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The lived experiences of student midwives subjected to
inappropriate behaviour.

By

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ABSTRACT

The lived experiences of student midwives subjected to inappropriate behaviour.

'Inappropriate behaviour' can be described as the thousand 'slings and arrows' that, on a daily basis, eat away at civility; such behaviours may be one-off events, or individual put-downs, that nevertheless cause the receiver significant harm. In this thesis, inappropriate behaviour is conceptualised as different from bullying, which involves the repetition of behaviours and is defined and supported within various legislation. Whilst there is research that focuses on the nature and impact of workplace bullying, there is very limited research that considers the impact that inappropriate behaviours can have on an individual.

This interpretive phenomenological investigation, whereby Heidegger's philosophical approach to phenomenology was used as a methodological framework support, explored the lived experiences of eight student midwives, who had experienced inappropriate behaviour within their academic and clinical environments. The research illustrates the nature of such experiences and further explores the resulting effects.

The experiences disclosed by individual participants were initially identified as struggling, being out of sight out of mind and loss and bereavement. The main findings revealed three interpretative themes that described what inappropriate behaviour represented for the participants and how it impacted upon them. These were: 'Breaching Covenant', 'Dispossession' and 'Liminality'. Each theme incorporated one super-ordinate theme, betrayal and struggling (Breaching Covenant), loss and bereavement (Dispossession) and finally angst and anonymity (Liminality).

For the participants, inappropriate behaviour was seen as single acts most commonly perpetrated by clinical midwives, without a sense of malice or intention to cause harm. It is important that the difference between bullying and inappropriate behavioural acts become known by of all those involved with student midwives' education and a concerted effort in changing attitudes is made to enable the development of both clinical and academic environments, where inappropriate behaviour is strongly contested and vigorously opposed.

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Declaration of Authorship

I, *Jane Diana Johnston*, declare that the thesis entitled:

The lived experiences of student midwives subjected to inappropriate behaviour

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

- this work was done whole or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been 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 works 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

Chapter 1 INTRODUCTION AND BACKGROUND

Introduction

The interest for this research study arose from the author's personal experiences, observations and the anecdotal evidence of student midwives who were, or had been, subjected to behaviour that, in the author's opinion, did not fit the many criteria identified as bullying. For the participants these acts occurred within both their clinical and academic environments; and I wanted to investigate if these forms of behavioural acts, in any way, impacted upon the student midwives.

1.1 Study aim

This chapter provides an orientation to my study. I have chosen to undertake a phenomenological investigation to explore the lived experiences of student midwives who have been exposed to inappropriate behaviour.

1.2 Rationale for undertaking this study

As both a student nurse and midwife I experienced behaviours, from qualified staff, which to me was not appropriate however, these types of behaviours were not on a regular basis from either one person or a group. As an example when I was a student midwife I worked a shift with a particular midwife without incidence, yet on the next occasion I was assigned to work with her she behaved towards me as if I was not really with her. She did not directly ignore me, more that I was not overtly included in conversations or that her body was slightly turned away from me when she was speaking to others. The behaviours which I experienced were very subtle in nature and were difficult to articulate to others however, the impact of these subtle behaviours left me feeling inadequate, I certainly lost confidence in myself and at times I did begin to believe that I was not going to make a good midwife. It was not out and out bullying, whereby it was repeated events from one individual or even a group, more treatment that left me in a position, that when I did attempt to highlight such behaviours, were I was given retorts such as 'don't be silly', 'grow up Jane' or 'oh that's just her'. These responses, I felt, were unfair and

unjust as I had no course of redress to stop these individuals from continuing in this manner.

As an individual I have always been opposed any form of injustice and unfairness. For me, justice is linked to the notion of fairness, although ideas regarding what is fair differ among various contexts (Brosnan and de Waal, 2014), to a point where it becomes difficult to give a comprehensive and adequate definition of justice or what it means to behave justly. Behavioural traits, which are unjust, can manifest in many ways, with bullying being most commonly discussed (Einarsen et al., 2011). For actions to be considered as bullying there are criteria which must be met, such as the behaviour is a repeated event, thereby excluding one-off events; that there is a negative effect resulting from the bullying of the victim; and, finally, that the victim has difficulty in defending themselves (Einarsen et al., 2011; Gillen, 2007; Zapf et al., 2011).

Before I considered commencing a doctorate I undertook literature searches, yet found difficulty in locating any research which addressed the term 'inappropriate behaviour' as a unique concept; furthermore, it seemed that any type of undesirable behaviour was placed under the umbrella term 'inappropriate'. At the same time, in the research arena, the term 'bullying' had become a more prominent research subject for investigation within the healthcare and workplace sector, thereby overshadowing any behavioural actions which did not meet the set definitions of bullying.

I was aware of observed acts of behaviour towards both students and qualified staff which, whilst causing distress to the individual, would not have been upheld in a complaint as they were one-off events, at the time, with no evidence to support the acknowledged criteria for bullying. Therefore, in regards to the dichotomy surrounding bullying and inappropriate behaviour recognition and having a personal understanding of how I felt and the impact the type of behaviours I experienced had on me, combined with the observations of my peers and comments from student midwives, I was spurred on to undertake a research study to explore the term 'inappropriate behaviour' as a unique concept and to try to gain an understanding of what, if any, the experience meant to student midwives.

I chose student midwives, as participants, as there is a certain vulnerability for them because they are in a learning situation and are reliant on clinical mentors and academic tutors for both their education and the acquisition and development of their clinical skills. From this perspective there is the risk that students may tolerate certain behaviours, acted towards them, as they may perceive that there is the potential for repercussions in regards to placement evaluation or marks awarded for assessments and programme progression. There are supportive measures in law that can offer protection to student midwives who are bullied (e.g. Equality Act, 2010) however, inappropriate behaviour expresses itself almost at the base of the range of workplace abuse where it is not regarded as hostility or aggravation, nor even as open dispute.

1.2.1 My positioning

As identified earlier, I do not tolerate injustice and unfairness however, I acknowledge that my perception of observations of both injustice and inappropriate behaviour has been generated from a third-party perspective. Folger's (2001) deontic justice delivers a theoretical account to understand why third-parties react to unfairness experienced by others, through which it is emphasised that people should treat one another fairly because unfair treatment infringes a socially affirmed moral rule. Skarlicki and Kulik (2005) highlights that it is viable to consider that knowledge of another's unfair experience produces an empathetic reaction in which the third-party responds in the same way that the victim responds, as a result of the second-hand experience of the event. This insight could explain why my personal justice concerns might be engaged for reasons that are not derived from my self-interest or relationship with the victim, symbolic or otherwise.

As a researcher I must be aware of this ability to produce an empathetic response and execute a professional and a reflexive approach when analysing the data, to ensure credibility. Undertaking research when you adopt different roles in your working arena can lead to ethical conflicts, as the ethical codes for midwifery practice NMC (2015), for example, and those for undertaking research offer subtle differences. Ryan et al., (2011) explored the role of midwife practitioner as a researcher, using five narrative case studies of midwife-researchers, with their

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findings offering the argument that the midwife's role, as governed by their professional code of conduct, must override their role as a researcher and that their duty of care must come to the fore. I had the dichotomy of holding a variety of roles, whereby I am a midwife practitioner, academic and researcher, leading me to uphold a myriad of regulations, The Code (NMC, 2015) and the Midwives' rules and standards, (NMC 2012) being examples.

Once qualified I felt I was in a position whereby I could legitimately approach another qualified or unqualified colleague regarding her/his practice or behaviour towards a student midwife (NMC, 2008, 2015) and work with them to address any deficits in behavioural mannerisms. Equally, as a mentor in practice, I was reflective regarding my behaviour towards students and welcomed feedback from both colleagues and students as a means of personal growth. I felt it was important that I supported any student I worked with to feel at ease to discuss any aspect of their experience, without worrying about repercussions. I did recognise that students may have felt that they could not be as open as they wished because they saw me as the gatekeeper to the award of a grade for their practice. The same aspect applies to my role as midwife tutor.

As Innes (2009) described, I can be seen as an insider researcher, whereby I have conducted research surrounding my own homogeneous groups, those being my own profession, culture and workplace. An insider, as defined by Jenkins (2000), is a part of an in-group where they have access to its past, present, future and, furthermore, shares experiences with the research participants. Griffith (1998) elaborates on this aspect by suggesting that the researcher has lived familiarity, thereby leading to the possibility of a feeling of sameness between the researcher and participants. Although, Griffith (1998) does offer caution that one cannot identify the insider position with just a shared characteristic history such as race, culture, gender or ethnicity. Insider status, from my perspective, can be clearly recognised as having numerous commonalities with my participants such as personally experiencing behaviours which I deemed to be inappropriate towards me, both as a student nurse and midwife, shared culture, language (both from a clinical and mother tongue perspective), educational experiences, profession and working practices. The sharing of these commonalities led me to experience dilemmas during the process of my data collection. As I listened to the narrative

content regarding the behaviours exhibited towards the participant's and the subsequent impact on them, I felt, at times, ashamed of the profession I was part of as I was reminded of my own experiences as a student and further that, so many years later, the recounted behaviours were still evident and that they had similar impact on the participants'. The experience of such dilemmas permitted me to become reflexive in terms of understanding the notion of me, as the researcher, and of the participants. Additionally, I was enabled to address the influence of my own subjectivity and enhance, I believe, the trustworthiness of my research endeavour.

1.3 Student midwife education

Before the 1980's almost all midwifery education in the UK took place in hospitals, within a School of Midwifery directly linked with the hospital in which the training was based. At this time, midwifery training was normally only open to those who were already qualified general nurses, with the programme being 78 weeks in length, whereby the student would be paid a wage by the employing Trust. The United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC 1986) proposed to combine an 18-month basic nurse training with an 18-month midwifery programme, which was vigorously opposed by the Royal College of Midwives, which resulted in the introduction of a three-year direct-entry midwifery programme (Radford and Thompson, 1998). This enabled a person who was not a qualified adult nurse to undertake training to become a midwife. Since the introduction of direct-entry midwifery (Dike, 2005), both midwifery programmes are provided by approved higher education institutes with university fees funded by the Government. Over 90 member states have registered midwifery practice within the International Confederation of Midwives (ICM), with the united purpose to secure women's rights and access to midwifery care (ICM, 2010).

In the UK, midwifery practice is regulated by the Nursing and Midwifery Council (NMC), as set out in the Nursing and Midwifery Order 2001 (NMC, 2001), with midwives upholding their practice as referred to in the 'Rules and Standards' (NMC, 2012) and 'the Code' (NMC, 2015). As from September 2008, all student midwives were required to be educated to degree level, with the NMC (2009, p. 15) stating that direct entry midwifery training '*should be no less than three*

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years, or 156 weeks, equivalent for a full-time commitment'. The practice-to-theory ratio is stated as being no less than 50% clinical practice with a minimum of 40% theory. A full-time programme for those students who are currently on the adult part of the professional register must be no less than 18 months or 78 weeks in duration. For the purpose of this study, I am interested in exploring the experiences of direct entry student midwives (156 week degree student midwives) who would not have had prior exposure to the realities of working within the NHS as a qualified adult nurse.

1.4 The central role of midwives in health care practice

As a means of placing the practice of midwifery in context, midwives are autonomous practitioners, responsible for providing care in the antenatal, intrapartum and postnatal periods for women up until 28 days after the birth (or longer if deemed appropriate by attending midwife). They are the lead professional in normal/low risk pregnancy in the UK and, as experts in normal pregnancy and birth, midwives are typically the first and main contact for the woman and family. Midwifery care continues to be governed by a raft of Government policies: In the House of Commons Health Committee *Winterton Report*, (1992), plans were outlined which strove to ensure that women were at the centre of care. Midwives endeavoured to support these plans, however, aspects such as funding and the myriad modes of maternity service delivery resulted in a fundamental failure of the report's recommendations being implemented (Mander and Fleming, 2002). *Changing Childbirth* (DoH, 1993) expressed a vision of midwifery-led, woman-centred care in which women could advocate where to give birth. The outcome of this report resulted chiefly in many pilot projects being implemented throughout the country; however, no true systematic changes within maternity care ensued (Dimond, 2004). The Department of Health published *Maternity Matters*, which endeavoured to build on the maternity services commitment outlined in the Labour government's *Our Health, Our Care, Our Say* (DoH, 2006), which set out the wider choice framework for maternity services. These choices included:

- How to access maternity services - Women were offered the choice of accessing a midwife or doctor directly.

- Type of antenatal care – Midwifery-led or shared care with a doctor.
- Place of birth – Dependent on their medical history and circumstances, women and their partners to be offered the choice between home births, giving birth in a midwifery unit, or with midwives and doctors in hospital.
- Place of postnatal care – Women to be able to choose how and where to access postnatal care.

