen's hermeneutic phenomenology; it is appropriate to work with these six themes. Table 3.2 shows how I have interpreted the six themes in relation to the thesis structure and highlights where in the thesis they are located.

Table 3.2: van Manen's (1990) six themes in relation to the thesis structure and where in the thesis they are located

van Manen's (1990; p 30) methodological structure of human science research	**How I have linked to structure of thesis**	**Chapter**
Turning to a phenomenon which seriously interests us and commits us to the world	Introduction and background Initial review Design and methodology	1 2 3
Investigating experience as we live it rather than as we conceptualize it	Design and methodology	3
Reflecting on the essential themes which characterize the phenomenon	Method of analysis The findings The discussion of findings	4 5 6
Describing the phenomenon through the art of writing and rewriting	Findings	5
Maintaining a strong and oriented [pedagogical] relation to the phenomenon	The findings Discussion	5 6
Balancing the research context by considering parts and whole	Method of Analysis Findings Application to practice Implications for practice	4 5 6 7

3.4.1 Turning to a Phenomenon Which Seriously Interests Us and Commits Us to the World

This first stage of the methodological structure, commits the researcher to the area of interest thereby, the researcher is continually thinking about one aspect in more depth than others (van Manen, 1990). The researcher is trying to make sense of the one thing he or she is 'thinking' about. This research project comprises an interpretive phenomenological exploration of a cohort of student midwives' experiences as newly qualified midwives who have undertaken a three year university based qualification leading to registration onto the 'Midwives part' of the NMC's register of eligible practitioners. Interpretive phenomenology is the selected approach because it focuses on the '*lived experiences'* of individuals undergoing an event thus permitting the researcher to analyse what the life experiences of midwives are actually like as they see them. The newly qualified midwives provide a deep and rich articulation of their experience, pre-consciously, to make visible the taken for granted or as van Manen (1990; p 30) states '*to make sense of a certain aspect of human existence*' that is situated within the social, historical context of the individual. 'Pre-consciously' means that the individual has never knowingly reflected upon a situation; never stopped to consider the experience presented to them. Key limitations to this concept are presented in section 7.2.

There are infinite possibilities for interpretation as 'our' situatedness determines 'our' understanding of the individual's experience (Finlay, 2006) implying that 'our' experiences, values and beliefs affect how 'we' interpret someone else's experience. Therefore, two different researchers will interpret and understand the phenomenon differently (Dean et al., 2006) as do two different qualitative approaches (van Manen, 1990); it has been considered '*impossible to be objective as the researchers' identity and stand point shape the research process and findings in a fundamental way*' (Finlay, 2006; p 19). The one interpretation presented in this thesis is underpinned by me, interactions with the participants, my colleagues and through reflective sessions with my research supervisors. The interpretations that I have placed on the participants' experiences can be seen throughout chapters 4 and 6. Individuals can consider credibility and transparency

with my findings (see also section 3.4.5). When and if, for example, two researchers disagree with the findings, a professional dialogue would provide insight to the perspectives and interpretations held by them. Rigor would be demonstrated by articulating the complexities with the interpretation, which is similar for those who consider transferability/generalizability of the findings to their own environments.

As a practising midwife and SOM, the conception of this research study came from my experiences within a previous clinical midwifery management role. Since this I have progressed to a different perspective as a midwifery lecturer. The same issues remain paramount, but I no longer 'live' them directly within frontline midwifery practice. My change in role has produced a more holistic experience. However, this is still not the experience of the newly qualified midwife hence the need to conduct this study.

3.4.2 Investigating Experience As We Live It Rather Than As We Conceptualize It

While my experiences drove me to want to investigate this phenomenon of interest, it was the lived experiences of newly qualified midwives currently experiencing the phenomenon that were required. Phenomenological research aims to re-establish contact with the original experience (Merleau-Ponty, 1962). Detailed methods for data collection were required in order to 'collect' lived experience material (van Manen, 1990; p 53), but before this could be done it was important to consider the ethical components of doing this research. This is detailed below.

3.4.2.1 Ethics

Prior to the investigation stage of the research study, permission is required and safeguards need to be in place to ensure beneficence, non-maleficence (Robson, 2002; p71) and anonymity of potential participants and institutions are maintained. Ahead of approaching people for possible involvement of this study, consultation was sought on the best ethical pathway for this study. Based on the advice given, a research proposal was submitted to the local University School's Ethics Committee. Ethical permission was obtained from the University School's Ethics Committee prior to the start of this research project (appendix 3). University ethics approval was sought for the entirety of the project

as the initial interview was conducted (DH, 2005) when the participants were students of the university; subsequent interviews were undertaken when the participants were no longer students of the university in their non-working hours.

3.4.2.2 Potential harm

With any research project there are ethical considerations. If any issues or professional disclosures of concern surfaced during the interview which contravened or breached the safety of mother and infant (NMC, 2004a) then the participant was made aware that as a SOM it can not be left un-addressed. Participants were aware of this factor prior to the commencement of the research study. If clinical issues affecting the safety of the mother and/or infant arose, then they were to be reported to the participants own SOM to address. The balance for me was doing right by protecting the public (clinical responsibility) versus maintaining anonymity for participants (research ethical responsibility). No issues of poor practise or concern arose and no SOM was contacted. If in the event of disclosure, a SOM was required to be contacted, the participant would be encouraged to do this herself. Failing this I could approach individual SOMs with concerns without the need to disclose participant involvement in the research study.

If the participant became upset during the interviews, about any aspect concerning practise or the profession, then accessing their named SOM was advised or offered to discuss the potential issues within a professional boundary. No interviews were halted due to an upset or distressed participant. SOM's are appointed via the LSA (NMC, 2004a) and not employed by NHS Trusts to perform that role. The LSA has direct links with the NMC to ensure that high standards are maintained in order to protect the public through safe and evidence-based practice (Dimond, 2006). Supervision incorporates reflective practise; by doing so it facilitates a process of debriefing and/or personal/professional development enabling the supervisee to analyse complex issues to inform future practises. All midwives who submit an ITP (chapter 1) have a named SOM. Those that have not submitted an ITP or are no longer practising as a midwife can opt to meet with any SOM as is current with any member of the general public ((LSAMO) Local Supervising Authority Midwifery Officer's Forum UK, 2008). However a SOM contact had also been identified for this purpose.

This study did not promise to benefit the participant, but the information from this study should help improve understanding of the needs of newly qualified midwives for them to be able to perform competently. They may perceive this as satisfaction from helping the next generation of students. Participants may consider aspects of the interview as a form of 'debriefing', which may be considered as a possible benefit of taking part in this study.

The participants were based at one higher educational institution (HEI) at point of recruitment where I had no responsibility for their curriculum. The HEI will not be acknowledged in any publication to maintain confidentiality for the participants. This adds to the trustworthiness of the research process in that it was anticipated that, for example, participants would not feel obliged to participate. The prospective participants could respond to the interviews in all honesty without criticising me personally. The fact that I share an insight into the participants' environment due to my experience as a practising midwife confirms that van Manen's approach to phenomenology is appropriate. I used my own experiences to enter the world of the cohort, seeking an interpretation of that experience (Lucock, 1997).

3.4.2.3 Informed consent

Consent was required from the participants. This was ongoing and could be withdrawn at any stage throughout the project. Withdrawal of consent may have led to total withdrawal of all gained information or partial information. The consent form was designed as per the National Research Ethics Service (2007), which included an explanation of ongoing consent (appendix 4). Consent for recording was obtained, as well as for the research study.

3.4.2.4 Data protection

Whilst it is usual for small sample sizes within qualitative research, there may be challenges to protect the identity of individuals within the study. Anonymity, confidentiality and data protection are utmost (Robson, 2002, NMC, 2004a); the rule of beneficence and non-maleficence (Koch and Harrington, 1998) remain paramount. So as to maintain anonymity within the human sciences research paradigm and this study, all

participants' information collected during the research is kept strictly confidential. Any information about individuals had their name and address removed so that they cannot be recognised. At no time has or will the participant's personal data be stored with the interview data. The participant's personal data was used for the sole purpose of contacting for the subsequent interviews. Participants were given the opportunity to self select a pseudonym that was not a name from the cohort. This meets the requirements of the NMC's (2008a) law in statute that anonymity and confidentiality remain paramount; along with the EU Code of Ethics (Dench et al., 2004).

All data including copies of the digital recordings are locked in a filing cabinet for the duration of the study, at the host institution, and also after the study has been conducted. These will be kept and archived for 15 years as per the Data Protection Act (DH, 1999) and management procedures and disposed of according to the protocol. It is typical practise to keep data as part of research governance (DH, 2005) to protect against charges of fraud.

The interview data was accessed by the researcher and the two research supervisors during the analysis stage of the study. The security of data remains paramount therefore it will be kept locked within the University premises. Participants' employers have not and will not be aware of individual participation within this study. While I believe that other people cannot identify the participants, it is possible that participants themselves may identify aspects within this thesis.

3.4.2.5 Sample

It was a purposeful sample, which was small and appropriate for this research design (Morgan 2004, Smith and Osborn, 2008). Smith and Osborn (2008) assert that this type of research is about obtaining detail about perceptions and understanding of a particular group of participants, not about making general claims. All pre-registration student midwives from one cohort who were at the point of registration to the 'Midwives part' of the Nursing and Midwifery Register (NMC, 2005) were approached. The proposed cohort was 15 students strong. All were female from a varying age profile and from varying ethnic, social and cultural backgrounds. All were UK students. The cohort that

was approached was the next to qualify after the start of the research study. Twelve participants were recruited to the study. The age of all 15 students at commencement of their programme varied from eighteen to forty-five; some students had young or grown up children themselves. At recruitment the participants had the potential to gain employment across the UK[13] therefore, to facilitate feasible follow up interviews, a small purposeful sample was appropriate given the constraints of time for this project. Phenomenological researchers need to remain pragmatic. The sample is defined by who is prepared to be included in it. The sample used for this research project were representative of the cohort; with more than three quarters of the group participating.

3.4.2.6 Recruitment to the project

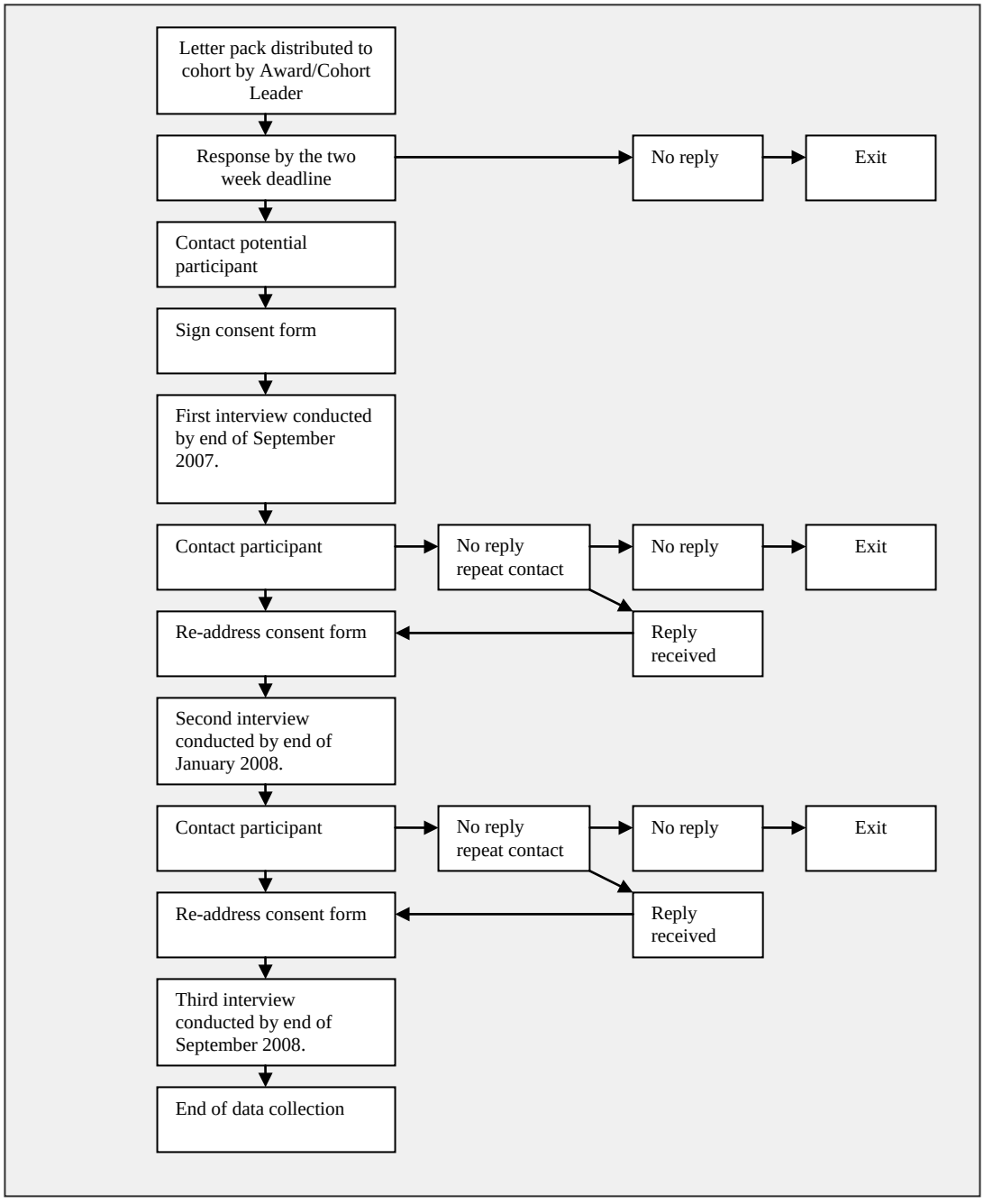
A letter was written to the Midwifery Award Leader, once ethics had been achieved, asking permission to conduct this research with the student midwives. The Award Leader was given an information letter (appendix 5) and a copy of the student information for reference (appendix 4, 6, 7, 8). After the Midwifery Award Leader had given consent the cohort tutor was asked to distribute envelopes by hand to offer information to prospective participants prior to the end of their educational programme. The envelopes contained a *'Participant Invitation Letter'* (appendix 6), '*Participant Information Sheet'* (appendix 7), a '*Participant Consent Form'* (appendix 4) and a '*Participant Contact Details Card*' (appendix 8). Recruitment was indirect, mediated by the cohort tutor as protection for the participants; by doing so it was anticipated that the students did not feel they had to say yes. However, both the Midwifery Award Leader and cohort tutor are in positions of authority for students, which could influence participant recruitment.

If the student agreed to participate in the research project (s)he was asked to complete the participant contact detail card and consent form and return them in a sealed envelope to either the cohort tutor or post them to the researcher. The cohort tutor may have known who was in the study if they handed sealed envelopes to her in person however; all of the participants responded to me directly so the cohort tutor had no knowledge of who had

[13] I have contacted the NHS Workforce Review Team and the regional educational team asking how many student midwives are recruited across the UK this last financial year and the corresponding data relating to first post. I have been informed that this data is not collected.

provisionally agreed to take part. The students had my contact details if they required further information prior to consenting to the study. The students were also able to return the participant contact card if they required contact prior to agreeing to take part in the study (appendix 8). Once the student had made contact, an appointment was arranged to ensure full understanding of the study and to ensure the consent form had been completed prior to undertaking the first interview (see figure 3.1).

Figure 3.1: Flow diagram of recruitment process



The recruitment process commenced on 1st September 2007. Students had two weeks to decide whether they wished to join the study. If no contact had been made by individual students after this time it was assumed that they did not wish to take part in the research study.

There was the potential that participants would not respond to any correspondence for follow up interviews. I sent the first letter inviting them to the interview four weeks in advance. Then if no contact had been made, a second letter was sent two weeks prior to the interview time. If no contact had been made by the time the interview was due to be scheduled a final letter was sent to the participant. If there was no response after this contact, it was assumed that the participant no longer wished to take part in the research study. All twelve participants responded after the first or second request. Twelve participants commenced the initial interviews and all returned for the second and third interviews.

3.4.2.7 Interview location

It was envisaged that the initial interview would take place within the University campus, whilst the participant was a student. The two follow up interviews did not infringe upon the participants' employment or employer and hence took place outside their place of employment. The benefit of this to the participant is that it ensured that anonymity and confidentiality were maintained and that it aimed for participants to feel safe enough to be open and honest with their responses. The place of the interviews was negotiated with the participant near the time of the planned interviews and the lone working policy (appendix 9) was implemented accordingly by the researcher for her protection.

Historically, students consolidate their training within one of five local NHS Trusts. This was the case for 11 participants who agreed to meet at their midwifery training school. In fact, the participant employed away from the region requested to return to her midwifery educational institution.

3.4.2.8 Interview process

3.4.2.8.1 Data collection

Prompt statements were devised before doing an interview for each set of interviews (Kvale, 2007). They set out a structure to ensure the same format was used for each participant. The initial prompts were to remind me to check consent forms, contact details and consent for digitally recording the semi-structured interview. The session prompts acted as a '*gentle nudge*' (Smith and Osborn, 2008; p 61) from the interviewer. The first prompt was used to open the conversation i.e. '*tell me what you expect being a qualified practising midwife will be like'* (first interview) and '*tell me about the realities of working as a practising qualified midwife*' (second and third interviews). The semi-structured interview then developed from comments made by each participant (Kvale, 2007). Participants were given time to talk freely to expose their experiences and feelings with me asking questions to elicit further meaning and understanding as to what had been articulated. In accordance with Kvale (2007), all interview sessions ended (after recapping on main points raised) with me asking if the participant had anything else they wanted to say and when they said no, the interview was clearly ended with '*well, thank you very much'*.

After the full consenting process (appendix 4), the first participant's initial interview was conducted to check understanding of prompt statements (appendix 10) and for the interviewer to gain confidence in the interview technique (Brett-Davies, 2007). The transcription from this 'pilot' interview is included in the final analysis (van Manen, 2002). To some extent all the semi-structured interviews act as a 'pilot' in their own right, by the nature of them being individual in structure.

Data collection was via three digitally recorded conversations conducted with each participant. Each interview lasted approximately 30 to 60 minutes and was digitally recorded in order for accurate transcriptions to be made after the event for analysis. Where possible the interviews were conducted face-to-face. In the event that face-to-face interviews were not feasible, due to place of participant employment e.g. outside of

reasonable travelling distance telephone interviews were conducted (Gabbay and le May, 2004). It is acknowledged that this approach to data collection was less than ideal for phenomenological studies as facial expressions and nuances could not be observed via this mode of communication. However, digitally recorded telephone conversations highlighted the subtle changes in tone of voice, pauses between words etc which adds to the richness of the data. Two of the interviews were conducted via the telephone. This is considered further in the reflexivity section (section 6.4).

Data provided from all three interview sets were denoted by the pseudonyms chosen by the participants. The numbers '1', '2' or '3' were recorded to denote the first, second or third interview sets (for example, Sarah 1; Sarah 2; Sarah 3). This was to ensure confidentiality was maintained throughout the research process and whilst discussing the findings with my research supervisors. Although I could recall the participant speaking the words as I typed them and read the transcripts through, I was able to be reassured that the outside world could not identify the real person by the pseudonym.

3.4.2.8.2 Equipment

A digital voice recorder was used for recording the conversations. The quality and working order of the digital recorder was checked prior to the interviews. Spare batteries were in supply for each interview. Prior to each interview a test of the recording device was undertaken to ensure working order and quality of the recording was satisfactory. Data were transferred from the hand held digital recording device to recordable compact discs immediately after the interview had concluded. Back up audio CDs were made to ensure that data could not be lost to broken or faulty materials.

3.4.3 Study Timeline and Interview Schedule

Figure 3.2 depicts the timeline of the research study.

Figure 3.2: Timeline

Recruitment Phase	Interview cohort of student midwives (participants) at point of registration	Follow up interview of participants four months post registration	Final interview Iterative design to reflect upon first interview
1st September 2007	September 2007	January 2008	September 2008

The rationale for the timescales is as follows:

i. Point of registration – the students had experiences of being a student and had no experience of practising as a qualified midwife. This enabled participants to articulate their expectations of life as a practising newly qualified midwife.

ii. Four months post registration – anecdotally, newly qualified midwives appear to experience a wide range of emotions within the first six months of qualification. Four months was chosen as this was a perceived time where the newly qualified midwife has greatest transitional factors. This point of time was chosen to capitalise on this.

iii. Twelve months – a period of consolidation had occurred. It was anticipated by me that the participants had 'passed through' the wide range of emotions linked to being newly qualified. It was anticipated that the experience gained through the first twelve months had led to confidence and competence in their role as a practising midwife.

3.4.4 Reflecting On the Essential Themes Which Characterize the Phenomenon

van Manen (1990; p 32) asserts that a '*true reflection on lived experience is a thoughtful reflective grasping of what it is that renders this or that particular experience its special significance*'. The purpose is to provide an interpretation of an individuals' pre-conscious reflection on an experience to bring to '*nearness that which tends to be obscure*'. This is

achieved through techniques for 'surfacing' the data and through analysis of the data collected by gathering perceptions from the text in terms of themes that are recurring ideas (see chapter 4) , thoughts and feelings (van Manen, 1990). This is considered in greater depth in chapter 4 and not within this chapter.

3.4.5 Describing the Phenomenon through the Art of Writing and Rewriting.

van Manen (1990; p111) states that '*human science research is a form of writing'*. A phenomenological enquiry has to be appreciated for the fact that writing is never perfect, nor is the interpretation ever complete or final (van Manen, 2002, Wolcott, 2009). The interpretation for the purpose of this project is mine and all responsibility for the interpretation rests with me. It is imperative that the actual words used to explicate meaning in the written format are in sync with those spoken by individuals that live in the world being described. The art of writing and re-writing is to bring to the forefront that which is taken for granted; to make explicit the tacit (Bukowitz and Williams, 2000; p 4). Tacit knowledge traces back to Aristotle (Eikeland, 2001); Polanyi (1962) describes it as a type of personal know-how that forms the foundations of cognitive action. van Manen (2002) lists the art of writing as seeking, entering, traversing, drawing, gazing and touching. To seek is to want to find meaning; by entering the space of the text one identifies what language really is. The words draw 'us' in as they seize the meaning of the world. The writer tries to bring things to presence through traversing by gazing into the experience through the art of writing hence striving to make the essence clear. Constructing a phenomenological text brings 'us' in touch with that phenomenological observation. However to gain credibility for this research approach one must ensure trustworthiness.

Guba and Lincoln (1981) and Lincoln and Guba's (1985) seminal works considered terminologies used for rigor in quantitative research and substituted them with more appropriate concepts befitting to qualitative research. Trustworthiness consisted of credibility, transferability, dependability and confirmability. Their 'guide' to authenticating trustworthiness considered aspects such as audit trails, member checking,

confirming results with participants, peer debriefing , negative case analysis, structural corroboration and referential material adequacy[14] (Lincoln and Guba, 1985, Trochim, 2006, Morse et al., 2002, Merrick, 1999, Onwuegbuzie and Leech, 2007, Hoepfl, 1997, Cohen and Crabtree, 2006, Eisner, 1991). At first it appeared that member checking the study findings would not be wholly appropriate to my project. It appeared to be futile as the analysis processes deconstruct the individuals' experience. As Morse (1998), Sandelowski (1993) and more latterly Morse et al (2002) highlight, the study results have been synthesized, decontextualised and abstracted from individual participants therefore they are unlikely to recognise themselves or their experiences. Equally participants will have 'moved on' from the experience. After careful consideration of this point, a variation of member checking was carried out to add to trustworthiness and is discussed further in 4.3.1. Sandelowski (1986) based her criteria on that of Guba and Lincoln (1981) therefore the trustworthiness is presented below using Guba and Lincoln's (1981) criteria headings of credibility, transferability, dependability and confirmability.

3.4.5.1 Credibility

Credibility of the research findings is achieved when themes are recognised by another person on reading. Data were captured from one source: semi-structured interviews at three points in time spanning twelve months. These were digitally recorded and transcribed prior to analysis. There are issues related to the recording quality of interview which have been apparent from the poor acoustics during the two telephone interviews. In an attempt to minimise this risk for all interviews, I chose a quiet and private location to conduct the interviews (appendix 11).

[14] Audit trails or inquiry audits are where reviewers examine both the process and the product of the research for consistency (Lincoln and Guba, 1985; p317). Member checking/confirming results with participants is a process of asking participants to corroborate the findings (Hoepfl, 1997). Merrick (1999) describes peer debriefing as engaging with others to discuss what has been found via the research process. Negative case analysis '*involves searching for and discussing elements of data that do not support or appear to contradict patterns/explanations emerging from data analysis'* (Cohen and Crabtree, 2006). Structural corroboration, according to Eisner (1991; p55) is also referred to as triangulation, where consideration is given to what sources have been used to give credibility with the evidence presented. Finally referential material adequacy concerns with assessing truth value (Onwuegbuzie and Leech, 2007).

The phenomenological themes emerged from the experiences given from the participants of the study. Whilst my interpretations of their experiences of living through being a newly qualified midwife may be different to that intended by the participants, by checking and returning themes and transcripts after the analysis process a form of respondent validation/member checking was undertaken (see section 4.3.1). No participant disagreed with or made comment on either the themes or transcripts. This project contains much in the way of data to demonstrate how themes emerged. This can be located in chapter 4 of this thesis.

3.4.5.2 Transferability

Phenomenological research aims to provide an account of an individuals' experience. While this remains pivotal, the findings from the cohort as a whole need to make sense to others outside of the study arena. Interpretive phenomenological research studies do not claim to be generalizable to the wider population (van Manen, 2002) which includes this study. There is potential for transferability of the findings to other similar contexts, but this is something that readers of this research have to judge in relation to their own situations. Section 4.1 provides the context of the participants' experiences. Phenomenological research is concerned with the experiences of a group of individuals at a given moment in time and it is acknowledged that this would be different for others in a similar position.

3.4.5.3 Dependability

In order to determine dependability, readers need to be presented with a documented audit trail so they can judge whether all methods and decisions are transparent. It concerns the decision-making process and can be likened to an audit process (Morse et al., 2002, Yardley, 2008). The decision trail has been demonstrated throughout this thesis. Chapters three and four in this thesis present a step by step approach to this study's development and analysis. Through this, it is anticipated that readers could not only understand why decisions were taken but also replicate the study.

Respondent validation/member checking for this is discussed in section 4.3.1. The researcher for this project was only one person therefore, to ensure trustworthiness, back

up readers were identified to check transcripts and analyses fully. These were my two researcher's supervisors. Appendix 12 outlines the decision trail for this project cross referencing it to the appropriate aspects of the thesis.

3.4.5.4 Confirmability

Phenomenology is subjective in nature; theme identification and clustering of 'units of meaning' from the data has come from the researcher. The process by which I have undertaken to move from the data to interpretation is articulated within chapter four, where examples of the actual process of analysis can be viewed. Examples from the 'real' data are used where appropriate to demonstrate transparency within chapter 5. Whilst space is limited within a thesis such as this, 'clean' copies of the transcripts of data and original recordings are stored for the obligatory fifteen years in case of discrepancy and examination.

An important aspect for consideration is the use of a reflexive journal for identifying any presuppositions. This was something that I had not considered in great depth at the start of the project due to my lack of appreciation of its value at that time, but have since re-evaluated its usefulness and it has been in use mainly for recollecting analysis of each stage of the project. It has been used, for example, to consider the decision trail in appendix 12.

3.4.6 Completing Van Manen's (1990) Methodological Structure

The last two headings of van Manen's (1990) methodological structure that complete the human science structure are: '*maintaining a strong and oriented [pedagogical] relation to the phenomenon*' and '*balancing the research context by considering parts and whole*'. The first is concerned with the findings and discussion of the findings from the analysis whilst the final statement returns the findings back to clinical practice. Both can be located in chapters 5 and 6.

3.5 Synopsis of Chapter

The research approach and design have been outlined within this chapter. van Manen's (1990) methodological structure has been justified and utilised to support this interpretive phenomenological investigation into ascertaining the lived experiences of newly qualified midwives during the first twelve months post registration. The sample selection and data collection have been explicated along with the ethical considerations for the study. Finally trustworthiness has been considered in light of Guba and Lincoln's (1981) seminal work.

Chapter 4: Process of Analysis and Audit Trail

4.0 Introduction

This chapter presents the audit trail of the analysis process leading to the findings from three sets of in-depth interviews with twelve participants who have experienced 'being' a newly qualified midwife. The first set of twelve interviews was conducted between September and October 2007, the second set between January and February 2008 and the third set between September and October 2008. Figures and tables have been included to guide the reader through the process of analysis and audit trail.

4.1 Biographical Details of the Twelve Participants

4.1.1 First Interview: Point Of Registration

The twelve participants had passed all academic and clinical components of the pre-registration Bachelor of Midwifery (Hons) programme. An understanding of their midwifery programme was gained from the Midwifery Award Leader. The curriculum undertaken by the participants was influenced by Fraser et al's work on assessing clinical competence (Fraser et al., 1997, Worth-Butler et al., 1996, Fraser, 2000c) and transition, especially the ENB report into the preparation of effective midwives (Fraser et al., 1998). The programme consisted of three years (156 weeks) academic (50%) and clinically based (50%) learning. Areas of clinical exposure included: low risk (normal), integrated team midwifery, where antenatal, intrapartum and postpartum care provision were undertaken in both community and hospital settings; case-load held midwifery teams (see section 1.3.3); high risk antenatal, intrapartum and postpartum care provision within a busy regional maternity unit, which included theatre and recovery, induction of labour and high dependency day care, neonatal unit experiences; a brief gynaecology ward placement to gather basic nursing skills; and management experience within low risk birthing centres. The academic path followed low risk midwifery (normality) in the first year, high risk midwifery in the second year and management experience combining both high and low risk settings (with a view to consolidating experiences) in the third year.

What is important is the impact that this curriculum had on these participants once they had completed their training.

Participants had applied for entry to the professional register and none had commenced their first job prior to the first interview. Nine participants had midwifery positions offered to them and were waiting to commence their first post. Three were waiting for interviews, as they chose to wait until nearer the end of their course before applying for their first post. One of these participants planned to not work in the NHS Trust that she had trained in for personal reasons and was waiting for an interview in her chosen place of employment. All the participants were female. Of the twelve participants, four had families and because of this had planned to work part-time hours. Those with no commitments outside of the workplace such as children or childcare, partners or other family commitments etc, planned to work full-time hours, but were predominantly offered less than full-time hours with the awareness that these hours could be increased with extra hours paid through an internal 'bank' system (midwifery definitions). Table 4.1 highlights the ages of the participants at the first interview and provides insight into their work and educational experiences prior to the onset of their midwifery training. This information provides insight into each participant's background to help understand their experiences.

Table 4.1: Participants' age, previous work and education experiences

Pseudonym of participant	Age at First Interview	Work experience prior to midwifery training	Previous educational experience prior to midwifery training
Alicia	23 years	Part-time jobs as receptionist and carer	Geography degree
Ashleigh	33 years	Maternity Care Assistant at a birth centre	Access course
Claire	38 years	Occupational therapist assistant (13 years)	Access course
Edith	25 years	Lab technician in an HIV research lab	BSc Biomedical Science
Jade	25 years	Marketing work and graphic designer	English degree
Martha	27 years	Lifeguard/swimming coach, exercising and breaking ponies, waitress/barmaid, cashier, animal care assistant and worked in a day nursery with babies	Biology degree
Naomi	22 years	College work	Pre degree diploma
Sally	38 years	Mortgage advisor and bank care assistant	College undertook Maths and English GCSE and Access course
Sam	26 years	Dental nurse	Dental nurse training and BTEC national diploma
Sarah	25 years	Part-time in a clothes store	Studied social psychology at University so had A Levels
Valerie	35 years	Food production	Access course
Vivienne	22years	Worked in vet practice for 10 years	A levels

4.1.2 Second Interview: Four Months Post Registration

The participant Edith, who had purposefully declined to work in the place she had trained, resigned from her first post after four weeks of work. She had not decided whether she wanted to continue to be a midwife, but had applied to undertake employment outside of the health care arena to allow time and space to consider her options. The participant Valerie had still not commenced her first post by this point of time as the initial job offer was rescinded prior to commencement. She was waiting to commence her first post, as a hospital midwife, in a neighbouring NHS Trust which was due to start the following week. Jade was experiencing personal doubts as to whether she wanted to remain practising as a midwife. The rest of the participants had commenced and continued to work within their first post as newly qualified midwives.

4.1.3 Third Interview: Twelve Months Post Registration

The participant, Edith, who resigned from her first post after four weeks had re-commenced working as a midwife, however this was in a different unit to the last post and to the place she had trained. Jade, who was experiencing personal doubts about her career choice resigned from her first post with the intention of never practising midwifery in the future. Valerie, who had not commenced her first post by the second interview, had commenced her post within the neighbouring NHS Trust. The remainder of the participants continued to work in their first posts.

In Summary, table 4.2 provides an overview of the participant job status and/or type of role undertaken at the time of each interview.

Table 4.2: Summary of participant job status and/or role at time of interview

Pseudonym of participant	Interview 1	Interview 2	Interview 3	Amount of time in practice
Alicia	Waiting for interview	Case-loading team	Remained in first post	1.0 WTE for 10.5 months
Ashleigh	Awaiting first post	Integrated team	Remained in first post	0.8 WTE for 11.5 months
Claire	Awaiting first post	Integrated team	Remained in first post	0.8 WTE for 11.5 months
Edith	Awaiting first post	Hospital midwife (4 weeks) left post prior to interview	Commenced second post at different maternity unit	1.0 WTE for a total of 4 months
Jade	Waiting for interview	Integrated team	Left midwifery profession	0.8 WTE for 6 months
Martha	Awaiting first post	Integrated team	Remained in first post	0.8 WTE for 11.5 months
Naomi	Awaiting first post	Case-loading team	Remained in first post	0.8 WTE for 11.5 months
Sally	Awaiting first post	Integrated team	Remained in first post	0.6 WTE for 11.5 months
Sam	Awaiting first post	Hospital team midwife	Remained in first post	0.8 WTE for 11.5 months
Sarah	Waiting for interview	Integrated team	Remained in first post	0.8 WTE for 11.5 months
Valerie	Awaiting first post	Waiting for first post	Hospital midwife delivery suite	1.0 WTE for 7.5 months
Vivienne	Awaiting first post	Case-loading team	Remained in first post	1.0 WTE for 11.5 months

4.2 Justification and Process of Analysis

This section within the process of analysis considers the third statement from van Manen's (1990; p30) methodological structure of human science research which is '*reflecting on the essential themes which characterize the phenomenon*'. The purpose of undertaking a process of analysis is as van Manen (1990; p 41) asserts, to recognize '*description as a possible experience which means as a possible interpretation of that experience*'. This means that the researcher provides a 'unit of meaning' for a possible interpretation of the lived experience. As both van Manen (1990) and Dean et al (2006) explain, to do analysis is to reflectively analyze and describe the thematic structure of the experience.

Phenomenological interviews demonstrate an iterative and inductive (Smith, 2007) approach to elicit meaning from the lived experience of an individual within a given situation. By doing so it generates great amounts of data in the participants' own words that is rich in experiential detail. As with much qualitative data (Smith et al., 2009a) and my data collection, these data were unstructured therefore, a structure was required to make sense of it all. van Manen (1990) provides a guide to analysis, but this presents as an unstructured framework to guide the process of reflecting on essential themes (table 4.3). As a novice researcher this was not explicit enough to be of great benefit and so greater consideration was given to alternative processes to use in conjunction with van Manen (1990).

Table 4.3: van Manen's (1990) guide to analysis and how it has been interpreted for this study

van Manen's (1990) guide to analysis	Meaning to each 'guide to analysis'	Interpretation of the 'guide to analysis' for this study
1. The holistic or sententious approach	Attend to the text as a whole	Consider the whole interview as one piece to elicit general themes.
2. The selective or highlighting approach	Listen to or read a text several times	'Hear' and 'see' the words to elicit key phrases from each interview
3. The detailed or line by line approach	Look at every single sentence or sentence cluster	Consider every sentence separately and ask what it 'really' means

A modified version of Colaizzi's (1978) (appendix 13.1) framework, Streubert's (1991) ten step methodology (appendix 13.2) and Hycner's (1985) 15 stage guidelines (appendix 13.3) were considered to provide a detailed framework for the phenomenological analysis of interview data; to aid the process of reflection on essential themes. However, after careful consideration not all aspects of the frameworks were applicable and hence these frameworks were not used. Streubert (1991) and Hycner (1985) consider 'bracketing' within the initial stages of the analysis process and validating the descriptions with each participant prior to devising final themes. As stated previously, I had decided that 'bracketing' and participant validation at each stage would be inappropriate for this study.

Colaizzi's (1978) modified framework considers description as a fundamental aspect, whilst this is the case for the analysis in this study, I have placed more emphasis of interpretation on the description. This phenomenological study requires participants to impart their 'lived-experience' which was done from a pre-conscious perspective (van Manen, 1990), meaning they have not already interpreted the experience.

Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009a) was developed with psychology in mind and considers three basic elements; '*phenomenology, double hermeneutics and idiography*' (Smith et al., 2009a; p11). Smith et al (2009a) ascertain that the phenomenological roots lay with both Husserlian and Heideggarian theories. The two theories 'should' not be seen as separate entities, but be combined to fully embrace phenomenological concepts. Therefore, Husserl's need to be reflective, hence using 'bracketing', has proven essential as has Heidegger's 'Dasein' ('there being' or 'being-in-the-world') (Heidegger, 1962). Thus on considering both van Manen and Smith et al, Smith et al appear to 'push' van Manen's work to 'the next level' making it appropriate for 'thinking' and 'application' in the modern day. For example, van Manen's (1990) hermeneutic phenomenology roots are based in an educational philosophical perspective i.e. the theoretical perspective, whereas Smith et al's psychological IPA perspective concerns itself with how the philosophical 'really' affects people. Whilst my research study has a basis within philosophy, actually it is the psychological that is also of interest and that is expressed by individuals.

The hermeneutics considered within IPA has a 'double' perspective and hence is referred to as 'double hermeneutics'. Here the researcher is attempting to make sense of the participant trying to make sense of their experience. Idiography is concerned with wanting to know what it is really like for an individual to experience something and what sense they are making from it (Smith et al., 2009a).

Whilst van Manen (1990) does not articulate his hermeneutic phenomenology quite as eloquently as Smith et al, there are many features and principles within IPA that I believe can be considered concordantly within the analytical process of this research project. On

closer examination of Thorne et al (2004), Smith et al (2009a) and Smith and Osborn's (2008) IPA and from critically evaluating published work by Fade (2004), Seamark et al (2004) and Hunter (2008) that used this approach for analysis, a modified version was used for this project. The detailed logical approach to undertaking data analysis appealed to me which paradoxically sits with the fact that Smith et al (2009a) stress that there is no right or wrong way of conducting this sort of analysis. It may be that for the more experienced researcher a less linear approach to analysis is adopted, which is iterated by Smith et al (2009a). By this they infer that although the process is written from a linear perspective within their texts and within novice's theses, the actual processes occur simultaneously (Wolcott, 2009; p 105) and do not manifest in a linear format (showing the 'messiness of reality' (Offredy, 1998, Mok and Stevens, 2005)) which is more appropriate for the phenomenological approach to research. However, this higher level thinking is probably gained by intense and frequent experiences and exposures to phenomenological research projects, which may come, for me, postdoctorally.

Box 4.1 provides a brief overview of the strategies used within IPA taken from the work of Smith et al (2009a) which also demonstrates the '*moving from the particular* [the individual's experience] *to the shared* [and] *moving from the descriptive to the interpretive'* (Smith et al., 2009a; p79). Diagrammatic representations of each of these stages/processes in relation to this study are presented in appendix 14.