In 2007, The Royal College of Midwives (RCM) responded to the Government's guarantee of a first-class maternity service by 2009 with caution, indicating that action was required urgently to overturn the movement towards a diminishing maternity service and midwifery labour force. The report prepared by Darzi, *High quality care for all: NHS Next Stage Review* final report (DoH, 2008), offered little or no input on the way forward for maternity services as a whole. The National Audit Office's report (2013) did recognise some improvement in maternity services since the previously noted reports, although it also identified that the NHS was not meeting a widely recognised benchmark for midwife staffing levels (32.8 births per midwife, as opposed to the recognised 29.5 births per midwife). Since these publications, there remain sections of excellence within maternity services but little cause to believe that much is fundamentally changing. Midwives remain in short supply in many Trusts and the RCM report of 2102 indicated that, whilst there was a 19% rise in midwives being employed, overall there was still a deficit of five thousand full time equivalent midwives.

A number of contributing factors led to some midwives diversifying and acquiring skills to enable them to develop their role. Some of these factors were the reduction in junior doctors' hours (General Medical Council, GMC, 2009), the reduced involvement of General Practitioners (GP) within maternity care (Smith et al., 2010), the wish to provide continuity of care for women and the need to provide a clinical career pathway framework (Midwifery, 2020). Those aspects identified in the previous paragraph have had a huge impact on the organisation of maternity care, whilst, in line with these changes, the number of consultant obstetricians in many units has increased. However, simultaneously, there has been a reduction in the working hours of junior doctors since the New Deal and the European Working Time Directive was introduced in 2003, which, in turn, created

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a gap which had to be filled to maintain high quality care; a gap which many midwives are now filling (Lavender and Baker, 2013).

Over the last 10-15 years, midwives have attained a variety of skills to enable them to provide a complete assembly of care for women and to minimise unnecessary input from other professionals. While these extended roles are to be applauded, there is evidence to suggest that some midwives are anxious that their roles are extending to a point which may, in the long term, impede them from doing the job for which they were trained (Lavender et al., 2001, 2002). While role extension can increase continuity of care (meaning that the same midwife stays with client throughout the treatment period), midwives have also proposed that it can undervalue normal midwifery practice (Lavender et al., 2002). Furthermore, with the shortage of midwives, the time bestowed upon carrying out such extended roles may redirect attention away from the core principles of midwifery practice (Sandall et al., 2011) and the potential for mentoring students. The extended role of the midwife does have some impact on student learning and relationships within practice. Within Kroll et al.'s (2009) study, student midwives commented on the fact that, due to competing demands, qualified midwives were unable to be released from practice in order to undertake a recognised mentorship programme. In turn, the continuing repercussion of the lack of midwives without a mentorship qualification resulted in the students having difficulty attaining summative assessments in clinical practice. In the clinical environment, findings showed that heavy workloads were seen to impact on the midwives' ability to teach, identify and maximise learning opportunities for the students.

1.5 Midwifery and culture

The emergence of midwifery as a profession can be evidenced in written format within the Hebrew scriptures, where the idiom 'midwife' is literally translated as 'one who delivers a baby' (Mitchell and Oakley, 1976). In ancient Egypt, midwifery was deemed to be a female profession; this female dominance was likewise prevalent throughout Greco-Roman antiquity, where midwives were considered as female physicians, such was their standing within the community (Flemming, 2000). Midwifery throughout history and today remains a predominately female profession (Phillips, 2009), which has led to a culture profoundly influenced by

gender codes, in turn influencing both the structure of social institutions and that of an individual's patterns of relationships and socialisation (Davies, 1995). Current midwifery practice is seen from different viewpoints, such as having developed from an occupational culture that has been described as one of blame (Kirkham, 2001), in turn, this has led to a culture of bullying, which overawes midwives to a point where they begin to doubt their skills and abilities (Robertson, 2004). From an organisational perspective, midwifery has been described as being situated low within the hierarchy of the National Health Service (Pollard, 2010), a consequence of which, suggests Hillier (2000), is the portrayal of midwives as an oppressed group who, at times, through tensions, manifest unacceptable and inappropriate behaviour.

Within the culture of midwifery, a sub-culture of harassment and bullying has been identified as rife (Hadkin and O'Driscoll, 2000). During adulthood, it is suggested that women will use 'social manipulation' (Björkqvist et al., 1994), representing covert or disguised aggression in which the aggressor utilises others to undertake the manipulation, thus avoiding identification and/or counter attack. Salin and Hoel, (2013) discuss the indirect form by which this type of social manipulation occurs, with examples including insulting comments about one's private life and insinuations without direct accusation. Kirkham (2007) has described the hostile working environment for midwives in the UK, in the hierarchical NHS, considering that it is almost impossible for midwives who experience or fear workplace bullying to provide supportive and cherishing care for childbearing women. A sense of powerlessness is observed by those who are subjected to this type of behaviour; victims do not always report the matter, particularly if the bullying is indirect or if the victim is being socially isolated or excluded.

1.6 Inappropriate behaviour

Inappropriate behaviour manifests itself almost at the base of the range of workplace abuse, where it is not viewed as hostility or aggravation nor even as open disputes, although it can escalate to become any of these situations (Einarsen et al., 2011). Lee (1999) describes inappropriate behaviour as the thousand "*slings and arrows*" that on a daily basis eat away at civility, nuances of inappropriate workplace behaviours which, potentially due to their nature or

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infrequency, may well not be classified as bullying. From that rationale these behaviours have a tendency to be either overlooked or treated as part of the 'rough-and-tumble' of organisational life (Pearson et al., 2001). Inappropriate behaviour can be triggered by interactions between individuals or events in the vicinity of the individual, by environmental factors or personal/social aspects of the individual's life, taking the form of verbal or non-verbal behaviours which could be social, physical, sexual or emotional in nature (Thomas-Peters, 1997). Hoel and Cooper (2000) and the Task Force on the Prevention of Workplace Bullying, (2001) conducted studies which established that the majority of inappropriate workplace behaviours were of a lower frequency ('now and then' and 'occasionally', respectively) than those reported as overt bullying. Under most definitions of bullying, which require repeated events to warrant the term, such behaviour would not be classed as bullying because of its low frequency.

In a qualitative study conducted by Jones and Wylie (2008), findings from focus-groups, using volunteers from a convenient sample from both second and third year student midwives, identified that some student midwives described their experiences of inappropriate behaviour from their midwifery mentors as being 'made to feel like a leper', or as being ignored and constantly referred to as the student, despite the fact that a name badge was displayed on their uniform. With this type of behaviour, there is the potential for a student midwife to be ill-prepared to function as a qualified midwife, which can have an impact on mother and infant safety, as well as the psychological effect upon the student (Pope and Burns, 2009).

1.7 The literature

To date, there is no study which has specifically examined the effects of inappropriate behaviour, as a unique concept, towards student midwives and any subsequent impact it may have had upon them. Chapter 2 offers insight into relevant literature which explores in greater depth inappropriate behaviour and bullying, as a means of offering context.

1.8 Defining the research question

A gap in the knowledge base has been demonstrated in regards to the impact that inappropriate behaviour may have on student midwives within the midwifery culture of academia and practice, highlighting the need for a study to explore lived experiences of student midwives who have been subjected to inappropriate behaviour. This thesis will, therefore, seek to address the following research question:

What are the lived experiences of student midwives subjected to inappropriate behaviour within their practice and academic environments?

The main objectives of this study are to:

- Recount the experiences and perceptions of student midwives of inappropriate behaviour within their working and studying culture.
- Identify what the concept of the term 'inappropriate behaviour' means for the participants.
- Identify the extent to which the act of inappropriate behaviour impacts upon student midwives.
- Highlight any implications for individuals and the midwifery culture as a whole.

Furthermore, the aim is to contribute to the body of research and theoretical knowledge of the participants' lived experiences by:

- Highlighting current activity within the midwifery culture of academic study and practice.
- Drawing attention to the need to practice in a culture free from inappropriate behaviour.
- Identifying the consequences of such behaviour in regards to student midwives' experiences.

1.9 Research design

This research study has been designed to explore the lived experiences of eight student midwives and gain an understanding of their experiences and perceptions of inappropriate behaviour within their working and academic culture. A qualitative paradigm approach was taken, utilising a phenomenological perspective. The ontological perspective taken was that the participants' views, perceptions, understandings, elucidations and experiences were, as Mason (2002, p. 63) describes, "*meaningful experiences of the social reality.*" The participants were not given pre-specified constructed concepts of inappropriate behaviour – they were free to express their own concepts with gentle guidance from me in the manner of an introduction and prompt words.

1.10 Methodology and conceptual framework

McGaghie et al., (2001) proposes that the conceptual framework provides the platform for the presentation of the research question that has been identified, which in turn steers the investigation being reported upon, based on the stated problem. The problem statement of this thesis surrounds the concept of inappropriate behaviour and how the consequences of such actions may impact on student midwives. The methodology of choice is phenomenology and whilst there is an intention to not build theory, but to describe a lived experience, it is acknowledged that there is the potential to recognise patterns which may contribute to theoretical frameworks. The roots of phenomenology lie in philosophy or as a movement in the history of philosophy: The main purpose of this methodology is to determine what an experience means for an individual, from those who have lived the experience and are capable of providing a comprehensive description of it.

Phenomenology does not propose a single procedural system for conducting an enquiry, more guidelines and pointers. Heidegger's philosophical approach to phenomenology served as the methodological framework for my research. Based on Heidegger's interpretive phenomenological approach, which is also called hermeneutics, I am afforded the ability to use my own thoughts and ideas of prior

experiences to interpret data in the research process (Mapp, 2013). I believe that an interpretive phenomenological approach, as described by Heidegger, is the most appropriate methodological framework to utilise for this study. I am familiar with the issue of my own perception of inappropriate behaviour and I am interested and willing to explore the phenomenon in-depth. I have also sought to gain a greater understanding through interpretation of the experiences, which was best accomplished through the support of Heidegger's phenomenological as my methodological framework.

1.11 Data collection

It was determined that an investigation into the experiences of the participants could be best facilitated through in-depth discussion, by conducting extended interviews. Eight student midwives were interviewed (from different geographical areas) regarding their perception of inappropriate behaviour within their culture of clinical practice and academic environments. In-depth interviews were the primary source of rich data collected for analysis. From a phenomenological perspective, Marshall and Rossman (1995, p. 82) describe the interview as a "*specific type of in-depth interviewing grounded in the theoretical tradition of phenomenology.*" The use of in-depth, semi-structured interviews was utilised, as this acknowledged the methodological preference for gentle guidance rather than firm control (Rose, 1994). Interviews constitute engagement, which provides significant benefits in terms of facilitating the acquisition of important information (Guba and Lincoln, 1989, p. 237). Amongst these benefits is the opportunity to respond to information immediately as it is received and to clarify responses. Thus, in-depth interviewing allows for sharing of information to occur, in that the individual can explain to the researcher, in their own words, what being in a certain situation means to them.

1.12 Reflexivity

Reflexivity is the ability to reflect or think critically, honestly, with care and openness, about the research experience and process (Pillowa, 2003). Finlay and Gough (2003, p. 5) highlights that, as a researcher working in the qualitative paradigm, one is a "*central figure who actively constructs the collection, selection and interpretation of data.*" This viewpoint rests well within Heidegger's

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philosophical approach to phenomenology, whereby I, as the researcher, am part of the experience and not distanced from it (Heidegger, 2000). Through the process of reflexivity, I can show how I learned as I progressed through the research experience and offer a lens to how my thinking, intuition and reflection can be drawn upon as primary evidence. As a means of aiding the reader to contextualise, I considered it appropriate to produce elements of a reflexive account of my journey through the development of this thesis. This is explored in-depth within Chapter 6.

1.13 Data analysis

There are several established approaches to phenomenological interpretation, with the contention that there is no 'right' way to broach the analysis; and with caution identified in applying rigidity to any particular method (van Manen, 1997, p. 345). There is a need to determine the meaning of experiences within a framework which allows for a methodical process, preventing any escape of data. For the purpose of this study, Interpretative Phenomenological Analysis (IPA) was utilised (Smith and Osborn, 2008).

1.14 Expectations and anticipated benefits of this study

Whilst it is possible to surmise the challenges faced by student midwives who have been or who are being subjected to inappropriate behaviour, this study seeks to better understand the experience(s) of a student midwife and the impact that inappropriate behaviours may have on them. At the outset of the study, it was clear that the benefits of conducting this research cover both education and clinical practice. Having an insight into experiences, as described by the participants, will enable me to identify where any required support mechanisms can be developed and implemented more effectively. The findings may then be utilised to bring awareness to Approved Educational Institutions (AEIs) and to management within the NHS, both of whom have a responsibility to ensure the physical and psychological well-being of the student midwives placed within their environments.

1.15 Overview 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 review of appropriate literature, in order to provide context and credence for the study. The term 'credence' is used here as a means of demonstrating credibility for the undertaking of this phenomenological study, based on the preliminary review. Chapter Three provides the reader with the principal research question, the methodological consideration and the study design. Within Chapter Four, the process of data analysis is explored, including the audit trail of how the data was managed, leading to the development of the super-ordinate themes and the emergence of the three final interpretive themes. Chapter Five considers these themes, while the purity of the participants' words has been used to explicate the findings. Chapter Six offers a presentation of the findings from Chapter Five in relation to contemporary literature in the form of a discussion. Within Chapter Seven, the conclusion to the study (incorporating its strengths, limitations and implications for practice and future research) are presented.