Box 4.1: Overview of the strategies used within IPA taken from Smith et al (2009a; p 79-80).

a. Line by line analysis of the experiential claims, concerns and understandings of each participant
b. Identify emergent patterns – emphasising convergence and divergence, commonality and nuance
c. Development of a dialogue between researchers and what it might mean for the participants = more interpretive account
d. Development of relationships between themes
e. Organisation of this material to allow for analysis
f. The use of supervision, collaboration or audit to aid testing and development of the interpretation
g. The development of narrative usually theme by theme, evidenced with commentary and visual guides
h. Reflection on one's own perceptions, conceptions and processes

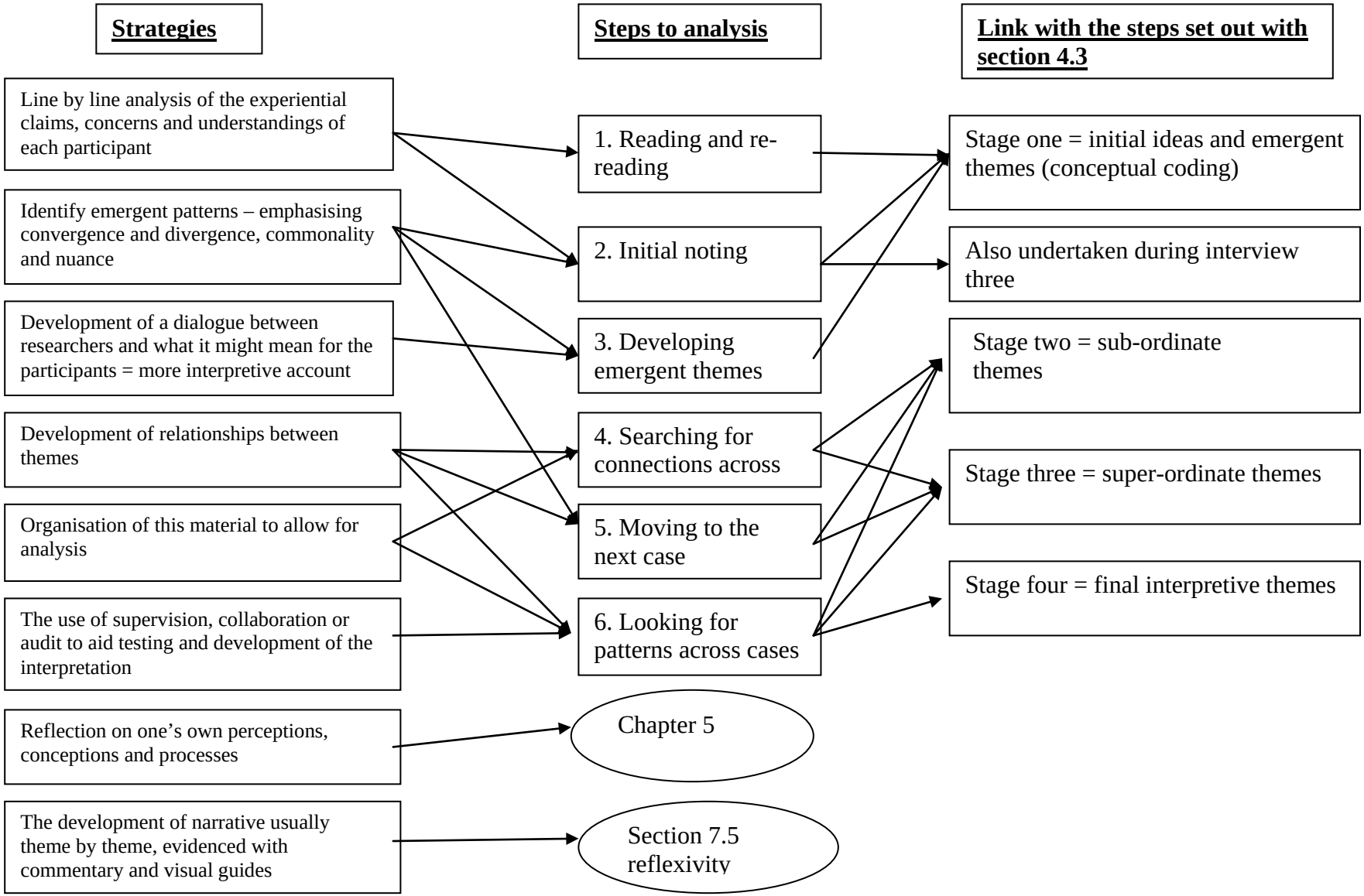
4.3 Audit Trail

This section of the chapter outlines the audit trail of the analysis process. Each of the stages of the analysis is described below along with the rationale for the stages. Processes and terminologies used for the stages have arisen and been adapted from the works of van Manen (1990), Smith et al (2009a) Walliman (2001), Bryman and Burgess (1994), Dean et al (2006) Brett-Davis (2007) and Wilkinson (2008). van Manen (1990) debates the terminology of 'theme' as a means to an end to arrive at the notion of the focus of investigation. It is a term used to provide order to research and writing. This is the case for this project where, as the novice researcher, structure and guidance are preferable for comprehension and writing. For this purpose the term 'theme' is used throughout the analysis process and the thesis to '*allude to or hint at an aspect of the phenomenon'* (van Manen, 1990; p92) being investigated.

As discussed in section 4.2, the analysis process for this research project incorporates aspects from the principles of IPA (Smith et al., 2009a) to expand upon statement three of

van Manen's (1990) methodological structure of human science research. Figure 4.1 has been devised in order to aid the reader with the terminologies (taken from Smith et al (2009a)) I have implemented throughout this chapter in order to achieve the analysis process. This figure highlights the relationship between the strategies (Smith et al., 2009a; p 79-80) and 'steps to analysis' within the IPA process along with how they have been implemented. The strategies do not portray a linear approach; they move throughout the steps within the IPA process. The 'steps to analysis' produce various types of themes which Smith et al (2009a) discuss and can be seen under the third column within the figure.

Figure 4.1: Relationship of IPA strategies (Smith et al., 2009a) with steps to analysis within the IPA process linked with steps set out in section 4.3



4.3.1 Stage One – Initial Ideas and Emergent Themes

Step one of Smith et al's (2009a) process involves '*reading and re-reading*' (2009a; p82) to become fully immersed within the data and to begin to provide a descriptive account of the world which the participant inhabits. To gain familiarity with the content of each interview I transcribed all the digital recordings myself, immediately after each of the conversations. A constant reflection by returning to the original recordings and transcriptions occurred thus allowing me to be immersed in the narrative data by reading and re-reading the transcriptions as well as listening to the digital recordings. This process was undertaken with each transcript separately in order to obtain a sense of the whole interview and to ensure that the participant of each separate interview remained the focus of that analysis (Smith et al., 2009a). During the first and second interview transcriptions, descriptive '*initial ideas'* were recorded on 'post-it' notes and attached to the front page of each printed transcript. '*Initial ideas'* were the initial thoughts, ideas and statements that became highly visible during the transcribing, reading and re-reading stages. These were kept and discussed with participants; checking for quality, after 'interview three' had been completed.

During the third set of twelve interviews, '*initial ideas'* were hand written and recorded during the semi-structured interviews (they were also checked against the transcripts for accuracy once typed). This was because I decided to undertake participant validation of the '*initial ideas'* after the third set of interviews and also I became more confident in the ability to listen and do this. The risk of doing this is '*listening* [but not] *hearing'* (Covey, 1992; p240) what participants are saying. Also it may be off putting for participants if someone is writing and appearing not to be taking notice of what has been said. I was conscious of this prior to the onset of each 'interview three' so participants were made aware that this would be happening and why prior to the start of the third and final interview. All participants consented to this occurring during the interview.

Member checking of interview transcripts between interviews was not undertaken as, by the time transcription and analysis had taken place by the researcher, the participants had

moved on in their 'lived-experience' journey. Their interpretations of their experience will or may have changed from the time of the semi-structured interview (Koch and Harrington, 1998). Participants may have in this case changed their minds about what they were saying and/or alter what they actually meant by their comments. This may have impacted on subsequent interviews and I did not want them to reminisce heavily on the previous interview during the current interview because of this. This would have an influence on the study, leading to potential bias and skewing of the data interpretation. I took the written '*initial ideas'* from the previous interviews with me. These were not on view to me or the participant during the interview however, after the third interview had been completed I read out the '*initial ideas*' highlighted from the participant's own separate set of three interviews (Walliman, 2001). This was to ascertain if they represented a true reflection of the individual journey each participant had undertaken. Although at this point each participant would have 'moved on' in their experiences, it was felt that once the year's journey had been completed, the progression of their experiences could be seen through the '*initial ideas'*. All participants agreed with the '*initial ideas'* from each of their individual interviews. However, they were not provided with the transcripts at this stage to refer to only their recollections of their interviews. The danger with this was that they would not have remembered what they had said at that time. The purpose was not to compare their transcripts with their interpretation of what was said, but to ascertain if my primary interpretation of their experiences was realistic to them; to establish if they could see themselves and reality in my interpretation of their experiences. Kvale (2007) asserts that this process confirms the researcher's understanding of what participants had said.

Once all three sets of twelve transcribed interviews were completed, I then replayed the recordings and re-read the text at the same time as highlighting the key phrases and interesting issues raised (Walliman, 2001) within the transcribed text using a highlighter pen. Immediately after this, the phrases were allocated an interpretive '*emergent theme*; in this case a word or two to signify a meaning of the phrase highlighted. Smith et al (2009a; p88) refer to this as '*conceptual coding'*; the process of providing an overarching statement to summarise what the participant has explicated. Hermeneutic theorists refer

to the consideration of '*the parts and the whole'* (van Manen's (1990) sixth statement) as the hermeneutic circle (Smith et al., 2009a, Moustakas, 1994). Throughout the process of hermeneutic interpretation, there is a constant 'spiral' between both whole and parts of a text as understanding of the one assumes understanding of the other (Smith et al., 2009a). The concept of the hermeneutic circle works at many levels such as a single word (the part) and the whole sentence (the whole), the interview (the part) and the research project (the whole) (Smith et al., 2009a). van Manen (1990) considers this from the perspective of for example, the part being the research project and the whole relates to implications to practice. This is in keeping with Heidegger's (1962) image of the 'whole' being in terms of a reality that is situated in the detailed experiences of everyday existence by an individual; that of which is the 'part'. This is a process of delineating meaning in its 'raw' context and clustering the units or codes of relevant meaning (Giorgi and Giorgi, 2008). It could be considered that this moves the interpretation away from what the participants have expressed directly, but because the interpretation has been derived directly from the participant's experience it remains as true an interpretation as possible to the lived-experiences had by the participant. These '*emergent themes*' were checked against the '*initial ideas'* on the 'post-it' notes to ensure commonality. The '*emergent themes'* were recorded in pen on the right hand column on the transcribed scripts (figure 4.2). Both '*initial ideas'* and '*emergent themes'* correspond to van Manen's (1990) guide to analysis (table 4.3) (with the initial ideas corresponding to the first stage and emergent themes with stages two and three).

Figure 4.2: An example of the conception of an emergent theme

Claire Interview 3		(Initial idea) emergent theme
I:	you've also said you need the supportive people around you and [C: mmm] that was same at home and in work [C: uh mmm] talk a bit more about the support you've received in the unit [C: ok] from your team members	(Need support) preceptorship
C:	ok well obviously my, my sort of um senior midwives um she's you know she's been very available to me to contact her in certain situations particularly the more community setting for er advice also have used you know a lot and awful lot um so that's been very useful to have someone to go to, to er you know to fire questions at um on the ward situation you know there's always who ever the shift leader is if you're somewhere like [*said name of ward*] you know there's always er somebody to go to for advice talk about care of the woman or what's happening but as it I've found everyone a-a-approachable and obviously there are times when its especially on labour ward if its very busy you know you are a little bit more conservative than perhaps [laugh] some of the times you might be going to ask the coordinator for something or you'd think another midwife more senior to ask you know or something um but I you know I er I have I've always had positive responses from people um and it is important it is very important to have that otherwise you would tend to feel quite cut off and you know well but I um isolated I suppose if you didn't	
I:	so you had the preceptorship programme	
C:	Yes I did well I did yeah and that was um it was quite useful in the first session or two that I attended I think I did go to two in the end because it just um see how the equipment er they were teaching moves and things er yeah it was useful to see and find other people going through similar sort of experiences yeah that was good um and I think some of the issues that we've probably raised are you know I can see are going are being addressed or in the process of being addressed so	

This stage links to step two of the IPA process and is referred to as '*initial noting*' (Smith et al., 2009a; p83). Step three of the IPA process (Smith et al., 2009a; p91) concerns '*mapping interrelationships, connections and patterns between exploratory notes*' in order to develop '*emergent themes'* and has been weaved concurrently throughout my stage two. Smith et al (2009a) infer that there are no rules as to how or what is to be commented upon and that there is nothing to say that a text has to be divided up or

decontextualised in any way or that comments need be assigned to 'meaning units'. They do state that the importance is placed upon the researcher being in a process of engaging with the transcript as much as with the outcome of doing so. By immersing oneself in this way there is '*likely to be a descriptive core of comments* [which] *stay close to participant's explicit meaning*' (Smith et al., 2009a; p83). Smith et al (2009a) also postulate that there is an element of personal reflection during the development of the '*emergent themes'*. The phenomenological interpretation draws upon my experiences and my professional knowledge which can not be removed from my analytical process, but can and must be acknowledged and are therefore considered within the reflexivity section of this thesis (section 6.4).

Once steps two and three of the IPA process were completed for all three sets of twelve transcripts, the '*emergent themes* from all transcripts were recorded in an excel spread sheet to show comprehensive process (appendix 15), in alphabetical order, with the three interviews per participant in columns next to this (figure 4.3). These collective '*emergent themes'* could then be cross examined to show commonalities, dissonance etc. Two hundred and sixty three '*emergent themes'* were recorded in all. Ticks were used to identify if the participant had this theme highlighted in the interview one, two or three.

Figure 4.3: Example of how emergent themes have been presented per participant.

Claire **Collective emergent themes**	Interview 1	Interview 2	Interview 3
Practise defensively			√
Preceptorship/supernumery		√	√
Preparation	√		

The purpose of this was so that comparisons could be made across the year's journey for each participant singly. Once this had been completed for all the participants individually, findings from all participants were added together on one excel spread sheet (figure 4.4).

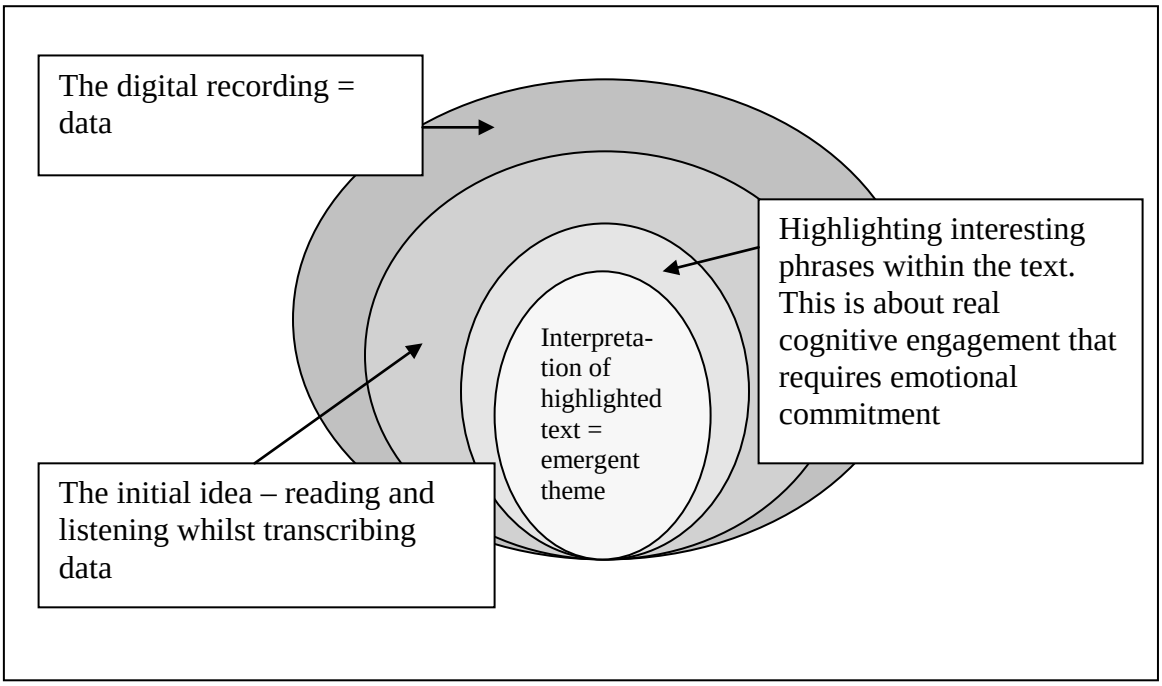
Figure 4.4: An example of all three interview findings compared with other participants

Collective emergent themes	Alicia			Ashleigh			Claire		
	Interview 1	Interview 2	Interview 3	Interview 1	Interview 2	Interview 3	Interview 1	Interview 2	Interview 3
Practice defensively									√
Preceptorship/Supernumery		√	√		√			√	√
Preparation				√			√		

This enabled cross comparisons not only between an individual's journey throughout the first twelve months after registration, but also the findings could be compared to the other participants' journeys simultaneously to see commonality and outliers.

The process outlined in stage one confirms the analogy of peeling an onion (van Manen, 1990) where the different layers of the onion refer to the layering of the analysis stages outlined below (figure 4.5); in this case, to get to the real essence of the experience newly qualified midwives had during the first twelve months after registration. Shaw (undated) explicates this process as identifying themes, looking for theme clusters, continuing with other clusters whilst not being theory driven.

Figure 4.5: My interpretation of the onion analogy



4.3.2 Stage Two – Sub-Ordinate Themes

A new column was added to the left of the excel spread sheet and labelled '*sub-ordinate themes'*. The '*emergent themes'* were grouped together, due to their commonalities; an example of this can be seen in figure 4.6. Commonalities were denoted by meaning of words (sometimes two words or phrases were used which had similar implications i.e. working environment and place of work) and by interpretation of the meaning of these words within the context of midwifery practice for both student and qualified midwives. Occasionally, emergent themes with only one or two respondents were also considered as sub-ordinate themes due to the fact that they 'stood out' (for me and from the professional literature) as being important or unusual, for example, three participants considered the issue of bullying/intimidation. For those who witnessed or experienced this, it appeared to have a profound affect on their perceptions of practice. Equally, one participant considered being an advocate for her client. This stood out due to the fact that, from my educational judgement, midwifery education programmes consider advocacy as an important aspect of professional practice and it was surprising that only one participant discussed it in one of the semi-structured interviews. This led to 31 '*sub-ordinate themes'*.

Figure 4.6: Example of one sub-ordinate theme with accompanying emergent themes.

Sub-ordinate theme	Emergent themes
support	Supernumery
	Support
	Support/buddy/from cohort/ personal/ professional
	Preceptorship/Supernumery
	Not made to feel silly
	Orienting new staff
	Lonely
	Making new friends
	I didn't feel ready
	I feel alone
	Induction program
	Induction weeks
	Management
	Supporting students

This process is concordant with step four of the IPA process (Smith et al., 2009a; p92) which is concerned with '*searching for connections across emergent themes'*. Brett-Davies (2007; p193) states that this process is concerned with developing a coding frame in which (most of) the accumulated data will gradually fit. Occasionally words and phrases identified within the '*emergent themes* were difficult to link together into one '*sub-ordinate theme'*. The challenge was to stop myself from placing an '*emergent theme'* into a '*sub-ordinate theme'* just because it did not fit anywhere else. By using my research supervisors, I was able to discuss and justify my decisions throughout this process to minimise bias and skewing of these data.

Steps four, five and six of the IPA process have run concurrently throughout the development of sub-ordinate themes as they are concerned with looking across individual cases and then the three data sets.

4.3.3 Stage Three – Super-Ordinate Themes

The 31 '*sub-ordinate themes'* were then reviewed and reduced further to produce six '*super-ordinate themes'* by repeating the process as set out in stage three. This resulted in another column being added to the left side of the excel spread sheet. This process was undertaken by writing each '*sub-ordinate theme'* onto a 'post-it' note. They were then laid out on a table and moved into clusters of closely related themes. Smith et al (2009a; p96) describe this as '*eyeballing'* the, in my case, sub-ordinate themes to locate themes of similar meaning that can be clustered together under another given name (abstraction), or finding a theme that is super-ordinate that other emergent themes are pulled towards (subsumption), or finding contrasting themes (polarisation) that can be clustered into another theme. Smith et al (2009a) use the analogy of magnets attracting to show how some themes appear to pull towards other themes.

Originally eight '*super-ordinate themes'* were considered and through discussion with my research supervisors, there appeared to be overlapping of the themes. Therefore this process was repeated again to produce six '*super-ordinate themes'* for consideration. Both the '*sub-ordinate'* and '*super-ordinate'* themes relate to my interpretation of the experiences I have interpreted from the twelve participants experiencing 'being' a newly qualified midwife. Table 4.4 highlights the relationship between the '*sub-ordinate'* and '*super-ordinate'* themes.

Table 4.4: The relationship between sub-ordinate and super-ordinate themes

Sub-ordinate themes	Super-ordinate themes
Autonomy/advocacy/responsibility Decision-making Delivery suite versus community	Beyond competence
Workload Inter-professional working Team working Philosophies of care Organization and staffing Midwifery skills and resources On my own	Reality shock
Belonging/being valued Culture	Part of the club
Mentorship Developing practise Asking questions Leaving/returning	Self doubt
Place of work Expectation Experience Work life balance Tired Realities of role Support/preceptorship/supernumery Conflicting info re-job Learning Preparation for role	False promises
Self belief/attitude Anxiety Negative feelings Feelings of role Positive feelings	Struggling

After this stage had been completed each participant was sent and received their 'individual journey' (by way of the full transcript of each interview) of the studied year as a 'keep sake' along with the six super-ordinate themes. They were asked to provide comment on any aspect they did not agree with and confirm if they believed the themes to portray a realistic interpretation of their experiences. This occurred after the final analysis and themes had been agreed with my research supervisors. No participant disagreed with any aspect presented to them. A disadvantage to this process was that the participants did not receive their 'individual journey' until one year after they had

completed the third interview. In effect they had been qualified for two years so they were likely to have forgotten exactly what they had said. However, by undertaking this aspect of the analysis process I endeavoured to demonstrate trustworthiness within the data collection and analysis.

4.3.4 Stage Four – Final Interpretive Themes

I began to work with the six '*super-ordinate themes'*, but it transpired that the six '*super-ordinate themes'* were very closely inter-linked. To reduce the risk of repetition in the writing and re-writing stage of van Manen's (1990) methodological structure (see chapter 3) it made sense to discuss the most closely linked themes together under the guise one of two '*final interpretive themes'* (table 4.5). These '*final interpretive themes'* were the product of a refining process of the super-ordinate themes.

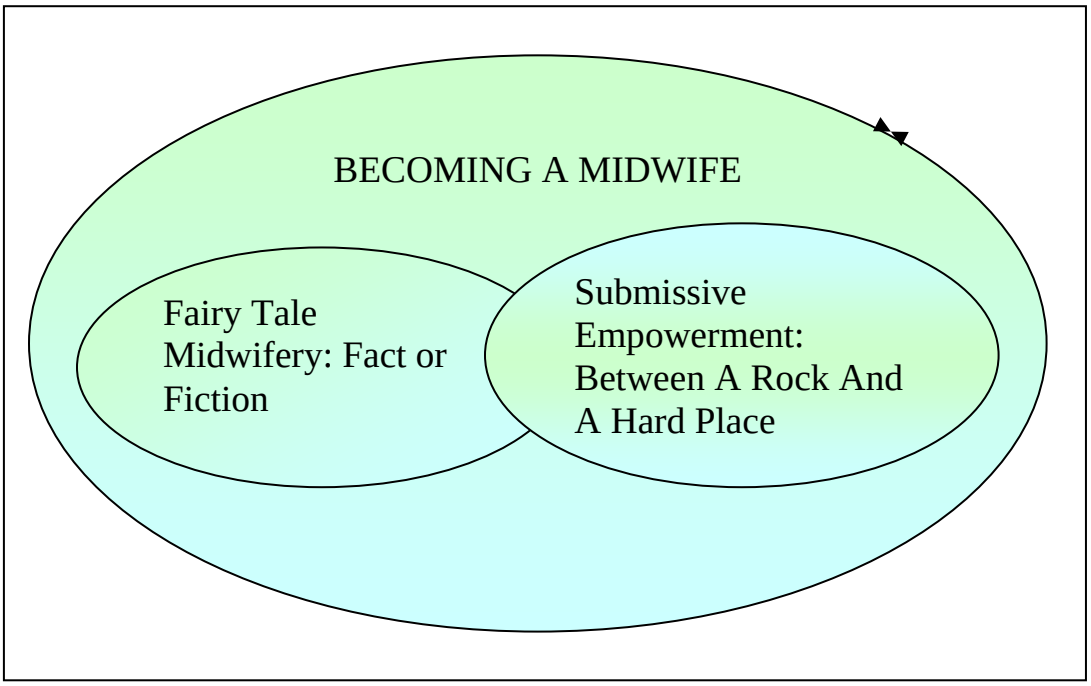
Table 4.5: Formation of 'final interpretive themes' from 'sub and super-ordinate themes'.

Sub-ordinate theme	Super-ordinate theme	Final interpretive theme
Place of work Expectation Experience Work life balance Tired Realities of role Support/preceptorship/supernumery Conflicting info re-job Learning Preparation for role	False promises	Fairy tale midwifery –fact or fiction
Workload Inter-professional working Team working Philosophies of care Organization and staffing Midwifery skills and resources On my own	Reality shock	
Autonomy/advocacy/responsibility Decision-making Delivery suite versus community	Beyond competence	Submissive empowerment – between a rock and a hard place
Belonging/being valued Culture	Part of the club	
Mentorship Developing practise Asking questions Leaving/returning	Self doubt	
Self belief/attitude Anxiety Negative feelings Feelings of role Positive feelings	Struggling	

The two '*final interpretive themes'* that constitute becoming a midwife are: '*Fairy Tale Midwifery: Fact or Fiction*' and '*Submissive Empowerment: Between A Rock And A Hard Place*'. This research study sought to understand, over a twelve month period, what it is

like ‘becoming a midwife’. Diagram 4.1 pictorialises the two final interpretive themes in relation to this study’s aim. (Appendix 16 tabulates the analytic process).

Diagram 4.1: The two final interpretive themes in relation to the study aim.



This in-depth four stage process has been used to compliment the third statement from van Manen’s (1990; p 30) methodological structure; ‘*reflecting on the essential themes which characterize the phenomenon*’. The findings of the two ‘*final interpretive themes*’ are considered in the subsequent chapter.

4.4 Synopsis of Chapter

This chapter provided the biographical details of the participants at the three interview points. The justification and process of the analysis has also been explicated along with an in-depth audit trail which has resulted in the conception of two ‘*final interpretive themes’* for consideration. These interpretive themes were developed from initial descriptive themes which emerged from the data collected via semi-structured interviews. Participants own words were used to inform this process.

Chapter 5: The Findings from the Interviews

5.0 Introduction

This chapter provides my interpretation of the lived experiences of the twelve participants throughout the first year in their roles as newly qualified midwives. The findings are taken directly from the semi-structured interviews through following the analysis and audit trail as outlined in chapter 4. The participants' own words have been used within the interpretation which includes single words and descriptive phrases. Single words themselves are powerful in their own right to denote meaning as well as long sentences. The findings are explicated in depth under the two '*final interpretive themes*'. These two themes are '*Fairy Tale Midwifery: Fact or Fiction*' and '*Submissive Empowerment: between a Rock and a Hard Place*'. This is a long chapter which may question the ordering of the content. The complex interlinked findings reflect the 'spaghetti world' of the newly qualified midwife.

The collective experiences articulated by the participants during data collection constitute the lived experience of newly qualified midwives during the first twelve months post registration. The experience of becoming a midwife is akin to 'coming of age' or:

> *'…passing your test when you've just learnt to drive and then you're out and you could really begin to learn and kind of consolidate your learning from being a student…'* [**Claire 1**].

Once professional registration has been achieved, the midwife starts to learn midwifery; once exposed to the realities of the role. At the point of registration, successful students have met the minimum standard set to practise midwifery (NMC, 2009a) and earned the label of 'midwife', but it is unclear when a midwife really becomes a midwife. At the point of registration participants stated that they were ready to move on in their professional development:

> *'When I was working on the wards for the last few weeks um I, I definitely thought I'm ready and I can do this um [pause] you know so from that point of view that was yeah.'* [**Ashleigh 1**]

As the point of registration is the start of the journey of learning midwifery, then it is appropriate to consider how and if the destination has by, in this case, twelve months post registration, been reached:

> *'I was talking to a midwife who qualified the year before me …. she said it goes in peaks and troughs she said you know you, you go down when you first start because you have no idea what you are talking about and then you come back up on a high and the end of your first year, she says, you end up on a high; you're on a high because, she says, I know what I'm talking about. I'm a midwife and I think that I'm at that place now'* [**Sam 3**]

In order to present the salient points from these experiences and to bring to the fore the rich descriptive data, the findings are presented below under the two '*final interpretive themes'*.

5.1 Fairy Tale Midwifery: Fact or Fiction

The first of the two '*final interpretive themes'* is '*Fairy Tale Midwifery: Fact or Fiction*'. Participants had their own perceptions and expectations as to what the role of the midwife entailed. When considering the collective data from the participants a general consensus was that much of what the participants believed '*being a midwife'* was like was not entirely the reality. The reality once qualified for some was somewhat opposing. Fairy tale midwifery encompasses the idealistic, almost 'dreamy' perception of what the role of a midwife entails and considers this from the participants' experiences of the reality i.e. fact or fiction. Ten participants stated that their perceptions concerning their new role were predominantly based upon their experiences as student midwives both clinically and academically. At the point of registration ten participants articulated that they believed

their training had given them the basic underpinning knowledge and skills to undertake their first post as a midwife:

> *'I think that I've been given really good grounding for, for almost working above and beyond that kind of basic level of training, I think and, and starting to think about um research and how that impacts upon good practise, um and I think our training is very holistic and um having spoken to other people in different hospitals who have qualified elsewhere um its been very much more medically based and they're not very autonomous um they don't seem to have the kind of grand idea that we have almost and I, I think that has set us up really well because it, I think that will make us better practitioners and push ourselves further'* [**Jade 1**]

and

> *'I know that* [stated name of city that trained in] *is um a bigger unit with a lot going on and a lot of high risk and a lot of … things that we sort here and I've seen quite a lot of um, yeah, I think that's good and although I've not been in another hospital I know that its [pause] just important; that its, there's a lot that goes on here'* [**Sarah 1**].

After four months as registered and practising midwives, two participants stated that their midwifery training was unrealistic for practice as a qualified midwife:

> '*… because, um most midwives don't case-load and um and don't obviously work in that team and that area um…'* [**Edith 2**].

and

> '*… the only thing in my training that I would have liked to have done more is to learn some more tips and tricks from experienced midwives who, forget evidence based practice, tell me what works for you, tell me what you did when your intuition and tell me some stories about that, that might help me one day you know that's what I want to know … but is that proper midwifery?'* [**Jade 2**].

For Jade, there is a clear move from her positive perception of how her training was going to support her to her reality within the first four months. One reason for the change could be that as a student, the focus is to gain experiences so that skills and experiences can be 'signed off' in order to move to the next academic level and ultimately registration. At the point of registration, participants come with ideas of how practice will be, but only seeing them from a narrow perspective. It is not until they are living 'in it' that they can fully appreciate the reality. For Jade, she thought she was adequately prepared to practise as a midwife, but in reality she felt she needed extra input. As a newly qualified midwife there is the need to cut away the perceived unimportant aspects of the training and gain instruction from people experienced to do the job at a practical, ground floor level. Conversely, the '*variable training*' [**Martha** 2], the '*rotation'* [**Valerie** 2] to different areas, the '*variety … practice is quite rounded'* [**Vivienne** 2] and the fact that as '*independent learners… you get out what you put in…*' [**Sally** 2] were considered as good preparation for the role.

Even though as students, participants described that they worked hard to gain experiences and knowledge of many areas, they felt that '*nothing can prepare you for the realities'* **[Valerie 3].** Participants were under no illusion that becoming a midwife was going to be challenging, but the reality at four months post registration was greater for most participants. One postulated that this was because as a student one is protected from the realities of the role:

> *'… you've got the shelter of the university to run to if you need to whereas now you're kind of out there exposed and on your own'* [**Ashleigh 1**].

One participant in comparison to her current role as a newly qualified midwife felt like she had '*bluffed it*' **[Sam 3]** through her training and was now having to work hard to make up for it:

> *'I think when I started I didn't have a clue, I think I just bluffed it for three months, bluffed my way in pretending that I knew what I was talking about yeah'* **[Sam 3].**

It would appear that she had embraced the student role throughout her training and completed the aspects that she needed to, to become qualified and achieve her degree. The difficulty perhaps here lies with the change of role, seeing the realities of the new role and responsibilities that accompany it. This implies that for some students, they are living the moment and not seeing beyond that.

As previously intimated, participants completed their training with their own ideologies of how they wanted to practise the art of midwifery. Participants found their work rewarding when they were able to work in a way congruent to a '*with-woman'* ideology. However, within the first four months of registration their own philosophies of care were challenged and in some cases suppressed. Participants refer to university education as unrealistic:

> *'I think there is a bit of a gap between the way that we're trained and the way that people work where I work … I think bringing the low risk stuff that we were taught and that, you know, the treating the person as a person kind of thing taking that into the high risk area is really lovely and um I was glad that we were trained like that [I[15]: uh mmm], but I don't know whether I was quite as prepared for looking after high risk women um, you know, we know that obviously the theoretical side of it inside and out...'* **[Martha 2]**

[15] 'I' written amongst participant comments refers to the Interviewer during the semi-structured interviews. In all cases this was me.

'… when you're a student you've got none of this stress you turn up you find the midwife you're working with and you work with her you haven't got any of the five women that have phoned for you this week and you cant get hold of them. You haven't got any of the, 'this woman needs to see the drugs person', 'this woman needs to see the child protection' and I need to fill in the form …. when you're a student you turn up for work, wait around for a couple of hours whilst the midwife's running around, not really knowing what she's doing and then you go out on community, have a nice drive around, turn up at people houses where, weigh the babies and bob's your uncle' **[Ashleigh 3].**

One can postulate why after three years of 50% clinical practice exposure, they did not 'see' this hidden work. It is not clear if this work was really hidden from them as students or if they just did not 'see' it. For three years, the participants, as students, were taught that once qualified they could practise midwifery in a way that befits best evidence, autonomy and client choice. Once qualified the participants assumed, from the positive discussion in educational fora, they could be the change agents of midwifery immediately, only to realise quickly (by four months) that this was unlikely to happen:

'… they [managers] thought that more people would come in change it but you cant you, cant change the actual structure of it not for, not for quite a while only if you really work there a, a while and work your way up and things there, only they're the ones that can change that and they know the problems and its not even like you can go and feed back to them because they're aware of it…' **[Edith 2]**

and

'I don't think I can change midwifery which again is another thing as a student you kind of geared up, you know, positive you're the new midwives of the future change, change, change that's impossible there's not enough power for us um and I think it would wear me down to try and change something and I've heard other midwives that have tried to bring in certain lets try and change this guideline and it just doesn't work at all so I think as long as I'm happy and I know the, the grounds I can work in is a sa-safe practising area then I'm happy and as long as I can give my care to the women I look after I'm ha-I don't I don't worry about what's going on next door if its not my woman I'm caring for as long as I'm doing my job for the women I'm looking after that's what I'm trained to do…' **[Sally 3]**

This battle with their professional values and anticipated roles led to physical and emotional exhaustion. This is interesting because ten participants secured employment in the place they had trained, where they had experienced restraints on practice philosophies due to their mentors being responsible for them as students. All twelve participants (as students) had exposure to qualified midwives feeling restricted in their practise, which causes one to consider why they continued to believe they could 'change the world' on qualification. Eleven of the twelve participants felt that to work in the place they trained was important with participants expressing that:

'*its daunting enough becoming newly qualified from a student and without having all the additional you don't know, you've got a new post, you don't know the area, you don't know the staff, you don't know all the paper work and systems like that' [**Vivienne 1**]*.

'…well you trained here, you know how it works…' [***Sam 1***].

'I think that's a good thing actually to stay um to stay where you've trained because it consolidates your training I think um you know the people you know how the hospital works yeah paper work and all that kind of thing… it makes it easier for that…'
[***Sarah 1***].

The thought of working in an NHS Trust outside of the place of training was, for one participant, considered as:

'… possibly a problem because I might get knocked down a little bit um and I don't mean in terms of confidence I think may be just I – I – I maybe take it for granted; some of the …aspects of the training that we've had here and some of the protocols and procedures that we have in this hospital um are actually fairly forward thinking compared to other places …'
[***Jade 1***].

The decision to stay local is taken prior to qualification, which is evident from the fact that all but one of the participants stated this desire during the first interview set. Family commitments meant that gaining employment locally was the only option for four participants.

Valerie had become less idealistic between the first and second interview. She was very excited that she had been told she successfully had a job on registration at the place she had trained. She was pleased to be consolidating her training with her peers only to be told a week prior to starting the role that she was no longer required. For her, the 'fairy tale career' she had envisaged was not to be. This was a concern for her because as she had never practised as a qualified midwife, she felt her confidence and skills base were eroding:

'I feel that the four months that I haven't been practising has done a lot to erode the confidence that I had built up throughout my third year um, because at weird times things will pop into your head and you think well, how would I deal with that, so sometimes' [**Valerie 2**]

By contacting her peers she was keeping herself motivated to commence her first post. She was also clear in stating that midwives within the new NHS Trust were welcoming and positive towards her, which made her feel welcomed and valued prior to her commencement. This was contrary to how she felt at the place she had trained:

'*I was introduced to several um members of staff, senior members of staff who also, you know, came across as being extremely supportive they seemed to have um, they, they just seemed to be very supportive… Um, the thing is it, it where, where I trained it depended who was coordinating dramatically affected the atmosphere on, on the ward*' [**Valerie 2**]

This participant was led to believe the support would be available to her, the reality twelve months post registration was that the midwives working with the participant in her NHS Trust were true to their word:

'I was like a duck actually quite happy swimming on top but paddling like mad underneath um fortunately I had I've had good support, good support um which is essential' [**Valerie 3**].

Support was a significant issue for all participants. All twelve participants expected to receive support upon commencing first posts:

'…there will be someone you know sort of over seeing for the first at least for a few weeks.' [**Martha 1**]

and

> '*… I'll take, take a couple of courses and things when we first qualify…*' [**Alicia 1**].

Those employed outside the place they trained appeared to have had a more robust orientation and supernumery package in situ:

> *'I'll have um a good induction programme put in place for me… I will um be well supported by both my manager and the staff…*' [**Valerie 2**]

and

> '*I was given support by the by the manager erm but she wasn't there every day so when I was with her she, she had a lot of good things to say and erm and when she got us together there were three other girls who started with me that was good erm and she made sure that we all kind of knew each other and were bonding things erm and when she was talking to us about what would be expected of us and what to try and do erm to get our confidence up by saying you know look guys its exactly what we did in our area and things erm that was all fine'* [**Edith 2**]

All participants received a minimum of a two week induction period at their respective NHS Trusts and preceptorship programmes were offered. All had been provided with a period of supernumery status at the start of their employment however, most received this dependant on staffing levels and who was coordinating shifts at that time:

> *'I because I had trained in the place that I was going to work I kind of knew the reality of oh you'll get your six weeks of supernumery and … then we will support you was possibly a little bit of an expansion of the truth um on the whole it was really good a lot um I'm in a lovely team working team that can't be more supportive and are … very keen for me to meet my um benchmarks so I can go up to band I've got five and go up to band six um. I think the reality was my sixth shift as a qualified midwife being in charge of an antenatal ward on my own I think that's when it sort of hit home that it was me now and what I said actually mattered yeah, it came as a bit of a shock I have to say'* [**Sam 2**].

The reality of being in charge of a ward soon after registration shatters the 'fairy tale' illusion of being supported during the induction period. One reason for these findings could be due to the fact that experienced midwives know the newly qualified midwives through their training and they know their individual abilities, assuming that they are ready to practise. External units do not and so need to spend time developing trust with their new employee whilst gauging their level of competence and skills acquisition. Edith, who chose to work away from her place of training, received an induction programme with supernumery status planned for four weeks although for some shifts she was counted in the staffing numbers due to shortages.

Transition from '*studenthood'* to '*midwifehood'* is hard enough, but if individuals are not provided with the time and support, then this can lead to negative consequences such as low morale and error. It is worth investing time up front than having to spend time rectifying issues later, especially when considering healthcare is about people and their lives. Edith appeared to expect a gentle introduction to her working environment when she commenced her first job, but the reality was that qualified midwives were just so relieved to have more staff to help with the workload. She did not seem to understand why she was expected to take on a full workload for her shift straight away, but felt that her new colleagues were:

'Well they were they were supportive there's not always someone there to ask but its horrible having to constantly kind of ask and they're just not that friendly… they weren't to be honest very helpful' **[Edith 2]**

She anticipated that it would be better at a different unit than the place she had trained, but soon realized that other places had similar situations and were possibly worse in some aspects. This participant worked for a total of four weeks in that NHS Trust, but left employment after this time. She did not enjoy the experience because:

'… it's a lot harder than I expected it to be [erm] I think if you go into an experienced hospital at the start I think I was a bit naïve and I didn't realize how difficult that would be erm yeah there was when everything's new its not just that I think when you qualify, you kind of you have, you find you're confidence goes down a little bit erm, but when everything's new you can't even just like get a bit of security from the things you do know …' [**Edith 2**]

The experience had caused her to deliberate as to whether a career in midwifery was for her. She left midwifery to work in an office to allow time to decide her future. By the final interview she had commenced a second midwifery job in another NHS Trust which was less busy, befitting Edith's expectations, where she was enjoying the role much better. For Edith, the space to recollect her thoughts and decide what direction she wanted to head in was enough for her to realise that she did have skills and knowledge and want to practise midwifery clinically.

Induction and preceptorship programmes existed for all participants new to NHS Trusts as well as those working in the place they trained, but it is not clear as to whom they were designed for, for example: a tick box to demonstrate, to external reviewers, that one existed in organisations to ensure the practises of newly qualified midwives are to an acceptable standard to '*hit the ground running'* **[Valerie 2]**; or to really support and value the newly qualified midwives from an individualised perspective. Preceptorship works two-fold; not only is the organisation ensuring through clinical supervision that

individuals are able to practise safely at a standard they deem as acceptable, but the preceptee is gathering information so she can have the tools to carry out her duty effectively. This is about both sides building trust. Edith, who chose to work away from the place of training had received preceptorship along side other newly qualified midwives and valued being with others in a similar position.

Although preceptorship meetings were mentioned by participants not all accessed them due to them being organised on their days off, during their shift (not protected time on off duty) or place of work being away from the venue of the meeting. Of those who attended preceptorship meetings (six in the second interview set and five in the third), this was about peer support, meeting up with those they had trained with and/or making new friends:

> *'…its nice to meet up with them and see how they're getting on as well because you don't get much chance when you're on shift to talk to anyone really so that's, that it, it's a good idea its just that I don't think its, its as um crystal as it should be'*
> **[Ashleigh 2]**

For Valerie (employed by a neighbouring NHS Trust to where she had trained) a solitary preceptorship package was devised as she was the only new person to commence her employment at that time. This meant that she did not have the interactions with other newly qualified midwives, although she did have access to an experienced 'buddy'. Whilst preceptorship is about having an experienced buddy and support in practice, added value of peer support with someone in the same situation is immeasurable. After attending the induction period, one participant did not see the need to attend preceptorship sessions so did not access it at all, leading one to favour the thought that the programmes were designed to meet the needs of the majority and not the individual:

> *'…hands up I, I haven't been to any because I've either um been on holiday or um I did mention because I felt it wasn't appropriate for me because I was happy with what I was doing however, it was then said to me well other people might be struggling and possibly your support could help make it [I: uh mmm] fit for people um, but that particular meeting is not pushed 'you need to come' um, or 'you must come''* **[Sally 2]**

Sally clearly was comfortable with her ability in practice, but surprisingly she was less happy to provide support to her peers.

Despite preceptorship and induction programmes being available, participants still commented that they '*felt alone*' [**Ashleigh 2**] and '*lonely*' [**Valerie 3**] doing their role within the demanding areas of the maternity services. For participants '*not having that one person*' **[Martha 2]** '*sitting on your shoulder* [or] *just behind you*' **[Ashleigh 2]** took some readjustment. For three years all had an allocated mentor supervising them providing reassurance and advice to develop their knowledge and skills base during their clinical placements. Unsurprisingly, this has meant that once qualified and practising this person is no longer a constant support leading to a loss in confidence as a newly qualified midwife.

The participants stated that they don't have time; time to reflect, time to conduct their work effectively, time to debrief, time to plan and time to prioritorise:

> *'I just found it too much because when you're doing your case-loading you need so much extra time to sort of sort out when you're gonna see them and things that you can't do at the time and when I, my full 12 hours is spent on labour ward, you know, looking after labourers [I: uh mmm] I was ending up working in my own time so that didn't really work for me it still doesn't [laugh]'* **[Alicia 3].**

This suggests that being a newly qualified midwife is about having time and space to gain confidence. Participants remarked that it took them longer to complete midwifery tasks

especially community linked ones, compared to their more experienced colleagues. A significant amount of participants' time was spent consolidating training in the delivery suite, with one day working in the community setting as an integrated midwife or on the antenatal or postnatal wards, dependant on place of employment. For those in the community, on this day the expectation was to undertake a number of visits, complete a clinic and sort through the administration at the end of the shift. Many commented on the fact that working on their own in the community was harder and due to the workload in the community shifts would finish '*way after your shift*' [**Sally 3**]. On occasions this was two hours after their shift was allocated to end. Even though these participants had spent three years working fifty percent of their allotted course time clinically within the NHS environment, many commented upon how busy the workload was as if it was unexpected to them. There were issues with team working in that often there was no person who could continue the follow up work in their absence. They also commented that the more experienced midwives showed little empathy when they articulated this or when allocating out community workloads. As a newly qualified midwife working in an integrated team, Ashleigh commented on the fact that with her consolidation on delivery suite and working one shift a week in the community, she did not have adequate time to complete her community workload. She had approached her team leader for support:

> *'I said I'm having trouble keeping up with all the, the clinic and you know bookings and that sort of thing one day a week and she said well you should be able to [pause] well I'm not'* **[Ashleigh 2]**

In comparison the experienced midwives within their allocated teams had rostered themselves more community days and less or no hospital shifts. Participants, especially those with families, found conflict between the expectations of their work compared to family roles difficult, leading to guilt.

> '*… you make certain sacrifices but it all seems to be a sacrifice'* [**Edith 2**].

Most of these participants worked part-time hours so they felt they could devote time to family commitments. Although not all participants had families of their own, to them their parents and friends were equally as important. Despite this, one participant was concerned that working part-time hours would mean that she would not retain her new knowledge and lead to greater anxiety:

> *'…I don't really want to work less than four days a week because I think you start to have, yeah you forget, you forget things and I want to get to a point where I [pause] I know, know enough that I don't start forgetting and of course when you have a holiday you are actually are going to forget something, but I think you can sort of kind of build on it……'* [**Alicia 1**]

The reality was that they worked beyond their shift or came in to attend team meetings and preceptorship on their days off. Participants had commented how tired they had become since registration. This was due to working longer hours, potentially long stretches at a time with no study day to break up working patterns. This linked with the '*up hill battle'* [**Alicia 2**], '*thrown in the deep end'* [**Martha 3**], '*still finding feet'* [**Valerie 2**], '*frustration'* [**Sarah 2**] and '*doing it on my own'* [**Naomi 3**] contributed to a more stressful and pressurized feeling of the reality of the role. Participants in this study are concordant with the fact that they spend a large amount of time sleeping and working often stating that it was harder than they thought it would be. One participant, although finding it harder than anticipated, still remained defiant in taking it '*one day at a time'* [**Sam 2**]. The pace of work, length of time to complete tasks, the unrealistic expectations of self and others led to a roller coaster ride of emotions through their '*variable days*' [**Martha 3**]. Participants '*… just can't switch off from it'* [**Jade 3**] after their shift, often worrying at home if they had '*missed*' [**Vivienne 3; Martha 3; Sam 3**] anything to do with care giving. The actual job being undertaken and what participants said they thought they would be doing were not always congruent. Despite this, participants had clear views on their standards of client care and stated that they did not have difficulty in executing client choices and requests whilst consolidating in their respective delivery suites:

> *'I'm not a particularly um loud or confident person myself um, but I think its almost like in, in at work its more of a necessity because you are there on behalf of someone else, you're there as an advocate for the woman so its not so much for standing up for yourself, you're standing up for the woman'* [**Naomi 3**].

The reality for many was the fact they could not achieve the care provision they perceived they would due to workload. Participants commented that the units they worked in were political and that not all aspects of client care were based upon philosophies deemed important by newly qualified midwives, but were politically motivated:

> '*I think you're a lot more aware, I'm a lot more aware of kind of the politics of how it all works as well, I think as a student you do sometimes miss out on this, the how do hospitals run in terms of you know the problems that go on in the hospital*' [**Naomi 2**].

Understanding the organisational sub-culture as opposed to organisational processes such as, what and who has influence and why things are organised in such ways, could alleviate some of the newly qualified midwives' frustrations and inner conflicts. As students, the focus is to achieve successful entry onto the professional register and secure a first post. It appears to subsume the ability to question why certain organisational practices are as they are. However, until exposure to organisational working has been gained, in the role as responsible practitioner, it is unlikely that students can fully appreciate these aspects. In view of the fact that newly qualified midwives could work in any area of midwifery practice such as, case-load practice or within a busy main maternity unit, appropriate consolidation is key to both the organisation and midwife. The participants had been informed at interview that they would spend a set period of time consolidating their pre-registration midwifery training on the delivery suite:

> '*…that's all, that's all every, every one always talks about consolidation on labour ward no one ever talked about actually maybe people need to consolidate in the community or um its all about consolidating your um skills on labour ward which I can see why, but then I'd say nothing and um and need equal on the community work or home birth or birthing units and anything like that'* [**Vivienne 1**].

And

> '*…they're very practical me getting my skills so that I-I'm competent at suturing and that I'm competent at knowing what obviously goes with what and what I can do and what I cant do…'* [**Sam 1**].

This training beyond training was in order to gain competencies in e.g. suturing and cannulation prior to moving out to their proposed main areas of work and be appropriately skilled for roles within any eventuality:

> *'I think its definitely come in stage, I, cos, I, my first six months I spent just working in the hospital um and after six months after I got my suturing skills and my cannulation skills done, I was then moved out into community and the reason I had to get those skills done was because I'm in the middle of the, no-where in the community so they wanted me to have those skills done ready for home births'* [**Naomi 3**]

Not all participants had achieved these competencies by the final interview and were concerned that their competency related pay-banding increase (DH, 2004a) would not be honoured despite the experiences and promises directed at them. Participants described that some clinical opportunities had not been available to them, leading to their consolidation period being extended on the delivery suite and hence, delaying joining their allocated permanent teams.

Community visiting is not without its criticism. One participant highlighted the issues of undertaking missed community visits in the dark. As an on-call midwife any missed visits are telephoned to them to complete during their on-call period. Jade articulated a community visit that had scared her enough to consider whether she wanted to continue working as a midwife:

> '*I have rung my husband and said I'm going somewhere if I don't get to you within the hour then make sure you ring me cos nobody else knows where I am …'* **[Jade 2]**

On enquiring, the unit did have a lone workers policy, but this was not known to the participant at that time, which begs one to consider the appropriateness and effectiveness of the orientation program upon commencing first post.

There were tensions between workloads within the community and delivery suite in that community was considered to be a '*shambles an absolute shambles'* and '*rubbish*' [**Ashleigh 3**] for participants. This perception may be linked to individuals' personalities and/or level of experience, for example, someone who needs structure and organisation (requiring a more paternalistic approach) versus someone who is comfortable in the unexpected and possible chaos that unpredictability may bring (possibly a more humanistic perspective). It was often the case that ever expanding community workloads remained invisible to busy core hospital staff. Participants appear to be caught up in the middle of the 'politics' between community and hospital workloads. The expectation was for them to undertake both aspects of the role whereas, experienced midwives tend to choose either hospital or community roles. This suggests that newly qualified midwives need to 'complete' training (consolidation) prior to selecting their preferred job/role.

As delivery suite is the main area for consolidation with most participants spending approximately six months there, many questioned the relevance to their skills acquisition as they felt they needed to consolidate community skills equally. Although delivery suite was considered stressful, it was seen preferable to community:

> '*I'd rather be in the hospital any day of the week I much rather cos you go you come in you do your job you look after a woman you give her your all you give her your best you do everything you possibly can for her and then you go home*' [**Ashleigh 3**].

This contradicts how participants felt at the point of registration where there focus seemed to be providing 'woman-centred' care. Perhaps internal conflicts and contradictions have left newly qualified midwives too exhausted to fully adhere to this philosophy of care. A small number (n=4) of participants said they felt safer on the delivery suite due to the level of support available and having support with complex decision-making processes. Those that were allocated to work within total case-load held practices were less critical of community and generally more confident and content with their roles. They were not required to consolidate in a main maternity unit upon registration and employment. One participant stated that in her unit, she was given time to build up her own case-load of clients, but when in the delivery suite because she worked different clinical hours to the main unit staff, there was often no-one to relieve her at the end of the shift:

> *'…on the unit um generally for 12 hours I've worked shifts where I haven't had a break and I haven't been relieved at the end of my shift'* [**Alicia 3**].

She was then expected to stay on duty until core hospital night staff commenced their work some hour and a half later. Participants felt that they were not in control of their working lives, ultimately affecting confidence and expertise with developing and sustaining professional relationships. Conversely those undertaking case-loading (n=2) in Sure Start teams, felt the opposite:

> *'…the thing with case-loading you do um a very intensive period followed by a week off um so I think that obviously there are sometimes when, when you become stressed with the amount of work you have to do um but I wouldn't I wouldn't ever want to well wouldn't ever say at the moment and for the foreseeable future that I wouldn't want to be working in any other way than I am right now because um the stress that, that you see where wearing midwives down I don't see in my team I see it else where…'* [**Vivienne 3**].

Participants across their NHS Trusts commented that the services were '*so stretched*' [**Alicia 3**] and they themselves felt that staffing and skill mixes were inappropriate. Despite this perceived (or not), skill mix and staff shortages may contribute to staff having to work long hours and reduced face-to-face time with clients and increase stress which adds to the stress for newly qualified midwives. The issues of client to staff ratios were also a concern for participants who found:

> *'…I've been the only midwife on an antenatal ward with eight or nine extra beds and at one point I had something like 25 women and 30 babies and me as the midwife*' [**Sam 3**].

Although support staff were readily available i.e. maternity support workers, nursery nurses, ward clerks etc, their means of support was via telephone to the delivery suite and/or the management team/duty manager. Maternity care was thought to be deteriorating due to workload and increasing risk management:

> *'…but you could see they* [the client and her partner] *were pissed off you know they they'd been left on their own and I just I couldn't do anything about it…'* [**Jade 3**].

One participant described feeling that if situations:

> '*…got to the stage where it was ridiculously dangerous, I would tools down'* [**Sally 3**].

Throughout the first twelve months participants acknowledged that they had learnt a vast amount and this was articulated in a positive manner. It was a commonality that they had learnt as they had '*gone along'* **[Sarah 2]** which resulted in a '*steep learning curve'* [**Naomi 2**]; becoming more knowledgeable professionally and developed '*personal growth'* [**Sarah 2**]. The findings show that for this study, participants had learnt more since qualifying by having to think on their feet. One consideration for this was a heightened realization that they were accountable for their practices as registered midwives. The life-long learning culture had become further entrenched into their philosophies and by the end of their first twelve months post registration they had begun to make plans to undertake further academic studies. Comments, such as, '*needing to be at the top of* [their] *game* [and] *be one hundred percent focussed*' **[Claire 3]** led one to feel that she needed to '*challenge and question practice more'* **[Vivienne 3].** Training had given them the basis to do this, but with a year's experience and confidence they were ready to take it to another level.

5.2 Submissive Empowerment: Between A Rock And A Hard Place

The second of the two '*final interpretive themes'* that emerged was '*Submissive Empowerment: Between A Rock And A Hard Place*'. This theme considers the unspoken turmoil's of a modern midwife; the complex 'spaghetti world' of experiences. Part of the midwife's role is to act autonomously and responsibly whilst promoting client empowerment alongside developing self empowerment (NMC, 2008a, NMC, 2004a). Participants have all provided evidence that confirm and contradict these professional requirements. The words '*submissive empowerment*' highlights the paradox with what a midwife <u>is</u> reportedly, to the reality of what a midwife <u>experiences</u> at the coal face. This is in line with the participants' perception of being restricted in their provision of care

within NHS confines; thus becoming submissive to the needs of the organisation. These two words are meant to not really make sense at face value, thus highlighting the reality for the participants. The idiom '*between a rock and a hard place'* concerns the dilemmas that newly qualified midwives are faced with in order to be able to practise and to 'be' in accordance with the regulatory body's law in statute.

On asking participants what they '*think being a newly qualified midwife will be like'*; change in responsibility was the commonest response for eleven participants who commented that they expected the change to be:

'*… daunting… I will feel more worried'* [**Alicia 1**]

'*… more stressful...*' [**Vivienne 1**]

'*… challenging…'* [**Claire 1**]

' *fulfilling…'* [**Valerie 1**]

and

'*… strange…'* [**Naomi 1**].

It was the concept of '*this is my registration on the line'* [**Valerie 1**] that made participants feel this way. Participants typically worked hard, not just for the three years of training, but prior to commencing their midwifery programme, to get to the point of being that midwife they aspired to be. The thought of potentially making a professional error and losing their registration was profound for two participants at the point of registration and at twelve months post registration. Uncommonly, one participant stated that she was:

'*…looking forward to actually being there and being responsible for that woman…'* [**Ashleigh 1**].

Six participants articulated that as senior students they were increasingly aware that mentors were '*…putting a lot of responsibility on us'* [**Martha 1**] by working '*…closely with a first year student* [to] *run clinics'* [**Jade 1**] and not '*…having your mentor in the room'* [**Sam 1**]. These comments were viewed positively. The participants, as senior students, were provided with opportunities to care for women as if they were qualified midwives and to refer to co-ordinators or other senior midwives as necessary for support and guidance. It would appear from the participants' experiences that anxiety was still prevalent in their roles as newly qualified midwives, despite the fact that six participants stated that they had experienced the extra responsibility placed upon them by their mentors when they were students. Senior students are 'gently' exposed to this concept, but cannot fully realize the enormity of it until entry to the professional register is achieved.

Twelve participants spent three years as undergraduate student midwives, training to be competent practitioners at the point of registration (NMC, 2009a). They successfully passed both clinical and academic components to enable entrance onto the professional register. However, once qualified it appears that they had yet to pass an initiation phase to be fully accepted within the midwifery culture. This was an unspoken, hidden initiation whereby even though participants had qualified they had to prove themselves worthy of their registration to their fellow midwives then:

'*… you've earned your place…'* ***[Claire 2]***.

By earning '*your place*' they have become 'part of the club'. This initiation appeared disparaging for half of the participants (n=6) whereas others made no reference to it during the interview. It may be that personality makes this more or less of an issue rather than the questioning the existence of the initiation itself:

*'I think however soon or late you leave starting you've always gotta go through that horrible bit and I'm glad that I'm over that cos it that was horrible you know the sort of worrying before you go into work and just sort of constantly being on edge even if nothing bads happened or gonna happen…' [**Martha 2**]*

Perhaps this is not about initiation, but about joining a well established team, which suggests that midwives are a team. This may be unsurprising considering the nature of the job. Some may say a well established team is strong and supportive whereas others may see it as a 'clique'. Belonging to a team or the profession as a whole and/or being valued as both an individual and professional was not something considered by any of the participants at the point of registration. However at four months post registration, feeling valued and belonging to a group or team of midwives was important:

'I find that good actually because you fit in and not kind of yeah, so I, so I think that's a good thing' [**Sarah 2**]

'…they had a high turnover of staff so I was just, people just didn't know each other um and even though I thought it was quite bitchy an unsupportive um, at least they knew each other and they, they some of them were quite friendly…' [**Edith 2**]

Even at 12 months post-registration, participants did not always feel that they belonged to a team. One participant's allocated team, worked several miles from the main maternity unit. Consolidating her training on the delivery suite in the main maternity unit meant missing team meetings and building vital relationships with her team members:

'I haven't really felt like part of a team because I haven't really been part of their core staff even though I've been in the hospital more than anywhere else and didn't see my [said name of team] *members very often so its difficult to have relationships with them'* [***Alicia 3***].

For Alicia, she theoretically belonged to two teams (her main allocated team and her temporary hospital based team), but she did not 'belong' or was 'accepted' into either. Participants working in areas where their team members are easily accessible for communication concerning the team also felt not included:

> '… *they had a team meeting and it was done* [duty roster] *in the team meeting that I wasn't invited to …*' **[Ashleigh 2]**

These newly qualified midwives were 'new-comers' to a fairly well established group of midwives; 'fairly well' because team dynamics within some midwifery units are constantly changing with midwives leaving or joining teams. This has implications to belonging and working effectively. One participant described practising defensively so she did not '*get into trouble*' [**Claire 3**]. It is conceivable that being new to a team can lead to reduced confidence in one's own abilities and justifications of one's actions:

> '*I suppose I'm thinking right what if something's wrong and we have to go downstairs to labour ward and then they're, you know, you're just sort of covering your back because you, you go downstairs and the doctors will say 'oh where's the partogram and what do you mean this woman's been eight centimetres since blah, blah, blah, blah' you know, you just can, you know, its those sorts of things I'm sort of practising defensively from, those from that point of view and how I don't want to get into trouble if you like*' [**Claire 3**]

Participants in the main under went a process of impressing their senior colleagues, even if they were unkind to them, in an attempt to feel they 'belong' in their new culture. Issues of not being valued by management and/or colleagues caused some participants to feel distressed. This may explain why participants appear to have tried hard to impress those senior midwives on delivery suite, sometimes to the detriment of client choices whilst in labour. Only those that did have strong feelings or opinions concerning belonging and being valued commented upon it:

> '*you shouldn't have to deal with other staff being rude and the politics and all the rest of it that goes on they say that doesn't happen but it does…'* [**Sarah 3**].

Those that appeared to have settled into their first post, at their training hospital, made no reference to these aspects. This leads one to consider if some participants had been 'accepted' whilst practising as students and others had not. It was those participants who had experienced the concerns at four months that appeared to continue to articulate similar views at twelve months post-registration; which makes the fact that some participants may never be fully accepted (thus feel like they do not belong) a reality. Again, this could be due to personality as opposed to skill.

Within the main hospital maternity units, some (n=5) participants felt less valued than others. This ranged from having somewhere to put bags when starting a duty to how individuals treated them whilst on duty:

> '*…if you don't look after the people who work for you how can you possibly expect them to perform in the best way they can basic things like not being provided with somewhere to put our bags not having a tea facil-facility in the hospital apart from between the hours of 10 and 4 on a week day. It's not good enough. We don't have a secure place to put our handbags when we come into work, they're just shoved in this little cupboard on the labour ward'* [**Alicia 2**]

One participant described:

> '*… That's frustrating because saying 'go for a break', but that doesn't mean you can actually go for a break…'* ***[Sarah 2]***.

From the participants' experience, the phenomenon of not having regular breaks during a working shift has become almost accepted as the norm. It has become expected that individuals work on through their break and often past their shift in an act of good will. This expectation does not necessarily come from management, but over a period of time

and custom and practice. Midwives often feel guilty for asking or taking a break, despite the fact that they have a legal right (Health and Safety Executive, 2009):

> '*I think our training as a student was such that you kind of understood what it was gonna be like once you were qualified yi-i-it you knew the pressures that were for working in hospital that sometimes you wouldn't get a break and sometimes you would get a break and you knew that what people asked of you would kind of sometimes feel like a bit much, but you just get on with it because that's the way it is'* **[Sam 2]**

There was a marked difference to how participants felt valued dependant upon where they were working. Participants working as integrated midwives, but with most of their time consolidating on the delivery suite felt unappreciated in the role of newly qualified midwife and that no consideration was given to the fact they were within their first year since registration:

> '*I need to know if it's more than just a job but also that I'm valued enough for people not to take advantage'* [***Jade 2***].

Frequently participants explicated the feeling of:

> '*…we're in just a job and you're a number'* **[Edith 2]**

or that they were:

> *'… just a body'* [***Ashleigh 2***]

and as long as they had turned up for their allocated shift time that was all that mattered. This was not solely related to those in managerial or senior positions, although the inference from participants was that there is a 'them and us' culture. This could be due to the fact that everyone appears to be busy and no-one has time for pleasantries whilst in

the working environment. Conversely, one could speculate that those in a senior or managerial position are working under immense pressure, that they do not see outside of their own world and forget what the reality is like for those working as newly qualified midwives. For them the reality is to get the required minimum number of staff to ensure safety within the ward environments. This is not perceived as good management or leadership due to the distancing from the human emotion perspective. By this it is easier to perform a role if you don't personalise it however, for the participant, she may feel that as an individual in a large organisation, she is a forgotten entity within the hierarchy and hence feel unvalued. One participant stated that she felt:

> *'…also really angry that [pause] that um that I felt so undervalued so kind of used…'* [**Jade 3**].

She genuinely perceived that no one cared; the only reason people cared was if she was there or not:

> *'When I gave in my resignation my manager sort of shrugged her shoulders and didn't really say anything and that made me feel even less valued because I thought well you obviously don't want me to stay then..'* [**Jade 3]**

Often participants:

> '*… were expected to almost go above and beyond a little bit...*' [**Sam 3**]

during their shifts, with six participants staying past their allotted time (as previously stated). There was a strong need to '*don't want to be seen as lazy'* [**Martha 3**] despite the fact they perceived some midwives to be so and typically participants commented that '*there's no praising at all'* **[Vivienne 3].** This has caused participants to feel undervalued. Despite this, one participant commented upon the positive value asserted when delivery suite coordinators:

> '*…said oh you know thanks for your help today it's been busy and you know and that makes all the difference'* ***[Ashleigh 3*]**.

The participants were under no illusion as to the culture of midwifery they were entering into. At the initial interview four participants had made a direct articulation of the culture; one had expressed positively:

> '*… I know who to ask and who not to ask so I there is some kind of reassurance in that and I do have a lot of confidence in that I know people who you know are happy to help and things like that'* [***Naomi 1***].

One participant expressed a concern that the culture would be something that would stop her practising as a midwife. In fact three participants had indirectly experienced bullying in the workplace as a student midwife and expect:

> '*… that it will be occurring whether it's happening to me or someone else'* [***Martha 1***].

The expected culture was dismissed by one participant as

> '*I think that you do get that where ever there is lots of women working together … I think there is a certain amount you've got to um put up with and deal with'* [**Edith 1**].

Two participants described experiences of overt bullying in front of other members of staff. For one, it was a coordinating midwife on delivery suite, the other, a consultant obstetrician whilst in an inter-professional training session:

'… there was actually an incident I saw with one of the midwives by one of the co-ordinators and I felt really uncomfortable I thought what do I do, do I leave do I stay do I say something and I stayed for a little bit and I looked at the person and I just walked out you know in a way that it was very obvious that I didn't agree with what was happening and I went up to the midwife who I felt was sort of under the firing line and asked her how she was, you know, whether she was ok and what she wanted to do and actually the co-ordinator came and apologised to her about it and said you know that she shouldn't have spoken to her in that way and the reason she had done it was she was stressed about this that and the other so you know' [**Martha 3**]

'*… its enough to make people leave and so is the way some of the consul-consultants speak to members of staff its an absolute disgrace um I had a particular incident with one of the consultants a female one when I was on a drills and skills day and um she, she just aggressively questioned me and after that day at least four members of staff including one supervisor of midwives came to me and said how awfully she spoke to me'* [**Ashleigh 3**]

For the last participant, the key distressing action was her colleagues observing the incident, but not intervening:

'*…I was more upset about that than I was about the way she spoke to me because not one person sat there or stood up and said actually this is a bit inappropriate or, or you know gave me any back up at all I was stood up in front of the whole room on my own being aggressively questioned by this person'* [**Ashleigh 3**].

The perceived bullying culture within midwifery has mainly been linked to senior midwives within the delivery suite environment. It was rationalised as:

'*I suppose they've* [the coordinator] *they, they've got different stresses*' [***Martha 2***]

This was considered due to the heavy demands and unpredictability of the high risk environment of the delivery suite and that it is not actually bullying, but assertiveness[16]. It is not clear if it is due to the fact that these coordinators are working within stressful high risk places, undertaking complex decisions and feel they have a high level of responsibility to clients, staff and the service as a whole to ensure safe outcomes for all or if it is an issue of hierarchy. The former would imply assertiveness, the latter intimidation and harassment to sort the 'men from the boys' (Musselman et al., 2005). One participant after a year of being registered and working predominantly in the delivery suite environment said:

> '*…that's not the sort of midwife I wanted to be so you know, but it's the sort of midwife this hospital's turning me into'* [***Ashleigh 3***].

Uncommonly, she felt that the environment was having an impact upon her; enough to change her professional values. Newly qualified midwives qualify with a view to changing practice in favour of the clients, but this soon changes as they settle into the norm. Individuals '*modify their originally held opinions to conform to the group norm*' (Berger, 1998; p15). This links strongly to the human desire to be accepted by whatever group is around to do the accepting. It may be the fact that as participants don't feel they belong to a particular group or team of midwives, they have an allegiance to those individuals they spend most time with therefore, adapting their personal views to fit with the norm.

Being 'part of the club', '*belonging'*, '*being valued*' **[Claire 2; Jade 2]** and 'midwifery culture' if positive, can lead to effective working environments and practises. However as considered above, if the experiences are more challenging or negative (even insidious) then the move from '*studenthood'* to '*midwifehood'* can be destructive leading to a loss of individual and professional empowerment. This loss of professional empowerment has a

[16] This is considered further in chapter 6.

knock on effect to the acceptance of professional responsibility. The phenomenon of being responsible elicited a range of emotions.

These participants had trained for three years and were elated that they had achieved what they set out to achieve, but once the reality of what this meant came to the fore, they became anxious about taking on full responsibility. At the point of registration two participants stated that they felt fairly confident about taking on responsibility with one acknowledging that:

> '*might be a bit of a different story once I'm kinda in and taking that responsibility on board*' [**Jade 1**].

The stark realisation that '*it stops with you'* [**Claire 1**] and that people '*expect more from you'* [**Naomi 1**] was sobering for participants with them comparing their new status with that as a student. Participants describe having a '*get out clause as a student'* [**Claire 1**] as they have a '*shelter* [to] *exposure'* [**Ashleigh 1**] since '*it isn't ultimately your responsibility'* [**Claire 1**]. Generally participants share mixed views concerning their future place of work i.e. within the main hospital maternity services unit or within an integrated or team community approach to service provision and individual responsibility. This further confirms the fact that students cannot fully appreciate the full onus of responsibility until they have experienced it within their new role as newly qualified midwives:

'I've had little kinda steps along the way like when I first qualified obviously that's where a big change you just suddenly think I'm a student I can always ask and in the end you know its someone else's qualif-its someone else's um, um registration yeah registration that you're working under um, but now its my registration that I'm working under and I think its been like little steps of kind of I think how I see it as a stage about six months and I was just thinking it was just its like a battle all of the time but you, you do get through that and you think well that's just how it works that's what its like that's fine, do you know what I mean, …' **[Naomi 3].**

At the second and third interview sets, participants stated that they did not '*have anyone to answer to*' [**Jade 2**] and that they would prefer to have '*somebody to back you up'* [**Martha 2**] as they did when they were students. So, taking the participants' experiences, one can question where and what the preceptors are doing and if the preceptors understand what their role is. Loss of confidence in one's own actions and abilities initially after qualification and registration is anticipated and for this reason preceptors are allocated to each newly employed midwife. From the participants' experiences however, it appears that a greater understanding is required to determine the differences between mentors and preceptors. This is challenging when they themselves do not attend preceptorship meetings. Preceptees need to be mindful that they are themselves responsible for the care they administer to the public and that this responsibility is not devolved to their named preceptor or any other supportive person in their presence when it suits. The focus for participants was on having people affirm that what they were doing was correct, which is typical for the inexperienced newly qualified midwife. It was not until being qualified that participants fully appreciated the:

'*…underneath stuff that you don't ever see as a student'* [**Ashleigh 3**]

for organising, for example, community workloads.

It was apparent that by the end of the first twelve months that participants had clearly taken '*ownership'* [**Claire 3**] and had begun to be '*responsible for myself now'* [**Sally 3**], which was evident in them articulating '*it's my fault um if anything goes wrong*' [**Sam 2**]. The process of assuming responsibility was '*different than I first thought'* [**Vivienne 2**] and '*hard'* [**Martha 3**] which led to feeling tired. Accepting responsibility was described as one of the biggest issues to come to terms with, where five participants did state that they had either found it '*overwhelming'* [**Jade 3**] or that they '*had no concept of the bigger picture*' [**Sam 3**] and that at twelve months post registration they found that it was '*getting easier*' [**Naomi 3**]. Despite these comments, two had '*enjoyed'* [**Ashleigh 3; Martha 3**] the challenges that came with the changes in responsibility. These findings show commonality with the majority of the cohort where participants described '*it was just like a battle all of the time'* [**Naomi 3**]; *'it really hit me half way through*' [**Sally 3**].

The participant, Jade, who had left the profession ultimately, said:

> '*I didn't feel ready …I haven't yet reached a stage where I can embrace that responsibility'* [**Jade 3**].

It could be that this participant never really wanted to accept this level of responsibility as opposed to just recognising the enormity of it on qualification. A failure to recognise and accept the huge change in responsibility after qualification can lead to reduced confidence resulting in leaving the profession. Conversely, by four months post registration two participants experienced '*lots of responsibility'* [**Naomi 2**] which they enjoyed as it '*makes you um an autonomous practitioner'* [**Vivienne 2**]. It is not clear if these two participants were encouraged as senior students to undertake care provision with mentoring occurring from a distance. If they had, it may be that their level of perceived confidence in developing responsibility is related.

Despite the fact that at the point of registration all practitioners are 'accountable' (NMC, 2008a), many participants commented that they did not feel so. Participants questioned how as a midwife they could take responsibility and accountability for the care provided

to their clients when overall decision-making was controlled by the coordinating midwife or obstetric team. This was linked more to delivery suite where they felt their decision-making skills at four months post registration were not valued due to their inexperience. The role of newly qualified midwives is to be competent in low risk midwifery i.e. case-load practice and integrated low risk midwifery, which may explain why those participants in case-load teams are finding the transition easier:

> *'… in your training yeah you're very much aware that you are an autonomous practitioner and yeah, I don't know, down on labour ward you are, do you know I think you follow instructions down on labour ward [pause] quite a lot. I was thinking about that earlier this morning actually I was thinking well ok low risk yeah midwifery led yeah your decision but do I make that many decisions on labour ward no I don't think you do'* [**Ashleigh 2**]

> '*I think er in the community um [pause] your kind of not a free spirit that's not the right word but you know you're you are given the overall responsibility for that woman at the time that you're seeing them um and well I get to do it you know, you do make decisions most of the time by yourself, but sometimes you rely on others on like on the day unit or colleagues to just back up what you're thinking um I guess you do use decision-making you know you are making decisions much more solo obviously but in the community which is good and er I think its good, boosts your confidence'* [**Claire 2**]

Two felt they were carrying out pre-ordained instructions. The inference is that by doing so, it stops the thinking midwife from thinking. As a newly qualified midwife, one commented that:

> *'I think when I first qualified I was relying a lot on peoples opinions peoples um other peoples advice and things like that whereas now I would use my own experience even though its really small I've still got something to base you know my skills on and something to base my um advice on for women and things like that um so I think that's been quite a big thing'* [**Naomi 3**]

This could be perceived as dangerous, because there may not always be another practitioner readily available to make the decision. The consequences could lead to reduced confidence in one's own decision-making abilities. It could also be due to newly qualified midwives not being nurtured especially under the pressure of intense situations, because of the belief that they are 'on their own' by being '*responsible for myself now'* [**Sally 3**]. This is less plausible than the probability of issues of confidence in their own abilities.

Participants perceived that although they would be '*making your own decisions'* [**Naomi 1**], they could still ask for help; after all '*you're just a few days different from being a senior student'* [**Martha 1**]. One participant said she felt '*hesitant'* [**Vivienne 1**] about decision-making as the '*responsibility falls on you … it may put you off*' [**Vivienne 1**] with another wanting a sign clearly stating '*don't ask me I'm newly qualified'* [**Naomi 1**]. The difficulty with decision-making was that they perceived themselves as not having '*enough back ground knowledge to kind of base my decisions on'* [**Claire 2**] and during the first four months of practise '*learning… has been in a-all about decision-making*' [**Ashleigh 2**]. By the end of the first year the same participant stated:

> '*I probably make a lot more decisions now … I just haven't noticed it*' [**Ashleigh 3**].

As practitioners gain experience, confidence builds and decision-making processes become less obvious. One participant articulates this as:

'… becoming more assertive and more confident in your own decisions'
[**Vivienne 3**]

by the end of the first year led to the realisation that:

'*I've actually started to … make those decisions without asking anybody'*
[**Sally 3**].

It was not easy for all participants where they '*do struggle with* [decision-making] *quite* [a] *lot*' [**Alicia 3**]. Participants within this study reported that:

'*… you're following that plan of care…. almost told what to do'* [**Claire 2**]

and that they are:

'*… prescriptive '* [**Claire 2**]

The problem relating this back to midwifery is that not all senior students have the opportunity to take responsibility or work autonomously because they are practising on another's registration. Despite this, one participant stated:

'I have worked closely with a first year student as well that made me you know be a bit more responsible and go out on my own and run clinics and that kind of thing um [clearing throat] so it works quite well but it really didn't come together like that until the very last few weeks of training I don't know if that's me not pushing myself to be more autonomous without my mentor or if it is a bit of a mixture' [**Jade 1**]

However, the reality for participants was that once qualified they felt they had no autonomy especially on the delivery suites they worked in. This same participant considered:

> '… *maybe the autonomy thing has finally hit me that you don't really have any'* [**Jade 2**].

This level of loss of autonomy (or never having any) was dependant upon which midwifery co-ordinator and '*obstetrician* [was] *in charge*' [**Ashleigh 2**] for that shift, leading to one description of the autonomy of the more experienced midwives being '*a bit of a power thing…'* [**Valerie 3**]. Even though participants '*didn't really get to care for women'* [**Jade 2**] in the way they envisaged themselves being an autonomous practitioner, four '*felt a bit safer in labour ward*' [**Jade 3**] as they had other practitioners around them. The concern here is that participants implied that they believe the coordinators assume the responsibility for the decision-making, when the reality is they do not. Participants articulated that hospital environments dominate, leading to a feeling of reduced autonomy:

> *'I don't think that your confidence is necessarily built on labour ward I think its often knocked and unless you go unle-well labour ward any where really unless you feel supported um in the place that you're in your confidence is gonna is gonna get knocked and then your practise will suffer as a result of that'* [**Vivienne 2**]

The implementation of guidelines, based upon best and current evidence, provides a degree of flexibility in interpretation and execution of care:

'…there are some incidences where you think why do we do that what's the point in that do you know what I mean there is no reason why we do that um we have just little things we have for the high risk women we kind of there's kind of a list of things we do and I can understand why we do it its in case we have to go to theatre there's not a big rush the thing is if that increases their chances of going round to theatre in the first place its worse isn't it so I'm just a bit like mmm so sometimes you I mean you do the things that are necessary and hospital guidelines they are guidelines aren't they but I'm if there was ever I come in and not do something that was that people like you to do and sometimes they're not even written down, do you know what I mean? It's just something that we do and its often those ones that you just think well that wasn't that didn't make sense, do you know what I mean? but I've found myself still checking that that's ok that I'm doing that I don't feel do you kn-I still don't feel comfortable just to do my own thing I still feel like I, I tell, you know, the medical staff and I tell the coordinator kind of and I know we usually do this but she's so and I know we usually examine at this point but she's only just started contracting so why am I doing it now? Do you know what I mean? so I'm gonna wait until this time um and you know if you can justify what you're saying people you know are generally well but you have to justify it [laugh]' [**Naomi 2**]

This leads one to question if midwives are truly autonomous when the reality would suggest that autonomy does not really exist. One could question the awareness of autonomy gained as senior students, as in if they truly know what it means to be autonomous. It could be suggested that many experienced midwives, let alone newly qualified midwives, do not truly know what it means to be autonomous or if autonomy really exists. From participant experiences, it can be questioned whether autonomy can really exist within the NHS maternity services because of the need to 'manage' risk and minimise potential litigation. It would appear that practitioners who believe in autonomy, true autonomy are those who practise independently. This remains controversial, but it is essential that as a profession, midwives need to fully understand what autonomy is, how this fits within large risk adverse organisations such as the NHS and what this really

means for client care. It is reassuring to note that one participant assures that if managed care conflicts with client choice then '*I would be her advocate'* [**Ashleigh 2**].

The concept of autonomy was becoming easier for some participants by the third interview, presumably with those participants who were finding the acceptance of their responsibility easier compared to those who were finding the responsibility harder. One participant concluded:

> '*I suppose in a year I'm more of an autonomous practitioner'* [**Sam 3**].

Uncommonly, one participant commented upon being a professional and this was during her final semi-structured interview:

> *'…when you're a midwife you're definitely seen as a professional expert in that area people ask your opinion and that's nice I like that so'* [**Naomi 3**]

This was surprising considering that a great emphasis is placed upon student midwives during their training to behave in a professional manner, to be professional and adhere to professional standards. Other participants only used the word profession/professional when communicating about inter-professional team working:

> *'I think that's quite good to be able to work with other professionals'* [**Sarah 1**]

and

> *'…from inter-professional I think I think there needs to be more um well there needs to be more respect inter-professionally for the decisions that are made…'* [**Vivienne 3**]

It is part of the role of a midwife to '*facilitate students and others to develop their competence*' (NMC, 2008a; p5). During the first twelve months since registration,

participants were tasked to mentor student midwives and medical students. One participant experienced this whilst in her supernumery status and on challenging was told that it would '*help her'* [**Sam 2**] to work with a senior student midwife. Another participant challenged the decision to take a student out with her into the community to work instead of the other newly qualified midwife who had trained out of area and was also orientating:

> '*I said well I'm also newly qualified and she said yeah but you trained here so it's much easier for you'* [**Jade 3**]

During the interviews, the participants reflected upon their mentoring role and compared it to being mentored themselves as students. Two commented on the fact that they emulated their mentors who they deemed to be role models. Supporting students had exacerbated an already anxious period of time where they '*were trying to find* [their] *feet'* **[Valerie 2]** clinically. Participants had described the conflicts between trying to consolidate their training and develop their confidence and this made working harder and occasionally intimidating. There was also conflict with them devoting time to caring for the labouring client and allocating time to teaching and explaining aspects to these new students.

It is unsurprising that the participants elicit some negative descriptions of their experiences within the first twelve months post registration as a newly qualified midwife. Any human on occasions, elicits feelings of trepidation and self doubt with change and inexperience. These participants were no exception to the rule. It is not uncommon for individuals to feel that they are a failure and they blame themselves for each mistake they make during this time:

'I know that if there is someone missed and, and its the its a lot its not that just you can go through everything and be really, really thorough and make sure everyone's been there that if the paper work's not there if the person's not known about there's nothing you can do but then you still feel guilty you know when something's faxed through and oh someone hasn't been seen you know a primip she's been released into the community and it you know the paper work's just not got through and they've not been seen for two weeks and you feel guilty even if you haven't been there on community you know, but there's nothing you can do…' **[Martha 3]**

'I called them and they came 10 minutes later to me that's fantastic [I: mmm yeah] but I didn't document that I called them at that point and they came, came 10 minutes later, know what I mean, and I just I just wrote down that doctor are in the room to do a review and its almost like you become quite defensive in how you write things down and that sort of stuff' **[Naomi 2].**

Individuals experiencing this form of reality shock may feel crushed inwardly when they are not successful in all they undertake. There is an apparent link as to the nature of attitude of an individual and how they experience change and new situations. However, two participants assumed a positive stance to their experiences exhibiting an attitude of:

'*I'll take it as it comes'* [**Sarah 1**]

Participants expressed disbelief that they were qualified with one stating '*I'm a midwife now*' [**Martha 2**]. With this disbelief came the implied need for reassurance for all twelve participants, but was more evident within the second interview set. This was strongly intimated as they discussed facing their fears and new situations. This is akin to a child seeking affirmation and security. A number of newly qualified midwives felt their experiences throughout the year were '*awful'* [**Edith 2**] '*disappointing'* [**Ashleigh 3**] leading to being '*disillusioned'* [**Jade 2**] and generally not enjoying their experience. Two participants particularly had 'negative' experiences where they felt '*not nurtured*'

[**Jade 3**], '*unhappy*' [**Alicia 2**] and '*miserable*' [**Jade 3**]. Several had commented that their experiences were '*rubbish'* [**Alicia 3**] however, for many this became less as the year progressed and their confidence levels increased. Most of these comments were linked to frustration and stresses within the maternity services, culture and own abilities.