1.16 Chapter conclusion

This chapter has provided the rationale for this study and the general policy context within which it has been undertaken. Further, it has offered insight into the varying nuances which surround bullying and why the term 'inappropriate behaviour' is the focus of study. For the purposes of this study, 'inappropriate behaviour' will be used in a deliberately broad manner, with the intention to take account of events and interactions that the participants themselves describe. Midwifery has been placed into a cultural context with the aim of demonstrating how inappropriate behaviour has infiltrated the culture. The research purpose and design has been illustrated and proffered as a rationale for the need of a study of this type. The expectations of the study have been articulated. As a result, this phenomenological study is designed in order to gain an understanding of the experiences of student midwives who have been or are being subjected to inappropriate behaviour, together with the described impact that this may have had upon them.

Chapter 2 LITERATURE REVIEW

2.1 Introduction and purpose

When preparing for any research project, there is the requirement for a review of the literature as a means of providing a theoretical background when considering if there is any prior knowledge available and to ascertain further what new knowledge the researcher seeks to obtain and contribute to the research arena (Bolderston, 2008).

Through the process of conducting a literature review, I have the means to demonstrate my knowledge surrounding the chosen field of study, including theories, vocabulary, key variables and phenomena; and its methods and history. From a methodological perspective, there is debate about whether a literature review should be thoroughly conducted prior to actual research or post-completion of data collection and analysis. This being the case, there are authors who offer the argument that a thorough literature review should be conducted at the beginning of the research process, as is common within quantitative studies (Creswell, 1994; Yin, 2011, Miles and Huberman, 2014). The rationale being that researchers must describe their project in terms that are familiar to central groups (e.g. peers, funding agencies) and that exploring existing literature can avoid wasting time and help reinforce the design of the study. In doing so the researcher is able to review critically the subject matter related to the research in hand, thus providing background history and drive for the research to be undertaken. Contrary to this thinking is the proposed challenge that by undertaking a literature review prior to data collection and analysis, within a qualitative research design, there is the risk that the researcher could influence the findings and bias could be invoked (Streubert-Speziale and Carpenter, 2003).

In examining Heidegger's philosophy, the researcher's preconceptions are integral to the entire research process, so distancing oneself from phenomena under investigation is almost impossible, especially as I have an inherent interest and in-depth knowledge of the research topic.

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This sits well with Heidegger's concept of *In-der-welt-sein* ('being in the world'), whereby Heidegger argues that we are not entities which exist parallel to our world; rather, at all times we are submerged in our world (Heidegger, 1962). Thus, in subscribing to Heideggerian philosophy it is acknowledged that the researcher only interprets something according to their own beliefs, experiences and preconceptions, which form a legitimate aspect of the research process and should not be left out (Lowes and Prowse, 2001). In reviewing the arguments, I chose to offer initially a review of the literature surrounding the issues, philosophies and rationales behind the subject matter of inappropriate behaviour and bullying in order to situate the core concepts and allow the reader to place the study in context. It is consistent with the principles of phenomenological research that following the generation and collation of themes, from the current research study, a further literature search is undertaken to examine the evidence surrounding the findings. A critical appraisal of the newly identified literature was then conducted to support or refute the findings and I undertook this process towards the end of the study, to reduce potential data contamination (Polit and Beck 2012) and, therefore, it is integrated within Chapter 6.

I initially limited publications to the European Union (EU) and United Kingdom, resting on the fact that many countries outside of the UK and EU do not permit midwifery practice (as interpreted within the UK). However, with regard to the topic I am researching it was considered that behaviours, and the varying types of actions exhibited, were likely to be encountered beyond the EU and UK policy and practice contexts. Therefore, in reviewing the literature it became apparent that by limiting articles to just the EU and the UK excluded the exploration of the available evidence from other countries. Further, limiting the literature to a time frame of publication within the past ten years, and using the term 'student midwife', resulted in the omission of some texts. Therefore, both a serendipitous search and a repeat of the electronic search, without a date restriction, or geographical region, and the term 'student midwife', were carried out. A summary of the papers identified is located in Appendix 1 and these are discussed below within the body of the thesis.

2.2 Inappropriate behaviour as opposed to Bullying

There is the need to differentiate between bullying and inappropriate behaviour in order to provide context and to situate my research. On this basis the rationale for examining inappropriate behaviour, as opposed to bullying, is that the latter involves the repetition of various types of hostile behaviours, and is defined and supported within various legislation whereby the victim has a course of redress.

Conversely, inappropriate behaviour involves subtle and subjective actions, whereby they can be seen as low level and overlooked or dismissed by others when redress is sought by the victim. It is contended by Keashly and Neuman (2010) that the negative consequences of workplace bullying on employees, such as mental health and general well-being issues are equally evident in those subjected to inappropriate behaviour. However, due to the fact that the behaviours are understated and subjective in nature and that criteria for bullying and other workplace mistreatments is not met, the victim is left vulnerable (Lee 2000).

Within the literature a definition and the use of terminology around inappropriate behaviour, as an independent meaning, remains unclear and is most commonly used as an umbrella term to cover the many types of workplace mistreatment. These types of workplace mistreatments have been identified as bullying Namie and Namie 2009, Vartia 1996, Einarsen et al., 2011,), horizontal, lateral and vertical violence (Jackson et al., 2007, Buback 2004), mobbing (Matthiesen et al., 1989, Leymann, 1996, Zapf 1999,) harassment (Brodsky, 1976), psychological and emotional abuse (Follingstad and Dehart 2000, Keashly 2001) and aggression (Björkqvist et al., 1994).

However, these terms also are used interchangeably (Ariza-Montes et al., 2014, Zapf, 1999, Duffy, 1995, Clark and Springer, 2007, D'ambra and Andrews, 2014; Khadjehturian, 2012). Clarifying the boundaries between these different constructs is essential to conducting robust studies on workplace behaviours. However, each of these concepts in themselves would separate into distinct categories such as characteristics of the offending behaviour in regards to frequency, intensity and in/visibility, as well as qualities of the relationship between perpetrator and its victim (Hershcovis, 2011).

Within Table 1 terms used for the various forms of workplace mistreatment are offered, as a means of placing the terms into context.

Table 1 Terms applied to work place mistreatment behaviours

Author(s)	Term	Definition
Brodsky, 1976	Harassment	Repeated and obstinate attempts of one person to torment, frustrate, or break the resistance of another person, an attempt to get a wanted reaction from them. It is a form of treatment that, applied with persistence, provokes, pressures, frightens, intimidates, and inconveniences the victim.
Matthiesen et al., 1989	Mobbing	One or more person's repeated and enduring negative reactions and conducts targeted at one or more person of their work group.
Leymann, 1996:	Mobbing	A malicious attempt to force a person out of the workplace through psychological terror, unjustified accusations, humiliation, general harassment and emotional abuse. It systematic and repeated over a period of time with the intent to harm.
Zapf 1999	Mobbing	Repeated harassment and social exclusion of someone or assigning offending work tasks to someone in the course of which the person confronted ends up in an inferior position.
Buback 2004	Vertical violence	Repeated abusive behaviours from a co-worker in a superior position towards a subordinate.
Cantey 2013	Vertical violence	Vertical violence is defined as any act of violence that occurs between two or more persons on different levels of the hierarchical system and prohibits professional performance and satisfaction in the workplace. Such acts can include yelling, snide comments, withholding pertinent information, physical, sexual, and emotional abuse, rude, ignoring, and humiliating behaviours.

Author(s)	Term	Definition
Follingstad and Dehart 2000.	Psychological abuse	The systemic and repeated destruction of a person's self-esteem and/or sense of safety, often occurring in relationships where there are differences in power and control. It includes threats of harm or abandonment, humiliation, deprivation of contact, isolation and other psychologically abusive tactics and behaviours.
Björkqvist et al., 1994	Aggression	Repeated activities with the aim of bringing mental but sometimes also physical) pain, and directed toward one or more individuals who, for one reason or another, are not able to defend themselves.
Keashly 2001	Emotional abuse	Targeted, repetitive workplace communication that is unwelcome and unsolicited, violates standards of appropriate conduct, results in emotional harm, and occurs in relationships of unequal power.
Jackson et al., 2007	Horizontal/Lateral Violence	A series of undermining incidents over time, as opposed to one isolated conflict in the workplace.
Hoel et al., 1999	Bullying	Someone is subjected to negative behaviours from another individual or a group of people consistently for a period of time.
Vartia 1996	Bullying	A long lasting, recurrent, and serious negative actions, and behaviour that is annoying and oppressing. It is not bullying if you are scolded once or somebody shrugs his/her shoulders at you once. Behaviour develops into bullying when it becomes continuous and repeated. Often the victim of bullying feels unable to defend.
Namie and Namie 2009	Bullying	The recurrent, cruel verbal mistreatment of a person by one or more workers.
Einarsen et al., 2011	Bullying	The systematic mistreatment of a subordinate, a colleague, or a superior, which if continued and long-lasting may cause severe social, psychological, and psychosomatic problems in the target.

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As demonstrated in Table 1 there are a myriad of behavioural actions which constitute workplace mistreatment however, they do share commonalities such as the actions are repeated over a period of time, there is the intent to harm and the victim feels unable to defend themselves (Leymann, 1996; Björkqvist et al., 1994; Hadjifotiou (1983), and Einarsen and Raknes 1997). Further, these commonalities have been highlighted in the literature whereby bullying is defined by the way it manifests within the social setting, namely as aggressive behaviour (Razzaghian and Shah, 2011), which most commonly transpires during interpersonal exchanges within the workplace (Zapf and Einarsen, 2001).

(Einarsen et al., 2011, Einarsen 2003, Einarsen 1999, Simons, 2008) support the agreement that bullying can be defined in terms of intention, frequency, length of time the behaviour is exhibited, reaction(s) of the victim, the perception of power imbalance and misuse of power between the offender and victim and the victim's incapability to defend themselves from such hostility. However, Keashly and Jagatic (2011) do highlight that problems with both measurement and perception of bullying have been observed due to the disagreement between researchers in regards to the term applied to describe the workplace mistreatment. Thomas-Peter (1997) offered the argument that the criteria for what is and is not acceptable are often unwritten assumptions, with the ways in which individuals and organisations interpret said behaviours having important implications for support and help. In other words, how bullying is classified and what definition is used will influence the type of occupational help and support that is afforded.

For Simons (2008), bullying is defined as exposure to at least one negative act at least once a week for six months, whereas Einarsen et al., (2011) identified that a conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal 'strength' are in conflict, such as two persons who attract the same title or pay grade. Zapf et al., (1996) identify that the bullying process may start between two equal parties as an interpersonal conflict but their relative strength may alter in the course of time.

These perpetuating aspects of bullying have been accentuated in order to differentiate it from what is deemed to be 'normal' social stress in the workplace (Einarsen and Skogstad, 1996; Vartia, 1996; Zapf et al., 1996).

It is acknowledged that isolated or 'one-off' instances of negative behaviour are not generally classified as bullying (Cowie et al., 2002, Einarsen et al., 2011, Saunders et al., 2007).

Bullying is reported as being common within the healthcare sector worldwide (Koh, 2016, Randle, 2007; Carter et al., 2013). Within the United States (US), Speroni et al., (2014) undertook a survey of 762 nurses and found that 76% had experienced some form of verbal and/or physical workplace mistreatment by patients or their visitors in the previous year. Also in the US Vogelpohl et al., (2013), using quantitative methods and a descriptive design process, surveyed 135 newly licensed RN's where findings showed 20.5% reported experiencing workplace bullying from colleagues, physicians, and patients' families.

A Canadian study by Clarke et al., (2012) accessed 674 nursing students, undertaking a four year bachelor programme, with survey results identifying that 80% had experienced at least one episode of bullying and 8% reporting episodes of physical abuse and 13% being threatened with physical harm. Further, bullying was noted to be highest within final year students with the most common perpetrators being clinical educators or staff nurses.

In total 888 nursing students in Australia participated in a study by Budden et al., (2015), which supports the findings of Clarke et al., (2012), whereby utilising a cross-sectional survey design, they sought to identify the incidence and nature of bullying experienced during clinical placement. The findings concluded that despite spending limited time in different clinical areas, over 50% of respondents reported that they had experienced bullying/harassment behaviours. Whilst clearly demonstrating definitive experience of bullying and or harassment, an additional 10% of participants indicated they were unsure if they had been bullied, which the authors concluded may possibly be due to the limitations of contemporary definitions of bullying and harassment. Budden et al., (2015) further consider that the judgement taken not to define the terms bullying or harassment may have provided a constraint for some respondents, thereby adding to the participants' uncertainty regarding the behaviours they had experienced. Findings also gave rise to single events and the authors do acknowledge that isolated negative events should not be rejected, just because they do not meet the criteria for

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bullying/harassment, as serious psychological and long-term consequences for students can still be evident.