The participants above did not show excessive signs of anxiety or distress through their three descriptions and generally were more positive with their experiences throughout. For half (n= 6), initially anxiety related to fear of the unknown which made the thought of becoming a newly qualified midwife very '*scary'* [**Sally 1**]. Throughout the first year two participants were worried about the issue of mal-practice on their part with one participant articulating that she was waiting for '*if something goes wrong'* [**Martha 3**] and it would only be a matter of time before they would lose their professional registration. Words used to describe this included '*nerve wracking'* [**Alicia 2**], feeling *'pressured'* [**Jade 2**], '*a catastrophe waiting to happen'* [**Sally 3**] however; throughout the year participants commented that it was '*getting easier*' [**Alicia 2**] and they were '*glad doing midwifery now'* [**Martha 2**]. There was a strong need to '*not miss anything'* [**Martha 3**] coupled with feeling guilty when they had not managed to complete work or if they forgot to discuss something with a client, for example. Despite the negative comments, participants were quick to highlight the positive aspects relating to their experiences. Even though they felt it was '*awful'* [**Edith 2**] and '*didn't enjoy it'* [**Jade 2**], they also said they were excited about it and that they had '*good and bad days*' **[Alicia 2].** These more positive comments were more common during interview three. As the role became easier they began to enjoy their roles more and found the job rewarding:

> '*I like my job'* [**Sam 3**].

Participants were proud of their achievements with most commenting on this during the first and second interviews. Participants commented that it's '*not bad…it's not good either…it's been alright'* [**Ashleigh 3**] and that it was '*different'* [**Edith 3**] or '*better'* [**Sally 3**] than they had originally expected. For most this was a fulfilling and rewarding job, but they were still finding it hard. Over the twelve months since registration

participants shared a change in feelings for their role. Two participants commented that they were surprised in their change through development and:

> *'… I think it changes a lot I think I didn't realise how much um you change in your practise and how much you change in your opinions over one year'* [**Naomi 3**].

The first twelve months post registration had passed quickly. Despite this the conflicts between one's own expectations for the role and the realities have been profound. Participants envisaged that the experience would be difficult and throughout the data collection period, many had remarked on the comments made from other fledgling midwives that their experiences had been difficult with minimal support. Some of those midwives were themselves experiencing issues of low morale. Although not the direct experiences of the participants within this study, the experiences of others had an effect on them. From the descriptive accounts provided during data collection, other people's comments can have a strong influence on individuals, in that, if someone says it will be hard one automatically thinks it is going to be hard. People generally comment on experiences or beliefs that are generally not as positive and sometimes they exaggerate things to make it sound impressive. One has to be mindful of the extent that participants take this on board themselves as opposed to finding out the reality for themselves. One participant however, was very clear in that she would consider things as she finds them and not be persuaded by others.

One participant struggled with conflict between personal philosophies of care and workload in that she was unable to complete the administration and follow up of investigations after her clinic because she was not allocated time to do so. She, like many participants, was working several hours past the end of her allocated work time in an attempt to catch up and complete her tasks. Her colleague (qualified less than two years) stated:

'…what are you doing here why are you spending so much time doing it and I said because look this is the work that I have to do and she said oh I started like that I started like you, you know made sure I followed everything up from clinic and, and eventually I realised that I couldn't do it so I have jobs that I just don't do now…' **[Jade 3]**

This participant struggled through her training with the concept of practising as a midwife because she had never enjoyed the training, but intimated that once qualified she thought she would be able to provide women centred care in the autonomous way she envisaged during her training. The reality for her was that she had decided to leave midwifery between the second and third interviews as this experience was one of many that caused her to reconsider if a midwifery career was for her. She had no desire to return to the profession. This decision and high level of frustration had been a painful process for her. The number of people that leave are likely to be small in comparison to the numbers that would like to leave, but cannot due to financial commitments. This could lead to disillusioned staff providing sub-standard care to clients, high sickness levels and low morale generally.

5.3 Overview of findings

Although some participants continued to practise cautiously, most had stated that they had gained an insight into their own practise through reflection and debriefing. At the end of the third interview one participant stated:

'I'm a midwife now' **[Sam 3].**

This has left me to ponder, when does a newly qualified midwife become a midwife. The reality here is that it is different for each individual. Some however, may never truly '*become a midwife'* and these may be the people that leave the profession.

5.4 Synopsis of Chapter

My interpretation of the lived experiences of twelve participants during their first year as newly qualified midwives has been provided via two final interpretive themes. These are: '*Fairytale midwifery: fact or fiction'* and '*Submissive empowerment: between a rock and a hard place*', both of which contribute to becoming a midwife. These interpretations covered accounts of individual and collective experiences during the three semi-structured interview sets. This chapter has highlighted the complexity of interlinking points identified within the findings.

Chapter 6: Analysis and Synthesis of Findings to the Wider Literature

6.0 Introduction

Twelve participants were involved in three sets of semi-structured interviews providing personal accounts of their experiences as newly qualified midwives through their first twelve months after registration. The rich descriptive data have been analysed and the key findings presented within interpretive themes in the previous chapter. In this chapter I offer a broader understanding of these themes by situating them in a discussion of contemporary literature.

In order to do this I undertook a concept analysis, using a combination of the methods described by Walker and Avant (2005) and Rodgers (1989) for each of the super-ordinate themes within the two final interpretive themes of '*fairy tale midwifery: fact or fiction'* and '*submissive empowerment: between a rock and a hard place'*. This analysis allowed me, as Meleis (1991) suggests, to describe further and better structure the phenomenon under study; that is the lived experience of newly qualified midwives throughout their first twelve months after registration. Additionally, it allowed me to recognise elements of similarity between the literature bases underpinning each of the super-ordinate themes of *false promises, reality shock, part of the club, self doubt, struggling* and *beyond competence* which led to the discovery of a common denominator. This synthesis is presented below using the common denominator of 'reality shock' in order to locate the themes in every day existence and make apparent any new knowledge that this study contributes to the wider world of midwifery education, research and practice. This chapter then provides a short closing review, which updates the original review undertaken when the study was designed (presented in Chapter 2) by capturing any additional information, not previously captured, related to the transition from student to midwife. The literature presented throughout this chapter not only expands understanding of the themes exposed by this study, but also enables realistic recommendations for future research, education and practice to be made.

In addition, this chapter satisfies the fifth and sixth statements within van Manen's (1990; p30) methodological structure of human science; '*maintaining a strong and oriented [pedagogical] relation to the phenomenon*' and '*balancing the research context by considering parts and whole*'. These are considered first.

6.1 van Manen's Fifth and Sixth Statements

Through his fifth statement van Manen (1990) reminds researchers of the need to be aware of the relationships between research and interest, current available theory and the experiences of those undergoing the lived experience. One has to remain mindful of the process of examination within a particular research investigation. In this case the question of '*what is the meaning of the lived experience of newly qualified midwives throughout their first twelve months after registration*?' has constantly been posed to maintain focus. Box 6.1 provides the three main 'problems' related to theory and research as foretold by van Manen (1990; p 135). As his focus is 'pedagogy' he has used this word within the given examples. As stated in section 3.3, to make sense of this for this study, the word pedagogy is to be replaced with '*becoming a midwife'* (hence the [ ] around the word in the box).

Box 6.1: Three main 'problems' related to theory and research (van Manen, 1990; p 135)

1. confusing [pedagogical] theorizing with other discipline-based forms of discourse
2. tending to abstraction and thus losing touch with the lifeworld …
3. failing to see the general erosion of [pedagogical] meaning from the lifeworld

When considering the first potential 'problem' (van Manen, 1990), accessing literature covering a range of health disciplines has been and is essential to contextualize the findings from my participants' lived experiences. However, the links may appear tenuous due to, for example, differences in philosophical perspectives between the disciplines and professions, therefore due consideration is required. Secondly, text and real life are inseparable. It would be easy for researchers to become so engrossed in their participants' lived experiences that they lose touch with the real world and what the

findings mean within the bigger picture. Equally it would be easy during the discussion to focus upon the wider literature and the interpretive themes that one forgets the experience under investigation. The third potential aspect concerns the bigger picture; the reader must be able to identify with the findings and/or develop an understanding of how one acts, and is, as a newly qualified midwife. This links with van Manen's (1990; p 30) sixth statement (section 4.3.1).

6.2 Positioning the Super-Ordinate Themes within the Current Literature

A literature search was conducted for each of the super-ordinate themes using the process as outlined in appendix 17. Concept analysis (Rodgers, 1989, Walker and Avant, 2005) was considered to aid the search of the key theoretical and conceptual issues linked to each of the super-ordinate themes. Concept analysis is a strategy that permits the examination of the attributes and characteristics of a concept (Walker and Avant, 2005). Concepts are themselves mental constructions (Rodgers, 1991, Beckwith et al., 2008) however, the analysis of these concepts may result in a 'tentative' outcome (Walker and Avant, 2005; p35). This is because two people may consider different attributes to the concept in question which may in turn lead to the identification of differing literature. There are several approaches to concept analysis such as Duncan et al (2007), Sartori (1984), Rodgers (1989), Chinn and Jacobs (1983), Walker and Avant (2005), Morse et al (1996), Norris (1982) and Paley (1996), but for the purpose of this study the techniques of Walker and Avant (2005) and Rodgers (1989) have been selected to seek out the wider literature surrounding the super-ordinate themes that were identified in chapter 4 through the use of IPA. Walker and Avant (2005) encourage the user to consider uses of the concept under consideration, in every day terms. This can be done through searching electronic databases and/or considering every day situations where the concept may be used. Once related 'uses' of the concept are identified then a search for 'empirical referents' is conducted. Rodgers (1989) considers conducting a search of the literature early on in the process. Despite the apparent initial links to an evidence based approach, Rodgers encourages the user to randomly choose items of published literature from a list prior to analysing each paper to ensure best available literature is being used. Both

processes are presented in figure 6.1 with an amalgamation of them linked to stages within the analysis process of this study. This amalgamated process was used to support the identification of literature and in doing so contributes to an added layer of analysis for my study. This added layer adds great depth of analysis and greater synthesis to my work.

Figure 6.1: Concept Analysis Processes

Walker and Avant (2005)	**Rodgers (1989)**
• select a concept • determine the aims or purposes of analysis • identify all uses of the concept that you can discover • determine the defining attributes • construct a model case • construct borderline, related, contrary, inverted and illegitimate cases • identify antecedents and consequences • define empirical referents	• identify concept of interest • obtain list of published literature • select items to include in the sample • retrieve the literature • collect and organise data • analyse and describe each category • identify a model case [to show the concept in context] • apply and communicate findings
My amalgamation of concept analysis processes used to inform the discussion chapter	
1. Identify the concept as each super-ordinate theme (chapter 4) 2. Re-engage with the '*sub-ordinate themes'* (from chapter 4) for each '*super-ordinate theme*' and all 'uses' of the concept that you can discover 3. Identify any key definitions related to the concept 4. Determine defining attributes 5. Consider whether the 'uses' identified in stage 2 are related, borderline or contrary* 6. Consider the antecedents and consequences 7. Conduct search of the literature to identify items linked to concept 8. Apply and communicate findings, incorporating 'model cases' [actual experiences from study participants] from the findings of this research project (chapter 6 discussion of themes) * The meaning of related, borderline or contrary is within the text below	

Stage two within the amalgamated process considers the 'uses' that the concept (super-ordinate theme) may be considered for. Stage five then identifies whether these 'uses' are

relevant to the super-ordinate theme being discussed in the context to this research study i.e. related, borderline or contrary. Related 'uses' clearly demonstrate the concept whereas borderline 'uses' contain some aspects of the concept. 'Uses' that are considered contrary are clear examples of what is not the concept (Walker and Avant, 2005). For the purpose of this study the 'uses' were considered in relation to the experiences of the participants. The full concept analysis process per super-ordinate theme is presented in appendix 18. Section 6.3 utilises the results of these concept analyses to inform a synthesis of the wider literature.

6.3 Synthesis of Findings with Wider Literature

On taking the super-ordinate themes back to the wider literature it became clear that there was a considerable amount of overlap. In view of this, another layer of analysis was exacted identifying the commonality between the literature presented for each theme. All six super-ordinate themes are connected with the crisis of '*reality shock*' concerned with making the journey from student to qualified midwife. The reality shock for the participants within this study comprises '*false promises'*, '*reality shock'* per se, being '*part of the club'*, having '*self doubt'*, '*struggling'* and that which is '*beyond competence*'. Hence the nature of reality shock for my participants is manifest as an experience of 'fairy *tale midwifery: fact or fiction'* and '*submissive empowerment: between a rock and a hard place'*.

'*Reality shock'* although not a new phenomenon remains significant for individuals making a transition from one place to another, one role to another and/or one experience to another (Kramer, 1974). This is something that one cannot fully be taught about, warned against or protected from and, as is evident from my participants, has to be experienced to be appreciated. This can result in feeling cheated, leading to the loss of the '*fairy tale'* an individual holds in their mind.

Pearce (1953) considers the concept of '*false promises'* especially theft by false promises. He writes from a legal perspective and considers the law surrounding misappropriation of property and theft by deceit. A false promise is a promise that is made without the intention of performance; it is a deceit in effect. There is a parallel related to 'theft by

false promises' in relation to anticipatory socialisation and expectations of a role. This links with the idiom of having one's 'hopes dashed' i.e. to put an end to someone's dream and/or aspirations (The Free Dictionary, 2010). Participants within this study had their idealistic perception of the role of a midwife, but when they became that midwife those self made promises of what to expect did not materialise. In effect they experienced a theft by deceit or by false promises, but this was not something that another individual had bestowed upon them, it was themselves that had committed the theft. Whilst potentially complex in nature, my research inserts a new, midwifery related perspective to Pearce's (1953) work by also adding the idea that false promise can be self-inflicted however, this may not just be midwifery related.

The following synthesis of the literature focuses on the crisis of reality shock showing how this relates to the super-ordinate themes under the foci and application to education, clinical practice and professionalism.

6.3.1 Education

The desired outcome required by HEIs, SHAs and the NMC is to ensure that all students that commence a training programme complete it successfully and that those midwives are fit for purpose and first post (NMC, 2009a). It is feasible that the process of becoming a midwife begins at least as far back as the selection process for suitable candidates to the three year degree programme. From experience there are many candidates that apply for limited midwifery placements nationally, which is also a trend witnessed in the nursing profession (Kenyon and Peckover, 2008). With tight deadlines and competing pressures to fill university places with the most suitable candidates means that interview and selection processes require new thinking (Ehrenfeld and Tabak, 2000). However, Harris and Owen's (2007) pilot study, prior to their longitudinal study, has highlighted that admission interviews can be streamlined and be efficient for student selection through a series of mini interviews. Candidates prepare and present a most favourable picture and can project the best image at interview leading one to consider whether it is at this point that a self deception or a '*false promise'* starts. It is conceivable that students are under a false-pretence if accepted onto a programme when they themselves are not sure that a career in midwifery is for them. It could be that

experienced practitioners judge that some students will not 'make good midwives', but equally it may be impossible to really know who in three years time will '*become a midwife'*. It is possible that, in reality, these students have to expend great effort in order to '*become a midwife'* which may result in them leaving the profession as newly qualified midwives or '*struggle'* throughout their first year after qualifying, never really adopting the role of the midwife. Further research is required in the selection of potential students, the interview process and the outcomes for these students at regular intervals post qualifying to determine whether individual career choice, the HEI process of sifting and eventual employment are compatible.

The NMC standard 12 (NMC, 2009a) considers the balance between clinical practice and theory. They assert that learning is no less than 40% academic and no less than 50% clinically based. Participants within this study experienced a 50% clinical and 50 % academic divide. From an educational perspective midwifery is taught using current evidence to meet the requirement of developing credible evidence-based professionals (Fitzgerald et al., 2003) who strive for optimum care for clients and their families (Lavender, 2008, Fraser et al., 1998, Maggs and Rapport, 1996). Education within the HEI aims to stimulate thought processes and open students up to alternative ways of undertaking care delivery, not just from what they see and experience in practice settings. Whilst it is acknowledged that the concepts underlying some aspects of midwifery may be idealistic, students are informed that they are a possibility. Each student is an adult learner in their own right (Biggs, 2003) and is encouraged to follow their own search of the literature and current practices to widen their knowledge base for their future practice. Whilst this is recommended it is not specifically monitored, but it is evident in their academic writing with higher grades being awarded to those students who have demonstrated wide reading, reflection and analysis. There is no way of exacting the success or not of this espoused deep approach to learning to the impact within clinical practice. This type of university education has been considered by participants to be unrealistic which is congruent with the findings of van der Putten (2008) and Maben et al (2006) who demonstrated that participants have difficulty in adapting to their new role

because of apparent conflicting ideologies and discrepancies with what has been taught in university.

Midwife teachers may not be current in midwifery practises; this may affect how current evidence and literature is interpreted within the classroom. It could be considered therefore that educationalists are out of touch (Diekelmann and Gunn, 2004) with the real pressures asserted by the modern day changing population and competing demands within the NHS. However, many midwife teachers do maintain clinical links. This does not necessarily mean that all midwife teachers need to practise clinically (Elliott and Wall, 2008) or hold a case-load of a designated number of clients to stay up-to-date or to mean that they are a practising midwife. Being a midwife is more than that; it is a set of personal values and a belief system (Armstrong, 2010) which therefore makes it more than just the practice component. Midwife teachers who practice have the knowledge, experience and status to practice as they wish, which newly qualified midwives do not, hence these teachers may inadvertently be making '*false promises'*. Here it's about expecting to be fully fledged, competent, experienced (even senior) professional when as newly qualified midwives that is not possible, hence the '*reality shock'*. Perhaps midwife teachers forget what it is like for the newly qualified midwife whilst at the same time the newly qualified midwives are too inexperienced to know. However, from experience, practising midwifery does increase credibility within the classroom. Students may feel a connection with someone who experiences the reality of what they experience and are more likely to trust and consider what has been articulated with confidence.

Alternatively the '*false promise'* may be considered in relation to those midwife teachers who are not deemed to be clinically credible. The implication here being that they may have lost touch with reality, leading one to question their application of theory to contemporary clinical practice. van der Putten's (2008) Heideggarian phenomenological exploration of midwives' preparation for practice aimed to inform midwifery educators how to address that preparation through curricula changes. It is not clear which year this study was undertaken however, she outlines the then current medicalised model of midwifery care practised in the Republic of Ireland and how it was on the cusp of change

to a midwifery-led care focus. The themes highlighted in her study show commonalities with the findings from the participants in this study related to the practice-theory gap, clinical support and mentorship. Both Ewens et al (2001) and Baillie (1999) have postulated similar concepts in relation to nurses implying that as a student one is protected from the realities of the role of the qualified practitioner. However, Maben and Macleod-Clarke (1998) assert that any over protection is carried out by the clinical mentors rather than their educational mentors and it is this that can impact upon some student's independent practice once qualified.

Fraser (2006) commented upon the mentor who is good at developing the students' confidence and ability to use their initiative even if it meant getting it wrong. This was compared to the fact that some students preferred to wait for the mentor to make decisions relating to professional cases. This is in keeping with the concepts of adult learning where what people '*learn from an encounter depends on their motivation and intention*' (Biggs and Tang, 2007, Biggs, 2003; p 13). By simulating appropriate and meaningful experiences, students feel the need to know more to understand the full picture and tend to enjoy learning (Fox et al., 2005, Myrick and Younge, 2004). This deep approach to learning can be seen in the example of students and newly qualified midwives being confident enough to try (Biggs, 2003). '*Reality shock'* occurs through the creation of tensions in health care since if one's experimentation goes wrong, someone's health and/or wellbeing is at stake. This was something that participants were fully conversant with, which suggests that they may be less likely to learn through experimentation (Andrews and Roberts, 2003) and/or risk taking. With the current risk averse and legally minded society, this approach to learning is largely unacceptable, unless carried out under controlled simulated circumstances which do not pose a risk to anyone. Having and complying with ethical principles (Jones, 2000, Armstrong, 2010) are paramount to both the educational needs of the student and also the safety of the public (NMC, 2006). The outcomes for such practices will have a knock on effect to the next generation of newly qualified midwives where standards of high quality care provision are reduced. Both newly qualified midwives and students need time to reflect on their actions to enhance learning and development and ensure the tacit knowledge can

be articulated and that individuals have the time to ask questions (White, 1996, Ewens et al., 2001, Fraser, 2006, O'Shea and Kelly, 2007, Eraut, 2006, Larsson et al., 2007, Lindquist et al., 2006, Hamilton, 2006). As one participant explained, 'covering one's own back' appears to be the current approach.

From the descriptive experiences provided by participants in this study, a criticism of current academic curricula is that student centeredness protects students. They can choose, or at least greatly influence their own learning activities which distract them from the full opportunities within practice. As a midwifery student, the priority is to achieve set 'numbers' of, for example, births, antenatal and post natal checks or specific academic assignments. Once qualified they no longer need to do this therefore, the priority changes. When participants experience the 'real' world (Becker and Geer, 1958) as a newly qualified midwife, they may have to undertake work that previously they did not want to do and could opt out of as a student. In effect, there is no choice. This in turn can lead to misalignment of the realities of the professional role. Roberts (2009) and Ewens et al (2001) highlight that this restricted scope of student learning meant it was difficult for students to interpret evidence and theory from a more clinical focus and hence apply it to patient care once qualified. Maben et al (2006; p466) demonstrated that on the whole, students appreciated the way they had been '*conditioned to think*' and felt that having ideals was important. Duchscher (2009) and White (1996) consider similar findings adding that there are unrealistic performance expectations by the institution, their colleagues and graduates themselves. This may be difficult to comprehend when taking into consideration the fact that the participants in my study had all had placements within one NHS Trust working alongside familiar mentors, experiencing an eclectic array of pregnancy and birth related episodes using familiar guidelines and policies to inform their clinical workloads. This implies that reality is not appreciated or understood until the student is in a position of responsibility under their own registration. The '*reality shock*' here lies between what is '*fact*' [the reality of responsibility] and what is '*fiction*' [the less real expectation of what it is like to be responsible].

Maben and Macleod-Clark (1996) considered transition from project 2000 student diplomate nurses to staff nurse positions. These nurses demonstrated '*coherent and strong set*[s] *of espoused ideals and values'* once practising (Maben et al., 2007; p99) implying that they had an awareness that their education ensured they had effective preparation for practice. They also consider that these nurses had gained a more realistic expectation of what preparedness for practice really meant in comparison to the more traditionally trained nurses; these include a willingness to ask others when unsure and having a questioning approach, but equally they exhibit a lack of confidence in their own abilities. More recently, O'Shea and Kelly (2007) demonstrated that their participants had no compulsion in masking their inabilities and were unafraid to ask for help. Data within my study highlight similar findings leading one to consider that for the newly qualified practitioner, there is always more to learn as a life-long learner (NMC, 2004a, Midwifery 2020 UK Programme, 2010). Akin to Maben et al's (2007) study, my participants were working alongside midwives who traditionally trained as general nurses then converted to midwifery via a pre-registration shortened programme. These nurses as student midwives were salaried and by virtue, employed by the NHS Trust they were working in. They were part of the workforce, counted in staffing numbers and were expected to work allocated shift patterns with a named mentor throughout their placement, they understood clearly the politics and routines and had become socialised to the NHS way of life. Participants within my study differ in that they are all university graduates with little or no prior NHS experience preceding their training, which may explain why the '*reality shock'* here highlights that there is a personal '*struggle'* with their socialisation into the NHS. This leads one to consider the '*false promise'* and '*reality shock'* of adequate preparation for performing within the NHS.

Participants as student midwives generally had spent a long time wanting to be midwives, but when qualified, the real experience was not quite what they expected it to be, despite training in the field for three years. It is as if the mystery had gone with the reality. Kramer (1974) insinuates that this places the newly graduated, for example, midwife in a period of '*crisis'*. The amount of stress that a student may experience in view of this could be dependant upon their definition of what the role entails (Brief et al., 1979,

Charnley, 1999, Oermann and Garvin, 2002, Baillie, 1999). Kramer (1974; p 192) considers that the degree to which the academic environment differs to the working environment corresponds to the level of reality shock experienced. Success is '*dependant upon the degree or extent of accommodating devices possessed by or quickly learned by the new graduate'*.

Kramer's (1974) seminal work on reality shock exposes aspects related to what leads a nurse to leave her profession, which can be considered along side Ball's (2002) study focussed on why midwives leave the profession. There is an accord with current concerns within midwifery practice as to why after three years of training, working within the NHS environment, albeit as a supernumery student, some newly qualified midwives do not fully appreciate what the NHS and clinical practice environments are about. If this is the case then there is a strong case, despite the financial constraints, for student midwives becoming employed as part of the work force again and being less like students; taking on an apprenticeship model. Some midwives leave the profession because of these restrictions or they leave the NHS to become independent midwives. My study shows that some newly qualified midwives can take up to a year before they feel they have achieved '*becoming a midwife'* whereas some never feel they have actually reached this point. Perhaps for these newly qualified midwives, a work based model of learning could aid their consolidation period or as the Midwifery 2020 UK Programme (2010) advocate, 'The Flying Start Programme' (NHE Education for Scotland, 2010) (see also section 6.3.2).

White (1996) and Melia (1987) suggested that there is conflict between the skills developed in an educational setting and those required for undertaking the actual clinical work. This was clearly a concern as far back as the 1970s (House, 1975) and forty years later similar concerns are still evident for newly qualified practitioners however, it may not be the most important thing for every new midwife. Participants had stated that at the point of registration they perceived their midwifery training to be appropriate for their first post. However, not all participants stated that this was the case at four months post registration with one participant considering that the reality did not befit the expectation

at twelve months post registration. White (1996) demonstrated through his case studies of newly qualified nurses that graduate nurses had learned and developed the ability to question more and not take issues at face value. This is the case for current midwifery practices (Steele, 2008, Fraser, 2006, Fraser, 2000c, Fraser, 2000b, Fraser, 1998). Perhaps there was no conflict between the skills developed at university and those developed in clinical practice; rather it is more to do with the perception of one's own ability to perform such skills and/or one's personality. McCrae and Costa (1999) consider the five personality traits of neuroticism, extraversion, openness to experience, agreeableness and conscientiousness as characteristics to quantitively predict personality traits to job performance. This complex psychology text is made easier to comprehend by Tett and Burnett's (2003) paper explaining that trait inferences are the overt behaviours that we see people do and that the personality traits are predictions of job performances overall. When considering this against the personality types outlined by Jung (1971), which considers the 'type' from a qualitative perspective, it would seem pertinent that understanding an individual's personality would help comprehend how they cope within certain situations. However, personality trait or type testing was not carried out on the participants within this research study therefore I am unable to equate the personalities of the participants with how they perceived their own ability to perform skills. This would be an area for future research.

The reality for maternity services currently is that midwives are needed to provide safe and effective care for women and their families (DH, 2007, LSAMO's Forum UK, 2008, Midwifery 2020 UK Programme, 2010, DH, 2009). After three years of training (Carlisle et al., 1999), managers know what to expect from their 'home grown' midwives. The wider implications of this attitude question whether individual HEIs and NHS Trusts are producing 'home grown' midwives or for the profession as a whole. Some students come from out of area and after qualification decide to return to nearer their homes to practise (Dearmun, 2000, Fergusson and Hope, 1999). This may not be ideal when considering the funding allocation from individual SHAs, who undoubtedly want those they have invested in to stay in their locality. Equally, individual NHS Trusts invest considerable time and effort into supporting students through their training; they too hope that jobs

would be available as they qualify. '*Reality shock'* linked to '*false promises*' may be felt by those midwives who move away from their place of training believing that they have the skills to practise autonomously in any NHS Trust: in reality they require specific induction training to meet the needs of individual institutions.

The DH/NHS Finance Performance and Operations (2009) consider the need for SHAs, Primary Care Trusts and employers to develop workforce flexibility by advocating '*local clinical visions and new ways of working*' (p37) to meet the changing needs of local clients/patients. Ideally and practically (Department of Health, 2009) it would be useful for students to experience new ways of working within separate and different maternity units during their training in order to have a wider learning experience. In some areas, students may only have the option to undertake practice components of their training in one NHS Trust and/or hospital where they naturally become comfortable with the practices of that locality. Conversely, by moving from NHS Trust to NHS Trust, having to learn new routines, policy and guidance, meet new people and determine who to trust and become familiar with different paper work, for example, may be unsettling for some students and could make learning the ropes of the profession and job more challenging. This may also impact upon issues of developing confidence in order to learn to practise autonomously and responsibly as a newly qualified midwife. A study is needed in a setting where multiple locations are used for student midwives to consider these aspects.

Transition, including change in role (Kramer, 1974, Holland, 1999), has an impact upon one's ability to perform and one's confidence in 'self-performance' ('*self doubt'*). Being valued and fitting into an already established team has similar impacts (Tuckman, 1965, Maslow, 1954). Kramer considers the comparison of student to newly qualified (in her case) nurse to that of the child to adult. She asserts that '*to become functional in the adult occupational world one must be congruently socialised into the values and corresponding role-specific behaviours*' (Kramer, 1974; p 42). This is clear from my participants' accounts that education enabled them as students to find out about the values and norms of the midwifery profession, but not necessarily the NHS reality that they were to later experience. It is conceivable, from the findings within this study, that although there

appears to be some anticipatory socialisation (Porter and Steers, 1975, Rousseau, 1990, Brief et al., 1979, Kramer, 1974) into the occupation of, in this case, midwifery, the likelihood is that socialisation during the academic period focuses on the values and norms that universities necessitate and not necessarily of those within the NHS culture.

From the findings one can also identify with Kramer's four phases related to reality shock (table 6.1).

Table 6.1: Phases related to reality shock based upon Kramer (1974)

Phase	**How the '*newly qualified*' feels**
Honeymoon	The world is a wonderful and exciting place in relation to the newness of the role
Shock and rejection	The newly qualified identifies the conflict between what has been taught to them and the real work. The may feel: • Like a failure • Negative • Burnout – tired, angry, anxiety, have sleeping problems, comfort eat, feel depressed etc
Recovery	The newly qualified begins to lose some of the tension and anxiety and can begin to look at the situation objectively
Resolution	The newly qualified can either: • Learn new ways to cope or • Reject the role or • Continue with the burnout

These phases can be mapped against the data collection points, the participant comments and throughout this synthesis section. The honeymoon phase was clear to me at the first data collection point; the shock and rejection phase at the second and the final two phases were identifiable, at individually different rates, at the third data collection point. Holland's (1999) ethnographic study considered the transition period phases from the student perspective (Box 6.2) rather than when qualification had occurred. Holland's

findings concur with Casey et al (2004) suggesting that any transition experience can be stressful when an individual moves from a familiar environment to a less familiar educational environment.

Box 6.2: Holland's (1999) three stages of transition

1. becoming a student nurse
2. being a student nurse
3. becoming a qualified nurse

My findings add a fourth stage to Holland's (1999) three, whereby '*being a midwife'* completes the student transition. Becoming a qualified, in this case, midwife does not mean that one is a midwife at that stage. '*Being a midwife'* does mean however, that transition is probably infinite when considering life long learning and career development. This links with the 'Conscious Competence Theory' or otherwise known as 'The Four Stages of Learning' (Crosbie, 2005, Maslow, 1968) where the more one learns the more one realises how much one does not know and has still to learn. The process appears never ending, but there is a point at which one can be 'comfortable' with knowing enough for the day to day role and then recognize where to get more knowledge when it's required. Perhaps it is this that determines '*being a midwife'* rather than being overwhelmed by the role.

Duchscher (2009) presents a complex theoretical framework of initial role transition for newly qualified nurses to assist managers, educators and practitioners to support and facilitate professional adjustment. This framework is based upon 'accumulative knowledge' gained over a ten year period - this included over 1000 reviewed papers and four qualitative research papers conducted by Duchscher herself ranging from 1998 to 2007. It builds upon Kramer's (1974) work by considering how contemporary graduates engage with professional practice at the point of registration. The framework incorporates responsibilities, roles, knowledge and relationships of the newly qualified nurse whilst acknowledging that the components of transition shock i.e. doubt, confusion, loss and disorientation are interwoven throughout (Duchscher, 2009; p1106). My data

suggests that the framework applies to contemporary midwifery transition and '*reality shock*'. It is perplexing as to why, since despite this wealth of research similar issues related to support, reality shock and transition have been commented upon from 1974 to the present day. The reality remains that similar experiences have emerged from the twelve participants within this study. Perhaps the framework devised by Duchscher (2009) will be something that will encourage change, but from experience and anecdotally the reality remains that organisations, such as the NHS, place transition low down in the priorities compared to patient care and achieving political targets. It may be that once employers see the economic benefits (i.e. reduced litigation) of robust support packages that follow business models as opposed to vocational ones that change will come. Educationalists and/or researchers could be best placed to work closely with clinical practice and employers to help with understanding '*reality shock'* so that preceptorship programmes will be beneficial to those accessing them. Providentially, the DH (2010b) have recently published their good practice guidance on preceptorship with a view to encourage NHS Trusts to reinvigorate enthusiasm for effective preceptorship programmes for all newly appointed members of staff.

The most stressful time in the career of a qualified and practising nurse, is the first three months of initial employment (Godinez et al., 1999, Taris and Feij, 2004) which befits the reality for the twelve participants within this study. Godinez et al (1999) stated that between 35% and 60% of newly graduated nurses changed their job during their first twelve months of employment. This could be due to the fact that there is perceived disparity between the preparation programmes and the reality of the role. Given that Godinez et al's (1999) research is over ten years old and curricula and education advances have taken place, these results should be viewed with caution. From my study, one participant left the profession after six months into her first post and one participant temporarily left the profession before returning to a full time role as a midwife. The remaining participants stayed in their first post for the study duration of twelve months. Remaining in their first post potentially minimizes '*reality shock*'. Kells and Koerner (2000) state that job migration demonstrates a gap in expectations whereas Chang et al (2005) consider that it is more a result of having less job control. Gerrish (2000)

considered the transition process to be haphazard as newly qualified nurses learned to perform the role of a nurse by observing more experienced nurses. Again, observations were carried out in 1998 at the point of educational change for both nursing and midwifery professions. One may surmise that the gap in expectation has been reduced due to more aligned curricula (Biggs and Tang, 2007), but this is an area that is in need of further exploration.

McVicar's (2003) literature search concerning workplace stress in nursing highlighted that workload, leadership/management style, professional conflict and the emotional cost of caring have been the main sources of distress in nurses between 1985 and 2003. From my participants' experiences, issues surrounding lack of reward for performance and actual shift working may have more of an impact upon stress levels and ultimately the belief in one's own ability, '*self doubt'*, and performance. Confidence at the point of registration had lessened by four months and by twelve months it was starting to return, which fits reality shock theory (Kramer, 1974). With appropriate support and self-belief in clinical practice with the aid of academic knowledge (Steele, 2008), students and newly qualified midwives can successfully develop through the novice to expert continuum[17] (Benner, 1984). This is with a view to aspire to become strong and effective leaders of the future, as is the expectation of the DH/NHS (Department of Health/NHS Finance Performance and Operations, 2009) and the Midwifery 2020 UK Programme (2010).

Whilst literature is available addressing educational aspects of reality shock from a nursing perspective, midwifery related papers are scarce. It is important to note that midwifery philosophies and the NMC (2009a) standards for pre-registration midwifery education are different to current nurse education therefore due consideration must be applied to the interpretations and application of the nursing focussed studies to midwifery situations. My study highlights the need to re-evaluate the practice-theory gap in relation to current midwifery practices in an ever increasing resource and financially constrained environment, with a birth rate and level of activity predicted to rise (Office for National

[17] Benner's work is considered later in section 6.3.3.

Statistics, 2009). This is in line with the need to address the expectation that newly qualified midwives are to be fully functioning at the point of registration. Fully functioning from the view of the NMC (2009a) is functioning within completely low risk, normal midwifery. The problem with this is that few births are completely 'normal' (RCM, 2010a). In 2006, according to Birth Choices UK (2010), 46.7% of births in England were considered to be 'normal' using the definition of 'normal' provided by the World Health Organisation (1997). This is complicated by expectation since other midwives expect newly qualified midwives to be able to undertake the care of more complex cases competently at the point of registration. This in turn impacts on the newly qualified midwife's confidence; she thinks she should be able to undertake more complex care, not because she has the skills and knowledge, but because her colleagues expect her to. In this instance the '*false promise'* and '*reality shock'* is reflected in potential tensions between what the regulatory body (NMC) sets as its standards for midwifery preparation, the HEI's interpretation of these requirements and the employers' and experienced practitioners' expectations of the newly qualified midwife in daily practice.

6.3.2 Clinical Practice

Hall (1980) suggested that nursing was the only profession that expected graduates to be completely finished products upon completion of basic education. Gerrish (2000), Rungapadiachy et al (2006), Ewens et al (2001), Runciman et al (2002), Clark and Holmes (2007) and Ross and Clifford (2002) commented that the majority of newly qualified nurses were not ready for independent practice at registration. Despite this, Luker et al (1996) and Maben et al (2006; p472) stated that the expectation by experienced nurses, of newly qualified nurses was to '*hit the ground running'*. For the newly qualified midwife, this expectation is compounded by the fact that upon registration they are competent to work autonomously (NMC, 2009). This was a term used by one participant within this study, who did appear to be offended by its implication; being that she was expected to be able to perform as a fully competent practitioner despite the fact she did not feel she could. Interestingly no other participant used this phraseology to describe experiences although it was implied through their narrative. The inference and '*reality shock'* here is that newly qualified midwives are expected to qualify and immediately assume the intense (DH/HNS Finance Performance

and Operations, 2009) and often extreme work load of a more experienced midwife. If the anticipation from experienced staff and managers is for their newly qualified midwives to 'hit the ground running' undertaking more high risk work loads, then perhaps they are not ready for independent practice. If this is the expectation, then professional bodies, academic and clinical establishments need to re-consider training programmes for the immediate future and initial jobs (DH/NHS Finance Performance and Operations, 2009) however, it maybe that the expectation itself is wrong. Lauder et al's (2008) Scottish review highlights that newly qualified nurses and midwives should be seen as still work in progress which stems from the philosophy of the project 2000 nursing programme. In reality, a newly qualified midwife could directly enter independent practice without a consolidatory period and so would have to immediately assume this intense workload. However, it is fair to surmise that independent midwifery practice is less busy than midwifery practiced within the NHS; whilst remaining mindful that independent practice is within the scope of normality (NMC, 2004) implying that women 'should' be low risk/normal.

All participants, including the two that were employed away from the place they trained, received a brief supernumery period; brief in the fact that they could be supernumery if staffing figures permitted. The reality was contrary to what they were initially promised prior to commencing their first post. Participants did however, consider that losing supernumery days was not too much of a problem when they worked in the place they had trained, but was a concern if they worked in new NHS Trusts. These findings corroborate studies by Gerrish (2000) and Fox et al (2005) and the Kings College London NHS next stage review (National Nursing Research Unit, 2009). Supernumery status for a period of three weeks is deemed to be beneficial to newly qualified professionals (Boon et al., 2005). This allows time for the newly qualified midwife, to come to terms with the change of status and pace of work. To deny allocated supernumery days could be seen as the first step in eroding trust between staff and management. Participants were very clear in voicing their distress in not feeling valued during their first few weeks in their new post; perhaps this was the starting point of distrust for many. Without adequate support, the risk of becoming disillusioned is increased which may lead to adverse care provision

(Rognstad and Aasland, 2007). The reality remains that this is not unique to newly qualified midwives. Anecdotally, both local and national experienced midwives are finding that their workloads are increasing and support in general is decreasing. These midwives themselves are becoming disillusioned with current practices and some have decided to leave the midwifery profession, the unit they are working in or emigrating (Ball et al., 2002).

Preceptorship, in addition to supernumery status, was born out of the need to assist newly qualified practitioners in minimising stressful unsupported periods over the duration of the first four months post qualification (Gerrish, 2000, Standing, 2007, Bartlett et al., 2000, Baillie et al., 2003, Maben and Macleod-Clarke, 1998, DH, 2010b). Realistically this is not the sole purpose for preceptorship; it is also about the retention of expensively trained staff and ensuring high standards and quality of care for all. It implies that experienced practitioners do not expect newly qualified midwives to be fully 'formed' at the point of registration despite the fact that for the majority of the participants, they were mentored as students by these experienced midwives. This may provide contradictory messages for the newly qualified midwife in that these mentors would have deemed them to be competent at the point of assessment and registration. Morley (2009) and Ewens et al (2001; p 133) stated that '*preceptorship is idealistic'* and does not work due to the fact there was no evidence of a system being in place. Within my study, preceptorship was something that all participants were aware of as a source of support, but in reality some did not really appreciate the concepts and value it as a useful commodity. For the majority of participants, preceptorship was conducted in peer support groups led by an experienced midwife. Others were allocated a named preceptor. For those attending groups, it was about peer support, meeting up with those they had trained with and/or making new friends. Not one participant commented on the fact that a preceptor was a named midwife 'buddy' or a guide that they could turn to for advice. Perhaps this was the rationale behind not valuing or attending preceptorship. Billay and Yonge (2004), Ross and Clifford (2002) and Duchscher's (2009) findings concern building effective relationships with preceptors as opposed to with fellow preceptees, so the focus opposes mine.

Evidence elicited from participants indicates that both junior and more experienced peers placed little value on preceptorship especially if the clinical workload was intense. Busy shifts meant that preceptorship meetings and/or discussions did not happen hence, verifying a '*reality shock'*. This led to participants feeling misled as to what to expect, in effect being given '*false promises'* before they had even commenced their first post. Attendance at designated meetings (group and individual) for most participants was limited due to preceptorship not being a rostered and truly valued within their respective establishments. One participant did not see the need to attend any form of preceptorship or that she would benefit from attendance so, did not access it at all. As preceptorship and supporting junior staff is a measurable component through managing risk (DH, 2010b, Darzi, 2008, NHS Litigation Authority, 2010) it leads one to surmise that preceptorship programmes were designed to meet the needs of the organisations as opposed to really valuing and supporting the individual newly appointed practitioner. Other professions/employers bestow a set period of probation, such as the Police (Hampshire Constabulary, 2009) and my experience as a new university lecturer, for employees to address learning needs, gain confidence and to have support when executing their roles. Perhaps having a defined period of probation would highlight the value of continued support, but given the apparent lack of value placed upon preceptorship, a change in name is not going to make much of a difference; although it might if genuine monitoring was part of the package. In comparison, other non-health related professions such as in law (The Law Society, 2009), nurture their young and allow for development over time (Ewens et al., 2001). This would suggest 'real' preceptorship.

Macleod-Clark et al (1997; p 252) showed that a period of nine to twelve months is necessary for newly qualified nurses to begin to see beyond the '*responsibilities of their own patient group'*. This appears to be reasonable allowing for the development of skills in defined areas before expanding on this consolidated knowledge. Ten years after Macleod-Clark et al (1997), O'Shea and Kelly (2007) and Clark and Holmes (2007) reiterated this finding, relating positive preceptorship to reduced levels of stress. Larsson et al's (2007) inexperienced trainee anaesthetists and Fergusson and Hope's (1999) newly

qualified mental health nurses were exposed to stress at work and ran a risk of burnout especially where their experiences were in very demanding areas. Kramer (1974; p 7) considers the amount of energy needed to develop the '*self*' leads to excessive fatigue and illness, which is a physical response to shock and frustration that comes from the reality of the role. It is clear that all newly qualified staff would benefit from a period of six to twelve months of a preceptorship model upon qualification (Macleod-Clarke et al., 1997). NHS Scotland (NHE Education for Scotland, 2010) has embraced this concept and developed the 'Flying Start Programme' for all newly qualified nurses, midwives and allied health professionals where they can develop their skills and competencies throughout the first twelve months after registration. Midwifery 2020 (Midwifery 2020 UK Programme, 2010), a recent report into the current evidence surrounding midwifery provision for the future, provides a brief overview of the effectiveness of preceptorship programmes for the newly qualified midwife citing the 'Flying Start Programme' as good practice.

The findings from this study demonstrate that due to current trends related to skill mix, the likelihood of a newly qualified midwife taking on the responsibility of mentoring a student (when they themselves are developing and gaining confidence in their new roles as newly qualified midwives) is high. This is despite the NMC stating that mentors must have accessed and passed an approved mentorship course and completed one year post qualifying experience (NMC, 2008; p 19). It is impossible to mentor students whilst coming to terms with a new role as Maben and Macleod-Clarke (1998) highlight. Mentoring teams are common place for some NHS Trusts as there are reduced numbers of experienced mentors and even less who have sign off mentor status (NMC, 2008). Whilst this is an effective means of training the newly qualified midwives into their mentor role, it generally undermines their time for preceptorship and support (McGowan, 2006, Lauder et al., 2008). This could be considered as another example of the ideal being 'watered down' due to the day to day reality. Darzi (2008) and the DH/NHS Finance Performance and Operations (2009) reaffirm the recommendations and findings highlighted by Maben and Macleod Clarke (1998) by developing clear guidance on the importance of effective and protected preceptorship for all newly qualified practitioners.

My study identifies the need to further consider whether newly qualified midwives are receiving substandard mentorship as students who then could perpetuate the experience for future students coming through training because they do not know any differently. If the newly qualified midwives do not feel that NHS Trusts can afford them time and space to learn and develop throughout their preceptorship programme then again the '*reality shock*' here instils a sense of being undervalued.

Increasingly, employers need greater flexibility in their workforce to meet the needs of an ever changing population. The issue of staffing and skill mix will remain a prominent factor in many maternity services (Midwifery 2020 UK Programme, 2010) for years to come therefore, services will need to be pragmatic. With the increasing birth rate within towns and cities (ONS, 2008) and with the government's drive to increase the number of new builds in key areas (Audit Commission, 2009) maternity services have to look creatively at how they manage ways of working to meet the priorities of the service. Maternity services' workforce comprise many part-time, short-term flexible contracts along with more 'non-standard' working patterns (Brooks and Swailes, 2002). Deery (2005), the RCM (1997) and Sandal (1999) have all stated that new working patterns have meant that a large number of midwives are working longer hours than previously, which has led to midwives suffering with emotional exhaustion. My participants did not expect this at the point of registration. A shortage of experienced practitioners (Endacott et al., 2003) and issues concerning retention of midwives adds to the complexities employers are faced with on a daily basis. Maben et al (2006) refer to this as organisational sabotage. Ball et al's (2002) survey highlighted a source of dissatisfaction derived from the requirements placed upon midwives to rotate through all shifts and around all areas of clinical practice. Although this is an old survey, participants' experiences suggest Ball et al's (2002) work still to be true. They highlight that midwives feel they are not in control of their working lives ultimately affecting confidence and expertise with developing and sustaining professional relationships. There is concordance with these conclusions and the findings elicited from my participants, which at the point of registration was not a consideration.

Eraut's (2006) thought provoking editorial suggests that if people work together frequently and develop respect for the good work they undertake, few problems occur; which supports findings from Winter-Collins and McDaniel's (2000) survey of 95 registered nurses. However, without deep discussions related to practice, the sharing of good practice is limited. Without time to discuss the pressures of work within the team, disaster is looming. It is evident that participants have all expressed the busy-ness within the clinical arena and how midwives do not always have the time to speak with each other. This reality does not befit the ideal perception that the participants held prior to commencing their first post. Nonetheless, this would fit with the concept that individuals are too busy to share with their colleagues and to keep one's head down to just complete the workload is easier to contend with, but this has caused participants to feel undervalued and excluded from being *'part of the club'* by their colleagues. Altering behaviour from a senior level can improve the behaviours of all staff on the 'shop floor' (Ogbonna and Wilkinson, 2003) with a view to embracing time for reflection in and on practice (Schon, 1991). Smith et al (2009b) assert that effective communication and stable workforces aid client wellbeing, deeming establishments as caring thus promoting high morale in the workforce. With low morale, high levels of sickness and absenteeism prevail (Cotton and Hart, 2003). Rapid change generates diverse emotional instability which ultimately affects the organisation. Feeling undervalued has left two participants unhappy with their choice of career leading one to resign from her first post and the midwifery profession. Callaghan (2003) asserts that people would like to leave in these circumstances, but cannot due to financial commitments so in reality only a small number do.

Hughes et al (2002) detail a critical ethnographic approach to improve understanding of local midwifery morale of twenty midwives from one NHS hospital and its surrounding community area. Staffing problems were described as the biggest bugbear with midwifery establishment levels being '*derided as woefully inadequate given the changing working practices of midwives'* (Hughes et al., 2002; p 47), which endorse my participants' experiences. Hughes et al (2002) assert that inadequate staffing levels had led to increasing medicalisation of childbirth. This may contribute to staff having to work

long hours, having reduced face-to-face time with clients and resulting in increase stress levels (O'Shea and Kelly, 2007, Hunter, 2004, Ball et al., 2002, Maben et al., 2006, Brown, 2004). Whilst this was not unforeseen, participants in this study did not appreciate the full ramifications of limited staffing levels upon service provision and as a consequence, it resulted in a '*reality shock'*. It may be that staffing resources is a big issue and that newly qualified midwives are overtly expressing what everyone else also feels. That which may appear to be short or inappropriate staffing levels may in fact be midwives not 'doing midwifery'. Anecdotally, midwives appear to be taking on roles which do not befit the true remit of midwifery alongside the increasing legal environment and perceived excessive paperwork, all of which adds to the stress for newly qualified midwives. This has also been seen with the reduction of clinical hours for the medical profession (Sen and Paterson-Brown, 2005) and midwives expanding their roles to absorb the impact.

Fraser's (2006) paper depicts findings over a three year period, from six delivery suites where student midwives learnt intra-partum care. In-depth observations were undertaken where the 'Lead Midwife for Education' (LME) was responsible for the investigation. Key findings related to the culture of delivery suite and how students and staff are valued within it. As with Fraser's (2006) study, simple basic human needs and rights, such as eating and drinking have been attributed to not feeling valued in my study. My participants have not been told they can't have breaks, but in reality they have been left to feel guilty if they do take one or ask for one. It could be that participants place this feeling of guilt on themselves because they feel they must complete their workloads, especially given perceived inadequate staffing and in so doing, not wasting time having a break. The cost saved to organisations has been estimated at 7.3million hours with the general rationale for working through breaks being 'workload' (Growthbusiness, 2009); which equates to approximately £1.5 billion in unpaid labour. This covers all employment not just the NHS, but the saving made to the NHS would be significant. This is a serious issue for employers because long term health and wellbeing and morale have an impact upon retention and sickness levels amongst staff. Having breaks improves efficiency (Folkard and Tucker, 2003, Lowden et al., 2004) therefore, any

savings made by not taking a break could be counterproductive. Future ethnographic research could consider whether this is an organisational effect or custom and practice at a junior level. The inference here is that newly qualified midwives do as their experienced colleagues do in order to be seen to '*belong'* within the group and be '*part of the club'*.

At the point of registration members were in no doubt that they would be accepted members of a team. Members of a 'segment', a like minded group of individuals (Bucher and Stelling, 1977; p 21), share a specific professional identification and an understanding of the nature and activities of their profession along with the relationship of their profession to other groups. The reality, as identified by my participants at four months post registration, was that 'members' have to be able to enter the 'segment' initially to be able to belong. Miller (1970; p 118) states that '*newcomers in any social situation go through an initial process of learning the ropes*' which includes finding out who the other people are and what they do within that situation. Maslow's (1954) hierarchy of needs (figure 6.2) indicates that there is a deep need for humans to 'belong' and 'fit in'.

Figure 6.2: A modified version of Maslow's (1954) hierarchy of needs.

Level 5	Self actualisation	personal growth and fulfilment
↑	Esteem	achievement, status, responsibility, reputation
	Belonging	Introduce our tribal nature. If we are helpful and kind to others they will want us as friends. Family, affection, relationships, work group, etc.
	Safety	Protection, security, order, law, limits, stability, etc.
Level 1	Physiological	Basic life needs - air, food, drink, shelter, warmth, sex, sleep, etc.

Maslow's (1954) study considered the healthiest 1% of college student population rather than those he considered to have mental health or neurotic issues. His focus was that of innate behaviours which as Trigg (2004) suggests discounts the effects of socialisation and culture on individual behaviours. Despite this, Maslow's work remains key in

current day psychology and health theories. Maslow's (1954) publication presents the hierarchy in relation to motivation which portrays basic levels concerning survival and higher levels leading to self-actualisation, which is what makes 'us' human. The human need to promote self-actualisation drives ambition, leading to an enhanced understanding of ourselves and the world 'we' live in, but this is determined by human experience.

Gross (2005) considers this further by questioning why '*fear of making a bad impression'* (p154) has such a powerful effect on individual behaviour. Linking back to level three on Maslow's hierarchy; it is out of the need to be loved and belong. This way there is acceptance by individuals within society, providing a meaning to life (Campbell et al., 2006) and avoids rejection and isolation (Berger, 1998). Fiske (2004) further considers this human need for others as basic survival. She also states that over time humans have developed core social motives of which 'belonging' underpins understanding, controlling, self-enhancing and trusting. This links back to Maslow's second level of safety. Without belonging and safety, personal development and self-actualisation is unlikely to occur. In order to begin to belong there is a degree of impression management (Tuckman, 1965, Gross, 2005, Melia, 1987, May and Veitch, 1998) whereby new members deliberately attempt to influence other people's impressions of them. The new member attempts to take on the role of the person to be impressed, considers themselves from that persons' perspective and adjusts their behaviour to match what is perceived to be wanted. This may explain why six participants appear to have gone out of their way to impress those senior midwives on delivery suite who have been unpleasant to them, sometimes to the detriment of client choices whilst in labour. Melia's (1987) qualitative findings of student nurses showed that they were very keen to not be perceived as '*lazy'* (p 19), to be seen as '*pulling their weight*' (p 20) and to be '*fitting in'* (p 126). The student nurses within this study were both learners and employed workers which is unlike current midwifery training situations. Despite this, these findings mirror the comments made by the participant Martha (chapter 5).

Some midwifery units have a constantly changing workforce, with midwives leaving or joining teams which has an impact on team dynamics (Tuckman, 1965; p 20) and

implications to belonging and working effectively. Tuckman's (1965) four stage model (forming, storming, norming and performing) and more latterly Tuckman and Jensen's (1977) five stages (the extra stage is adjourning) of group development can be considered in relation to newly qualified midwives joining existing midwifery teams. This may explain why the reality was not akin to the expectation of participants initially being accepted as team members. 'Forming' can be likened to participants as student midwives moving into the first few weeks of their first post. Participants expressed the desire to be accepted by others and avoided controversy and conflict. 'Storming' is evident from the participant experiences provided during the second data collection phase up to four months post registration. This is the stage where minor conflicts arose and personalities clashed. The third stage, manifest from the findings at twelve months post registration, considers 'norming' where participants began to understand the group and culture they entered into (Melia, 1987). Mixed with this is the 'performing' stage where all group members trust each other sufficiently to be able to carry out their work both within the team and independently. This stage was only noticeable in experiences articulated by the participants who worked within case-load held groups that had a maximum of eight midwives in the team. Two participants reached the 'adjourning' stage by the final interview. These participants demonstrated their readiness to move on and undertake a new venture. It is unclear why the hospital based midwives did not demonstrate 'performing' through their experiences. Perhaps the teams are under a constant change implying the process constantly re-starts with forming or perhaps it is the size of the team that is the issue (Belbin, 2010) meaning participants never fully perceive themselves as being '*part of the club*'.

Participants' comments have highlighted the '*reality shock'* concerning disparity between working in hospital, usually delivery suites and within the community. Working in the main units meant that participants knew when their shifts were due to finish whereas community workloads were so '*hard'* that often these participants were working well past their allotted time just to, as one participant stated, '*get all the community stuff done'*. One consideration however, is the fact that community settings mean working 'on your own' and having to be confident in one's own abilities compared to team working within

units where someone is usually at hand to discuss through aspects of care. The increase in unqualified support workers (Midwifery 2020 UK Programme, 2010) and shorter hospital stays means there are higher risk women discharged earlier into the community. In effect this is pushing the workload from one visible establishment onto another that is invisible. This demonstrates the '*struggle'* that newly qualified midwives have when juggling the changes in perceived responsibility, coping with a double socialisation[18] (International Federation of Social Workers, 2005) and attempting to consolidate their training. Along side this, hospital and community environments present conflicting and diverse values and perspectives due to the different models of care and risk status of clients (Hunter, 2004, van der Putten, 2008, Begley, 2002). This is not unique to midwifery, nursing has also experienced increasing workloads to the detriment of hands-on patient care (Lofmark et al., 2006). As Hughes et al (2002) identified, maternity care is thought to be deteriorating due to workload and increasing risk management. This is echoed through participant experience, which they did not expect hence resulting in '*reality shock'*.

Typically, in-hospital services provide universal and equitable care to large numbers of women and babies 24/7 and community midwives are more likely to work '*with-woman'* offering individualised women-centred models of care. Hunter (2004) ascertained that the '*with-woman*' philosophy of care was emotionally rewarding, but frequently impossible for midwives to maintain. Ever increasing client expectations was considered threatening to newly qualified midwives for Hughes et al (2002). Hughes et al (2002) showed that midwives wanted to provide more continuity of care and also influence service development, but only if they had the resources and opportunity to do so. The participants within my study agreed with Mooney (2007a) and Hunter (2004) where respondents and my participants felt that they could '*change things'* when qualified, which was not the reality; and novice and integrated team midwives who demonstrate a strong allegiance to being '*with-woman'* often end up frustrated and unsettled when attempting to practise this approach in hospital.

[18] Double socialisation means that there are two socialisations occurring at the same time, in this case the two socialisations are community and hospital. There are two teams and environments to learn and belong within.

Begley (2002) considers that delivery suites work to an industrial model and because of this, participants lack confidence to speak as advocates for women when woman-centred-care is not delivered. As stated in chapter 2 (table 2.1), Begley's (2001a) eight themes concern the student midwife's journey through training and not once qualified. Participants within my study had clear views on their standards of client care and stated that they did not have difficulty in executing client choices and requests whilst consolidating in their respective delivery suites, which does not support this conflict. Neither does it concur with Begley's (2001a, 2002) work, as my participants are registered midwives and have greater responsibility. Yet, my participants intimated that they were feeling suffocated; suffocated because they could not practise in a way they believed they could once they qualified. It was often the case that ever expanding community workloads remained invisible to busy core hospital staff. Unfortunately this is not a new phenomenon, as Maben et al (2006) validate, visible nursing work is prioritised over invisible work and that talking to patients was not seen as real work. Kramer (1974; p11) refers to this as '*professional versus bureaucratic conflict*'. Understanding the way organisations work, what and who influences this and why things are organised in such ways could alleviate some of the newly qualified midwives' frustrations and inner conflicts. Fox et al (2005) and Baillie (1999) suggest this could make a positive difference therefore, further research is recommended in this area.

Participants identified experiences (section 5.2) which they perceived as bullying, although one participant suggested that the behaviour on delivery suite was that of assertiveness. These experiences left participants feeling like they had not been accepted as '*part of the club*'. Although participants had indirectly experienced this behaviour as students they did not appreciate that this could be their reality once qualified. Medical students in Musselman et al's (2005) qualitative methodological study reported intimidation and harassment that was described as 'good intimidation' as a form of feedback to promote motivation. This was not the view held by participants in this study, which may be due to the differing professional philosophies and tolerability or the educational given expectations. Fraser (2006) demonstrates that even when the pressure

was off, some midwives still didn't have the inter-personal skills to get on with all staff, but the same could be true for any set of people. Aggression is complex to define (Gross, 2005) however, Lloyd et al (1984), Berkowitz (1993) and Fiske (2004) consider it to be a behaviour that has an intention to harm another person. Assertive behaviour, if applied appropriately would be invisible to others (Chandler, 2010) and would not pose harm to another individual. It is a means of persuading another person to do something they may not have otherwise been prepared to do. Marcuss-Newhall et al's (2000) meta-analysis considers the effects of aggressive behaviour being applied to an innocent person when they are not able to retaliate against a provoking person. Fiske (2004) refers to this as indirect aggression, whereby the aggression is triggered by a frustrating situation as could be considered in the experience of the participants in this study. Therefore the consideration of assertiveness over aggression may not fully be supported by the theoretical concepts outlined.

6.3.3 Professionalism

Professionalism has been described as knowing when someone isn't behaving professionally (Darling-Hammond and McLaughlin, 1995) to a more in-depth four sentence definition by Cruess et al (2004; p74):

> '*an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism and the promotion of the public good within their domain. Professions and their members are accountable to those served and to society*'.

Cruess et al (2004) have commented upon the complexity of defining professionalism for themselves and have devised their definition based upon a number of clinical considerations however, it is long-winded and could be viewed as cumbersome. Smith et al (2007) provide three basic fundamental principles of professionalism for consideration. They are the: primacy of patient welfare; a commitment to social justice; and the respect for patient autonomy, but by no means comprehensively define professionalism. The NMC do not define professionalism per se, but state '*as a professional, you are*

personally accountable for actions and omissions in your practice and must always be able to justify your decisions' (NMC, 2008a; p1). One's practise '*should be based on the best available current evidenc*e' (NMC, 2004a; p17) and as a practitioner one is accountable for one's own practise where '*you cannot have that accountability taken from you by another registered practitioner, nor can you give that accountability to another registered practitioner*' (NMC, 2004a; p18). Reading this in the statutory regulations is interesting, but it is open to individual interpretation. There is no benchmark to base these statements on and this could potentially cause conflict between employee, employer, and professional regulatory body. By using the word '*should'* again conjures up the idea that it is not compulsory and hence any practice can be offered. Reed et al (2008) assert that it is necessary to be able to measure professionalism before expecting learners to acquire it, but as Andersson et al (2007) astutely consider, measuring professionalism might generally be difficult as, the conception of 'profession' as a role concept is dissimilar to role reality. They also postulate that the professional self is part of the person's self and role thus allowing for individuality. If defining professionalism is complex then learning it must be equally complicated. To be professional incorporates responsibility, autonomy and decision-making, but surely this can only be learnt when in a position of living it. From an educational perspective one can strive to inform the student what responsibility is, but the '*reality shock'* comes from the fact that it is not until that individual receives their registration and practises that they begin to realise the enormity of what that responsibility means, as was the case for the twelve participants. This is knowing versus experiencing (Ray, 2009); it is like being a parent teaching a child not to, for example, put his hand in the fire. He has to learn that it is hot for himself, the inference here being that there can never be a full preparation.

Fraser et al (1998) considered the effectiveness of pre-registration midwifery education programmes on newly qualified midwives development with regards to competence, responsibility and autonomy. This was at a time where common practice was for nurses to undertake the shortened pre-registration midwifery training (Fraser, 1996). This national three-year project (Fraser et al., 1998, Fraser et al., 1997) became the underpinning basis upon which midwifery curricula, nationally, have been developed.

The issue of defining and assessing competence was addressed early on in the study (Worth-Butler et al., 1996) and was explicated further in the ENB publication in 1998 (Fraser et al., 1998) in order to be able to make judgements about the effectiveness of the education. Once the issue of assessing competence was addressed it was shown that students showed good personal qualities and were able to adequately provide holistic care for low-risk or women deemed to be 'normal', but had difficulty with competence for caring for the more high-risk client. This implies that a change of mind-set was required for direct entry pre-registration student midwives, due to expectations of competence being unrealistic for all women's care compared to those students who were also nurses.

More latterly Butler et al (2008) present three essential competencies related to, being a safe practitioner, having the 'right attitude' and being an effective communicator. The emphasis placed was about developing skills first and competence later. One needs to remain mindful that this was one of the first groups using pre-registration students since the changes to education. These findings remain valid experiences for the participants within this study as their curriculum was influenced by Fraser et al's (1998) publication. More recently, Lauder et al (2008) assert that their respondents focussed on the maintenance of a high level of respect for people in their care. This was attributed to modern curricula despite the perception that curricula were considered to be over crowded with competing theoretical components. Regulations for nursing and midwifery education assume that at the point of registration nurses and midwives have reached a standard preparation of autonomous practice for which they can be held accountable (Lofmark et al., 2006, NMC, 2009a); the '*reality shock'* for my participants lies with the fact that they are deemed to be fully competent across all aspects of midwifery activity. The issue here is, is what educationalists' think of as 'competent' is not the same as the level of expertise, speed in carrying out workload, having 'high' and 'low' risk confidence, that midwives and newly qualified midwives expect. Lauder et al (2008; p 189) demonstrate that new registrants are greatly aware of their accountability which may manifest as a reduction in confidence or self-efficacy however, they assert that this must '*not be expressed as a lack of competence*'. The fact that these newly qualified nurses and midwives show this awareness is considered to confirm safe practice and a positive

incentive for learning (Lauder et al., 2008). Self-efficacy, based on social cognitive theory (Bandura, 1986, Bandura, 1977), is according to Harvey and McMurray (1994) dependant upon four principle sources of information. They are performance accomplishments of similar tasks, vicarious experience, verbal persuasion and self-evaluation of physiological state. Effective skills utilisation comes from the awareness of self-efficacy which in turn influences academic motivation, learning and skill development; all of which enhances career progress (Harvey and McMurray, 1994). For the purpose of my study this relates to being '*beyond competence*'.

Maben and Macleod-Clarke (1998) identified that many nurses felt unprepared for the sudden increase in the management of responsibilities; finding it difficult and stressful. Many of the new responsibilities never encountered as students included increased responsibility and accountability, management of others and breaking bad news. Theoretical management preparation as students was considered to be good, but help was needed with prioritorising, decision-making, organising workload and delegation once qualified. This further affirms the concept that learning reality only really begins once the burden of responsibility lies with an individual (Kelly and Ahern, 2008). Standing's (2007) phenomenological findings show responsibility was seen as being so great so soon; without the comfort blanket of student status and with the addition of sleepless nights. A failure to recognise and accept the huge change in responsibility after qualification can lead to '*reality shock'* and reduced confidence resulting in leaving the profession (Eraut, 2006). Gerrish's (2000) publication compares newly qualified nurses who trained in 1985 to those trained in 1998. This paper presents the comparative findings from both the thesis (and related publications) with the follow up 'mirrored' study concerning nurses that qualified in 1998. The nursing training for both groups had changed considerably and is clearly noted, where in 1985 it followed a 'traditional' approach and in 1998 project 2000 was in vogue and being delivered. For both groups, the burden of individual accountability was described as stressful immediately post qualification. The newly qualified nurses from both groups were extremely anxious about fear of litigation and fear of losing professional registration should they make an error. Participants within my study exhibited anxiety related to the potential to '*get it*

wrong', but mainly at the point of registration prior to the commencement of their first post. This lessened throughout their first year as they gained new experiences. This would support the need for a staged midwifery induction programme (Casey et al., 2004) to enhance learning and confidence.

'*Reality shock'* concerning decision-making linked with responsibility remained one of the most difficult aspects of the role change for participants. Participants were consumed with the practice of assuming responsibility for their own decisions '*beyond competence*'. In fact, in reality they did not feel that they were 'allowed' or 'trusted' to make decisions concerning their care provision especially when working on the delivery suite. Jormsri et al (2005) assert that nurses make decisions that define and maintain a certain ethic that fit with professional values however, Hollins Martin and Bull (2005) found that midwives' decisions were profoundly influenced by those midwives within the hierarchy. In an earlier publication they considered the decision-making that newly qualified midwives made in the presence of these senior midwives (Hollins Martin et al., 2004). Their newly qualified midwives articulated that they would commence a cardiotocograph (CTG) recording of the fetal heart 95% of the time when asked face-to-face by a senior whereas only 17% would make that decision when on their own. Interestingly, of these newly qualified midwives, 78% went against their own viewpoint and current evidence to appease the senior midwife. More latterly through analysis of semi-structured interviews Hollins Martin and Bull (2009) identified that participating midwives were faced with three options with regards to decisions made by senior midwives. These were to comply, resist or circumvent the direction given. There is commonality between these findings and those from my participants. This latest paper (Hollins Martin and Bull, 2009) presents a descriptive interview study of twenty midwives' views of how they resolve conflict produced from competing directives. It is not clear if this is a continuation of the 2004 study or new data. The consequences resulting from the pre-occupation of how to proceed with senior midwives decisions could lead to reduced confidence in own decision-making abilities (Jasper, 1996). My participants felt they knew what to do in theory, but in reality when faced with actual situations they had reduced confidence to act. This could be due to fear of getting it wrong. '*Reality shock'* affirms that it is

different learning something on paper and in simulation, but when real human life and the personal reasonability are at stake, the focus changes.

An interesting focus for future research would be to see if there is a correlation between senior midwives decisions leading to reduced confidence in newly qualified midwives own decision-making and near misses in practice. Anecdotally, there have been insinuations that mismanagement of care, increased post-partum haemorrhages, increased third and fourth degree tears, poor interpretations of vaginal examinations and increased incidents of poor decision-making are linked with newly qualified midwives. Whilst as a SOM, there has been little evidence to corroborate these comments, it is a concern and needs to be urgently audited and/or researched. As clinical risk investigations and cases continue to rise due to adverse events in clinical practice (NHS Litigation Authority, 2010) there appears to be increasing numbers of guidance and tools available to counter the chance of such events occurring again. This could be perceived as suffocating autonomy and undermines the work done over the past century that strived to make the midwifery profession autonomous in its own right (Stevens, 2002). As a SOM, it is right and proper that minimising risk is essential for all (LSAMO's Forum UK, 2008, NMC, 2004). Midwives, especially newly qualified midwives, need to be supported to develop their confidence and competence in developing their autonomy and hence, responsibility. Historically, this support comes retrospectively, typically when care provision has not gone as planned and to the detriment of the client and/or her baby's outcome rather than proactively (Kitson-Reynolds, 2005). Some NHS Trusts have devised 'stickers' for midwives to complete (Patient Safety First, 2011), care pathways or 'charts' with tick boxes to minimise risk (Sandall et al., 2011) and ensure aspects of care and documentation have been carried out. The problem with this is that it stops the thinking midwife from actually thinking and developing her skills and knowledge, which in turn perpetuates the problem. Midwives' autonomous practice appears to be restricted and controlled by obstetric protocols and policies which are designed to manage pregnancy and birth (Hunter, 2004). Both evidence-based practice and national guidelines appear to be colluding with this. There is an assumption that midwives are expected to follow this protocol-driven culture and orders by senior staff (Green, 2005). The '*reality shock*' here

lies not with the newly qualified midwife's perceived lack of skill, but potentially with the considered poor skill mix in practice and availability of senior/experienced midwives, which may impact on the level of support available to the newly qualified midwife.

Recruitment managers consider the development of autonomy from day one as a really important factor for newly qualified nurses (Palese et al., 2007) however, domineering hierarchy dictates the level of responsibility and authority afforded to the individual (Wade, 1999). As in Hunter's (2004) work, participants in my study articulated that hospital environments dominate, leading to the '*reality shock'* of a 'feeling' of reduced autonomy. Curtis et al (2003) suggest that this is because newly qualified midwives are subjected to criticism due to their philosophical approaches to care. The increasingly risk averse society (Nolan, 2008) that midwives practise within today could lead to a generation of less able midwives practising, who have not been afforded the luxury of learning through 'trial and error' (to a degree). It is arguable that if midwives are not truly able to practise in an autonomous fashion then they are less likely to learn it and assume responsibility for their decisions and actions. For the newly qualified midwife it would be easy to follow a set of pre-ordained instructions, in effect becoming the 'yes' person within midwifery. There may be few midwives who would deliberate whether they want to move '*beyond competence'* and experience autonomy for their own practice. After all, it is easier to follow a set of instructions than think for oneself. Unfortunately some of these midwives never move beyond this stage, which may lead to wider safety and professional implications. This begs the consideration that these professionals are not midwives by definition and regulation and therefore, it could be the beginning of the end for midwifery as a profession in its own right; where support workers or obstetric nurses could carry out sets of instructions. Such a move would be detrimental to women's care and choice so midwives have no option but to develop effective decision-making skills for themselves. Educationalists and practitioners have a responsibility to help newly qualified midwives achieve this.

The issues of decision-making in practice; how decisions are recorded through documentation; how management of care is derived from decisions made; what is meant

by autonomy and responsibility; and leadership and change management are outlined in Kitson-Reynolds and Rogers (2011). This paper considers facilitation from the perspective of enhancing practice through 'real life' experiences, reflection and audit. The potential is for the senior student to experience proactive support in developing thinking in relation to developing independent and supported decision-making. The effect of the outcomes of this method of facilitation has yet to be investigated and hence is an area for future research. Clouder and Dally's (2002) evaluative study used evaluations from modules and debriefing sessions over a two year period to show how preparation for practice could be achieved whilst still practising as undergraduates. The participants within their study were from the allied health professions. Each therapist was given increased responsibility through a case-load that they held along side a practice educator. Learners had the opportunity to plan and provide care whilst being under the 'safety net' of another's responsibility. The focus here was gaining confidence in one's own abilities in decision-making and risk assessment. They conclude that taking responsibility and working autonomously are all crucial factors in the development of professional identity and is a process of professional socialisation. Senior students in Fraser's (2006) ethnographic study stated that by having this assumed responsibility they felt less anxious about taking responsibility once qualified, although, if the mentor and student worked as a pair, the mentor automatically assumed responsibility. Despite evidence of educational activities aimed at developing awareness of autonomy and responsibility through decision-making, '*reality shock'* remains blatant during the first year post registration for my twelve participants.

If one accepts that autonomous practice is achievable in midwifery, research considering proactive support for newly qualified midwives, is urgently required with a view to increasing numbers of professional autonomous staff. It may be that autonomy in midwifery is unachievable and the professional regulatory body needs to re-evaluate professional law in statute (NMC, 2002) concerning this. It may also be that there are degrees of autonomy that are progressed through, where some newly qualified midwives move further along a continuum to full autonomy than others. Participants within this study have intimated that their reality is that they do not have autonomy or responsibility

whilst working within the delivery suite and that they feel suffocated by this. This could be considered as acceptable, in that, delivery suite is typically high risk in nature. Conversely they have stated that when working in the community, which befits the low risk 'normal' midwifery philosophy (a philosophy that newly qualified midwives should be competent in at the point of registration (NMC, 2009a)), they don't like being on their own making the decisions and in effect acting autonomously. This presents a real dilemma; a no win situation leading one could consider the need for better support structures such as telephone buddies for the community days.

Benner (1984) is known for her work within the area of competence through her seminal philosophical , interpretive text regarding the passage from 'novice to expert'. The five stages originally devised for computer science by Dreyfus and Dreyfus (1980) are proficiency stages that individuals pass through; novice, advanced beginner, competent, proficient and the expert. Benner (1984) considered the concepts and developed them further in relation to nursing practice where once the level of competence has been reached the individual develops their knowledge further through research and experience. Having stated this, she also proposed that an individual could gain both knowledge and skill (the knowing how) without ever learning the theory that accompanies it (the knowing that). Atherton (2010) and Dreyfus and Dreyfus (1986) consider that mastery of a skill comes once it has become second nature and as Benner (1984) iterates, one forgets that for every skill individuals will have passed through the often overwhelming feelings of being unsure, insecure along with possibly feeling vulnerable and, as my participants experienced, they feel a sense of failure if a mistake is made. The '*reality shock'* for participants within this research study experienced a regression towards becoming the novice practitioner during their first few weeks as newly qualified midwives. Aspects of their work were under taken and dealt with piecemeal (completing the task and/or undertaking one aspect of the role at a time), but by twelve months of exposure to skills and workloads participants began to provide a more holistic basis of care.

This study adds to the contemporary discussions related to Benner's (1984) work, as the participants of this study show that one can be at any stage at any given time, which is

perhaps related to the fact that, compared to some areas of nursing, midwives undertake numerous roles in numerous environments within their working week. Therefore, with expanding roles within midwifery practice, expertise must be linked to the activity and not the person per se. One cannot be an expert in everything, all of the time and also participants encountered new experiences frequently through out their first twelve months. Benner (1984) does consider that the label of expert in these cases cannot be pinned onto an individual, but that it is considered in light of the context to which the skill was undertaken. My study concurs with this especially in light of the fact that participants are moving between different work environments several times a week and consolidation of skills may come more easily in certain clinical practice areas. One of the strengths identified with Benner's (1984) model is that it has flexibility to be applied to different professional philosophies and levels of professional autonomy. However, there have been critics of Benner's work such as Cash (1995) who consider, for example, the expertise of the so called experts within the study. Experiences provided my by participants, as stated in section 6.3.1.2, consider the personality as opposed to the expertise of the midwives they encounter therefore, I am unable to align my findings with Cash's work.

6.4 Situating Literature from Themes into Transition

As is consistent with the principles of phenomenological research, once themes generated from the current research study have been collated, a critical analysis of the literature is conducted to support or refute the findings (Spiegelberg, 1965; p350). The analysis and synthesis has situated the findings from my participants within the wider literature concerning *false promises, reality shock, part of the club, self doubt, struggling* and *beyond competence* thus ensuring interpretation from the 'real world' and what the interpretations mean within the bigger picture. Box 6.3 presents key aspects from the synthesis of the super-ordinate themes with the wider literature. Both this section and 6.3 complete the critical analysis of the literature as set out in chapter 2 where the review was repeated from October 2009 to update 'transition'. There is occasional overlap between the synthesis of findings (section 6.3) and the review here. This updated review, as presented at this point, coalesce the findings of this research back into transition. This

also satisfies van Manen's (1990; p 30) sixth statement by way of *'considering the parts and the whole'*. The 'whole' in this case is returning and situating the themes to the wider literature.

Box 6.3: Key aspects from the synthesis of the super-ordinate themes with the wider literature

- The '*false promise*' lies perhaps, between what the regulatory body (NMC) sets for its standards for midwifery preparation, the HEI's interpretation of those requirements and what employers and experienced practitioners expect the role of a newly qualified midwife to be from a day to day perspective.

- The concept of '*reality shock*' cannot be fully taught, warned against or protected from and has to be experienced to be appreciated. Linked to false promises, this can result in feeling cheated leading to the loss of the 'fairy tale' an individual holds in their mind.

- One can surmise that newly qualified midwives desire to 'belong' and therefore they 'do' as their experienced colleagues 'do' in order to 'belong' within the group/profession.

- Newly qualified midwives can take up to a year before they feel they have really 'become a midwife' whereas some never feel they have actually reached that point.

- Participants within this study have intimated that they do not have autonomy or responsibility whilst working within the delivery suite and that they feel suffocated by this, but when they have autonomy in community settings, they do not like it.

Appendix 17 details the search strategy for this literature review depicting the revised aspects from chapter 2. Eighteen papers remained after sifting the identified literature and were in addition to those papers identified and critiqued during the preliminary review within chapter 2. Table A17.1 within appendix 17 presents an overview of these papers which can be used in conjunction with this section.

O'Shea and Kelly (2007), Jackson (2005b), van der Putten (2008) and Whitehead (2001) identified that at the point of registration, the impact of a shift in responsibility and accountability had resulted in a profound experience for the newly qualified nurses and midwives under investigation. The greatest angst for these participants came from the decisions that were made under their own sole responsibility. The sudden change in responsibility and accountability was something that they felt unprepared for and that being a student forged protection from these realities. Whitehead's (2001) subjects link this with the fear of litigation where as the other studies do not highlight this as an issue. Jackson's (2005b) participants did however express 'fears' about wearing the qualified nurse's uniform as it clearly identified them as being part of the club. With that comes the expectation they feel bestowed upon them to be able to perform as a qualified nurse which included making decisions surrounding individualised care for patients. Whilst Jackson (2005b) does not provide evidence suggesting whose expectations the newly qualified nurses were referring to i.e. from the qualified and experienced staff or patients, van der Putten (2008) does. Her student midwife participants reported their awareness of the 'depth' of trust placed on them by the women and their families that they care for. These participants also felt the enormity of the perception of the expectations that their more experienced midwifery colleagues had of them which proved to be demanding of them. One could consider whether the differing philosophies within the two professions and the levels of expected autonomy at the point of registration impact upon the levels of expectations for the newly qualified nurse or midwife. However, this cannot be answered from the presented papers.

As with Jackson's (2005b) participants, Mooney's (2007b; p1613) participants felt visible once 'metamorphism' from student to qualified nurse had occurred and they had a change of uniform. Prior to this, they felt ignored during their supernumery student status and had limited exposure to clinical involvement because there was an air of feeling burdensome to their mentors. It is reported that many of them decided to work on their own to avoid 'intrusion'. Conversely on qualification, they clearly articulated the difference in being trusted, for example, in making decisions and being asked for their

opinions regarding clinical issues. However, they too experienced great expectations placed on them (Mooney, 2007a) which they felt were often unrealistic because the assumption was that they knew everything. Despite the fact that they felt they were more accepted as qualified nurses, managers continued to make them feel uncomfortable when they asked questions about clinical issues. The newly qualified nurses felt un-prepared for the reality that they actually 'felt'.

O'Shea and Kelly's (2007) participants reflected back to their first days working in a ward environment as newly qualified nurses and reported feeling 'scared' and experiencing physical stress about their new role. These feelings lasted for approximately a week for most of the participants with fewer experiencing it for longer. There is overlap with my themes, predominantly those of '*self doubt*' and '*struggling*' however; the participants in my research study experienced these feelings for longer, up to four months. van der Putten (2008) has referred to this as reality shock, which is not a new concept and first considered by Kramer in the 1970s as previously discussed.