These findings are echoed by Zapf and Einarsen (2005) who highlight that individual behavioural acts may appear harmless however, the cumulative effect of aggressive behaviours substantially intensify personal harm, far more so than that of a single violent act

The findings from Pope and Burnes' (2009) non-experimental quantitative study, which examined the incidence and types of negative behaviours experienced or witnessed by healthcare workers in two Primary Care Trusts in the UK. In total 216 participated in the survey and 99 questionnaires were returned, with registered nurses accounting for the majority of the respondents. 74% of the respondents indicated that that incivility (which was not perceived as bullying) had very comparable levels and patterns of effect to behaviours which were also classed as bullying. Furthermore, now-and-then behaviour had similar levels of effect as more frequent behaviour on 'job satisfaction', 'motivation', 'commitment and cooperation'. In conclusion, Pope and Burnes (2009) commented that focusing on bullying alone neglects part of the picture, contending that any research findings that just focused on bullying alone neglects part of the picture and, further, focusing only on the high frequency negative behaviour also deters from dealing with the wide range of damaging behaviours. The major limitation of the study was the small sample size but the findings are supported by similar studies, such as the non-experimental quantitative study undertaken by Hutton and Gates (2008) The study involved 145 registered nurses and 33 nursing assistants, and examined the bullying experienced by direct care staff in healthcare workplaces, and findings suggested that overall the source of incivility was as important as the frequency of incivility being perpetrated.

Another comparable study to those of Hutton and Gates (2008) and Pope and Burnes (2009) was undertaken by Hoel and Coopers (2000), who examined the problem of bullying across a wide range of industrial sectors and occupational groups, with more than 5,300 questionnaires being returned, which represented a response rate of 43.4%. Findings revealed that respondents who had experienced

bullying behaviour, but did not label themselves as bullied, reported similar effects as those who did do so.

Another term used to describe workplace mistreatment is horizontal (or lateral) violence, which has been associated with displays of aggression, physical, verbal or emotional abuse towards someone on the same hierarchical level, such as staff nurse to staff nurse (Longo and Sherman, 2007, (Coursey et al., 2013). Nursing is considered to be the foremost occupation to experience lateral/horizontal violence (Carter 1999), where it is seen as a deliberate behaviour which is most commonly openly displayed; however, it is noted that aggressive behaviours can be masked as they are repeated and escalated over time (Hutchinson et al., 2006). Jacobs and Kyzer (2010) estimate that 44%-85% of nursing staff are victims of lateral violence.

Nurses were examined in the study by McKenna et al., (2003) which aimed to determine the prevalence of horizontal violence experienced by nurses in their first year of practice in New Zealand further, to examine the consequences, and measure the psychological impact, of such events as a means of determining the adequacy of training received to manage horizontal violence. They used a definition of horizontal violence as being the form of psychological harassment which creates hostility, as opposed to physical aggression in order inform the study. Findings indicated that many of the respondents to the survey were likely to have experienced horizontal violence, as defined in the study. Most common behaviours reported were direct verbal statements which were rude, abusive, humiliating or involved unjust criticism, and were prevalent across all clinical settings. Interestingly, whilst most of the behaviour experienced was subtle and covert in nature the impact on the respondents was profound.

Findings from Curtis et al., (2007), who surveyed 152 second and third year nursing student's experiences of horizontal violence, offers comparability to that of McKenna et al., (2003), whereby 57% reported that they had experienced or witnessed horizontal violence which manifested as abusive and hostile behaviour .

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When the previously discussed behaviours stem from a group and impact one individual, this behaviour is termed 'mobbing' (Zapf, 1999). A definition of mobbing is offered by Leymann, (1996; p168) as:

“a social interaction through which one individual . . . is attacked by one or more . . . individuals almost on a daily basis and for periods of many months, bringing the person into an almost helpless position with potentially high risk of expulsion”.

Leymann (1996) describes the differences between bullying and mobbing among adults in the workplace, explaining that although the term bullying is frequently associated with physical and psychological violence, which has a negative impact on the well-being of the affected, workplace mobbing is often conducted in far more sophisticated way. When the attacks are actioned it can appear inoffensive but when systematic and repeated over a period of time, their damaging effects start to manifest

Niedl (1996) explored mobbing and well-being in Austria with a total of 368 hospital staff returning questionnaires, with findings showing that participants identified issues such as anxiety, depression, irritation and psychosomatic complaints. The physical and mental health issues described as consequences of mobbing were wide ranging such as apathy, lack of concentration, psychosomatic symptoms, depressions, anger and anxiety. Caution however, is required when interpreting the results as the sample size was small and, therefore, generalisability is limited. Similar findings were reported by Yildirim and Yildirim (2007) who, through a descriptive and cross-sectional study, aimed to determine mobbing as experienced by nurses who worked in healthcare facilities in Turkey. Physiological symptoms were the most reported reactions, including feeling tired and stressed excessive eating or a lack of appetite and having gastrointestinal complaints. Further the most common emotional reactions were experiencing extreme sadness when recalling hostile behaviours, frequently reliving the behaviours and the fact home life was negatively affected.

Similar to Yildirim and Yildirim's (2007) findings, Rutherford and Rissel (2004) determined that the most frequently encountered mobbing behaviours were belittling, sneering, shouting or ordering followed by tones of voice or facial

expressions that left them feeling putdown. Participants also reported feeling stressed or depressed, feeling angry, helpless or fearful.

Aggression according to Richardson and Hammock (2011) is behaviour that harms, with Burns and Patterson (2005) commenting that there is the potential to cause significant harm to the development of a student. Börkqvist et al., (1994) explored aggression, within a university, using both questionnaires and interviews where analysed data from 333 university employees, (162 males and 176 females), identified that anxiety was an outcome from having been exposed to aggression. Whilst this study offered a cross sectional approach the results from the interviewed participants may be subject to recall bias due to the length of time between an event and the interview.

Most organisations view bullying and the other aforementioned workplace mistreatments as unacceptable, and have in place policies and processes to enable the victim to seek support and redress however, as (Pope and Burns (2009) indicate inappropriate behaviour that is technically not 'bullying' can still be extremely damaging and should be considered equally unacceptable.

Harassment is also noted in the literature, and Vartia (2001) offers the definition of harassment as a collection of negative behaviours that happen repeatedly over a period of time, and that the target of harassment begins to feel defenceless during this process. However, as single events, the negative acts may seem inoffensive, or at least tolerable, but as the negative acts become more frequent, persistent and long term both psychosocial and physiological issues can manifest - compromises to life outside of work (Vartia 2001), stress Smith et al., (2000) and chronic fatigue Pranjić et al., (2006) as examples.

Unlike the definitions and criteria applied to bullying and other terms given to workplace mistreatment, Einarsen et al., (2003) describes inappropriate behaviour as manifesting itself almost at the bottom of the range of workplace mistreatments, which in turn prevents it from being seen as hostility or aggression. Drucker views inappropriate behaviour as the “lubricating oil of our organizations” (Drucker (2007; p. 147). This sits well with Jennings and Greenberg’s (2010) consideration that these low level acts are subtle and incidental in nature, with effects that may go

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unnoticed, especially when they occur as single or isolated incidents. Along with Lee's (1999) description applied to inappropriate behaviour, as the thousand *slings and arrows* that on a daily basis eat away at civility, these subtle nuances of behaviours may potentially not be classified as bullying, workplace incivility, horizontal, lateral and vertical abuse or violence and psychological aggression due to their nature or infrequency.

Such terms as 'now and then' and 'occasionally' have been criticised as too narrow by Lee (2000), who argues that a one-off serious incident of workplace aggression can result in the same outcomes as those deemed to be attributed to bullying. The intensity of this subtle type of behaviour, one-off events and or single incidents against individuals means the issues remains subjective (Caponecchia and Wyatt, 2009). For some authors, inappropriate behaviour is noted to be the least offensive of the disruptive behaviours but one that is still capable of causing suffering (Lee, 1999; Pearson et al., 2001). Consequently, this behaviour may just be overlooked by those in charge of organisations (Lewis and Malecha, 2011). Lim and Lee (2011) consider workplace incivility to be comparable with low intensity stresses, such as daily hassles frequently occurring in daily life whereby some inappropriate behaviours can be attributed to the instigator's obliviousness or lapse of judgement.

Andersson and Pearson (1999) note that such behaviours can be ascribed to target-misinterpretation or hypersensitivity. However, there remains the ambiguous issue of intent whereby there is the inability of the perpetrator, the intended target, or onlookers of the behaviour to judge whether harm has occurred or not (Pearson et al., 2001). In such cases, the resulting harm may be accidental, which separates inappropriate behaviour from definitions of workplace bullying which assume more targeted, intentional, and conscious behaviours on the part of the perpetrator (Cox and Leather, 1994; Lawrence and Leather, 1999). However, Alberts and Brookes (2015) argue that bullying is different from behaviour which is inappropriate due to both the intensity of the negative behaviours and the perception of the intent to cause harm.

In summary, the terms applied to workplace mistreatment are multifaceted phenomena. As discussed, incidents of inappropriate behaviour are just as important as bullying and other workplace mistreatment and, therefore, deserves recognition. Failing to do so has the potential to condemn those affected to on-going distress, where they do not have an avenue to address issues which are not seen to fit accepted criteria or definitions, whereby an investigation would be warranted and support given to the victim.

2.2.1 Impact

Irrespective of the term used to describe workplace mistreatment, the impact on the victims are closely associated across studies whereby nursing students have reported both psychological and physical reactions, such as feelings of helplessness (Celik and Bayraktar, 2004); anger, anxiety, worrying, stress, and decreases in confidence (Foster et al., 2004; Randle, 2001).

The study by Celik and Bayraktar (2004) sought to identify the abuse experiences of nursing students in Turkey utilising a questionnaire, administered to 225 students. There was a 100% response rate with findings showing that 100% had been abused verbally, 83.1% within the academic environment. 53.3% reported sexual abuse and 5.7% identified physical abuse. Classmates, faculty staff, nurses, physicians, patients, and patients' family members were named as sources of the abuse. Of the participants who experienced verbal and academic abuse anger and a sense of helplessness were described towards those who abused them.

Gillen's (2007) study, which used an exploratory descriptive design involving a mixed method approach in four sequential phases, examined the negative effects that bullying has upon student midwives. Findings from a questionnaire, distributed to a convenience sample of 400 student midwives, of which there was a response rate was 41%, identified a loss of confidence, loss of self-esteem and anxiety as consequences of bullying. Gillen's (2007) findings are supportive of Björkqvist et al., (1994) whose showed that in nearly all cases bullied victims reported insomnia, nervous symptoms, melancholy, apathy, lack of concentration, and

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sociophobia. These findings are comparable to the study conducted in Ireland by O'Moore et al., (1998), where 30 self-reporting victims of bullying identified health issues such as anxiety, irritability, depression, stomach disorders, and headaches.

Einarsen and Raknes (1997) studied 460 industrial workers, supervisors and managers within a Norwegian marine engineering industry to examine harassment in the workplace and the victimisation of men. Their findings showed that there were significant correlations existing between exposure to harassment and both job satisfaction and psychological health and well-being. Aside from health issues other consequences of bullying reported include high levels of burnout, low psychological well-being, stress and low job satisfaction compared to non-bullied colleagues.

Vartia (2001) reports similar findings in her study, which was undertaken in Finland, which used a questionnaire design to examine the effects of workplace bullying and the psychological work environment on the well-being and subjective stress of the targets and observers of bullying. Data analysed from 949 survey responses, drawn from members of the Federation of Municipal Officials Union, revealed that both targets of bullying and the observers identified more general stress and mental stress reactions, compared to those respondents from the workplaces had not been bullied. The targets of bullying also expressed feelings of low self-confidence and fear more often than did those who had not been subjected to bullying.

Fear has been linked to the experiences of blocked learning (Finnerty and Pope, 2005). In their study examining non-formal learning a purposive sub sample of 19 student midwives was selected, drawn from a larger national study (Pope et al., 2003), whereby analysis of audio diaries identified participants describing feelings of uncertainty and anxiety. The study concluded that the fundamental problem of fear appeared to be the apparent lack of space within clinical practice for students to share their fears and concerns.

Similar findings are discussed by Quine (1999) who explored workplace bullying in an NHS community trust in the UK with key findings identifying that staff who had been bullied had significantly lower levels of job satisfaction, higher levels of job

induced stress, depression anxiety and intention to leave the job. Quine (2001) further examined the concept of bullying in nurses, with findings revealing that of the nurses who had been bullied significantly lower levels of job satisfaction and significantly higher levels of fear, anxiety, depression, vulnerability and propensity to leave were reported.

Socialisation plays an important part in reducing fear, anxiety and the feeling of vulnerability for students (Shari and Masoumi 2005). Students are left vulnerable to negative aspects when their socialisation process is interrupted by inappropriate behaviour, leaving them with a professional self-concept which is unhealthy (Arthur and Thorne 1998). Randle (2003) discusses that as nursing education predominately takes place in the clinical setting it is, as such, important that students are open to learning as part of learning is social in nature and, as a consequence, professional self-esteem begins to develop and socialisation regarding identify begins to be assimilated.