There is emphasis that services need to ensure that newly qualified nurses are receiving appropriate preceptorship (Ross and Clifford, 2002, Rungapadiachy et al., 2006). This needs to be evaluated nationally. Time management proved to be a problem for participants in O'Shea and Kelly (2007) and Jackson's (2005b) studies. One participant in Jackson's (2005b) study expressed the anxiety that time management with delegation would be something to be learnt once qualified and not as a student whereas my participants had no concept of this until they had exposure to practice. Managerial responsibilities within the clinical areas caused concern with regards to organising and planning client care, booking tests and making inter-professional referrals (O'Shea and Kelly, 2007). Baillie's (1999) student focus groups were able to identify management skills they felt were required when qualified. The students reported an awareness of the stress and pressure of working as qualified nurses which was linked primarily to managerial ability and working within limited resources. For Baillie (1999) this stems from the inability to work in a supernumery status alongside other staff nurses to gain skill and insight during their educational programme. Supernumery status as a student

was deemed to provide time to learning decision-making and prioritorising skills although, it appears that some did gain experience with providing care to a number of patients which included discharge planning and decision-making. It is unsurprising that students wanted more opportunity with developing these skills, but were aware that they were being counted in the workforce. This is something that was re-iterated by the qualified nurses through their experiences of dealing with the difficulties of delegation when being new to a team. The qualified staff commented that 'nothing can prepare you for it', but could conceive that university teaching would help in this area with the use of role-play. These general comments are akin to participant experiences expressed within the interpretive theme 'fairy tale midwifery: fact or fiction'. The inference from Mooney's (2007a, 2007b) papers suggests that there are negative feelings from under-graduate nurses as well as newly qualified nurses that the supernumery style preparation may not be as effective as previous preparation programmes. Mooney (2007a, 2007b) states that research into this area has not been undertaken prior to this study.

Holland's (1999) findings are presented under three 'states which take place as students undergo' change. These are 'becoming a student nurse', 'being a student nurse' and 'becoming a qualified nurse'. It is acknowledged that the participants' rationale for choosing nursing was ultimately about an idealised and vocational image of caring for those who are sick which has been described as '*an inner sense of vocation'* (Holland, 1999; p232). This paper is the only paper from those presented that considers the fact that student nurses have previously worked as auxiliary nurses and that some continued to do so whilst on programme. They did this during their non-student time. The main implication of this was role confusion in the clinical area which ultimately affected their skills and knowledge development in terms of the professional mindset. The complexity arises when working as an auxiliary and being able to remain working within expected parameters and not using the student skills outside of that remit. For the transitional process, the main observation focuses on the aspect of rostered practice. It would seem that when senior students are rostered for duties they begin to learn how to be a nurse. This is because they are part of the workforce undertaking the workload similar to the qualified nurse; something iterated by Baillie (1999). This prompted Holland (1999) to

look at the format of the Project 2000 programme where the first 18 months appeared to not be useful in developing nursing practice. This paper considers a justification for a three staged programme over the three years which translates to year one, year two and year three as understood in current practice. This paper also questions what makes a competent learner become an '*accountable'* practitioner over night. Holland (1999) concludes that it is about a transition into a new social state. She poses the thought that perhaps teachers will need to understand the culture of nursing before they can really help students understand what it is they need to understand in order to provide the reality for their future career. Perhaps, given the change in nurse education and preparation, there may be some justification in the implied perception that teachers don't understand the culture as they themselves are unlikely to have held supernumery status during their education.

Fraser has written extensively and has been instrumental in the development of midwifery education since the changes and introduction of three-year midwifery diploma and graduate programmes (Fraser et al., 1997, Worth-Butler et al., 1996, Fraser, 2000a, Fraser, 2000b, Fraser, 2000c). Many of the areas related to midwifery education raised in the ENB publication (Fraser et al., 1998) remain pertinent in current climates such as, considering attrition rates, supporting the learning needs of students post registration, failing students and assessing competence (Butler et al., 2008). However, modern curricula have reviewed this work and have developed accordingly for a more contemporary practice. The findings presented in the ENB publication (Fraser et al., 1998) were used locally to inform curriculum development which would have been the foundation for the midwifery programmes of the participants in this research study. With the development of curricula and practice since 1998, further research is needed to update knowledge on the current requirements and outcomes related to contemporary midwifery education and to offer comparison and insight into modern issues. Lauder et al's (2008) evaluation of the fitness for practice pre-registration nursing and midwifery curricula project encompassed a multi-phase and multi-method approach combining methods from both the quantitative and qualitative paradigms. The 2004 and 2005 cohorts of student nurses and midwives included in this evaluation undertook the initial postal survey;

however it is not clear how far into their education programme they were at the point of the survey. Considering the evaluation concerned nursing and midwifery programmes, the background and supporting literature was from a nursing perspective leading one to consider that there is a lack of midwifery related literature confirms that paucity in related papers for this research. Surprisingly, Fraser's work surrounding the changing midwifery pre-registration education (Fraser et al., 1998) and competency assessment (Worth-Butler et al., 1996, Fraser et al., 1997) are not included.

6.5 Synopsis of Chapter

This chapter provided an analysis and synthesis of the findings in relation to contemporary literature and their application to practice in light of local and national perspectives as well as from a personal interpretation. The focus for the synthesis was the crisis of reality shock in view of the fact that on taking the super-ordinate themes back to the wider literature it became clear that there was a considerable amount of overlap. The super-ordinate themes were related throughout under the focus of education, clinical practice and professionalism; hence satisfying the fifth and sixth statements of van Manen's (van Manen, 1990) methodological structure. Finally the chapter concluded by revisiting and updating the literature in chapter 2.

Chapter 7: Conclusion and Implications for Practice

7.0 Introduction

A hermeneutic phenomenological approach, incorporating an interpretive phenomenological analysis of the data, was utilised to consider the lived experiences of twelve newly qualified midwives working through their first twelve months after registration. This was achieved through addressing the research question:

What is the lived experience of newly qualified midwives during the first twelve months post registration?

Chapter 6 presented a synthesis of the findings and the wider literature with a view to bringing forward themes to this chapter to consider how they fit within contemporary practice. This chapter presents the key conclusions that have emerged from the study under the two final interpretive themes followed by the critical evaluation of the study and the implications for practice. Finally a reflexive account is provided outlining my learning and considerations of this learning into practice.

7.1 Study Conclusions

Participants have told their stories which have contributed to an interpretation of lived experiences related to '*becoming a midwife'*. The experiences of qualifying and practising midwifery were akin to coming of age or passing one's driving test and then really starting to learn to drive once exposed to the realities of the role. The reality is that '*becoming a midwife'* occurs at different times for participants. Some achieve this within a few months of qualifying, some after a longer period of time while others never truly achieve it.

Key study conclusions have been structured using the two final interpretive themes: '*Fairy Tale Midwifery: fact or fiction'* and '*Submissive Empowerment: between a rock and a hard place*' that constituted '*becoming a midwife'*.

7.1.1 Fairy Tale Midwifery: Fact or Fiction

At the point of registration, participants expressed the belief that their training and experiences had prepared them well for their forthcoming first post as a qualified midwife. They stated that their training included case-load held practice, community, birth centre and hospital focussed care provision thus providing a well-rounded experience. However at four months post registration they deemed that their training had not fully equipped them for the 'real' world of clinical practice, despite the fact that ten participants' first posts were in the establishment that they had spent three years training in. One participant wanted to have '*handy tips*' from the midwives '*doing the job*' to support her practise, which she felt would be more useful than evidence-based knowledge. The fact that university education was portrayed as idealistic by participants was the biggest factor to emerge and that as students they were protected by '*the shelter of the university*' and that '*nothing can prepare you for the realities*'.

Participants felt lonely in their new roles, predominantly due to the fact that for three years they had a named mentor that they worked with every shift. This was because prioritorising workloads and paperwork, for example, took a long time for them to complete and there was no-one to hand over the work to. If it was not done there and then it would be theirs to complete the next time. There was little support and empathy from more experienced colleagues for this aspect, with few being dismissive to participants' distress. Participants felt that their senior colleagues had unrealistic expectations of them. Participants needed '*time'* to complete even the most basic tasks within their role; something that they did not feel was acknowledged for the newly qualified. Lack of time to complete workloads in work-time impacted heavily on home and family life which led those with families to feel guilty. Eight participants worked part-time hours, but were working well over their contracted hours for little or no reward.

Long shifts and long stretches of working consecutive days led to feeling tired. Participants told how this left them feeling '*frustrated'* and '*stressed'*, that they felt they were doing the job on their own. They found it hard to '*switch off*' from the role once

they had left work often worrying that they had omitted something important or that they had done something wrong.

Support was an important issue for all participants. Supernumery and preceptorship periods were offered to all, but this was dependant upon staffing levels and workloads. Participants did not value preceptorship as a useful concept potentially because they were not fully conversant with what it was. Consolidating training on delivery suite to gain skills in, for example, suturing and cannulation was the priority set by management. Two stated that after a year they had not completed this remit which had impacted upon them and their job roles; this is beyond the scope of this project. Delivery suite appeared to be the priority to the detriment of community aspects. Community workloads were invisible to hospital staff and vice versa. For those working community shifts and being called in to cover hospital shifts, no consideration was given to the workload still to complete. Although this issue is beyond the control of the newly qualified midwife, the consequences impact upon the consolidation of training and building of confidence within their new role. Participants stated that they were becoming aware of the political aspects within their units and had wished they had more awareness as students.

Participants were surprised to experience, within the first few weeks of qualifying, being the only qualified midwife in a busy high risk ward area assuming responsibility for 25 to 30 women and babies. Their support was via telephone to the delivery suite or the duty manager for the day. This had led to a greater degree of anxiety, but more positively a steep learning curve. Despite this, participants preferred to work within the hospital setting to the community. Community workloads and organisation was considered to be a '*shambles'* and '*rubbish'* which questions the participants' perception to what case-load practice actually means. At least they knew that they could hand over care to the next midwife and not need to worry about not having time to complete all aspects in hospital. These experiences appear to have shattered their romanticised '*fairy tale'* perception of midwifery.

7.1.2 Submissive Empowerment: Between A Rock And A Hard Place

The twelve participants had trained and worked hard for three years to complete a degree programme and become registered as qualified midwives with the NMC. At four months post registration participants felt that they had still not been accepted as midwives by their experienced midwifery colleagues. They felt they had to pass through an initiation period before acceptance was achieved. Two never got there by twelve months post registration whereas four appeared to have achieved it as a student. Participants told of the perceived need for them to impress their senior colleagues even when they had been unkind to them in order to feel that they '*belonged*' and were accepted. This was related to experiences within the delivery suite where most time was spent consolidating training. Participants stated that they had not felt that they '*belonged*' within their teams. Commonly this was because of the need to consolidate their training on the delivery suite and hence being away from their actual team and their philosophies. Neither had they been accepted as part of the delivery suite team during this time (six months to a year). Having somewhere to put personal property whilst working in delivery suite and having a break were considered key aspects related to feeling valued.

Participants felt that no consideration had been given to the fact they were within their first twelve months of qualification and that '*people were too busy to be nice*' to them. For one participant this was enough to feel undervalued because no-one cared. On the whole participants felt they were expected to go above and beyond the call of duty because they did not want to be perceived as lazy. This was despite the fact they perceived some more experienced colleagues to be. If the delivery suite co-ordinator was nice, participants felt positive within their work and level of morale. They knew who to ask if they were unsure what to do and definitely knew who to avoid. Bullying and intimidation had been mooted linked to senior midwives with one participant excusing this behaviour as to the stresses of being responsible for managing busy delivery suites.

At the point of registration participants said they were '*worried*' and were '*daunted*', but '*fulfilled*' at becoming qualified and were fully aware that their registration was at risk if anything went wrong. Responsibility was the biggest cause of anxiety for the newly

qualified midwife, even though as senior student midwives they had the opportunity to experience work more independently. The realisation that it all '*stops with you*' made participants realise that students had '*shelter to exposure*' and that they did not fully appreciated it until they had commenced their first post. Confidence at the point of registration had lessened by four months and by twelve months it was starting to return. For one participant the realisation of responsibility was too much and she left midwifery altogether.

Despite being taught the professional aspects related to midwifery as students, participants did not believe they were accountable or autonomous. This was still the case for most at twelve months post registration. However, one could surmise that participants must have felt some accountability/autonomy because they were worried about losing their professional registration. Decision-making was deemed to be controlled by delivery suite co-ordinators and/or the obstetric team. Participants did not feel valued or trusted in decision-making and they perceived they were required to carry out pre-ordained instructions for their labouring clients. Consequently at twelve months participants had less confidence in their decision-making abilities. They did not realize that perhaps they had begun to make more decisions themselves or that they were moving from novice to advanced practitioner (Benner, 1984). The need to follow delivery suite guidelines made participants believe they had no autonomy. To not follow guidelines meant being questioned severely as to why they had not done as stated.

The newly qualified participant was expected to mentor junior students whilst trying to consolidate their own training. This was difficult for half of the cohort especially when it occurred within the first month of employment. This led to increased anxiety and frustration which undermines the newly qualified midwife's time for preceptorship and support. This can lead to ineffective mentoring of students who will become the midwives and mentors of the future.

In the main, participants were proud of their achievements, but the role was not as they had expected it to be. They had seen a change in themselves over the year in terms of

confidence, although they had struggled throughout the twelve months to perform their role to the best of their abilities. This '*struggle'* has led to '*submissive empowerment'* for those who had difficulty with being accepted into the midwifery culture. For most, the '*change in themselves'* has resulted from learning to contend with the dilemmas of being a newly qualified midwife; in effect being '*between a rock and a hard place'*.

7.2 Critical Evaluation of the Study

At the onset of this research project, it was not possible for me to be fully conversant with the underpinning methodology before embarking on this study. This was due to my limited understanding and exposure to studies with this approach. It was by doing this research that I began to develop an understanding of 'hermeneutic phenomenology' and develop my 'thinking' processes. Through my journey, I became aware that:

> '*…every qualitative study tends to be one-of-a-kind…'*
>
> (Wolcott, 2009; p 76)

An evaluation of the research process provides readers with the ability to consider the potential influences of the findings. Hermeneutic phenomenological studies potentially present a range of interpretations related to a specific lived experience (van Manen, 2002). This study aimed to interpret the lived experiences of participants with a view to giving them a voice; it remains appropriate to this study's aim.

Recruitment to the study could have been done via student representatives. Doing so would minimise involvement of the educational hierarchy and the potential for coercion into joining. The sample for this research project has the potential for bias, through using one cohort who were self-selecting. By self-selecting potentially those with particular views or personalities could influence the data.

It is acknowledged that the findings are related to the experiences of twelve participants, from a cohort of fifteen, experiencing what it is like to be a newly qualified midwife within the first year after registering with the NMC. The concept of pre-consciousness (van Manen, 1990) for participants in this study has its limitations. The first semi-

structured interviews clearly demonstrate pre-conscious reflection in that the participants had not considered their potential experience prior to the interview. Participants had already reflected upon their experiences by the second and more so the third interviews with four participants telling me that they could not wait until our third interview so they could tell me all about what had happened to them. Equally, midwives are reflective practitioners (NMC, 2008a, NMC, 2004a) therefore, participants may be expected to reflect upon their experiences in practice. This means that they had already applied an interpretation to their own experience which could be viewed as a potential flaw in the theory that suggested that participants would not do this.

As with any research study there are restrictions placed upon time and space for writing up the process and findings. For me, the researcher, this has led to the agony of choice; what to include and what to omit (Wolcott, 2009). However the selected data represents the findings from the participant experience. All data are important, but due consideration has to be placed upon most significant findings for presentation.

7.3 Specific Contribution of the Study

Through the analysis and synthesis of the findings in chapter 6, key specific contributions of this study to existing knowledge were highlighted. The twelve participants from one cohort had, as student midwives, generally spent a long time wanting to be midwives when qualified; the real experience was not quite what they expected it to be despite training in the field for three years. Student centeredness protects students through the identification of their own learning requirements, which distract them from the full opportunities within practice. This study highlights that when the participants experience the 'real' world as a newly qualified midwife, they may have to undertake work that previously they did not want to do and could opt out of as a student. It is questionable if they had ever accepted the role of a midwife whilst being a student which in turn can lead to a misunderstanding of the realities of the professional role. It has also questioned that perhaps these midwives are those that cannot embrace the concept of being an autonomous and responsible practitioner given the time and resources available to them.

Idealistic university education is a potential concern related to the practice-theory gap. Participants told how their training did not reflect the current NHS practices. Whilst evidence-based practice remains paramount in education and practice (NMC, 2009a, NMC, 2008a) the focus of midwifery education should reflect the realities within an NHS environment rather than what it could be in an utopic world. Whilst being aware that ten of the participants were employed in the place that they had trained, my study brings to this discussion the need to re-evaluate the practice-theory gap in an ever increasing resource and financially constrained environment. This is along with the need to address the expectation that newly qualified midwives are to be fully functioning at the point of registration and to determine if newly qualified midwives are fit for purpose.

Experiences elicited from these twelve participants indicate that both junior and experienced peers place little value on preceptorship especially if the workload is intense. This has led to participants feeling misled as to what to expect; in effect being given '*false promises'* before they had even commenced their first post. Attendance at preceptorship forums for most participants was limited due to preceptorship not being rostered and truly valued within their respective establishments. As a result of current trends related to skill mix, there is a strong likelihood of a newly qualified midwife taking on the responsibility of mentoring a student when they are developing and gaining confidence in their new role as a newly qualified midwife. Whilst this is an effective means of training the newly qualified midwives into their mentor role, it generally undermines their time for preceptorship and support. My study highlights the need for organisations to re-evaluate the priority placed upon preceptorship and support for newly qualified midwives in line with the Darzi (2008) report and recommendations portrayed in the newly published preceptorship document (Department of Health, 2010b).

The participants within my study naively show concordance with Mooney's (2007a) and Hunter's (2004) findings where respondents felt they could change '*things*' when qualified. Participants intimated that they were feeling '*suffocated*'; suffocated because they could not practise in a way they believed they could once they had qualified. As with Hunter (2004), participants in my study articulated that hospital environments

dominate, leading to a feeling of reduced autonomy. My study highlights that whilst there is no control over the environment; one has to consider who is there to support the newly qualified midwife in his or her decision-making and general actions. Personalities within delivery suite areas can leave newly qualified midwives feeling undervalued and that they do not '*belong'*. This is made more prevalent when consolidation of training occurs away from their main team and area of working. This study has shown that often experienced midwifery colleagues expect more, by placing the newly qualified midwife on a busy high risk delivery suite to consolidate their training. Despite this, these newly qualified midwives preferred to work on the delivery suite where they have instant access to support and advice compared to being '*on* [their] *own'* in what they perceive to be a '*chaotic'* community setting.

This study has contributed to existing knowledge by way of highlighting the complexities that twelve newly qualified midwives experience surrounding change of responsibility upon qualification. These newly qualified midwives do not perceive themselves to have autonomy and by virtue, responsibility. This is in relation to the complex decision-making skills and autonomy needed to care for clients on delivery suite during intra-partum care provision. Lack of autonomy and the ability to undertake decisions can lead to high levels of anxiety in the newly qualified midwife therefore, a national audit or study could consider this in relation to client safety.

7.4 Implications for Practice

Considering findings in relation to existing knowledge has, by implication, produced more questions for consideration. Wolcott (2009) asserts that it is appropriate to state what problems have arisen from undertaking research and what can be done to address them. This can typically be considered through suggestions made from the findings and from future research. These are presented via education, clinical practice and regulatory body perspectives.

7.4.1 Education

From an educational perspective this study has considered the finished product of 'competent qualified midwife' in relation to the journey of 'becoming' that midwife. The process of '*becoming a midwife'* commences prior to choosing the midwifery HEI. Potential students will have considered the role of the midwife with a view to undertaking appropriate qualifications to be accepted onto a training programme. For some this is straight from school/college, for others it may be a change of career path later in life. Those involved in the selection of potential students have an overwhelming responsibility to ensure those entering the course are appropriate and are not lost to the profession '*by reason of competition for places*' (Lauder et al., 2008; p 195). This is a complex task when potentially hundreds of applications are received for possibly 30 places. Potential students are encouraged to gain experience within health care arenas, preferably midwifery, to gain insight into the role. Perhaps undertaking a brief preparation course prior to applying to do midwifery would enable potential students to have greater insight. To justify cost effectiveness, this could be arranged as one cohort within each of the current Local Supervising Authority boundaries. This would be a course developed through the HEI and NMC. Further debate is required considering the selection of potential students, the interview process and the outcomes for these students at regular intervals post qualifying prior to the development of such courses. This could take the format of 'round table discussions' after auditing the student's pre-course interview when leaving the university (i.e. completion of course or attrition).

7.4.2 Clinical Practice

Supernumery status for a period of three weeks is deemed to be beneficial to newly qualified professionals (Boon et al., 2005). This allows time for the newly qualified midwife to come to terms with the change of status and pace of work. To deny allocated supernumery days could be seen as the first step in eroding trust between staff and management. If newly qualified midwives do not feel that NHS Trusts can afford them time and space to learn and develop throughout their preceptorship programme then again this instils a sense of undervaluing mentorship and support for the next generation of midwives. The first twelve months post registration could be structured in such a way as

to provide newly qualified midwives with preceptorship and support for the first six to nine months (DH, 2010b) with a view to preparing for the mentoring role from nine months to a year. Ideally, value needs to be afforded to protecting preceptorship and mentorship time for all qualified staff, which is clearly auditable and monitored for quality. This responsibility would lie with the NHS Trusts together with academic support, with perhaps penalties awarded to those services that continually provide substandard support to both newly qualified midwives and students. An audit is required concerning how effective preceptorship packages work and whether alternative tools would be more valuable. Perhaps having a defined period of probation or a staged workload would highlight the value of continued support.

Hospital and community environments present conflicting and diverse values and perspectives due to the different models of care and risk status of clients (Hunter, 2004, van der Putten, 2008, Begley, 2002). An interesting focus for future research would be to see if there is a correlation between this and near misses in practice from a national perspective, or through local audit of practises. Anecdotally, there have been insinuations that mismanagement of care, increased post-partum haemorrhages, increased third and fourth degree tears, poor interpretations of vaginal examinations and increased incidents of poor decision-making linked with newly qualified midwives. Whilst as a SOM, there has been little evidence to corroborate these comments, it is a concern and needs to be urgently audited and/or researched. This would be linked to the probationary period, whilst remaining sensitive to not undermining the idea of autonomy at point of qualification.

7.4.3 Regulatory Bodies

Newly qualified midwives are to be competent within 'normal' or 'low risk' midwifery at the point of registration (NMC, 2009a). However, in reality newly qualified midwives are expected to qualify and immediately assume the intense and often extreme workload of a more experienced midwife thus incorporating moderate and high risk midwifery care provision also. If the anticipation from experienced staff and managers is for their newly qualified midwives to '*hit the ground running'*, then perhaps they are not ready for

independent practice. If this is the expectation then professional bodies, academic and clinical establishments need to re-consider training programmes for the immediate future.

The increasingly risk averse society that midwives practise within today could lead to a generation of less able midwives practising, who have not been afforded the luxury of learning through 'trial and error' (to a degree). Midwives are autonomous practitioners (NMC, 2004a), but it is not obvious that the midwives in this study understood what this really means within clinical practice. Educationalists need to consider whether or not newly qualified midwives 'see' or 'experience' autonomous practise during their three-year training. If not, they may require support to achieve this understanding or else they may feel caught '*between a rock and a hard place'*. It is arguable that if midwives are not truly able to practise in an autonomous fashion then they are less likely to learn what it is to be autonomous. If midwives are not able to truly learn autonomous practice then it is questionable if they can truly learn and assume responsibility for their decisions and actions. This begs the consideration that these professionals are not midwives by definition and regulation and therefore, it could be the beginning of the end for midwifery as a profession in its own right. Hence, the future could see midwives as obstetric nurses (being registered on the 'Nurses part of the register') undertaking 'high risk' care provision and midwives (on the 'Midwives part of the register') providing 'low risk' or 'normal' care. This could lead to disappointment for all midwives especially newly qualified midwives.

7.4.4 The Future of Midwifery Training

Research to date (Fraser et al., 1998, Fraser, 1996, Fraser et al., 1997, Fraser, 2000b, Fraser, 2000a) has advocated a university based education for midwifery, which is supported by the NMC (NMC, 2009). This study has indicated that participants value the university experience, but as Jade stated:

> '… *forget evidence based practice, tell me what works for you, tell me what you did … that might help me one day you know that's what I want to know … but is that proper midwifery?'* [**Jade 2**].

Participants within this study have indicated that they felt the most challenging aspect of being newly qualified was related to the change in level of professional responsibility linked to having professional registration (section 5.2). Informal conversations with other local midwives would confirm the area of greatest challenge surrounds this changing level of responsibility and development of autonomy.

When considering the implications related to education, practice and the regulatory body, the future of midwifery training could follow an apprenticeship model. This could be a two stage process. During the first stage students would be as full university students, experiencing the 'student life' and following an educational pathway similar to that currently set out by the NMC (2009a). This would involve clinical experiences and related academic study over a two year period. At the end of these two years students would be required to demonstrate competency in low risk midwifery. With this, registration onto a provisional (restricted) part of the professional register would be achieved. The proviso here would be that they continue and complete their midwifery training and not 'step-off' the programme to become, for example, a Maternity Support Worker. This would be the equivalent of holding a provisional driving license and still being supervised so that students can then complete the second stage of the training. The second stage, also two years, would see students working more as paid (possibly band 4-5 (DH, 2004a)) apprentices, whilst focussing on developing autonomy and responsibility. Areas such as management, high risk care groups could be learnt whilst holding some degree of responsibility. By being on the provisional part of the register, the apprentice would 'feel' what it is like to be responsible without having full responsibility. The fourth and final year would act as the preceptorship and consolidatory year; perhaps having a gentle introduction to mentoring students prior to the end of the fourth year in readiness to undertake mentorship training upon qualification. Full registration as a midwife would not be achieved until the four years were successfully completed.

Further research is required to look into midwifery training recommendations, such as outlined in this section, as they have major implications on, for example, both the University and NHS setting, financial consequences and workforce numbers.

7.5 Reflexive Account

van Manen's (1990; p 30) fifth statement can also be addressed by having an awareness of the relationships between researcher, research and interest and experience of those undergoing the lived experience. Finlay (2003; p 5) highlights that the researcher in qualitative research is a '*central figure who actively constructs the collection, selection and interpretation of data*.' This fits well within the philosophical stance underpinning Heideggarian approaches to phenomenology where the researcher is part of the experience and not disassociated from it (Heidegger, 1988). The subjectivity of the researcher within research projects can be transformed into an opportunity (Finlay, 2002) instead of it being purged. The process of reflexivity shows that the researcher learns as he or she progresses through the research experience and the process of thinking, intuiting and reflecting are used as primary evidence (Finlay, 2003, Moustakas, 1994). The purpose of reflexivity is to become more explicit about knowledge claims, personal experiences and the social context. According to Gough (2003; p 32), the researcher needs to take responsibility for producing an analysis to '*support a particular view of the world whilst also recognising the researchers involvement in the production of the account*'. Maso (2003; p 39) refers to this as '*positioning the self*'. As a researcher, I bring my emotions, experiences, values, intuitions, presuppositions, prejudices, personal agendas, spontaneous and unconscious reactions to the research arena (Maso, 2003). The use of reflexivity aids me, as the researcher, to 'come clean' (Maso, 2003, Finlay, 2002) about how these subjective elements have affected the research process. The purpose of this is to promote the integrity, quality and trustworthiness of the research being conducted. I was encouraged to keep a reflexive diary throughout the project to refer to as a primary source of data to support my thinking and writing (Gough, 2003).

I have learned throughout the planning and execution of this research project along with the writing and re-writing of the chapters. My understanding of what is meant by phenomenological research has developed through conducting this research approach. I had originally chosen this approach because I wanted to investigate the lived experiences of newly qualified midwives and so the question and design was structured to fit the research approach i.e. phenomenology. Phenomenology remains the appropriate

approach for me to have investigated what it is like to be human, experiencing the phenomenon of being newly qualified. Without having gone through my research journey, I would have found it difficult to articulate a justification for this research approach. The analysis methods evolved with the progression of the project and have become more transparent through the writing of this thesis. The intension of this was to ensure trustworthiness so that the readers of this research have confidence in the findings.

I am a midwife, midwife teacher, Supervisor of Midwives and have been a midwifery team manager. My experiences within these roles have led me to have a number of presuppositions related to current midwifery practices and student experiences. I have also been 'that' student and newly qualified midwife experiencing 'those' issues related to living through the first year after registration. My experiences have aided the contextualisation of the interpretations from the participants' experiences. One has to remain mindful that my experiences are historical where societal, political and professional aspects have changed over time. This is evident from the literature reviews at the start and completion of this work. This has made me consider that my interpretations need to be wholly explicit. In an attempt to undertake this effectively, I have kept a research diary, field notes, records of my early analysis, diagrams, records of reading and supervision meetings as my primary data. Although as McKay et al (2003) assert, ['*spatial'*] time needed to fulfil effective and deep reflexivity was not always available to me. Therefore one can question how effective my research diary is within the reflexive process.

This study can be applied to individual, local and national perspectives. For me I have taken the findings from this study and developed my teaching style and knowledge with a view to being less self-centred and more open to the current issues relayed by current senior students. Some discussion led sessions related to my third year module encouraged the senior students to consider their roles as newly qualified midwives and develop strategies to aid their transition (Kitson-Reynolds, 2009, Kitson-Reynolds and Rogers, 2011). One student has since qualified and emailed me to say that she has been able to realise that what she is experiencing and feeling in her role as newly qualified

midwife is potentially 'normal'. She has reflected upon this and has considered positively how this has helped her through a difficult period of time.

In the current austerity measures, the NHS has been subject to a major review from which it is currently undergoing dynamic changes. The coalition government produced a white paper outlining the strategy leading to a structure where GP commissioning is central to the needs of the local population (DH, 2010a). Whilst maternity services, along with emergency department service delivery, do not fall directly within these confines, other remits within health care do, which will ensure a change in the way of working for many health care professionals and education provision. Midwifery resources such as 'Maternity Matters' (DH, 2007) and 'Midwifery 2020' (Midwifery 2020 UK Programme, 2010) show that midwifery and maternity service provision is in a state of flux.

Through the art of reflexivity I have highlighted four key areas that had caused apprehension for me. The first was undertaking the interviews and asking the questions; the second was undertaking recorded telephone conversations; thirdly participants told me things once the tape recorder had been turned off and finally through out the writing and re-writing phase of the thesis I had difficulty in articulating what I was trying to say and think. These four aspects are considered within appendix 19.

7.6 Final remarks

The conclusions from this study have been presented along with the implications for practice under educational, clinical practice and regulatory body perspectives. Suggestions have been provided through which findings may be used to complement and/or develop current practises.

Better preparation is needed within educational courses to support the developing midwife of the future. However, it may be that this transition is an emotional challenge and like birth, the reality is that preparation might help, but that the 'reality' can only be experienced.

Appendices

Appendix 1: Critical Appraisal Tools

1.1 An amalgamation of the Critical Appraisal Skills Programme (CASP) 'qualitative research', the 'cohort studies' tools (NHS Forth Valley, 2005) and Crombie's (1999) critiquing tools.

Was there a clear statement of the aims of the researcher?

Is a qualitative methodology appropriate?

Was participant group justified?

Size/selection/context provided

Was the research design appropriate to address the aims of the research?

Was the recruitment strategy appropriate to the aims of the research?

Were the data collected in a way that addressed the research issue?

observations/interviews/transcription

Has the relationship between researcher and participants been adequately considered?

Have ethical issues been taken into consideration?

Was the data analysis sufficiently rigorous?

Is there a clear statement of findings?

How valuable is the research?

1.2 Criteria for the evaluation of qualitative research papers (British Association Medical Sociology Group, 1996).

1. Are the methods of the research appropriate to the nature of the nature of the question being asked?
2. Is the connection to an existing body of knowledge or theory clear?
3. Are the clear accounts of the criteria used for the selection of subjects for study and the data collection and analysis?
4. Is the selection of cases or participants theoretically justified?
5. Does sensitivity of the methods match the needs of the research questions?
6. Has the relationship between fieldworkers and subjects been considered and is there evidence that the research was presented and explained to its subjects?
7. Was the data collection and record keeping systematic?
8. Is reference made to accepted procedures for analysis?
9. How systematic is the analysis?
10. Is there adequate discussion of how themes, concepts and categories were derived from the data?
11. Is there adequate discussion of the evidence both for and against the researcher's arguments?
12. Have measures been taken to test the validity of the findings?
13. Have steps been taken to see whether the analysis would be comprehensible to the participants, if this is possible and relevant?
14. Is the research clearly contextualised?
15. Are the data presented systematically?
16. Is a clear distinction made between the data and their interpretation?
17. Is sufficient of the original evidence presented to satisfy the reader of the relationship between the evidence and the conclusions?
18. Is the author's own position clearly stated?
19. Are the results credible and appropriate?
20. Have ethical issues been adequately considered?

Appendix 2: Review of the Phenomenological Approach

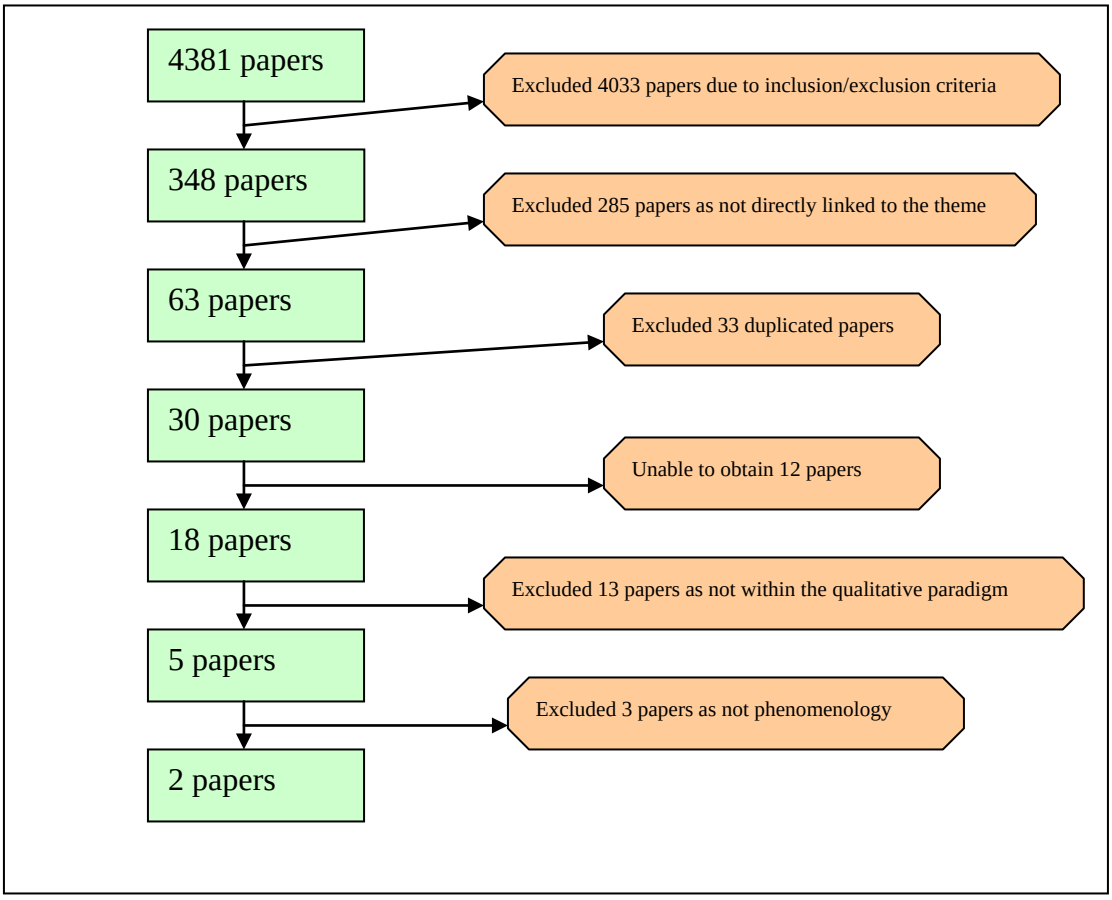
Example of Review and Critique of a Paper

This review was conducted in 2006 in order ascertain the appropriateness of the phenomenological approach for my study. The question posed to guide this search was:

How has phenomenology been used to study role transition?

From the search strategy, 4381 papers were identified therefore, a process of reducing hits to a manageable amount was necessitated (figure A2.1).

Figure A2.1: Literature selection flow chart



The two identified papers follow the phenomenological approach (Fagerberg, 2004, Wilson Cox, 2005). Fagerberg (2004) has been critiqued within chapter 2 therefore Wilson Cox (2005) is presented below (table A2.1).

Table A2.1: The study included in this review

Study – full reference	Intervention assessed and number studied	Entry criteria	Data collection	Results/findings
Wilson Cox, C. (2005) Shipboard nursing on aircraft carriers: the perceptions of twelve Navy nurses. *Nursing Outlook.* 53(5) pp247-252	A Husserlian phenomenological study to describe the experience of shipboard nursing on aircraft carriers. Total number of participants = 12	This was a purposeful selection of nurses who had previously stationed on an aircraft carrier for at least two years. Six female and six male	Tape-recorded face to face interviews took place in the setting familiar to the participant	Six essences were identified: • Experiencing the best but toughest job the navy has to offer its nurses • Ensuring readiness • Being one of one • Operating constantly in an environment of uncertainty • Having two families • Making the job better for the next generation

Appendix 3: Ethical Consent Letter

Names and Contact details have been removed to maintain confidentiality (NMC, 2008a).

Direct Line: [redacted]

LI02

Ms Ellen Kitson-Reynolds

16 August 2007

Dear Ellen

Re: Committee Decision: Internal Ethics Reference Number: SONAM/013/2007
A phenomenological study exploring the experience of the rite of passage of newly qualified midwives during the first year of practice within a health care environment
Meeting date: 14 August 2007

Thank you for re-submitting your application to the School Ethics Committee meeting of 14 August 2007.

The Committee is happy to approve your application, provided you make the following minor changes:

1. Add the title of the research to the top of the letter of invitation and to the PIS please.
2. Change the second sentence of the letter of invitation - it is not very clear or grammatically correct.
3. Last sentence, second para: Accommodate the fact that it may not be the cohort leader who gives out the information. Also, it is unclear why this sentence is in italics
4. PIS, part 2 – 'what if I don't want to carry on with the study' – please give details of HOW the participants can withdraw – who to contact etc
5. PIS 'who has reviewed the study' – we are the School Ethics Committee, please amend in two places
6. Consent form: point 1 – 'participant invitation LETTER' please add latter.
7. Point 5 – we assume you are not granting supervisors permission to access students' records – we assume you mean transcripts here – if so, please change

accordingly. If not please clarify with me why supervisors will need to access to student records, and insert this in the PIS etc

8. Refer to your self as 'principal' investigator, not principle investigator – this is important in information that will go to participants about the project.

I am happy for you to make these change independently with the guidance of your supervisor, and do not need to see these. Please make sure [redacted] has a copy of the final versions for the School records.

Wishing you success with your research,

Best wishes

Yours sincerely

Chair of School Ethics Committee

Members of the Committee

Reader
Research Fellow
Director of Research
Associate Directors

Academic/Research Staff

Ex officio
Research Students

Lay member
Student Liaison Co-ordinator

Appendix 4: Consent Form

Centre Number: actual forms were on headed paper
Study Number:
Participant Identification for this Study:

CONSENT FORM

Title of Project: A phenomenological study exploring the experience of the rite of passage of newly qualified midwives during the first year of practice within a health care environment.

Name of Researcher:
Research Supervisors:

Please initial box

1. I confirm that I have read and understand the '*participant invitation'* letter and *'participant information sheet*' dated 21st August 2007 (version 4.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my education, professional development or legal rights being affected. ☐

3. I understand that a maximum of three conversations will take place; the first being at the point of qualification and registration as a midwife; the second at four months post qualification and finally at twelve months post qualifying. ☐

4. I understand that the conversations will be audio taped for the purpose of transcribing. I am aware that this data will be stored, in accordance with research governance, after the completion of the thesis. ☐

5. I understand that the transcriptions of the information collected during the study, will also be looked at by both research supervisors (named above) from the [*name of University given*]. I give permission for these individuals to have access to my records. ☐

6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

When completed, 1 for participant; (original) 1 for researcher site file

Appendix 5: Award Leader Information Sheet

actual forms were on headed paper

Award Leader Information Sheet

Dear Cohort Leader,

I am a part time research student currently undertaking my Doctorate in Clinical practice within the [*name of University given*]. I would be grateful if you would spend a few minutes of your time distributing the enclosed envelopes to your cohort of Student midwives.

Ethical approval was given on 16th August 2007 through the [*name of University given*] School Ethics Committee.

I have enclosed a copy of the 'Participant information sheet' for your information as it is envisaged that students may ask for clarification on some aspects of the study. They have been given my contact details, but may ask you questions about the study.

If you are unable to answer/'field' the questions about this study, please either ask the student to contact me directly using the contact details provided or if they prefer, pass the query to me and I will provide the answer for you to give back to the student.

If the students are interested in taking part in this research study they have been asked to complete the consent form and contact details card and return to me via the envelope provided or via you as their cohort leader.

Part 1 of the information sheet tells informs the student about the purpose of this study and what will happen to them if they take part. Part 2 gives the student more detailed information about the conduct of the study.

Please feel free to ask me if there is anything that is not clear or if you would like more information prior to the distribution of the information packs.

Further information

Should you require any further information, please do not hesitate to contact me on the following telephone number and/or email address.

Name of researcher:

Contact details of researcher:

Telephone:

Email:

Research Supervisor:
Contact Address:
Email:

Research Supervisor:
Contact Address:
Email:

Appendix 6: Participant Letter of Invitation

written on headed paper

A phenomenological study exploring the experience of the rite of passage of newly qualified midwives during the first year of practice within a health care environment.

Participant Letter of Invitation

Dear ……..

Congratulations on reaching the end of your midwifery education programme.

I would like to invite you to take part in a research study, the focus of which is to explore the experience of newly qualified midwives working in a health care environment.