In conclusion the reviewed literature in this section has identified the impact that bullying and associated terms applied to workplace mistreatment has on victims. However, as discussed previously each of these terms have criteria and definitions that allow credibility to be given to any claim made and appropriate support given, whereas inappropriate behaviour, due its nature of subtlety and subjectivity, can be discounted and possibly be seen as part of everyday work stress (Pearson et al., 2001), therefore, leaving the victim vulnerable. Socialisation has been shown to be an important process for students and, that interference by inappropriate behaviour, can have an impact on this process.

2.2.2 Socialisation into a profession.

The means by which an individual learns a new role holds many similarities and requires some form of socialisation, irrespective of the position being adopted. Mead (1934), within his seminal work, described the outcome of socialisation as a dynamic relationship between society and the individual, with the individual being an active participant in the socialisation process and the learning of a role. From this there is the acquisition of the relevant knowledge and skills, including the

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internalisation and construction of both values and attitudes in order to satisfy an identifiable role within a specific social structure (Hinshaw and Atwood, 1988). For any health professional socialisation can have at least two aspects. Firstly organisational socialisation is whereby the individual begins fitting into the structure of the organization, during which relationships are maintained with work colleagues and both the organizational culture and the formal and informal rules of the practice environment begin to be learnt (Acevedo and Yancey, 2011). Secondly, professional socialisation is concerned with the individual internalising a set of values and the culture of their profession (Zarshenas et al., 2014). Further, it is the process where a sense of self as members of the profession and belongingness are developed (Gaberson et al., 2014, Levett-Jones et al., 2007).

Student midwives undergo socialisation to enable them to engage in their chosen profession within both the clinical and academic arena, and authors such as Crombie et al., (2013) and Stott (2004) contend that inappropriate behaviour encountered during these times can have profound and long-lasting effect on an individual.

Thomas et al., (2015) used grounded theory to explore 26 UK student nurses' perceptions of incivility during professional socialisation, with findings indicating that professional socialisation is central to practice, therefore, if during this process negative consequences occur, it may well impinge on the ability to learn and to care. These findings align with Mooney's (2007), from a study conducted in Ireland, whereby it is asserted that the implications of negative consequences of professional socialisation included reduced morale, dissatisfaction and stress for nurses, as well as a reduction in the quality of patient care. In developing this further findings from Hoel et al., (2007), who studied student nurses' experiences of inappropriate behaviour and bullying in clinical placement and the influences of socialisation processes, identified that it appeared to be the gradual result of steady relatively subdued negative experiences, and not necessarily the serious bullying incidents, that may represent the most significant threat to successful and positive socialisation. Parsons and Griffiths (2007) indicate that midwives are, on a regular basis, exposed to bully in the workplace and, in part, it can be suggested that this can be influenced by midwives' own initial socialisation into the profession

of midwifery that is, being socialised into an environment whereby workplace bullying is part of the accepted culture.

In reviewing the aforementioned issues it is contended that socialisation is important for student midwives and that inappropriate behaviour offers a threat to that process equal to that of bullying actions. As identified by (Hakojärvi et al., (2014 p143) failure to integrate due to being exposed to negativity during their training, can be detrimental for students to “progress as learners and on how they perceive the profession and their role in it”.

2.3 Chapter conclusion

The key points to draw from this chapter are that there are myriad definitions and criteria used for workplace mistreatment and at times, as a term, 'inappropriate behaviour' has been incorporated within the aspects which constitute bullying and other described terms. Regardless of the term used to describe workplace mistreatment there are distinctions to be made between their characteristics and inappropriate behaviour. The former requires that the intention to harm forms part of the perpetrator's thinking, the acts are repeated and perceived as hostile by the recipient, and legislation is open to the victim to seek redress. Conversely, inappropriate behaviour can be seen as subtle, low key, and subjective whereby the exhibited behaviours are difficult to challenge and can be dismissed as part of the rough and tumble of everyday life. However, detriment and harm can be caused to the victim, leaving them vulnerable and potentially without any course of redress. Moreover, professional socialisation forms a key role in enabling student midwives to engage within the midwifery profession and it is contended that interruption of this process by negative actions, including inappropriate behaviour, may well impinge on the ability for them to learn and to care effectively.

With no conclusive definition identified within the literature for the term 'inappropriate behaviour', there is a need to provide a working definition which allows for the examination of such behaviours in a meaningful way. For the purposes of this study, the term is used at this stage with the intention to take account of events and interactions that the participants themselves describe. I have chosen this unrestricted definition because it is important to the purpose of

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my exploration that participants themselves indicate what inappropriate behaviour means to them and any potential impact it has upon them. I did not wish to constrain my participants, but rather to free them to offer their own interpretations and describe their own experiences. I will return to the issue of a definition in Chapter 6.

It is for the reasons stated above that the rationale for exploring inappropriate behaviour is the focus of the study: I want to give a voice to my participants.

Chapter Three examines my chosen methodology and conceptual framework for my study which provides a rich and sensitive context in which those voices can be heard.

Chapter 3 METHODOLOGY

3.1 Introduction and study aim

This chapter describes the study aim, research question, methodological design, data collection, process of data analysis and ethical considerations. The aim of the study was to explore the lived experiences of student midwives and to what extent their ability to learn may have been impeded by being subjected to inappropriate behaviour within their environments of learning. The background and literature review have demonstrated a paucity of evidence that considers this specific focus. The manner in which research is conducted may be described in terms of the adopted research philosophy, the employed research strategy, the research objectives and the hunt for the solution of a problem.

3.2 My position in developing the research study

When I commenced training to be a nurse in the 70's the hierarchical stance of nursing was such that you did not question anything, essentially you did as you were told. Further you took being told off or being side-lined by a more senior student or a qualified nurse, without comment. I was not allowed, as a student, to directly communicate with the ward sister or with the matron, both of whom were very powerful figures. Mentors were not part of my training, I worked with qualified staff who could change for every shift: if they liked me then the shift went well and if they didn't I got the 'dirty jobs' such as cleaning, by hand, the metal bedpans, despite having an automated bedpan washer. Other jobs could include taking apart trollies and cleaning inside the screw sockets. I witnessed other students who worked with the staff who treated me in this way being given experiences such as teaching sessions or working with high risk patients. I know I wasn't the only student nurse who received this kind of treatment, however there was no course of redress as qualified staff were always in the right.

As I progressed to training as a midwife, in the early 1980's, the hierarchical system remained and the demonstration of inappropriate behaviour by qualified staff continued. I trained in a very small hospital where once qualified you normally

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remained in post until you retired and outsiders, mostly students who came from outside the area, were viewed differently and noticeably treated differently by some staff. I did not escape, I remember being taken out of a room where I had been looking after a lady who was pregnant with twins, just as she began to push, and replaced with a student who that particular midwife favoured. On another occasion I was told to fold Verillium in the sluice because I had asked too many questions. Again, trained staff were unable to be challenged and any issues that were raised were quickly dismissed, most commonly with the comment 'oh that's just her way'. I didn't not rock the boat because I wanted, more so needed, to work in that maternity unit. So I tolerated the inappropriate behaviour. Understanding the characteristics of bullying as I do now, I cannot say I was bullied during my training as a nurse and midwife just subjected to behaviour which was neither professional, welcoming nor appropriate. I must admit, especially when training to be a midwife, it hurt me and at the same time I was angry as I had no one in authority to turn to and could not approach senior colleagues, as I was dependent on them to write my assessments and teach me clinically. I drew strength from my peer group, as we were fully aware of the individual midwives who acted inappropriately and so we supported each other when we had to work with one of them.

As I continued to work as a midwife and as each new cohort of student midwives arrived, I observed the same colleagues continue to act inappropriately towards some individuals. I endeavoured to professionally challenge some of them however, in the early days of my career I was told that I was too junior to question more senior midwives. Subsequently as I became more senior it was pointed out to me that it was 'just her way' or that 'she is close to retirement' and not to let it worry me. I was worried however, as I saw strong women being reduced to tears and physically sick either when having worked the midwife or knowing that they would have to work a shift with them. Further, some potentially good midwives left midwifery due to their treatment. I am angry and to some extent disappointed in myself for not doing more to stop the individual midwives in behaving this way. This sense of helplessness was the drive for me to commence further education, I felt if I had post qualification credibility then I might be able to use research evidence to bring understanding to the healthcare profession. The opportunity to undertake my Doctorate, I felt, afforded me the possibility to bring awareness. I

had researched bullying and realised that what I had both experienced, and witnessed did not meet bullying criteria, therefore, I wanted to research inappropriate behaviour, which sat outside of these criteria and examine what, if any, the impact might be for student midwives.

This led to the development of my research question:

What are the lived experiences of student midwives subjected to inappropriate behaviour within their practice and academic environments?

3.3 Selecting my methodology

Philosophically, ontology involves individuals making claims about what is knowledge, epistemology is how individuals know it, axiology is what values go into it, rhetoric is how people write about it and methodology is the process for studying it (Creswell, 2013). Van Manen, (1997, p. 27) considered methodology to be the “*philosophical framework, the fundamental assumptions and characteristics*” that determine the view taken toward the knowledge being sought. Epistemology is “*the study of the nature of knowledge and justification*” (Schwandt, 2001, p. 71).

Subsequently, the methodology is selected and ultimately *is* the method itself, with each methodology affording the basis for the next. There is the need for the researcher to locate their study within a given paradigm, a definition of which is offered by Morgan (2007, p. 47) as “*the set of beliefs and practices that guide a field*”, whereby it can be used to encapsulate the beliefs of the researcher. Such terms as ‘world view’, ‘theoretical lens’ and ‘paradigm’ tend to be used interchangeably within the literature. A paradigm, according to Morgan (2007) will shape the questions that a researcher will ask and the methods utilised to answer them. In considering Morgan’s statement, it can be suggested that the world view of the researcher is significantly shaped by the positivist (quantitative) paradigm, naturalistic or constructivist (qualitative) tradition to which they affiliate themselves.

3.4 Choosing my method

Walsh and Evans (2013) discuss the need for a philosophical debate surrounding the various research methods and that crucial questions must be posed regarding ontology and epistemology. They assert that unless the appropriate questions are asked surrounding the reality that researchers are endeavouring to depict, investigate or portray, “*then our knowledge of that reality will remain superficial and impoverished*” (e1). Furthermore Clark et al., (2008) highlight that, as a consequence, research can be produced that lacks adequate justification and internal coherence, in turn lacking integrity.

In light of the points raised by Walsh and Evans, and as I sought rich descriptions of individuals’ lived experiences, it was important to reflect on an overarching approach to research which encompassed both philosophical (epistemology and theory) and methodological (data collection and analysis) needs. In addressing my philosophical standing, the typology which offered a ‘best fit’ was the constructivist-interpretivist (meaning and interpretation) paradigm. The inquirer in interpretivism becomes a member of an interface or communication with the inquiry subject, whereby the findings are the result of that interaction. Reality becomes a social construction. The interpretivist, or social constructivist, view is that the observer is a part of what is being observed and human interests are the main drivers of science (Easterby-Smith et al., 2002). Essentially, the human science standpoint considers that an individual cannot be understood as set apart from the world in which they live (Moustakas, 1994), acknowledging that the interpretivist researcher is part of the world they are studying. This viewpoint is in contrast to the natural science position whereby the exploration of cause and effect is grounded in the observation and verification (or non-verification) of theory. The ontological position within interpretivism is situated within the critical realist perspective, whereby meanings are considered to be fluid whilst accepting that participants’ accounts reflect aspects of their subjective perceptions of individual events (Finlay, 2006).

In order to inform the design for this study, a thorough exploration of research approaches with relevance to the insight of a phenomenon was conducted. I sought the views of student midwives’ experiences, not necessarily a direct view of their behaviour or how others reacted to them. Acknowledging that this thesis

explores enquiry regarding lived experiences, phenomenology emerged as the most obvious approach to the enquiry. According to van Manen, (1997, p. 9) a description of phenomenology is seen as '*gaining a deeper understanding of the nature or meaning out of everyday experiences*', whereby complex experiences are enabled to come alive and be understood (Clark, 2000, p. 35 - 54).

This methodological approach also sits well within the philosophical model of care that midwifery observes and within my own personal beliefs and values.

3.5 Phenomenological overview

Whilst the philosophers Hegel, Husserl and Heidegger are synonymous with phenomenology (McNamara, 2005), Brentano, who is predominately known for his works within the fields of philosophy and psychology, has been credited as having first developed the basic approach of phenomenology. This is based on his introspectionist approach to describe consciousness from a first person view point, as well as his contention that philosophy should be done with exact methods, like the sciences (Jones, 2001). The word phenomenology stems from 'phenomenon', a Greek word which refers to appearances. The approach to phenomenology adopted by Hegel (2009) was one that sought to represent appearances apparent to the human consciousness, which begins with the exploration of phenomena (presented as a conscious experience) as the means to fully understand the logical and ontological essence behind the phenomena. In essence, Hegel asserted that phenomena were not negated by the 'absolute consciousness', more that consciousness *assimilates* phenomena, thereby co-existing peacefully with it (Hegel, 2009, p. 64).

It is acknowledged that Husserl, who is generally noted to be the father of phenomenology (Koch, 1995) and having been a student of Brentano, then proceeded to develop the phenomenological method in a less formal manner. One element Husserl derived from Brentano's teachings was *intentionality*, the concept that the main characteristic of consciousness is that it always presents as intentional. Husserl's main focus, derived from his concept *Lebenswelt* (life-world) (Husserl, 1969), became one of studying the phenomena as they appeared through the lens of consciousness, claiming that mind and objects both occur within day-to-day experiences. Husserl, for example, purported that essences

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serve as the ultimate structure of consciousness contending that bracketing (i.e. setting aside preconceived notions) enables one to objectively describe the phenomena under study (Hallet, 1995).

Gregova (1996) offers a distinction between the *life-world* and the social world, by proposing that the *life-world* is constructed of formal structures, about which we are less explicitly aware, while the social world comprises everyday familiar actions and experiences. Phenomenological reduction was another element also discussed by Husserl, whereby an individual reflects upon the content of the mind to the exclusion of all else; this in turn led to the term 'bracketing'. In this situation, the experiences and contextual relations are placed separate to the phenomenon under investigation (Moustakas, 1994). Husserl (1982, p. 30) identifies that the transcendental reduction significantly involves the bracketing of the "*general positing of the natural attitude*", namely that it entails bracketing the tacit acceptance of the reality of the objects of our intentional states. From Husserl's (1982) viewpoint, this denotes bracketing the results of the positive sciences, all of which rely on the assumption that the world of intentional objects in fact exists. On this, McNamara (2005) comments that the researcher needs to acknowledge their own experiences, beliefs and values prior to data generation within the research process, so that they can 'bracket' them in order to reduce bias. Merleau-Ponty (1962, p. 15) has argued this as a 'final impossibility', since the researcher will never arrive at a finite position despite any advance through their study (Lavery, 2003).

Husserl's junior colleague Heidegger departed from Husserl's original school of thought with his development of hermeneutic (interpretive) phenomenology, relating to the life-world or human experiences as it is lived. Allen (1995) adds breadth to this approach by offering the argument that a clear distinction does not exist between phenomenology and hermeneutic phenomenology. He offers a description of phenomenology as *foundationalist*, i.e. seeking a valid interpretation of the text without reliance on the social, historical or biographical standpoint of the interpreter. In contrast, Allen (1995) regards *hermeneutic* phenomenology as *non-foundationalist*, whereby focus is placed on meaning arising from the interaction of the reader and the historically generated texts. The following discussion enables me to examine the application of phenomenology as a theoretical research

framework exploring the lived experience of student midwives exposed to inappropriate behaviour.

Phenomenology provided the ontological and epistemological rationale for my research, whereby lived experience of the everyday world, as revealed through consciousness, is the primary focus for phenomenological inquiry. It is through accessing lived experience that I may gain understanding of the meanings and perceptions of my participants' world. This forms the basis of an interpretive, or Heideggerian hermeneutic, approach to phenomenology.

Steeves (2000) noted that a basic premise of the hermeneutic phenomenological method is that a driving force of human consciousness is the need to make sense of experience. In general, people try to reach this understanding by interpreting their lives as they occur, by treating them as unfolding narratives. Thereby phenomenology was applied both as a research method and a philosophy that can illuminate the impact of being subjected to inappropriate behaviour. Heidegger's approach to phenomenology can be defined as a way to interpret experiences of shared meanings and practices embedded in specific contexts (Budd, 2005).

Heidegger reconceived many phenomenological perspectives, offering an alternate worldview from Husserl's beliefs regarding bracketing (Overgaard, 2003) believing that, as human beings, our meanings are co-dependent on the experience of being born human, our collective life experiences, our background and the world in which we live (Paley, 1998).

Heidegger offered a straightforward message:

"Understanding is never without presuppositions. We do not and cannot, understand anything from a purely objective position. We always understand from within the context of our disposition and involvement in the world" (Johnson, 2000, p. 23).

Heidegger recognised that issues such as gender, culture and related life experiences bar an objective viewpoint, yet enable people to experience shared practices and common meanings. However, he did not believe that it was possible

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to bracket our assumptions of the world more precisely, or that through authentic reflection there was the opportunity to become aware of many of our assumptions (Heidegger, 1962). Moustakas (1994) supports Heidegger where he contends that it is important to determine what an experience means for those persons who have lived through it and are capable of providing a comprehensive description of it. In exploring both philosophers' concepts, I took the decision that as Heidegger's concept appeared more applicable to the design of my study than that of Husserl's, a Heideggerian approach for this phenomenological study would be more appropriate. When considering this decision, I acknowledge that there are difficulties in adopting Heidegger's concept in respect of what Fried (2000, p. 11) describes as "*the difficulty and idiosyncrasy of his language*", in that Heidegger was German and his seminal texts have been translated into English. Herein lays the risk that the essence of his words may well have been lost in the various versions of his English translated works.

Mindful of this I searched the literature to explore if any authors had further developed Heidegger's work. van Manen (2002) was identified within the literature as having broadened Heidegger's concepts and within his book, *Researching The Lived Experience* (1997), van Manen demonstrates six methodological themes to be used as a framework. However, in reviewing his approach it became apparent that his writings combine the descriptive phenomenology of Husserl, employing an emphasis on the study of the world before reflection and also argues that it is scientific, whilst at the same time asserting that it involves interpretation.

Cohen and Omery (1994) identify that van Manen's approach to phenomenology is situated in what is termed the *Dutch School*, as it is both a combination of descriptive *and* interpretive phenomenology. Whilst Van Manen has indeed developed Heidegger's work, it would appear that he offers conflicting perspectives in respect of involving both the descriptive (non-Heideggerian philosophy) and interpretive concepts within his approach. From my perspective this does not offer a 'pure' approach to Heidegger's phenomenological theory or philosophy; therefore the decision was taken not to utilise Van Manen's (1997) conceptual framework.

3.6 Study design

Ultimately, Heidegger's theory provided a perspective for understanding student midwives' experiences of inappropriate behaviour and as a lens for seeing the data. Furthermore, I acknowledge there are many phenomenological approaches and that I have utilised a Heideggerian approach as my methodological framework. On that basis I consider the methodological underpinning to the study to be interpretive and hermeneutic, rather than following Husserl's more descriptive methods (Hoy, 1999). The basis lies in the difference between Husserl and Heidegger's concept of phenomena, whereby in Husserl's world, objects have no autonomy whatsoever: I (via a sense of bestowal) determine the meanings of objects. For Heidegger, I believe he offers depth to the sense of bestowal but furthermore, he believes that objects/phenomena also have autonomy. For Heidegger, objects/phenomena *reveal* their meaning in as much as I *give* them their meaning. For the purposes of clarity, it is important to state that I use the term 'hermeneutic' in relation to Heidegger's hermeneutic turn and not in loyalty to any other particular hermeneutic school of thought. Thus, a Heideggerian, interpretive phenomenology is the basis of the present study. The remainder of this chapter details the study design as ascribed to Heidegger, including ethical considerations.

3.7 The 'Style of Phenomenology' selection

3.7.1 Hermeneutics, the Hermeneutic Circle and Dasein

Pivotal to the philosophical stance of Heidegger is the concept of '*Dasein*'. There are no English words which offer equivalence, however; in German vernacular '*Dasein*' means 'being there furthered', translated as 'existence' (Cerbone, 2000). *Dasein* is not fixed and it cannot be measured objectively (Tonner, 2008), with Sheehan (2005, p. 193 to 213) stating that in summary ".....*Dasein is the answer to the questions about the meaning of being.*" In the tradition of Heidegger's philosophy, a hermeneutic enquiry aspires to clarify the subjective humanistic meaning of an experience, or (employing the hermeneutic circle) augments the elucidation of *Dasein* (Mulhall, 2005). The focus of Heidegger's (1962) seminal work, *Being and Time Sein und Zeit*, is his analysis of Being (*Dasein*), whereby the

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use of the word *Dasein* expressed human beings' uniqueness, rather than other animal or inanimate existence.

The hermeneutical circle is not a 'method' from Heidegger's (1962) viewpoint, to be more precise it is the existential character of human understanding. As such, he describes the circle in terms of an existential grounding. Accordingly, the circle of understanding is not a methodological circle, making it unnecessary at the end of the process of interpretation. However, it describes a component of the ontological structure of understanding. Within my methodology, the hermeneutic circle became a useful concept to address the ways in which people in dialogue, or a person reading a transcribed text, mutually transform each other's notions through maintaining on-going interaction. The hermeneutic circle relies on movement in circles from the whole to the parts, whereby deconstruction followed by reconstruction of the text occurs, from which shared understanding ensues (Ortiz, 2009).

In terms of this research, I am seeking to answer the question "*What is the experience of being subjected to inappropriate behaviour?*" It is important to emphasise that it is I, as the researcher, who asks the text what it means to be a student midwife living out the phenomenon in question. It does not fall to the responsibility of participants to analyse the situation; the participants purely offer description or give an account of the experience. By invoking the hermeneutic circle I attempt to detect hidden meaning and uncover the true essence of the experience. Annells (1996) highlights the infinite possibility of the hermeneutic circle and Koch (1995) considers that there are further possibilities which are feasible every time the transcription is re-examined. A hermeneutic enquiry, in the tradition of Heidegger's philosophy, aims to elucidate the subjective humanistic meaning of an experience or, as noted by Mulhall (2005), employs the hermeneutic circle to augment the elucidation of *Dasein* and *In-der-welt-sein* ('Being-in-the-world'). In line with Heidegger's thinking, my goals in hermeneutic research here is to enter the world of the person and interpret the meaning they assign to the experience.

3.7.2 Being-in-the-world (In-der-welt-sein)

Within his writings Heidegger (1962) offers the notion of the subject or person as a viewer of objects was rejected as being separate from the world. This inseparability he represented by the term 'being-in-the-world', about which he stated "*It is not pieced together, but is primordially and constantly a whole*" (Heidegger, 1962, p. 65). In the context of this study, *being-in-the-world* is reflected in the fact that the student midwife, when faced with inappropriate behaviour within the learning environments, remains within that situation all the time he/she occupies that space. Hence my task, as the researcher, is to ask the text (i.e. the transcripts of the interviewees' perspective) what it means to be a student midwife in the world of midwifery, faced with the act of inappropriate behaviour and the potential impact this had upon them.

3.7.3 Fore-structures

The process of interpretation is always built on or operates in what Heidegger (1962, p. 150-151) entitled 'fore-structure', or 'prior awareness': What is understood or known in advance of interpretation, the 'anticipation of meaning' (p. 324). The application of this concept has been interpreted by some authors to mean 'pre-understanding' or background opinions and experiences which the participant and the researcher bring to the inquiry (Benner, 1985; Andrews et al., 1996; LeVasseur 2003). However, from Heidegger's perspective the term 'fore-structure' has a far more comprehensive meaning. He viewed this as acknowledging that interpretation, in a fully formed state, already exists; stating that "*interpretation functions as disclosure*" (Heidegger, 1962, p. 198). In essence, interpretation permits disclosure of what is 'already there' in its entirety, allowing for what is already understood to be revealed; as Heidegger (1962, p. 192) states, when things in the world have been understood through interpretation, we can say that they have meaning. Thus, the phenomenon is revealed.

3.7.4 Care (*Sorge*)

Caring is a fundamental role within midwifery, with Nabb (2006) identifying 'professional caring' literally as kindness, feeling cared for and releasing worry. Midwifery practice is built on client needs, whereby birth is seen as a natural event during which the midwife and the woman do not act in isolation. Regarding the

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sentiment of care, Heidegger (1962, p. 238 to 239) declared that to be with another is to care; and further, that everything one does can be understood as a way of caring. Bradshaw (2009) critiqued Heidegger's sentiment of care, placing it in the terms that Heidegger was not primarily concerned with the care for others but rather care for self, for personal authenticity and for self-concern. Leonard (1989) contended that 'sorge' (care) is pivotal to *Dasein* and in reality *Dasein* is not a possibility in the absence of caring. Caring is symbolic of not only *being-in-the-world* but also being connected to others and furthermore indicates the belief that connectedness is of consequence. To provide comfort, which is a fundamental role of both student and qualified midwives, requires the 'being-with' of *Dasein*, i.e. to be actively engaged in another's life-world. Additionally, an integral part of *Dasein*'s identity is centred on *what* or *who* is cared about and deeming these entities significant. The notion of 'connectedness' is an area that will be explored in this study, by asking the text what it means to be a student midwife who has experienced inappropriate behaviour. Flynn (1980) and Martinez (1989) offer that care beckons the self (*Dasein*) back from the feeling of both anxiety and insignificance found in what they consider to be the flight from the self and alternatively enabling the ability to be one's own self, i.e. to be authentic.