Before you decide if you would like to take part in this study, you need to understand why the research is being done and what it would involve for you. Please take time to read the participant information sheet (version 4.1) carefully. Talk to others about the study if you wish. Whilst the cohort leader may not be the distributor of this information pack, please do not hesitate to contact your cohort leader, or me, if there is anything that is not clear or if you would like further information. Take time to decide whether or not you wish to take part.

If you are interested in taking part in this research study please complete the consent form and contact details card and return to me via the envelope provided or via your cohort leader, within two weeks of the date of invitation.

I would like to thank you for taking the time to read this information.

Name of researcher:

Contact details of researcher:

Telephone:

Email:

Appendix 7: Participant Information Sheet

was on headed paper

A phenomenological study exploring the experience of the rite of passage of newly qualified midwives during the first year of practice within a health care environment.

Participant Information Sheet

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Part 1 of the information sheet tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Please feel free to ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

Study title

A phenomenological study exploring the experience of the rite of passage of newly qualified midwives during the first year of practice within a health care environment.

What is the purpose of the study?

This phenomenological study aims to explore, over time, what the 'lived experience' of being a newly qualified midwife is for you, within the first year of employment as a midwife. This is in order to ascertain whether a university based graduate level training/education offers a positive transition from being a student midwife to being a newly qualified midwife.

Why have I been invited?

You have been invited to join this study along with the other members of your cohort as you are part of the next group of student midwives to qualify and enter Part 2 of the Nursing and Midwifery Council register.

Do I have to take part?

It is up to you to decide. This information sheet will describe the study and is yours to keep. You may wish to talk through this information sheet with me, your cohort leader or your peers prior to deciding to take part. If you are interested in taking part in the study, you will be asked to sign a consent form to show you have agreed to take part. You are free to withdraw from the study at any time, without giving a reason. This will not affect your education, professional development or legal rights in any way.

What will happen to me if I take part?

Three in-depth semi-structured interviews will be offered to you; the first being at the point of registration, prior to commencing employment as a qualified midwife to ascertain what your expectations of being a newly qualified midwife are. The second and third interviews will be offered to you at four and twelve months post registering to determine what your 'lived' experience is, in your capacity as a newly qualified midwife working in the health care environment.

Each interview will last approximately 30 to 60 minutes and will be audio taped in order for accurate transcriptions to be made after the event. Where possible the interviews will be conducted face to face. However, it is acknowledged that this may not be possible and in this event telephone interviews may be the alternative. This will also be audio taped.

It is envisaged that the initial interview will take place within the University campus, whilst you are within your student capacity. The two follow up interviews will not infringe upon your employment or employer and will take place outside of your place of employment. The place of the interviews will be negotiated with you near the time of the planned interviews.

Expenses and Payments

There are no expenses or payments available.

What will I have to do?

In the first interview you will be asked to talk about your expectations of becoming a newly qualified and employed midwife. During the two further interviews you will be asked what your experiences of being a newly qualified midwife are.

What are the possible disadvantages and risks of taking part?

If any issues surface during the interviews which contravene or breech the safety of mother and infant then your named Supervisor of Midwives will be informed. If you do not have a Supervisor of Midwives, a named Supervisor of Midwives identified for the purpose of the research project will be informed.

If for any reason you become upset during the interview about any aspect of practice or the profession, then it will be advised that you seek support from your Supervisor of Midwives.

What are the possible benefits of taking part?

I cannot promise the study will help you, but the information from this study will help improve understanding of the transition from student to newly qualified midwife.

You may consider aspects of the interview as a form of 'debriefing'. You may consider this as a possible benefit of taking part in this study.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

Please be aware that you can withdraw your participation in this research project at any time. You do not have to give any reasons. You may contact me directly in writing, by email or by telephone (see below for contact details) or [*name of School contact and telephone number here*] to withdraw from the study. Your decision will not affect your employment, professional development or legal rights in any way.

What if there is a problem?

If at any time during the study period you feel that you wish to make a complaint or if you feel concerned in any way about the study then you may contact [*name of School contact and telephone number here*]

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential; any information about you will have your name and address removed so that you cannot be recognised. At no time will your personal data be stored with the interview data. Your personal data will be used for the sole purpose of contacting you for the further interviews. You will be given the opportunity to choose a pseudonym for the duration of the study. Anonymity will remain paramount.

All data including the audio tapes will be locked in a filing cabinet for the duration of the study and also after the study has been conducted. All data will be kept for 15 years as per data protection and management procedures and disposed of after that time according to the protocol.

The interview data will be accessed by me, [*name of both research supervisors here*] (the two research supervisors) during the analysis stage of the study. Your employer will not be aware of your participation within this study.

Who is organising the research and what will happen to the results of the research study?

This research project has been organised by me with the help of [*name of both research supervisors here*]. It is in fulfilment of my Doctorate in Clinical Practice. The study will be written up as a thesis and publications will be considered. You will not be identified in any report/publication.

You will be given a copy of your 'individual journey' from the studied year as a 'keep sake' and will have at that point the opportunity to comment upon the themes and analyses made.

Who has reviewed the study?

All research in the University is looked at by independent group of people, called the School Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the [*name of establishment given*] Ethics Committee.

Further information

Should you require any further information, please do not hesitate to contact me on the following telephone number and/or email address.

Name of researcher:

Contact details of researcher:

Telephone:	Email:
Research Supervisor:	Research Supervisor:
Contact Address:	Contact Address:
Email:	Email:

Appendix 8: Participant Contact Details Card

Participant Contact Details Card

(Will be provided on an A5 size piece of card.)

Name:
Address:
Home telephone:
Mobile Telephone:
Email address:

Please feel free to make any comments or ask questions in the space below. These will be addressed accordingly.

Please return to:

Name of researcher:
Contact details of researcher:

Telephone:
Email:

Appendix 9: Lone Worker's Policy

School details removed

LONE INTERVIEWING CONTACT PROCEDURE

This procedure must be followed before a visit

- Complete the Researcher Location Form (see below) and return it to the Research Office and to agreed person or supervisor if interview is taking place outside office hours.
- Visits should take place in daylight if possible.
- All first visits should be carried out in daylight.
- Diary of researcher's whereabouts to be kept up to date in the office
- Researcher to take charged mobile phone and panic alarm.

After a visit

Researcher to phone the office once the visit is complete (during office hours) or to the agreed person (outside office hours).

If 3 hours have elapsed since the start of the researcher's visit the following procedure should be followed:

If there is no call after 3 hours

- Phone the researcher on their given mobile numbers.
  If they are still interviewing, arrange for the researcher to telephone the office when they leave.

- If no answer, try other mobile phones and contact numbers.

- If contact has still not been made, phone the patient.

    - If the patient says that the researcher is there, ask to speak to her personally and check everything is well.
    - If the patient says that the researcher has left recently (within 10 minutes), wait another 10 minutes. If there is still no contact, instigate emergency procedure.
    - If there is no answer from the patient, commence emergency procedures.

Emergency Procedures

Study secretary, or agreed person (if outside office hours) should inform the researcher's supervisor and then phone the police:

A police stations xxx xxxx xxxx
B police station xxxx xxx xxxx
C police stations xxxxx xxx xxx

If the researcher finds themselves in an uncomfortable situation

Leave immediately:

Make an excuse to return to the car, taking car keys, and leave.

If they are unable to leave the household:

Use the telephone to contact someone, preferably the secretary at the office. If this is difficult, explain that the office will be alerted if you do not return.

Relay a pre-decided message, this will be:
"Please inform Mr. Jones that I will not be back for our meeting this afternoon"

If the secretary hears this phrase, they should contact the police and researcher's supervisor immediately.

If a visit is happening outside office hours, the agreed person will replace the secretary as point of contact.

Appendix 10: Prompt Statements for Interviews

10.1 Prompt/ Trigger Statements for First Contact

First Contact – Point of registering and qualification

- Welcome participant
- Offer the participant the opportunity to choose own pseudonym for the duration of the research. This must not be an existing name from the cohort of student midwives.
- Check that participant has signed the consent form
- Check that participant has consented to the semi-structured interview being tape recorded.
- Ensure that participant may withdraw consent at any time through out the study period.
- Offer participant a drink
- Check that participant is comfortable.

Session Prompts

- Tell me what you expect being a qualified practising midwife will be like.
- Tell me how you think your training will impact upon your first post as a qualified practising midwife.
- If the participant is not going to practise as a qualified midwife – tell me about your decision not to practise as a qualified midwife.

10.2 Prompt/ Trigger Statements for Second Contact

Second Contact – four months post qualifying

- Welcome participant
- Clarify pseudonym
- Check consent for participation and tape recording of semi-structured interview
- Ensure that participant may withdraw consent at any time through out the study period.
- Offer participant a drink
- Check that participant is comfortable

Session Prompts

- Tell me about the realities of working as a practising qualified midwife
- If the participant is not or no longer practising as a qualified midwife since the first interview - tell me about your decision not to continue practising as a qualified midwife.

10.3 Prompt/ Trigger Statements for Third Contact

Third Contact – twelve months post qualifying.

- Welcome participant
- Clarify pseudonym
- Check consent for participation and tape recording of semi-structured interview
- Ensure that participant may withdraw consent at any time through out the study period.
- Offer participant a drink
- Check that participant is comfortable

Session Prompts

- Can you tell me about what you remember from our first conversation: your expectations of what it would be like as a practising qualified midwife
- Tell me about the realities of working as a practising qualified midwife
- If the participant is no longer practising as a qualified midwife since the second interview - tell me about your decision not to continue practising as a qualified midwife.

Appendix 11: Trustworthiness of Interview process

Interview Process

Data collection and data transcription have implications for trustworthiness in interview based studies (Kvale, 1996). Issues of poor acoustics on replaying recorded interviews are potentially caused by poor recording equipment and noisy environments. Consideration is essential prior to commencing the interview to ensure equipment is working, there are spare batteries, the venue is quiet, disturbance is kept to a minimum, telephones are switched off and participant telephones are switched off (Walsh and Baker, 2004). By doing so, playback for transcribing purposes is easier. I had learned this throughout my data collection sets.

On one occasion, I was in an office because all available rooms were occupied. The telephone rang and the fire alarm went off during this interview. This interrupted the flow of the interview and both the participant and I felt that the interview had lost its clout. On playback, the interview finished shortly after this interruption. Another interview, the participant was waiting for a telephone call which occurred during the interview. This had similar consequences.

Two telephone conversations occurred with two different participants. The quality of the recording was poor and it was very difficult to transcribe. This demonstrates the complexities of transcribing. The transcription aims to represent the interview conversation verbatim. Smith et al (2009a; p 55) re-inform researchers that the process of transcription is a lengthy one. A notation system was devised for the transcriptions to denote meaning within the text (figure A11.1).

Figure A11.1: Notation system for transcriptions

A normal conversational pause = [pause]

If the spoken words were inaudible then = … …

If the spoken word was difficult to hear and I was not 100% sure it was = whatever the word(s) was, but highlighted

Laughter and coughing etc was denoted by = [cough] or [laugh]

Appendix 12: Decision Trail

Decision Trail

This decision trail (figure A12.1) provides an overview of the decisions I have taken from the conception of this research study to completion from a reflective perspective. My reflexive diary has been used to facilitate this writing.

Figure A12.1: Decision trail

DECISION, RATIONALE and REFLECTION	Cross reference in thesis
Research aim The inspiration for this research project emerged through: personal experience of working (as a practising, clinically based midwife and more latterly a midwifery lecturer) with student midwives in their senior period and newly qualified staff; my personal considerations; and through pragmatic reasons. By doing so it has demonstrated the first theme from van Manen's (1990) methodological structure of human science research as applied to this research study	Section 3.3 Selecting the 'Type of Phenomenology'
Professional Through my previous experience, as a 'midwifery manager', of interviewing senior students and newly qualified midwives for their first post it became apparent that the candidates believed that they could dictate their hours and working conditions once employed. It was perplexing as to why after three years of training in an NHS establishment, some candidates had little concept of the need to provide a 24/7 service.	Section 1.1 Study aim
My view from above and beyond as a lecturer endeavoured to ensure students were provided with the most appropriate information for their transition period. I was concerned that students had an idealistic view of midwifery which was not common in the real world. Through understanding the newly qualified midwives views it was hoped that practice and education could be developed to support the newly qualified midwife through their transition and help the two worlds (education and clinical practice) to meet.	Section 1.2 Rationale for undertaking this study
Personal My passion for wanting 'the best' qualified midwives to care for women initially drove me to want to undertake this study. Through reflection and development of this research project I was able to realise that my personal values and beliefs were not that of other practitioners. Therefore I needed to ascertain what today newly qualified midwives experience is during the first twelve months post registration.	Section 1.1 Study aim

Pragmatic I had completed my Bachelor of Midwifery Studies (Hons) in 2002. I wanted to undertake a doctoral level study for my own personal development. I commenced my Doctorate in Clinical Practice six months after the start of my secondment to the university as a lecturer (October 2004). Part of this course was to undertake a research study. Considering newly qualified midwives experiences would help me in my development as lecturer and SOM. At the start of this project there appeared to be a paucity of midwifery related research looking at the newly qualified midwife. **Assumptions** made prior to commencing study included: • There is an apparent disparity between student midwives, newly qualified midwives and other midwives as to what they should be doing. • Midwifery education may not fully reflect the needs of the newly qualified midwife	Chapter 2 Contextual Section of the Research Problem
Study design I wanted to elicit the experiences of the newly qualified midwife within the first twelve months post registration. As this was about experience, the constructivist-interpretivist paradigm was most appropriate. Initially, from my novice standpoint, the only way to elicit experience was from a phenomenological perspective. Once research had commenced, the need to clearly justify this approach became consuming. Given that this project was about eliciting lived experience, it was important to me that I gain insight from the newly qualified midwives living with their reality. I also had to be mindful that it is easy to consider others' experiences from one's own perspectives hence, the need to be 'upfront' about my '*a priori*' assumptions and experience necessitated. After considering ethnography, narrative accounts and grounded theory, it remained appropriate that a hermeneutic phenomenological inquiry was undertaken to ascertain the true essence of what it is like to live and experience being a newly qualified midwife. For the novice researcher van Manen's (1990; p 30) methodological structure provided a framework to shape the research design. The approach befitted the philosophical stance of the midwifery profession where, it matters how people feel about what is done to them. **Assumptions** made: • That phenomenology was the most appropriate approach to consider the experiences of newly qualified midwives.	Section 3.2 Choosing my methodology Section 3.2 Choosing my methodology

Sampling strategy Potential participants from one cohort were considered for this research project. This was a convenient and purposive sample in that they were the next cohort of students to qualify given the time span of this project. I purposefully chose to follow the experiences of one group. The fact that this one group would potentially disperse nationally for their first post provides justification to keep the sample small. The Midwifery Award Leader was contacted for consent to meet with the potential participants and the cohort tutor was approached to provide the information packs and initially discuss the research with them to minimise potential bias and influence in recruitment. **Assumptions** made: • The cohort of students would want to share their experiences with me as they pass through their first twelve months after registration	Section 3.4.2.5 Sample Section 4.1 Biographical details of the twelve participants Section 3.4.2.6 Recruitment
Interview process Three data collection sets were via digitally recorded semi-structured interviews. Consent was discussed prior to each interview at point of registration, four and twelve months post registration and participants could withdraw at any stage of the data collection phase. A prompt sheet was used to open the interview from which participants guided the interview by what they said. Semi or unstructured interviews are usual within phenomenological research. Each semi-structured interview was transcribed by me verbatim. I had concerns initially about me being a lecturer and a SOM, but I had not known the cohort of students long and had not been influential in any of the programme design or their final course grading. The professional relation had changed by the second and third data collection point in that they had moved on in their professional journey. I had no personal 'dealings' with the participants in my SOM role during the data collection points. Participants were aware that as a SOM and practising midwife, if issues of poor or unsafe practise were disclosed that they would need to be addressed via a self referral to their named SOM. As a clinical midwife, I had been used to interviewing women during their pregnancies, as well as interviewing prospective staff members, to gather information.	Section 3.4.2.1 Ethics Section 3.4.2.3 Consent Section 3.4.2.8.2 Data collection Section 3.4.2.2 Potential harm Section 3.4.2.8.2

Often, I became very interested in the participants' story which meant I veered from the focus. On reflection I have also found it interesting that during the first interviews I did not go into depth as to what they said. The problem was resolved by: • Reviewing interview prompts • Reviewing literature on interviewing technique **Assumptions** made include: • I would be able to transfer my interviewing and information gathering skills from practice to the research area. • Participants would be willing to share their experiences with me regarding being a newly qualified midwife.	Data collection
Data analysis I had vast quantities of data from the three sets of twelve semi-structured interviews. I was overwhelmed with where to start with analysing these data. van Manen's (1990) methodological structure appeared relatively vague to me so I considered Colaizzi (1978), Streubert (1991) and Hycner's (1985) analysis frameworks (appendix 13) to aid the process of analysis. The process of analysis as set out within IPA (Smith et al., 2009a) was considered most appropriate as it clearly demonstrated how emergent themes could be developed to form interpretive themes for discussion. A modified version of this was used to produce themes that had come directly from participant conversations. Assumptions made include: • Transcripts of the interviews will hold the meaning of the phenomenon under investigation • I would be able to interpret the data and create something meaningful from it.	Section 4.3 Data analysis process

Appendix 13: Analysis Frameworks

13.1 The six parts of the modified Colaizzi (1978) framework

1. Read the text in order to understand it
2. Extract significant statements about the phenomenon being studied
3. Formulate meanings for each significant statement
4. Arrange the formulated statements into clusters of themes
5. Integrate all the ideas into an exhaustive description of the phenomenon
6. Reduce the exhaustive description to an unequivocal/ unambiguous statement of the fundamental structure of the phenomenon.

(Colaizzi, 1978, Koch et al., 2004, Cowman and Gill, 2001)

13.2 Streubert's ten step methodology' (1991)

1. Explicating a personal description of the phenomenon of interest.
2. Bracketing the researcher's presuppositions.
3. Interviewing participants in settings comfortable to the participants.
4. Carefully reading the transcripts of the interview to obtain a general sense of the experience.
5. Reviewing the transcripts to uncover essences.
6. Apprehending essential relationships.
7. Developing formalised descriptions of phenomena.
8. Returning to participants to validate descriptions.
9. Reviewing the relevant literature.

13.3 Some Guidelines for the Phenomenological Analysis of Interview Data (Hycner, 1985)

1. Transcription.
2. Bracketing and the phenomenological reduction.
3. Listening to the interview for a sense of the whole.
4. Delineating units of general meaning.
5. Delineating units of meaning relevant to the research question.
6. Training independent judges to verify the units of relevant meaning.
7. Eliminating redundancies.
8. Clustering units of relevant meaning.
9. Determining themes from clusters of meaning.
10. Writing a summary for each individual interview.
11. Return to the participant with the summary and themes: conducting a second interview.
12. Modifying themes and summary.
13. Identifying general and unique themes for all the interviews.
14. Contextualization of themes.
15. Composite summary.

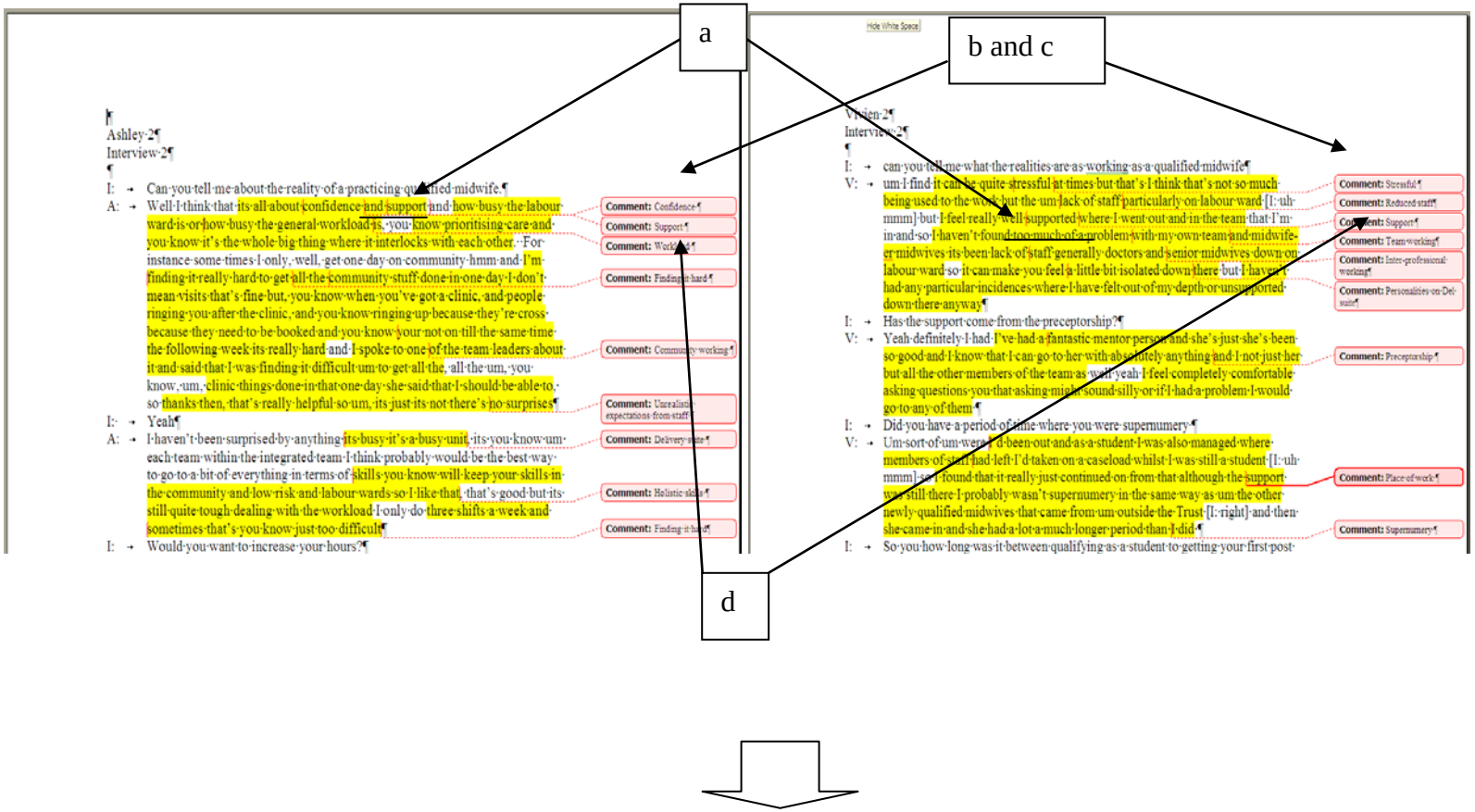
Appendix 14: The IPA Strategies as Applied to This Study

Diagrammatic representations (figure A14.1; diagram A14.1) of how the strategies used within IPA taken from Smith et al (2009a; p 79-80) has been applied to this research study.

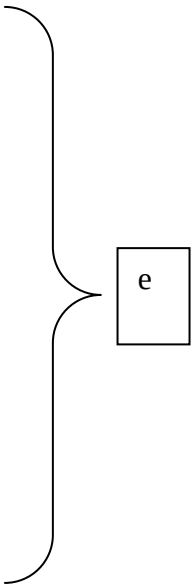
Figure A14.1: Legend to be used with diagram A14.1. Overview of the strategies used within IPA taken from Smith et al (2009a; p 79-80).

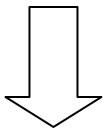
a. Line by line analysis of the experiential claims, concerns and understandings of each participant
b. Identify emergent patterns – emphasising convergence and divergence, commonality and nuance
c. Development of a dialogue between researchers and what it might mean for the participants = more interpretive account
d. Development of relationships between themes
e. Organisation of this material to allow for analysis
f. The use of supervision, collaboration or audit to aid testing and development of the interpretation
g. The development of narrative usually theme by theme, evidenced with commentary and visual guides
h. Reflection on one's own perceptions, conceptions and processes

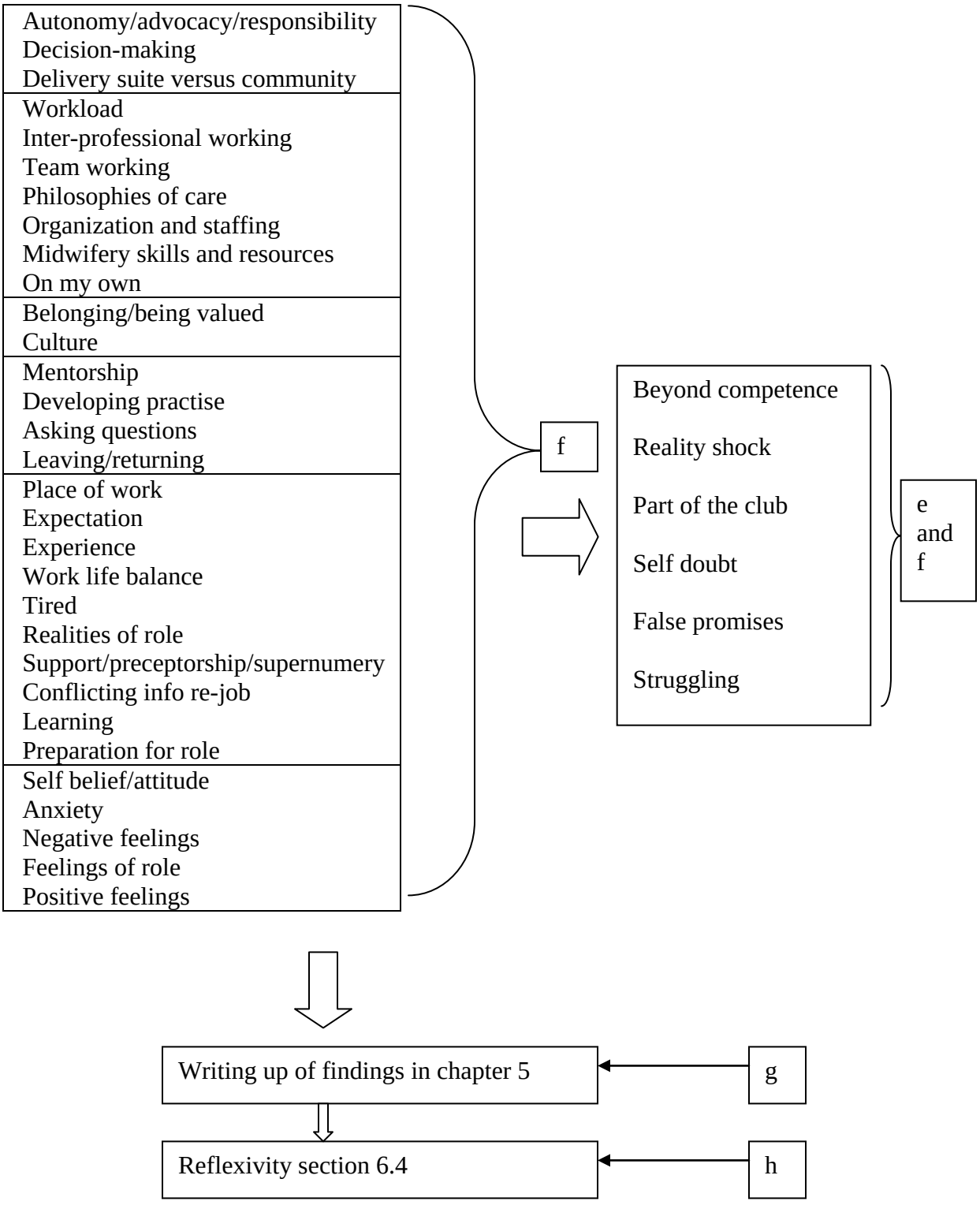
Diagram A14.1: The stages of the strategies used within IPA



Sub-ordinate theme	Emergent themes (conceptual coding)
support/	Supernumery/consolidation preceptorship
preceptorship/	Support
supernumery	Support/buddy/from cohort/ personal/ professional
	Preceptorship/Supernumery
	Not made to feel silly
	Orienting new staff
	Making new friends
	I didn't feel ready
	I feel alone/lonely
	Induction program
	Induction weeks
	Management
	Supporting students






Autonomy/advocacy/responsibility
Decision-making
Delivery suite versus community
Workload
Inter-professional working
Team working
Philosophies of care
Organization and staffing
Midwifery skills and resources
On my own
Belonging/being valued
Culture
Mentorship
Developing practise
Asking questions
Leaving/returning
Place of work
Expectation
Experience
Work life balance
Tired
Realities of role
Support/preceptorship/supernumery
Conflicting info re-job
Learning
Preparation for role
Self belief/attitude
Anxiety
Negative feelings
Feelings of role
Positive feelings
f
Beyond competence
Reality shock
Part of the club
Self doubt
False promises
Struggling
e and f
Writing up of findings in chapter 5
g
Reflexivity section 6.4
h

Appendix 15: Excel spreadsheet

NB: Colours denote changes of theme for ease of observation and are of no significant importance

super-ordinate theme	sub-ordinate theme	emergent themes	Alicia			Ashleigh			Claire			Edith			jade			Martha			Naomi			sally			Sam			Sarah			Valerie			Vivienne		
			Int1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3	Int 1	Int 2	Int 3
false promises	place of work	Working environment								√			√											√															
		Worked outside health care – back to midwifery												√																									
		Work in one place all time		√															√					√															
		Cant get a job													√																								
		Starting first post/place of work/ Work in place trained		√			√			√			√			√			√			√			√			√			√			√			√		
		Place of work/first post	√		√				√		√	√		√	√		√				√			√			√		√	√		√	√		√	√		√
		I haven't got a job/ reduced opportunity																															√					
		Working in place trained						√																															
	expectation	Expectation	√			√			√			√	√		√	√		√	√		√	√		√			√	√			√		√			√	√	
		Own expectations												√																									
		my Perception of midwifery was																																√					
		Its what I imagined it to be/ expectations											√				√			√									√										√
		Inappropriate/unrealistic/ expectations from others		√			√	√					√				√		√						√			√	√								√		
		The future							√			√			√									√			√			√									
		Hope	√									√																						√					
	experience	Experience /knowledge/instinct									√												√			√							√			√			
		Other peoples experiences				√												√			√			√										√					

		Acting more like a student												√																								
		Experience compared to/ as a senior student												√																								√
		I have not worked that long												√																								
		Experienced midwives only there 1-2 yrs																					√															
	work life balance	Cant switch off/taking work home mentally					√										√			√		√			√	√			√									
		Work life balance/guilt									√			√			√						√			√			√									√
		Family/work balance					√			√															√			√										
		Sacrifices											√																									
	tired	Tired		√					√	√	√			√		√	√					√	√		√	√		√	√									
	conflicting info re-job	(not) doing job meant to do/ changing boundaries			√												√																					
		Conflicting info re role		√	√								√																									
		Conflicts of opinion																																				√
	realities of role	Realities of role	√	√		√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√		√		√	√	√	√
		Uphill battle/ pressured		√												√																						
		Uphill struggle/ Difficult year/hard/frustrating			√															√															√			√
		Realization		√			√									√									√	√												
		Thrown in deep end																		√																		
		Time				√			√																													
		Work harder																											√									
		Variable days																		√																		

		Treated same as experienced midwives														√																													
		Still finding feet		√														√																			√							
		Stressful/ >pressure			√											√						√											√		√	√		√					
		Writing statements																										√																
		Women's expectations														√												√																
		Takes time to complete workload/ I need to go slower/No time to complete work effectively			√			√								√									√																	√
		Roller coaster ride																							√																		
		No breaks women's place of birth choice			√																																						
		Pace of work											√												√																		
		Paperwork						√																																			
		It takes longer as newly qualified										√			√																												
		I am struggling																										√																
		Time gone fast								√																																	
	learning	Learn as you go along												√																													
		Learning curve/more knowledgeable/personal growth		√	√		√			√	√			√							√	√			√				√			√					√					
		Life long learning	√											√									√			√	√		√													
		A good year learnt lots																																									
		Keeping up to date																								√																
		Knowledge																						√																		
	support/ preceptorship/	Supernumery/consolidation preceptorship	√			√											√				√		√	√			√					√	√			√				
		Support	√	√		√	√		√	√		√	√		√	√		√	√		√	√		√	√		√	√		√	√		√	√		√	√		√	√	

	supernumery	Support/buddy/from cohort/ personal/ professional			√			√			√			√			√			√			√			√			√			√			√			√
		Preceptorship/Supernumery		√	√		√			√	√		√	√		√			√	√		√	√		√	√		√			√	√			√		√	
		Not made to feel silly												√																								
		Orienting new staff									√																											
		Making new friends												√																								
		I didn't feel ready															√																					
		I feel alone/lonely					√																												√			
		Induction program		√			√									√									√													
		Induction weeks															√																					
		Management															√																					
		Supporting students																										√			√							
	preparation for role	Training (well prepped/ unrealistic)											√			√			√						√			√						√			√	
		Worked hard as a student																																				√
		Nothing can prepare you																																	√			
		Preparation				√			√						√			√			√			√			√			√			√			√		
		Protected as a student																															√					
		Previous role					√																					√										
		I bluffed it																											√									
		Student education	√						√						√			√			√			√			√			√			√			√		
reality shock	workload	Workload			√		√										√		√	√		√	√			√			√								√	√
		Building up caseload/case loading																					√									√						√
		You have to push to get women seen																					√															
		Changes in workload		√						√			√									√																
		Change in priorities																				√																
		Moving goal posts		√																																		

		If it becomes too dangerous- tools down																								√												
		Communication									√									√																		
	interprofessional working	Inter-professional relations				√	√						√		√			√	√			√			√			√		√							√	
		IP relations						√									√			√			√			√			√			√			√			√
	team working	Team																			√			√			√			√								
		Team morale/ team working		√	√		√	√		√	√		√			√			√	√		√	√		√	√		√	√		√	√					√	√
		Trusting your team to do your work									√																											
		Just gone into team			√																																	
	philosophies of care	(Cant) give care want to		√			√	√			√					√			√			√			√	√											√	
		Working in own way							√			√									√									√						√		
		Evidence based practice/question practise/many ways to practise																																	√			√
		Continuity of carer								√						√	√									√											√	√
		Own philosophy of care		√				√		√			√			√			√			√	√		√			√	√			√			√		√	
		Freedom to practise																					√															
		Conscientious midwife																																				√
		Providing care/part of people’s lives																		√															√			
	organisation and staffing	Service stretched/no one to take over from you/busy																					√						√									
		Ways of working/flexibility																					√															√
		Skill mix								√												√															√	
		Client: midwife ratio																								√												
		Number of women															√									√			√									
		Off duty/shift work			√		√			√			√	√		√	√					√			√	√		√	√									
		Often finish late																					√			√												

		Busy service			√																					√												
		Part time/full time					√	√		√				√											√	√						√						
		Payment						√		√						√																						
		Political																				√											√					
		Qualified to newly qualified ratio / skill mix																								√												√
		Institutional organization			√					√			√				√		√			√			√	√		√	√									√
		Increasing birth rate																				√						√										
		Home births																					√															
		Staffing		√	√			√		√						√	√		√			√	√		√	√		√	√			√					√	√
	midwifery skills and resources	Skills /not using mid skills		√	√		√	√		√	√			√					√		√	√	√		√		√			√				√	√		√	√
		Progression points		√																								√										
		Drugs																	√																		√	
		Equipment		√	√																																	
	on my own	Doing it on my own														√												√										
		Doing it on my own/ I am left on my own/working on own (3)			√			√						√						√			√												√			
beyond competence	autonomy/ advocacy /responsibility	Autonomy					√			√						√			√			√	√						√						√		√	√
		Accountable	√																																			
		Working on own registration																					√															
		Advocacy (know your women)					√						√				√		√				√															√
		Responsibility	√			√		√	√	√	√		√		√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√	√		√	√	√	
		Record keeping																				√																
		Registration																																			√	
		Ownership			√						√																											√
		legalities																				√																
		Gaining consent					√																															
		Informed choice																	√																			

		Prof relations with client									√																											
	decision making	Decision making/ own clinical judgment			√		√	√		√							√		√	√		√	√		√	√		√	√			√			√			√
		Planning care																																	√			
		I relied on other peoples opinions																				√																
	delivery suite versus community	Del suite – I felt safer-consolidated – stressful – why the priority-atmosphere		√				√		√							√					√	√														√	√
		Del suite compared to community			√			√																								√						
		Labour ward is changing me/ others' experience change my practise						√			√																											
		Nobody breastfeeds						√																														
		Community (is a shambles/its harder/on own)						√			√						√			√			√			√						√						√
Part of the club	belonging/ being part of the club	Being part of the club/one of the gang/ initiation/Belonging/part of team			√					√	√								√						√			√			√	√					√	
		Belonging/being valued		√			√	√		√			√			√	√						√					√	√		√			√				
		They don't care						√																														
		They don't want staff to leave																				√																
		They go out of their way to be nice												√																								
	culture	Culture/(bullying)										√						√			√												√					
		Witch hunt																																				√
		Bullied /bullying						√												√															√			
		Develop a thick skin																																				√

		Worried what others might say/ practise in case others think bad of you/grapevine						√			√									√						√												
		Don't want to be seen as lazy																		√																		
		Context of coping/its not acceptable															√																					
		No praise for good work																																				√
		No reward														√																						
		Midwives are not midwives															√																					
		Midwives not united																																				√
		Personalities/depends who is coordinating		√			√			√			√			√			√					√			√			√			√			√	
		Personality	√			√					√			√				√		√			√	√		√			√	√		√			√			√
		People see me differently/how others perceive me																					√						√						√			
		Practise defensively									√											√			√				√									√
		I can see what wears a midwife down																																				√
		I see my colleagues cry						√																														
		Its every man for himself															√																					
		I felt like a burden											√																									
		Some midwives - power																																	√			
struggling	self belief/ attitude	Belief in own clinical judgment																																	√			√
		(its much) better than I thought					√			√																												
		+ve/-ve attitude		√			√				√		√									√	√		√						√	√			√		√	
		Confidence/assertive	√		√	√		√	√		√			√	√		√	√		√	√		√	√		√			√	√		√	√		√	√		√

		Being in control													√																							
		Confidence		√			√			√			√			√			√			√			√			√			√			√			√	
		A duck happily swimming on top																															√			
		Seeing myself grow/developing																													√					
		Self belief/achievement		√						√		√	√	√		√		√	√	√	√	√						√	√					√	√	√		√
		Take it as it comes				√			√									√									√	√										
		Surprised I am qualified / I'm a midwife now									√																		√									
		Self motivation								√																												
	anxiety	Anxiety / the unknown//fear/scary	√	√		√		√	√	√		√	√	√	√	√		√	√	√	√			√					√		√	√	√	√	√	√		
		Worried about mal practice/ waiting for it to go wrong						√																														√
		What happens if it goes wrong																		√																		
		Scary/nerve wracking	√									√									√			√			√						√					
		Don't want to miss anything																																				√
		Needing reassurance					√	√		√	√								√			√			√			√			√						√	√
		New situation/facing fears								√			√						√						√			√			√							
		It's a catastrophe waiting to happen																								√												
	negative feelings	Awful											√																									
		Didn't enjoy it											√			√																						
		Disappointment						√									√																					
		Not nurtured at all															√																					
		Not very enjoyable			√																																	
		Disillusioned														√																						

		I was very unhappy/miserable															√																					
		I've had things go wrong					√																															
		It is rubbish		√			√									√												√									√	
		I feel very cynical																											√									
		I tolerate it						√																														
		I was doing a bad job															√																					
		Bad experience											√																									
	feelings of role	Feeling guilty when things not done																		√																		
		Feeling happier/not happy		√												√																						
		Feeling pressured															√																					
		Frustration / stressful											√																		√			√			√	
		Fulfilling/ rewarding	√																													√						
		Finding it hard					√																														√	
		Glad doing midwifery now												√																								
		Getting easier		√															√																			
		Big brother is watching you									√																											
		Change in development/I didn't realize how much you change									√												√															
		I just wanted to get it right															√																					
		I'm confused/ not sure what I want											√																									
		I got very safe																																	√			
		Its getting easier									√																											
		I feel like a midwife now																	√																			

		Glass is half full																				√																
		Change in (feeling of) role			√															√																		
	positive feelings	good																			√											√						
		A rewarding job/ I like my job																										√										
		Different/better than expected						√						√												√												
		Excited										√									√			√						√								
		I enjoy it																		√			√			√						√						√
		I am very happy																																				√
		Its good/loving it/ happy/enjoyment/excited																				√			√			√			√			√			√	
		Good/bad days		√												√						√						√			√							
		Proud/achievement				√			√		√	√						√		√																		
		Its alright (not good/not bad)						√																														
		Its exciting																																	√			
		Looking forward to																			√									√								
self doubt	asking questions	Asking questions –ask for help					√	√	√	√			√	√	√	√	√		√		√	√	√		√	√	√	√			√				√	√	√	√
	leaving/ returning	Decision to leave midwifery															√																					
		Surprised how soon back to midwifery												√																								
		No-one cared I left															√																					
		Not being accommodated with back injury															√																					
		Left job/midwifery											√																									
	mentorship	Mentor as role model																				√																
		Mentor(ship)										√			√			√			√						√						√					
		Mentoring students v caring for client																					√															

		Comparison mentor role to being mentored									√			√						√			√												√			
		Mentoring students/working with students									√			√			√			√			√						√									
		Having that one person/Not got that one person				√	√		√				√					√		√						√				√		√		√			
		Mentorship when senior student								√			√			√			√			√			√												√	
	developing practice	Reflecting on shift					√																								√							
		Reflective practice/debriefing																	√			√			√												√
		Need to be top of the game/100% focused									√																											
		Challenge							√		√											√						√					√			
		Organization of workload/being more organized			√												√														√						
		opportunities																		√					√											
		Personal development																																			√
		Having to think for myself																						√													
		Questioning practice																			√																
		Insight into my own practise																																			√
		Joined a committee group																			√																
		Ready to move on				√																															
		I am believing in what I am seeing																							√												
		I get on with it							√										√						√	√		√			√						
		Cautious practice									√																											
		Need to challenge practice more																			√																

Appendix 16: Analytic Process

Table A16.1 provides an 'at a glance' overview of the five stages within the analytic process leading to one overarching theme 'becoming a midwife'. This is as outlined within chapter 4; considering each stage as either descriptive or interpretive in focus.