3.7.5 Authenticity

One of Heidegger's main themes was authenticity and, in his terms, for the human being to exist as *Dasein* is to exist authentically (Heidegger, 1962, p. 68). To be 'authentic' is to be one's own self as opposed to belonging to some other, for example a social group, family, friend, institution or whatever. By way of explanation, Zimmerman (1986, p. 44) offers that "*to care for something inauthentically would mean to manipulate it for selfish purposes. To care for something authentically means to let it manifest itself in its own way.*"

Furthermore, Krasner (1996, p. 23) offers the explanation that "*...responding to the appeal of the presence of other Dasein*" is inherently involved in an authentic relationship, meaning that *Dasein* is not isolated but rather is absorbed within a relationship with others. Consequently, my study aims to uncover the *Dasein* that exists when an individual, a student midwife, is exposed to inappropriate behaviour.

3.7.6 Disposition (*Befindlichkeit*)

In translating *Befindlichkeit* into English, difficulty arises in attempting to keep the word intact; the term 'state-of-mind' is inappropriate (Heidegger, 1962, p. 184). Further refinement offers "*the state in which one may be found*" (Heidegger, 1962, p. 134). According to McConnell-Henry et al., (2009), such was Heidegger's belief that *Dasein* is relative to context, so he believed that *Dasein* is never devoid of a mood or disposition. Effectively, regardless of the phenomenon, the point of origin is always the mood in which the experience is lived. In terms of the research in question, what influences the experience is the midwife's feelings in approaching the situation of inappropriate behaviour, underpinned by '*Befindlichkeit*'. Whilst being completely in control of the context is only a reality in idealism, humans are at all times in control of deriving meaning (*Verstehen*) from the situation (Heidegger, 1962, p. 137).

3.7.7 Time (*Temporality*)

So important was the concept of time to Heidegger that he chose to refer to time as '*ecstasis*', from the Greek derivative meaning 'to stand out' (Heidegger, 1962, p. 416). According to Korab-Karowicz (2001), Heidegger claimed *Dasein* to be essentially temporal. Namely, human beings exist within our own personal and social/historical context. In other words, if the setting and time were different, then so too would the experience because every experience is context specific.

I appreciate that any inappropriate behaviour, addressed to an individual, can have a wider-reaching impact on others; however, the time and moment when the inappropriate behaviour occurred will have impact only on my participants, who are my focus; and any resulting impact. If the behaviour had been exhibited in another time or setting, the outcome would be different for the individual.

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As Smythe et al., (2007) articulates:

“To remove a story from its rich textual background is to remove meaning and thus the possibility of understanding the experience as it as lived, for we can only ever live in a context of time, place and situational influences.”

3.7.8 Space (*Spaciality*)

Being-in-the-world means existence is not only temporal but also spatial, which grounds the individual in a location. Heidegger (1962, p. 136) contends that being-in-the-world has this characteristic because everything in the world ‘belongs somewhere’, further calling this spatial situatedness ‘the there’ (Heidegger, 1962, p. 171). Examining the position of ‘the there’, the person always either brings something close to them or else experiences it as remote. In respect of the tendency of *Dasein* to closeness, Heidegger (1962, p. 138) called this ‘de-severance’. He emphasised that this is not about literal measurable distance but about what matters, or what is of concern to the person. With regard to my research, I aim to examine and re-examine the text with the question *‘What does it mean to be in the space of a student midwife who is experiencing inappropriate behaviour?’*

3.7.9 *Mitsein* (*Being-with-others*)

My study has a holistic focus on ‘being-in-the-world’ as temporal and spatial care authenticity and disposition. As Inwood (1999) identifies, *Mitsein* is fundamental to our ‘being-in-the-world’, where we are ultimately inseparable; there is no ‘us and them’. Being-with-others is regarded by Heidegger as an *a priori* existential which enables *Dasein* to relate to others and is further seen as the *a priori* dimension of the self, which provides us all with the potential to understand and relate to others in all possible ways (Watts, 2001). As Cohn (2002, p. 105) asserts, *“It is our inevitability that we will be with others; it is an existential given”*. Being-with-others is still applicable even when we are alone or isolated, whereby others become conspicuous through their absence but remain with us through the man-made things that surround us (Heidegger, 1962; Watts, 2001). Thus, we are not self-sufficient beings but born to be part of a world that is mutually collaborative.

As the researcher, I cannot assume that the meaning of the same situation is similar for different people. In relating this aspect to my study, it is about the inseparability between the student midwife and the perpetrator of the inappropriate behaviour and the relationship between the two as a means of understanding the experience(s) offered by the participant.

3.8 Justification

As identified previously, in line with Heidegger's thinking, it is impossible to interpret a text devoid of any personal judgments; and furthermore I wish to stress that the concepts I have employed are used to couch my questioning and understanding of the data which has been generated in my research study. In particular one needs to bear in mind that the appraisal of Heidegger, in this context, is not wholly about the philosophy *per se* but more about interconnecting relevant philosophical viewpoints into a usable, methodological framework, in order to guide and ultimately interpret my research. In essence, I am seeking to capture holistic 'being-in-the-world'. From a phenomenological perspective, 'being-in-the-world' is the basis of human existence whereby Heidegger (1962, p. 80) claimed, '*Being-in is thus the formal existential expression for the Being of Dasein, which has Being-in-the-World as its essential state*'. Cohn (2002) contends that 'being-in-the-world' can be understood as the inter-connectedness and interdependence of human relationships.

3.8.1 Heidegger: examining the argument

Debate, regarding the use of Heidegger's philosophy within healthcare research, arises from controversies surrounding his involvement in Nazism in the Second World War (Holmes, 1996). I take the personal stance that fascist, anti-Semitic beliefs do not have a place in healthcare or healthcare research; however, as Mackey (2005, p. 181) states "*this is not grounds for rejection of Heidegger's philosophical ideas, rather a reminder that all scholarly work must be read and considered with awareness.*" Whilst I am mindful of the identified warnings, I nonetheless believe that many aspects of Heidegger's thinking are relevant to generating thought in healthcare research of today, irrespective of his life choices. Ultimately, when choosing a philosophy it should be determined by its relevance to

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a particular study, not purely by the philosopher, as an individual, judged by a set of life choices.

3.8.2 Ethical considerations

As previously discussed it was my own experiences which drove me to investigate this phenomenon of interest. Ultimately it was the lived experiences of the student midwives currently experiencing the phenomenon which were required. As Merleau–Ponty (1962) indicates, phenomenological research aims to re-establish contact with the original experience and, as such, detailed methods for data collection were required in order to use the material which offered these lived experiences. However, before this could be achieved consideration needed to be given to the ethical components of undertaking this research project. Before the investigatory stage of a research project may commence, permission needs to be sought and safeguards need to be in place to ensure the beneficence and non-maleficence of the research and that the anonymity of the potential participants and institutions are maintained. Prior to approaching midwives for their possible involvement in the study, ethical permission requests were submitted to the University's School of Education Ethics Committee and approval granted for the study to commence (Appendix 2).

3.8.3 Potential harm

Harm, in research terms, refers not only to direct or immediate physical threats but also to psychological impacts which may be experienced at the time of the interview or later. Therefore, it was important to establish a safeguarding procedure. If any participant became distressed during the interview, about any clinical issue, then they were encouraged to access, along with other support networks, their named Supervisor of Midwives and/or Academic Support Tutor (A separate sheet was given out, when the participant signed the Consent Form, Appendix 3, and the support names were reiterated within my thank-you letter, Appendix 4).

This study did not promise to benefit the participants directly however, the information from this study may help improve the understanding of what inappropriate behaviour is within the midwifery culture and how this has a bearing on student midwives. On that basis the participants may perceive this as satisfaction from helping the profession and may also see aspects of the interview as a form of debriefing.

However, the possibility of harm to the researcher is also ethically important and deserves consideration. I chose to limit the interviews to no more than two in one day as there was the potential for me to be overwhelmed by the content of the narratives of the participants. Furthermore, there were the potential feelings of guilt that I needed to consider, in so much of listening to their experiences and not being able to comment or support if required, as my position was one of interviewer and not councillor. As a personal support mechanism, I had access to my Supervisor of Midwives, who offered me counsel, as well as my Doctorate Supervisor.

The participants were based in Approved Education Institutions (AEI) with the United Kingdom, which will not be identified in order to maintain the confidentiality of the participants. Having agreed to take part in my study, individual physical contact between myself and the participants was limited to the interview only. However, a thank you letter was sent to the participants 3 to 4 days following the interview that also reminded them of support contact details (Appendix 3).

For ethical reasons, I did not interview any student midwives from my own AEI. I made this decision due to the fact that I would have held a hierarchical position, being that I would be a member of the participant's teaching team, in the relationship of researcher/participant. I was, therefore, sensitive to the fact that a student might have felt potentially coerced to take part in my study due to the position I hold. Further, if a student from my own AEI did agree to take part, there was the potential for them to hold back from describing their experience(s) in depth due to the fact that any names of mentors/academic tutors discussed by them may have been known to me.

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Confidentiality is crucial as midwifery programmes within AElS are, by nature, comprised of small cohort numbers. In order to protect the individual student midwife, a mutually acceptable place was agreed to conduct the interview in order to maintain confidentiality.

3.9 Informed consent

Consent was required from each participant and this was an on-going situation as they could withdraw from the interview and the project at any time, up until the commencement of the analysis stage of the study. The consent form was designed as per National Research Ethics Service (2007) which included explanation of on-going consent (Appendix 2). Consent for the recording of the interview was also sought as well as for the research study as a whole.

3.10 Data protection

As Robson (2002) and the NMC (2004, 2015) identify, anonymity, confidentiality and data protection are uppermost in good ethics practice; where the rule of beneficence and non-maleficence remain paramount (Koch and Harrington, 1998). Each participant was offered the opportunity to choose their own pseudonym in order to maintain confidentiality (NMC, 2015; Dench et al., 2004). This study has been designed in accordance with the requirements of the Data Protection Act (1998), whereby all data will be archived for 15 years, following completion of the study and following advice from the University's legal services. Reply slips identifying contact details of the participants and consent forms were kept in a locked cabinet in a locked office within the University. They were stored separately from transcripts and recordings. All copies of the reply slips were stored in sealed files in a locked cabinet in a separate locked office. Numerical codes were assigned to each individual student midwife and recorded on the consent form. This number was used to link the pseudonym to the student midwife. A record of the pseudonyms and numbers were recorded and stored in a file on a password protected personal computer that had a firewall and regularly updated anti-virus protection. A back-up copy was saved onto the researcher's password protected storage drive on the University's network. As soon as the pseudonym had been recorded, the form on which it was originally written was destroyed by means of

shredding. Interviews were transcribed onto the computer mentioned above. Files containing transcriptions were also saved onto the researcher's password protected drive in the University's network. Hard copies of transcripts were stored at the University in a locked cabinet that was separate from that in which the reply slips are stored. Participants were given a choice as to the outcome of their recording. This choice was:

- The recording will be kept in its original form, identified only by pseudonym and archived securely at the University. In this instance only the researcher will listen to the recording;
- Or:
- The recording will be destroyed but authenticity of the transcripts would need first to be verified. This would be achieved by the researcher's supervisor(s) reviewing random parts of the recording, together with the transcripts. They would not be told the identity of the student midwife.

All eight participants decided to choose the first option. In either case, recordings will be retained in their original form until completion of this thesis. Whilst I am of the belief that other people will not be able to identify the participants, there is the possibility the participants themselves may identify aspects within this thesis, so in order to reduce this risk the AEs were not identified and the sample was recorded as being drawn from Universities within the United Kingdom, with no specific region identified.

3.11 Sampling criteria

The purpose of the study was to gain as rich an understanding as possible of the effect of inappropriate behaviour on an individual and to what extent this had impacted upon them. A purposive sample of student midwives who had experienced such incidence was, therefore, sought (Streubert-Speziale, 2007). The rationale to exclude first year student midwives and to only recruit 2nd and 3rd year student midwives stemmed from the position that at the time of recruitment, current 1st year student midwives would have only experienced the academic

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environment due to the timing of the academic year, in that their first clinical placement would not yet occurred.

In keeping with the qualitative paradigm, it is not always possible to stipulate the intended sample size at the outset of the research. However, pragmatic considerations, such as access to student midwives and time factors, did influence the ultimate number of participants. In considering eligibility for inclusion to the study I sought student midwives who were currently enrolled on a recognised and approved programme and who had experienced inappropriate behaviour within their learning environments. Ultimately, the sample became defined by who is prepared to be included in it.

3.12 Recruitment to the study

Following ethics approval, a letter was sent to the respective Heads of Programmes, within each Approved Education Institution (AEI), seeking permission to approach their student midwives. Initially, I placed posters in student areas of the AEIs, which outlined my research intentions and inviting interested parties to attend an information session. I organised three sessions at each of chosen AEI's in order to endeavour to capture all interested students. At the sessions I was able to discuss my research intentions with the student midwives present and was able to answer questions posed and clarify any aspects about the interview process. I left behind both copies of the participant information sheet (Appendix 5) and pre-paid reply slip (Appendix 6) in appropriate areas, such as student common rooms, so that the students could access them at their convenience and without alerting others to their intentions should they so wish. Furthermore, I had no wish to pressurise any prospective participant into confirming their agreement to partake in my research study at the information session.