Table A16.1: Analytic process

Stage	**Name of grouping**	**Comment**	**Descriptive or interpretive**
Stage one	initial ideas emergent themes	Initial thoughts from reading listening and re-reading each transcript were recorded on post-it notes and attached to the front of each transcript. These were holistic ideas. Interesting comments and phrases were highlighted from reading the transcripts. Emergent ideas were hand written in the right hand column on each transcript. There were 263 key emergent ideas.	Descriptive ideas Descriptive themes. These came from the text. This is a process of delineating meaning and clustering these units of relevant meaning.
Stage two	Sub-ordinate themes	Interpretation was generated through determining themes from clusters of meaning and pattern themes (key emergent ideas). These came from collective transcripts. There were 31 central themes.	Interpretive themes
Stage three	Super-ordinate themes	By considering the commonalities between the central themes, the numbers were further reduced to leave six core themes.	Interpretive themes
Stage four	Final interpretive Themes	Core themes clustered further due to their commonalities to leave three themes for interpretation	Interpretive themes

Appendix 17: Literature Search Strategy for the Final Literature Review

This appendix details the literature search strategy for the final literature review for chapter 6. The question used to guide the search remained the same as in the preliminary search located in chapter 2:

What is the current evidence surrounding transition from: student to health care professional; student midwife to midwife; student nurse to nurse?

Electronic databases were used to search the literature for the final review (box A17.1) which occurred after the data analysis stage of the research project. The post-findings search incorporated three extra search engines to those in chapter two. This is due to researcher awareness and experience through conducting the research project.

Box A17.1: Databases searched for the literature review pre-research and post-findings.

Preliminary search (chapter 2)	**Post-findings (chapter 5)**
British Nursing Index	
EMBASE	and EMBASE Classic+EMBASE 1947 to October 2010
Medline	and Ovid OLDMEDLINE ® 1950 to October wk 2 2010
CINAHL (Citation Index for Nursing and Allied Health Literature)	
OVID	
Journals @ OVID full Text	
MIDIRS	
Pub Med	
Copac National, Academic, and Specialist Library Catalogue	
	Books@Ovid
	AMED (Allied and Complementary Medicine)
	Google scholar

Search parameters were specified for the preliminary review in chapter 2 and these were carried forward for the final review. Keywords used for the preliminary review were reconsidered. From experience through conducting this research project I have become aware of differing terminologies used, some of which are synonymous with education (Worth-Butler et al., 1996) and these have been included in the revised keywords (box A17.2). The number of hits increased significantly, but one has to remain mindful that more research studies have been published since the preliminary review in 2005. By implementing these extra key words, publications that I had originally missed through conducting the preliminary search have come to light and have been considered for the final review.

Box A17.2: Keywords for the review of literature.

From chapter 2 (preliminary review)	Revised keywords (final review Chapter 5)	Number of hits from final review with primary inclusion/exclusion criteria applied
Assess$	Assess$	3117838
Clinical experience	Clinical experience	61696
Expectations	Expectations	104881
Expectations and reality	Reality	77067
Experience$	Experienc$	1305170
First post	First post	4322
First six months	(*removed*)	-
Job satisfaction	Job satisfaction	34428
Lived experience$	Lived experienc$	5994
Newly qualified midwives	Newly qualified midwi$	30
	Newly qualif$	1350
Newly qualifie$	Perceive$	281252
Perceive$	Perception$	445175
Perception$	Preceptorship	4132
Preceptorship	Research$	4680811
Research$	Role$	2251141
Role$	Student midwi$	306
Student midwives	Transition	179368
Transition	Pre-registration midwi$	46
	Reality shock	248
	Graduate	80748
	Neophytes	221
	Under graduate	51024
	Role	2251141
	Novice	10111
	Preparation	374617
	Health care professional	5374
	Nurs$	487394
	Practice theory gap	21
	Passage	85194
	Knowing	47048
	Socialisation	1163
	Coaching	7017
	Becoming	142122

$ = truncation for search purposes

Primary selection criteria were adopted due to the vast quantity of data generated. These necessitated clear parameters which can be identified in box A17.3. They were applied to the electronic searches of keywords and the number of hits are provided in Box A17.2. The rationale for the criteria remains the same for the preliminary search however; the unlimited date restriction was applied for the primary inclusion/exclusion criteria. This was to capture seminal texts and also it is acknowledged that in 1989 The English National Board for Nursing, Midwifery and Health Visiting introduced a three year diploma and degree pre-registration programme of midwifery education (Fraser, 2000a). This appears to be the foundation upon which current midwifery practice lies upon.

Box A17.3: Primary inclusion/exclusion criteria.

Limit to articles written in English
No date limit
Seminal texts
Primary research articles
All experiences of roles
All health professions
Human

Keywords were then used in a variety of combinations to elicit evidence. Figure A17.1 presents an example of some of these combinations with the number of hits elicited.

Figure A17.1: Combinations of keywords with the number of hits obtained

Keywords used for searches	**No. of hits**	**Keywords used for searches**	**No. of hits**
Expectations + Reality	10312	Expectations + Reality + Clinical Experience	775
Expectations + Reality + Clinical Experience +Novice	100	Expectations + Reality + Clinical Experience + Student Midwi$	1
Expectations + Reality + Clinical Experience + Nurs$	390	Expectations + Reality + Clinical Experience + Health Care Professional	6
Expectations + Reality + Clinical Experience + Graduate	206	Expectations + Reality + Clinical Experience + Pre Registration Midwi$	0
Expectations + Reality + Clinical Experience + Under Graduate	206	Expectations + Reality + Clinical Experience + Transition	205
Expectations + Reality + Clinical Experience + Reality Shock	39	Expectations + Reality + Clinical Experience + Perception	448
Expectations + Reality + Clinical Experience + Newly Qualify$	22	Expectations + Reality + Clinical Experience + Newly Qualified Midwi$	0
Expectations + Reality + Clinical Experience + Neophyte	8	Lived Experienc$ + Expectations + Reality + Clinical Experience	42
Lived Experienc$ + Expectations + Reality + Clinical Experience +Novice	14	Lived Experienc$ + Expectations + Reality + Clinical Experience + Student Midwi$	0

Lived Experienc$ + Expectations + Reality + Clinical Experience + Nurs$	34	Lived Experienc$ + Expectations + Reality + Clinical Experience + Health Care Professional	0
Lived Experienc$ + Expectations + Reality + Clinical Experience + Graduate	17	Lived Experienc$ + Expectations + Reality + Clinical Experience + Pre Registration Midwi$	0
Lived Experienc$ + Expectations + Reality + Clinical Experience + Under Graduate	17	Lived Experienc$ + Expectations + Reality + Clinical Experience + Transition	14
Lived Experienc$ + Expectations + Reality + Clinical Experience + Reality Shock	8	Lived Experienc$ + Expectations + Reality + Clinical Experience + Perception	29
Lived Experienc$ + Expectations + Reality + Clinical Experience + Newly Qualify$	1	Lived Experienc$ + Expectations + Reality + Clinical Experience + Newly Qualified Midwi$	0
Lived Experienc$ + Expectations + Reality + Clinical Experience + Neophyte	3	Role + Transition + Newly Qualified Midwi$ + Nurs$ + Health Care Professional	0
Role + Transition + Newly Qualified Midwi$	2	Role + Transition + Nurs$	9049
Role + Transition + Health Care Professional	228	Role + Transition	72235
Role + Transition + Nurs$ + Health Care Professional	171	Lived Experienc$ + Expectations + Reality	489
Reality Shock + Pre Registration Midwife$	0	Reality Shock + Neophytes	
Passage + Socialisation	43	Passage + Knowing	

Passage + Coaching	154	Passage + Knowing + Socialisation + Coaching	
Knowing + Coaching	622	Knowing + Socialisation + Coaching	
Becoming + Role + Transition	172		

Papers were then gathered and the abstracts appraised for appropriateness for the posed search question. This left 82 papers for consideration. A secondary criterion was applied to represent the '*limit to UK and EU countries'* set in chapter 2. The justification for this remains the same. Seventy papers were excluded at this point leaving 12. Serendipitous searching, using the 'Webcat' database and using the 'Google Scholar' search engine elicited a further 32 papers/books and after the primary and secondary criteria had been applied 29 extra pieces of literature were added to the 12 from the previous electronic database searches. This left 40 for consideration. On appraising these papers it became obvious that 21 papers were not directly linked to the posed search question and were therefore discarded. One final paper was removed as it considered experienced qualified nurses who had taken on post qualifying education leading to an alternative professional registration. This review concerns those who have not experienced transition within a health care related profession before. This left 18 papers for consideration in the final review. Diagram A17.1 depicts the literature selection and table A17.1 presents an overview of each of the 18 papers.

Diagram A17.1: Literature selection flow chart for final literature review

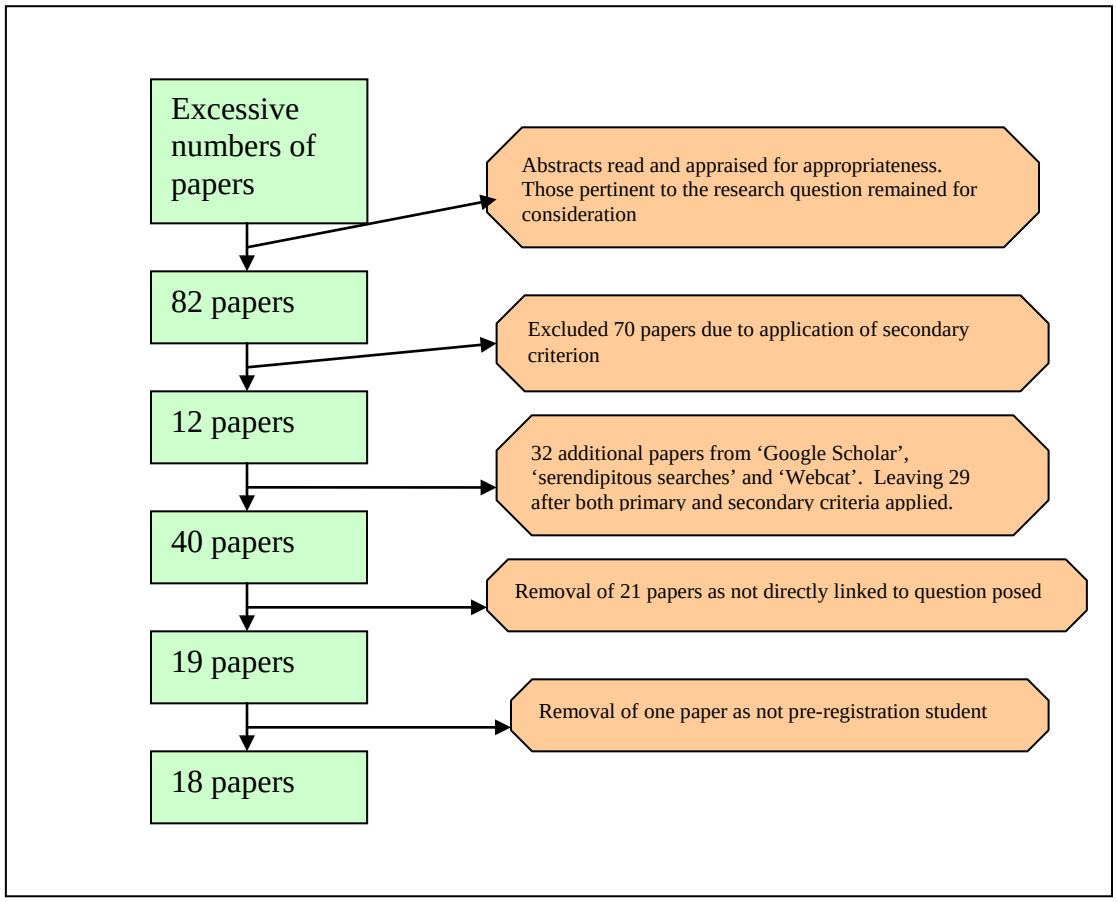


Table A17.1: Overview of the final 18 papers

Study- full reference	Intervention assessed and number studied	Entry criteria	Outcome measures	Results / Findings
Baillie, L. (1999) 'Preparing adult branch students for their management role as staff nurses: an action research project.' *Journal Of Nursing Management*, 7 225-234.	An action research project to investigate students' newly qualified staff nurses' and ward managers' views about the management skills and knowledge required by staff nurses, and how best students could be prepared for their management role. Total number of participants = 2 groups of 8 students 4 staff nurses 32 ward managers	Focus group interviews were held with volunteer Diploma adult branch students One focus group with staff nurses who had been qualified for about six months, were employed within the local trusts and volunteered to take part. A questionnaire was sent to 32 ward managers based on the adult wards in 2 local trusts with which had the university had a contract for pre-registration education	Specific aims of the project were to: • Investigate senior adult branch students', newly qualified staff nurses' and ward managers' perceptions of the skills and knowledge required by newly qualified staff nurses and how preparation for the management role could be best achieved • Develop, implement and evaluate an enhanced strategy for preparing adult branch students for their management role as staff nurses.	The students' views: • Aware of stresses and pressures which qualified staff nurses are under • Concerned about their own management ability when dealing with limited resources • Rostered during latter part of course and worked very little with staff nurses • Suggested being supernumery for part of their last placement to shadow a staff nurse • Being able to manage a whole group of patients is good experience • Being used as part of the workforce means learning takes second place The staff nurses' views: • Being new to a team and delegation was difficult • Nothing can prepare you for it • Critical incidences and role play would be useful teaching strategies

				The managers' views: • Maintaining health and safety procedures • Working as a team member • Handling issues of confidentiality
Butler, M. M., Fraser, D.M. and Murphy, R.J.L (2008) What are the essential competencies required of a midwife at the point of registration? *Midwifery* 24 pp260-269	A qualitative, descriptive, extended case study with depth interviews was used to identify the essential competencies required of a midwife at the point of registration. Participants were interviewed at four stages: 3 months prior to completing education programmes, on exit of programme, 6 months post-registration and 12 month post-registration Total number of participants: 39 students 20 depth interviews with experienced midwives across two sites	39 case studies from six cohorts of pre-registration student midwives at third level institutions across England 20 experienced midwives volunteered after being accessed by their senior managers.	Data were collected on each case through a triad of key informants • Student midwife/ newly qualified midwife • Assessor/ midwife • Midwife teacher/ supervisor of midwives These triads were used to explore experiences and views surrounding competency.	Competence at point of registration is both limited and conditional. Three categories of competencies have been considered to be essential at the point of registration: • Being a safe practitioner • Having the right attitude • Being an effective communicator

Fraser, D., Murphy, R. and Worth-Butler, M (1997) *An outcome evaluation of the effectiveness of pre-registration midwifery programmes of education (the EME project).* London, English National Board for Nursing, Midwifery and Health Visiting Fraser, D., Murphy, R. and Worth-Butler, M (1998) *Preparing effective midwives: An outcome evaluation of the effectiveness of pre-registration midwifery programmes of education.* London, English National Board for Nursing, Midwifery and	A three year long study using an interpretive and constructivist philosophy, to follow a cohort of midwives through their first year of professional practice. A multi-site case study approach was used to evaluate their continuing professional development needs and the provision made for them gather further data about their competencies, developed through their pre-registration programmes, being used once qualified <u>Phase 1</u> A review of existing three-year pre-registration programmes of midwifery education – using an examination of the curricula, developing assessment tools and assessing intended and actual outcomes of	In 1993 30 institutions' approved midwife teachers were written to asking to provide details for the selection of six case study institutions Students due to complete in 1994 or early 1995 – interviewed twice prior to end of their programme	• a review of current programme curricula • development of a model of midwifery competence • exploration of attrition • evaluation of actual outcomes of programmes • evaluation of current assessment strategies • guidelines for effective assessment and assessment matrix • guidelines for effective assessor preparation • examination of support and learning needs of students following registration • exploration of career patterns and retention rates • difficulties associated with failing students	• study midwives were prepared to provide holistic midwifery care to women with normal pregnancy and on a one-to-one basis • the majority could be relied upon to detect deviations from normal, take action and seek help • some did not have sufficient learning opportunities to achieve all requirements for holistic midwifery practice • an assessment matrix may be useful to ensure no gaps in assessment and to ensure appropriateness • assessment schemes tend to neglect or under-assess personal qualities/capability to assume responsibility and accountability/ management skills/care of high risk women/drug administration • there was a false divide between theory and practice assessment • students not always given opportunity to demonstrate integration of dimensions of

Health Visiting	midwifery programmes of education in terms of knowledge, attitudes, competencies and skills <u>Phase 2</u> Evaluating and tracking study participants following completion of their pre-registration programme into their first year in practice - involving interviews 4-6 months post registration and 12 months post registration with the participants, midwives, the students' SOM or manager Participants = 39 students were selected from the six chosen research sites			holistic midwifery practice • should fail students who cannot integrate dimensions into holistic midwifery practice • failing to fail students • documents for practice assessment not always easy to use • assessors not always prepared/updated to assess students • good communication between educators and practitioners leads to effective assessment • written final exams are less effective to show fitness for practice • consolidation is needed prior to registration • employers need to consider new midwives learning needs

Fraser, D.M. (2000a) Action research to improve the pre-registration midwifery curriculum – Part 1: an appropriate methodology *Midwifery* 16 pp213-223 Fraser, D.M. (2000b) Action research to improve the pre-registration midwifery curriculum Part 2: case study evaluation in seven sites in England *Midwifery* 16 pp277-286 Fraser, D.M. (2000c) Action research to improve the pre-registration midwifery curriculum – Part 3: can fitness for	Three papers presented to discuss the rationale and appropriateness of an action research (multi-method) approach to bring about curriculum improvement. The synthesis of two separate research studies – the EME project (Fraser et al, 1997 and 1998) and an evaluation of Fraser's own institution's three-year pre-registration midwifery programme <u>Participants</u> • 39 case study students/their teachers/assessors/preceptors/SoMs or managers • 50 students from the local university's midwifery programme/ their teachers/assessors • 41 women	Case studies from the EME project Students from the local university programme from six sites Women who gave birth to their babies in a large teaching hospital in the East Midlands A professional network of experienced midwives whose role is to advise the statutory body regulating midwifery programmes in England	<u>Paper 1</u>: overview of study methodology <u>Paper 2</u>: to identify factors which facilitate and inhibit the effectiveness of current pre-registration midwifery programmes <u>Paper 3</u>: to design and implement a robust scheme to more effectively identify student midwives' fitness for midwifery practice	• The three-year, pre-registration midwifery route was an effective preparation judged against a model of a competent midwife at the point of registration • not all students were equipped to practice competently and confidently in contexts of uncertainty and change in the health service Factors which emerged as influencing curriculum effectiveness related to: • recruitment and selection • curriculum structure • appropriateness • robustness of assessment schemes • the preparation of and support for assessors • the role of the midwife teacher in assessment in practice settings

practice be guaranteed? The challenges of designing an effective assessment in practice scheme *Midwifery* 16 pp287-294	• professional network of experienced midwives			
Holland, K. (1999) 'A journey to becoming: the student nurse in transition', *Journal of Advanced Nursing*, 29 (1) pp229-236.	An ethnographic study linking the disciplines of anthropology and nursing to explore the nature of transition experienced by student nurses in their journey to becoming qualified nurses. Total number of participants = 4 groups	Four groups of students undertaking the adult nursing branch	Participant observation and interviews within the field of nursing practice were chosen along with non-participant observation in the field of the nursing college. An open-ended questionnaire was also utilised. The data revealed a group of individuals with similar experiences and expectations of their course and of nursing who experienced three main states of existence during their three year transition: 1. becoming a student nurse	Eight key themes were identified: • Reasons for becoming o Helping and caring o Always wanted to do nursing o Giving and receiving • Being a student nurse • Giving care o Basic nursing care o Nursing care o Technical nursing care • Gaining skills o A learner nurse o Gaining confidence o Practising skills • Learning to become o Supporting and guiding o Learning how o A grounding in the basics • Performance and manner o Caring and doing

			2. being a student nurse 3. becoming a qualified nurse	○ Knowing and knowledge ○ Being able to do • A stressful experience • Learning and experiencing
Jackson, K. (2005b) 'The roles and responsibilities of newly qualified children's nurses', *Paediatric nursing*, 17 (6) pp26-30.	A phenomenological approach to acknowledge the creation of individual meaning of the role of the registered nurse and the potential for this to change over time and with experience. Total number of participants = 6	Qualified children's nurses who had been qualified for 10-12 months at the time of the study, drawn from nurses undertaking a rotational programme within the children's services directorate of a large multi-site trust.	Unstructured interviews were used to enable participants to describe their individual experience	Three inter-related themes emerged: • Self image and changing status • Doing the job • Support and expectations

Lauder, W., Roxburgh, M., Holland, K., Johnson, M., Watson, R., Porter, M., Topping, K. and Behr, A. (2008) *Nursing and midwifery in Scotland: being fit for practice. The report of the evaluation of fitness for practice pre-registration nursing and midwifery curricula project.* Scotland: NHS Education for Scotland NMAHP Directorate.	A multi-phase and multi-method evaluation design combining qualitative and quantitative methods to: evaluate pre-registration nurse and midwife education, the impact of fitness to practice and the structured programme for newly qualified nurses in Scotland <u>Phase 1:</u> postal survey - number in sample = 2011 Competency test total number of participants - 2004 cohort = 44 and 2005 cohort = 55 <u>Phase 2</u>: Stakeholder contributions –n = 311 <u>Phase 3:</u> In-depth interview data - Participants = 97	<u>Phase 1:</u> A stratified random sample design to select from Autumn intakes of 2004 and 2005 cohorts of nursing and midwifery students Participants who returned the questionnaire invited to undertake competency tests <u>Phase 2:</u>all 11 NHS-HEI working partnerships in Scotland <u>Phase 3</u>: a convenience sample of newly qualified practitioners who were registered as undertaking the Flying Start NHS online	Postal Survey measures: 1. Demographics 2. Self-report competence 3. Self-efficacy 4. Support Competency tests measures: 1. Demographics 2. Competency 3. Self-reporting competence 4. support In-depth interviews – narrative approach to determine what constitutes success in fitness for	1. Mean age: 28.39yrs (SD 8.97) 2. 2004 cohort had higher competency scores (mean 60.16, SD 6.52) than 2005 cohort (mean 59.50, SD 7.25) but this not significant (p = 0.173/0 3. lowest self-efficacy scores observed in learning disability programme and highest in mental health – but not significant (df=4, p=0.811) 4. highest support came from family/friends (mean 7.46, SD 1.82); lowest from university (6.15 SD 2.03) three key findings: • clinical skills • knowledge • attitudes and values 1. drug administration and venepuncture o clinical skills o working in a diverse and multi-cultural community o service user and carer involvement in the curriculum

		programme during Autumn/Winter 2007.	practice Cross-sectional survey measures: 1. demographics and career data 2. self reporting competency 3. self-efficacy 4. job demands	
Mooney, M (2007b) Newly qualified Irish nurses' interpretation of their preparation and experiences of registration *Journal of Clinical Nursing* 16 pp1610-1617 Mooney, M (2007a) Facing registration: The expectations and the unexpected *Nurse Education Today* 27 pp840-847	A grounded theory approach to consider effectiveness of preparation for nursing registration Total number of participants = 12	A purposive sample chosen by the researcher who were considered to be good sources of information from newly registered nurses from 2 cohorts within 10 months of qualification	Individual semi-structured in-depth interviews: -To report on the insights of newly qualified Irish nurses into their preparation for registration as general nurses and to develop insights into the post-registration experience. -To ascertain how newly qualified Irish nurses perceived the transition from being a supernumery nursing student to becoming a registered nurse	Two main categories were identified each with 2 sub-categories: • Learning the ropes o Learning on the edge o Feeling like a shadow • The metamorphosis o Becoming visible o A new awakening Four themes were identified: • An unexpected reality • Great expectations • No time for nursing • Facing the trepidations

O'Shea, M. and Kelly, B. (2007) 'The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland', *Journal of Clinical Nursing*, 16 (8) pp1534-1542.	A phenomenological, Heideggarian, hermeneutic approach to explore newly qualified nurses' experiences of being on clinical placement in the republic of Ireland and the meanings that this experience held for them. Total number of participants = 10	All general nursing diplomates who were more than six months and not more than seven months post-registration Participant representation from six clinical areas available within the clinical environment where research located 1-2 nurses who met the entry criteria from each of the six places	In-depth audio recorded interviews to answer the question 'describe for me what it is like to be a newly qualified nurse'	Two themes were identified: • The experience of being qualified: highs and lows • Stressful aspects of the staff nurse role
Ross, H. and Clifford, K. (2002) 'Research as a catalyst for change: the transition from student to registered nurse', *Journal of Clinical Nursing*, 11 545-553.	A qualitative exploration of the experiences of one cohort of students undertaking the pre-registration advanced diploma in nursing studies at the University of Sheffield. Total number of participants = 30 student nurses	A sub-set from one cohort of student nurses (n=177), based at the University of Sheffield School of Nursing who qualified in September 1999	following a group of final year students through to their early post-registration experience to: 1. examine the expectations of student nurses in their final year and compare these with the reality of being a newly qualified nurse 2. identify areas for discussion and development, both in	The study suggests: • transition period remains stressful for some nurses because of both pre-registration educational issues and the level of support received once qualified • careful planning of the student experience in the final year and addressing inconsistencies within the preceptorship programmes of newly qualified nurses are needed • the study is stimulating change with the aim of

			education and service settings	enhancing the overall experience of student and newly qualified nurses
Rungapadiachy, D.M., Madill, A. and Gough, B. (2006) How newly qualified mental health nurses perceive their role *Journal of Psychiatric and Mental Health Nursing* 13 pp533-542	A grounded theory follow up study of mental health nurses to examine whether nurses have changed their perception of their role having had – month post-registration experience Total participants = 11	Mental health nurses recruited from an original of 14 mental health student nurses	Semi-structured interviews were used to answer the following question: 'How is the role of the mental health nurse perceived after mental health student nurses have made the transition to mental health nurse?'	Four main themes were noted: • Transition • Role ambiguity • Lack of support • A theory-practice gap
van der Putten, D. (2008) 'The lived experience of newly qualified midwives: a qualitative study', *British Journal of Midwifery,* 16 (6) pp348-358.	A Heideggarian phenomenological approach used to evaluate issues important to newly qualified midwives by asking them individually about their experiences of this time in practice Total number of participants = 6	Newly qualified midwives who all qualified within the previous 6 months and who were currently employed in the maternity department of a large regional university teaching hospital in the West of Ireland	Semi-structured interviews were used to: 'explore newly qualified midwives' lived experience of clinical practice with a view to gaining a deeper understanding of their individual experiences and as a result, to highlight and inform the practice issues which need to be addressed by midwifery lecturers'	Six main findings were identified: • Reality shock • Feeling prepared • Living up to expectations • Theory-practice gap • Clinical support and mentorship • Continuous professional education

Whitehead, J. (2001) Newly qualified staff nurse' perceptions of the role transition *British Journal of Nursing* 10(5) pp330-339	A qualitative method used to explore the perceptions of staff nurses who had been qualified for a maximum of one year. Total number of participants = 6	A convenience sample of staff nurses employed by one NHS Trust known to the researcher	Audio-taped semi structured interview questions were used to answer the question: 'what are newly qualified staff nurses' perceptions of the role transition from student nurse to qualified staff nurse?'	Six key categories were identified: • Uncertainty • Responsibility and accountability • Support • Preparation and training • Knowledge and confidence • Management
Worth-Butler, M. M., Fraser, D.M. and Murphy, R. (1996) Eliciting the views of experienced midwives about the assessment of competence in midwifery. *Midwifery* 12 pp182-190	An investigation of the views of the English National Board for Nursing, Midwifery and Health Visiting (ENB) Professional Midwifery Advisory Network (PMAN) members about the assessment of competence in midwifery A two stage approach to data collection a questionnaire for an initial exploration of views a group discussion with questionnaire respondents - to clarify	An 'effectiveness of midwifery education' team (EME) was interested in exploring ways in which competence could be assessed. The ENB and PMAN agreed to participate. PMAN was a nationwide network of 54 midwives – selected for their expertise in midwifery education, management, research, practice or supervision	<u>Stage 1: questionnaire to consider</u> • what the most effective way to assess each of the 99 possible characteristics of competent midwives is • given options for formative or summative assessment in practice, simulation or theory • consider the need or not to assess an item or whether students had opportunity or not to be assessed	<u>Stage 1: questionnaire</u> • Difficulties with the questionnaire • Task-orientated versus holistic nature of assessment • Quality of assessors • Areas which cannot be assessed summatively • The balance of formative and summative assessment • Areas which are best assessed in the college/university setting • Areas which are best assessed in practice <u>Stage 2: Interactive group work</u> • There was a concern that if midwives' perceptions are so different there is an urgent

	and extend their individual and collective questionnaire responses Total number of participants = 54 PMAN midwives 6 ENB Education Officers (Midwifery)		<u>Stage 2: Interactive group work</u> • What was surprising about the responses to the questionnaire? • What are the implications of the findings?	need for a national assessment framework • There was the danger of moving towards a task approach to assessment where tasks are assessed without exploring understanding and knowledge and the individual needs of different women • The emphasis on assessment in theory could detract from the value of assessment in practice

Appendix 18: Concept Analysis Processes for Each Super-Ordinate Theme

The concept analysis processes per super-ordinate theme are presented:

Figure A18.1 False Promises

<table>
<tr><td>1</td><td colspan="2">The super-ordinate theme: ‘false promises’</td></tr>
<tr><td>2</td><td><u>10 sub-ordinate themes</u>
• place of work
• expectation
• experience
• work life balance
• tired
• realities of role
• support/preceptorship/supernumery
• conflicting information re jobs
• learning
• preparation for role</td><td><u>Uses of concept</u>
Control of organisation B
Cheating C (Self) Misinform R
Forgery C Default C
Idealism R Double cross B
Theft B Unreliable B
Trust B Hopes dashed R
Empty words B Lying B
Misguide R Hollow B
First post C Traitor B
Deceit B Renege R
Consolidation C Disappointment R
(Self) Betray R Promises C
Fit for purpose C Falsify R
Disloyal B Mislead R
Staying local R</td></tr>
<tr><td>3</td><td colspan="2">- A promise that is made with no intention of carrying it out (Merriam-Webster, 2000; p389)
- Deceptive practices (Pearce, 1953)
- Theft by deceit is the offence obtaining property by false pretences (Pearce, 1953)
- Cheating by fraudulent pretences (Burton, 2007; p473)</td></tr>
<tr><td>4</td><td colspan="2">Self idealistic expectations may lead to misinforming oneself
Education perceived as idealistic compared to reality
Changes of perceptions in role transition</td></tr>
<tr><td>5</td><td colspan="2">Borderline = B
Related = R linked to uses of concept
Contrary = C</td></tr>
<tr><td>6</td><td colspan="2">Antecedents – the practitioner had an ability to have a perception of midwifery prior to commencing training/qualified role
Consequences – disappointment – mistrust – exhaustion</td></tr>
<tr><td>7</td><td><u>Key authors</u>
Maben and Macleod Clarke
Fraser and Worth-Butler
Pearce
DH
Standing
Baille
Maggs and Rapport
Kramer
Charnley</td><td><u>Key concepts</u>
Education
False promises
Preceptorship/support
Theft by deceit/cheating
Idealism
Dashed hopes
Perceptions
Practice theory gap
Anticipatory socialisation
Organisational Culture
Children v adults</td></tr>
</table>

Figure A18.2 Reality Shock

1	The super-ordinate theme of: 'reality shock'	
2	7 sub-ordinate themes • Workload • Inter-professional working • Team working • Philosophies of care • Organisation and staffing • Midwifery skills and resources • On my own	Uses of concept Not as expected R Realisation/reality R Open your eyes B Change of values R Wake up B Change R Experience R Transition R Exhaustion R Welcome to the real world R Conflict B Suffocation R Frustration R Patterns B Ways of working R Skill mix R Long hours R Emotion R Guilt B
3	- Unsettling or jarring experience resulting from wide disparity between what was expected and what the real situation turns out to be, such as the first day on a new job (BusinessDictionary.com, 2010)	
4	The experience as per the definition in 3	
5	Borderline = B Related = R linked to uses of concept Contrary = C	
6	Antecedents – a perception of a role prior to transition of roles – needed to have secured a 'first post' in chosen role Consequences – disillusionment – unsettling – unhappiness – difficult adjustment	
7	Key authors Kramer Duchscher Sandall	Uses of concept Reality shock – phases Framework initial role transition Philosophies of care Working patterns Long hours Emotional exhaustion Morale

Figure A18.3 Part of the Club

1	The super-ordinate theme of: 'part of the club'	
2	2 sub-ordinate themes • Belonging/being valued • Culture	Uses of concept One of the boys R Loyal R Membership R Gang R Fitting in R Hierarchy R Acceptance R Adaptable B Skill mix C Conformity R Ability C Welcoming R Go along with it B Personality B Friendship B Trust B Comfort R Safety net B Exclusivity R Different B Privileged R Feel good B Clique R Player B Bullying R Initiation R
3	- Clique – a small, exclusive group of people (Dictionary.com, 2010a)	
4	Conforming to culture and performance Hierarchical structure Need for acceptance	
5	Borderline = B Related = R linked to uses of concept Contrary = C	
6	Antecedents – qualification onto the midwifery part of the professional register Consequences – acceptance leading to happiness and improved productivity – good levels of team morale –improved/high quality standards of care provision	
7	Key authors Maslow Gross Tuckman Melia	Key concepts Sense of belonging Team dynamics/team working Group or peer pressure Social pressure Aggression –v- assertiveness Valued

Figure A18.4 Self Doubt and Struggling

<table>
<tr><td>1</td><td colspan="2">The super-ordinate themes of: ‘self doubt’ and ‘struggling’</td></tr>
<tr><td>2</td><td><u>9 sub-ordinate themes</u>
• self belief/attitude
• anxiety
• negative feelings
• feelings of role
• positive feelings
• mentorship
• developing practice
• asking questions
• leaving/returning</td><td><u>Uses of concept</u>
Scared R
Self awareness R
Confidence R
Personality B
Hierarchy B
Valued B
Ability R
Inferiority B
Self esteem R
Socialisation B
Self-harm C
Identity B
Behaviour R
Unmotivated R
Apprehensive R
Unsure R
Hard R
Stressful B
Embarrassing B
Vulnerable R
Social pressure B
Lack of faith B
Loathing C
Insecurity R
Futility C
Life C</td></tr>
<tr><td>3</td><td colspan="2">Self-doubt
- lack of confidence in the reality of one’s own motives, personality, thoughts etc (Dictionary.com, 2010b)
Struggling
- to contend with an adversary or opposing force – to be coping with inability to perform well or to win (Dictionary.com, 2010c)</td></tr>
<tr><td>4</td><td colspan="2">Personality and confidence on own ability to undertake the role</td></tr>
<tr><td>5</td><td colspan="2">Borderline = B
Related = R linked to uses of concept
Contrary = C</td></tr>
<tr><td>6</td><td colspan="2">Antecedents – self awareness – trigger event leading to a reduced level of self confidence
Consequences – reduced/poor performance – anxiety – reduced motivation – fear – potential for error – overly cautious</td></tr>
<tr><td>7</td><td><u>Key authors</u>
Maben and Macleod Clarke
Fraser
Biggs</td><td><u>Key concepts</u>
Ethical principles
Mentoring
Deep learning
Defensive practice
Skills
Transition/change
Personality trait/Self awareness</td></tr>
</table>

Figure A18.5 Beyond Competence

1	Concept 5 = the super-ordinate theme of: 'beyond competence'	
2	3 sub-ordinate themes • Autonomy/advocacy/responsibility • Decision-making • Delivery suite –v- community	Uses of concept Professionalism R Ability B Safety B Competence R Confidence R Learning B
3	- Practitioners need to be able to construct and reconstruct the knowledge and skills they need and continually evolve their practice (Lester, 1995)	
4	The need to be exposed to situations regarding acting professional within delivery suite and/or community settings.	
5	Borderline = B Related = R linked to uses of concept Contrary = C	
6	Antecedents – learning the minimum professional standards at point of registration Consequences – development of professionalism – development of decision making skills	
7	Key authors Dreyfus and Dreyfus Benner Worth-Butler Fraser Bandura	Key concepts Competence Competence learning model Autonomy Responsibility Decision making Self-Efficacy

Appendix 19: Extracts From Reflexive Diary

Extracts from Reflexive Diary

19.1 The Interview Process

As a practising midwife and midwife teacher, I have had experience in interviewing women and prospective students and midwives. My confidence in these roles has increased with exposure. My role as a novice researcher caused me to be relatively apprehensive in asking questions throughout the semi-structured interviews. My anxiety throughout the first data set was whether I was leading the participants to answer what I wanted them to answer rather than encouraging free range responses and me probing those responses further to elicit a more rich description of the experience. I reflected upon the experience with my research supervisors and one research supervisor listened to one interview. This was to provide in-depth discussion and feedback to my interview process and to aid my reflexive journey.

On transcribing these data, I was surprised and frustrated as to why I did not question further to really get to the true interpretation of the meaning of some of the spoken words. During one of the second interview data sets, I recall asking one participant '*what do you think about that*?' during the semi-structured interview I panicked half way through after realizing that I was asking the participants' thoughts rather than what they had experienced. I ended the interview shortly after this time as I had lost my composure. I discussed this experience with my research supervisor who encouraged me to think of strategies for if this were to occur again i.e. '*OK, this is what you think now tell me what you experienced…*'

I had undertaken several interviews over a short period of time. One day I conducted three interviews. By the time I got to the third interview I could not remember if I had asked participants to elaborate on their comments already or if the comments were made by a previous participant. I was able to consider that this was not an effective approach to the data collection stage and subsequent semi-structured interviews were organised for a maximum of one per day. By re-reading Kvale (2007), I was able to re-focus on the data collection process and refine the way I was posing my questions, learning not to be

phased by the long and awkward pauses and to allow the participants time to speak with me not interrupting. On replaying the digital recordings I was able to reassure myself that I had captured appropriate participant experiences and I had asked participants to elaborate on aspects that they had brought to the interview and not what I thought they had said. I had not raised points that they had not said.

19.2 Telephone Interviews

Two telephone interviews were conducted. These affected two participants and occurred at different data collection sets. One participant chose to have a telephone interview for her first interview. The interview was much shorter than the remaining eleven face-to-face interviews. Many of the responses provided by the participant were short with minimal depth. I found that I could not always hear the responses well and because of the short responses I was keen to be thinking ahead to what I could be asking next to keep the conversation going.

The second participant chose to have her second interview via telephone. Again similar experiences arose and were noted. Both participants selected to meet for face-to-face semi-structured interviews subsequently as they also experienced complexities talking via the telephone. This may have been due to the lack of eye contact and the impersonal feeling of being on the end of a telephone. The fact that concentration was hard whilst communicating via telephone made the experience difficult for both the participants and me. Transcribing these data was extremely difficult as distortions on the telephone line, background noise and muffled words made hearing the words on the digital recording very difficult and impossible on occasions.

19.3 After the Interview Conversations

I was surprised that for some participants, once the digital recorder was switched off, they became more vocal about their experiences. I did not keep field notes about these conversations because they had not provided consent for this aspect. I reflected heavily on this. My perception was that once the recorder was switched off, I stopped being me the researcher and became me the person, colleague, equal etc. I discussed this with my

research supervisors where we considered the fact that I no longer knew the participants for interview sets two and three as our relationships had changed and moved on. Through reflection, it could be considered that off the record, non-recorded conversations were safe and the evidence did not exist to be used potentially to the participants' detriment. I discussed these issues with my research supervisors who helped me to consider all aspects of this information however, I decided to continue not to use this added information as part of the data collection as I could not be wholly convinced it was told to me in my remit of '*the researcher*'.

19.4 Writers Block and Thinking

I have experienced the total inability to find the words to articulate what I am really trying to say on occasions. Van Manen (1990) acknowledges that this is a common occurrence within phenomenological research. I have found this frustrating and debilitating at times. This caused me to stop and re-gather my thoughts and write notes to be addressed at a later time. 'Writers block' has also given me the space to think; this has been essential for determining my thoughts as implicit and tacit knowledge was leading my analysis and interpretations. This fits within van Manen's (1990) writing and re-writing stage.

During the emergent themes or 'initial noting' stage of the analysis process (section 4.3.2) I began to reflect upon the participants experience in relation to my own. This is as Smith et al (2009a) assert a common occurrence. I had been profoundly affected by one participant's comments about her being 'a midwife' that I began to consider if I was 'a midwife'. I spent a session discussing this with my supervisor. My values and beliefs about my role in midwifery had been challenged significantly to make me consider if I was in the 'right profession' primarily because I did not 'feel' or have ever 'felt' what the participants felt towards the role. I 'feel' that I have changed as a result of undertaking this research project; not just as a practitioner, but also as a person which is difficult to articulate.

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