The Participant Information Sheet explained the nature of the research and gave assurances about the voluntary nature of participating and confidentiality of all information obtained in the course of the study. It also indicated that returning the reply slip did not commit the student midwife to participation. Student midwives who returned a reply slip were contacted by me in the manner chosen by them.

Information regarding the study provided in the introductory letter was again explained and the student midwife's understanding checked. If he or she was still willing to participate, arrangements for an interview were made at a date and time of mutual convenience, in a location of the student midwife's choice. The day before the appointed meeting, arrangements were confirmed and the student midwife was given, if he/she choose, the opportunity to withdraw from the study.

Potentially, I was given access to a mix of approximately 60 second and third year student midwives however, on the dates and times I was given access there were factors which did not allow for engagement with this number. Some students had chosen not to attend their academic class on those days, some third year students were attending their case-loading clients and other factors, such as illness, accounted for the decline in the number of available potential participants. In total, 20 student midwives declared an interest in participating, some of which agreed to take part following my information sessions and others through the use of the pre-paid reply slips.

I contacted each of them however, factors such as the inability to make a mutually agreeable date and time with some of the participants proved to be problematic. The majority of students, having initially shown an interest, declined to take part. Some were admitted to being concerned that in doing so they may jeopardise any job potential (identified as third years) and that some form of retribution may occur (second and third year students). I did reiterate that all participants details were subject to confidentiality however, the students still declined. My final sample group resulted initially in nine participants but, due to personal reasons, one student midwife was unable to continue.

3.13 Interview process

The primary data source for my study was semi-structured interviews with the participants. Additionally, I observed the non-verbal attributes displayed by the participants during the interview, such as hand mannerism, pauses, face patterns and emotional actions such as crying. I made written notations to check alongside the transcripts as a means of corroborating what the interview respondents said as aligned to their demeanour at the time (Patton, 2002). This afforded a method of

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triangulating the qualitative data sources, with Glesne (2011) identifying that these actions help to make the data more rich and the findings more complex.

Prior to the one-off interviews I had constructed prompt statements which enabled me to devise a structure to ensure that the same format was present for each participant (Appendix 7). The prompts aided me in remembering to check consent forms, contact details and consent for digitally recording the semi-structured interviews. The interviews then developed from the comments offered by each participant. The prompt sheet contained a few main themes for discussion, which were merely the basis for a conversation and were not used prescriptively nor as a means of limiting, in the sense of overriding the expressed interests of the participant. It was important to me that the participant took the lead during the conversation. The interview began with me thanking the participant for attending and then explaining the process. In commencing the actual interview I asked them to recall any experiences when they felt that they had been party to behaviour which they felt was inappropriate.

Prior to each interview the participant was invited to submit a pseudonym which would be used for presentation purposes within my thesis. All the participants were given the time to talk freely in order that they could reveal their experiences and feelings with me asking questions, as appropriate, to elicit further meaning and understanding as to what had been articulated. All the interviews ended with me asking the participant if there was anything further they would like say and, when they answered no, the interview was brought to a close clearly, with me saying *'Thank you very much for your time'*. The first interview was conducted to check understanding of the prompt statements and, for me as the interviewer, to gain confidence in the interview technique.

The transcription from this pilot interview was used in the final analysis, which is discussed in more depth in Chapter Four. However, to some extent all the semi-structured interviews acted as a pilot in their own right, by them being unique in nature. Data was collected via a digital recorder to ensure that an accurate transcription could be captured for analysis after the event, with each interview lasting between 60 to 90 minutes. All the interviews were conducted face-to-face in a location which was comfortable to the participant, as it is an important

consideration not to create a power differential between the participant and the researcher (Balls, 2009), although it must be acknowledge this power differential will always be present but my role as the researcher was to minimise it as much as possible.

3.14 Equipment

A digital voice recorder was employed for recording the conversations. The recorder was checked for working order and quality of sound prior to each interview. Spare batteries were held in supply for each interview. Following completion of the recording the data was transferred to a non-overwrite recordable compact disc (CD) and a backup of each disc was made to ensure that data could not be lost to either broken or faulty materials.

3.15 Describing the phenomenon

As Wolcott (2009) indicates, a phenomenological study has to be understood in terms that the writing is never perfect, nor is the interpretation ever complete or final. In respect of this study, the responsibility for the interpretation of the data rests with me and it is, therefore, imperative that the actual words used to explicate meaning in a written format are in sync with the words spoken by the participants that live in the world being described (*Dasein*). However, in order to gain credibility for this research approach one must ensure trustworthiness.

3.16 Trustworthiness

Seminal texts by Guba and Lincoln (1981) and Lincoln and Guba (1985) considered terminologies used in quantitative research and then substituted them with more appropriate concepts for qualitative research. The aim of trustworthiness, in qualitative inquiries, is to support the argument that the research findings are 'worth paying attention to' (Lincoln and Guba, 1985, p. 290). This differs greatly from the conventional experimental standard of attempting to show validity, soundness and significance. Such consideration is given to audit trails, whereby the researcher provides clear details of the study setting, participants and process that can enable both the research to be audited but could

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also allow for the study to be replicated in another setting (Jasper, 1994). I believe that throughout this thesis I have provided an audit trail which would enable my study to be replicated by a fellow researcher.

Member checking, returning to the participant in order for them to validate their words, is also seen as a means of demonstrating rigour. However, therein lays the risk that when asking a participant to revisit a concept they may seek to overemphasise it, thinking that it may be of importance to the study in hand (McConnell-Henry et al., 2011). Furthermore, the Hawthorne and Halo effect may have been invoked. The Hawthorne effect (Merrett, 2006) refers to a phenomenon in which participants adjust their responses or behaviours because they are aware that they are being studied. The Halo effect is a bias whereby participants might give the researcher answers that they think are appropriate and expected (Mackey and Gass, 2005). I endorse the view that at the point of re-engaging with the participant the study results would have been synthesised, decontextualized and abstracted to the point where individual recognition of either self or experiences is unlikely. I believe that the participant would have moved on from the experience as narrated at the point of the original interview. Therefore, after careful consideration I chose not to member-check my findings.

Finally, peer-debriefing, as a means of assisting removing researcher bias and validating the findings, is a further means of adding trustworthiness within a study. I employed this method whereby a group of my scholastic peers, who had no vested interest in my study, examined each step of the development of the themes and related these against the annotated transcriptions. I also found it beneficial to talk through these processes with my supervisor following my peer debriefing as a further mode of validation. Aspects using Guba and Lincolns' (1981) criteria of credibility, transferability, dependability and conformability will be discussed in the next section.

3.17 Credibility

Internal validity is one of the key criteria addressed by positivist researchers whereby they seek to ensure that their study measures or tests what is actually intended. However, Merriam (2009, p. 213) identifies that the qualitative

investigator's equivalent concept, i.e. credibility, deals with the question, "*How congruent are the findings with reality?*" Credibility of the research findings is achieved when themes are recognised by an objective party on reading. Data was captured from one source, that being semi-structured interviews, during the eight interviews undertaken. These conversations were digitally recorded and hand-transcribed prior to analysis and the phenomenological themes emerged from the experiences as described by the participants of the study.

Whilst my interpretations of each participant's experiences of living through inappropriate behaviour may be different to that of the intended participant's interpretations, by moving through and continually checking the themes and the transcripts after the analysis process, peer-debriefing was invoked as a mode of validation.

Through sound debate and interrogation of the process, my peers did not disagree with either the themes or the transcripts. Further, as discussed previously, my supervisor also became involved in this process and agreed with my themes and the transcriptions. This project contains much, in the way of data, to demonstrate how themes emerged and can be located in Chapter Four. A full transcript of one of the interviews is offered in Appendix 8.

3.18 Transferability

The aim of phenomenological research is to provide an account of an individual's experience and, whilst this remains pivotal, there is the requirement that the findings from the cohort sample as a whole need to make sense to others who are outside of the domain of the research project (De Vos et al., 1998).

Typically qualitative research is "*not explicitly driven by theory*" (Glesne, 2011, p. 37). As a qualitative phenomenological study the point of this research is to understand the experiences of the participants: it does not seek to prove formal hypotheses (Creswell, 2013; Glesne, 2011; Lunenburg and Irby, 2008; Patton, 2002). My study is directed by the broader theoretical perspective of interpretivism, within which researchers believe the world is constructed by each knower and as a result there exist "*many truths*" (Sipe and Constable, 1996, p. 158). This is

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consistent with the phenomenological concept of searching for the meaning and essence of the experience (Patton, 2002). Interpretive phenomenological research does not make the claim to be generalizable to the wider population (van Manen, 2002); and the same is true of this study. There is the potential for transferability of the findings of this project to other similar contexts but this is something that readers of this research have to judge in relation to their own circumstances.

3.19 Dependability

Patton (2002) views dependability as focusing on whether the results found are consistent with the data collected. In order to determine dependability, readers need to be presented with a documented audit trail so they can make a personal judgement regarding whether all methods and decisions are transparent. My trail has been demonstrated throughout this thesis along with my decision processes.

In Chapters Four and Five of this thesis I present a staged approach to this study's development, and analysis, and in doing so it is envisaged that the readers can not only understand why decisions were taken but can also replicate the study.

3.20 Confirmability

Phenomenology is subjective in nature; the identification of themes and the clustering of 'units of meaning', from the data, have come from me. The process by which I have undertaken to move from the data to interpretation is expressed in Chapter Four, where examples of the actual process of analysis can be viewed. 'Real' data examples are used, where appropriate, to demonstrate transparency within Chapter Five. It is acknowledged that space is limited within a thesis such as this; therefore, '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 is to consider reflexivity and its position within this study; and to support this I maintained a reflexive journal throughout, as a means of identifying any presuppositions and this can be viewed in Chapter Six of this thesis.

3.21 Chapter conclusion

The justification for the use of aspects of Heidegger's (1962) philosophy to support as a methodological framework for this interpretive phenomenological investigation has been discussed. Heidegger's philosophy of *Dasein*, as in being involved with and caring for the immediate world in which we live, while always remaining aware of the contingent element of that involvement, was the driver for my rationale for only interviewing my participants once. Returning to re-interview may have removed them from the 'immediate world' in which they lived and were involved with at the time of the interview. Discussion of the techniques used for the selection of participants, data collection and data analysis were undertaken. Next, the ethical implications of the study and the measures taken to ensure ethical standards were maintained have been discussed. The chapter concluded with the strategies used to validate the study.

Chapter 4 PROCESS OF ANALYSIS

4.1 Introduction

This chapter offers an audit trail of the analysis process which leads to the findings from eight in-depth and semi-structured interviews with participants who have experienced inappropriate behaviour, alongside their stories surrounding the impact this behaviour and the effect this had on their ability to learn. The interviews were conducted between November 2012 and February 2013.

4.2 Participants' biography

The Standards for Pre-Registration Midwifery (NMC, 2009) identify that a midwifery programme will be divided equally with 50% attributed to clinical experience and 50% attributed to academic study. The NMC (2009) determine the following regarding the nature of midwifery educational programmes:

Standard 10 – Length of programme

“The length of a pre-registration midwifery programme of education should be no less than three years (equivalent to 156 weeks full time) and each year shall contain 45 programmed weeks. Where the programme is delivered full time it must be completed in not more than five years (including interruptions), or where the student attends part time in not more than seven years. Where the student is already registered with the NMC as a nurse level 1 (adult), the length of the pre-registration midwifery programme of education shall not be less than 18 months (equivalent to 78 weeks full time) or an equivalent pro-rata part-time period” (NMC, 2009, p. 17).

The participants were recruited from areas within the United Kingdom and drawn from 156 week midwifery programmes, as I sought the experiences from student midwives who had not been exposed to previous nursing training. My rationale for this was that I did not want the participants to have their stories influenced from their nursing training encounters, only from their engagement with midwifery.

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The eight participants were in different stages of their 156 week (3 year) midwifery educational programme, with five of the participants in their second year of education and the other three within their third and final year of education. I elected to interview only second and third year students, as they would have had exposure to both normal and complex midwifery care experiences within the clinical areas. It is common, for first year student midwives, to have practice placements which predominately surround normal midwifery and I wanted to seek experiences from as many clinical encounters as possible. All eight had had clinical experiences and exposure to normal (low risk) midwifery where antenatal, intrapartum and postpartum care provision was delivered through a variety of settings such as birthing units and in the community. Furthermore, all eight participants had practiced within high risk environments such as labour wards, theatres and recovery, high dependency care units, neo-natal intensive care units as well as antenatal and postnatal wards. The three participants who were in their third year were also in the process of holding a case load of clients for whom they had responsibility (under the supervision of a qualified midwife). All eight participants had had periods of education and assessment within a nominated academic arena whereby low risk and high risk educational subjects had been taught.

The interviews were conducted in environments chosen by the participants as this ensured that anonymity and confidentiality were preserved, further aiming to provide an ambience which allowed for the participants to feel safe enough to be honest and open with their narratives. Numerical codes were assigned to each individual student midwife and recorded on the consent form. This number was used to link the pseudonym, as chosen by the participant, to that participant.

Error! Reference source not found. highlights the participants' biographies.

Table 2 **Biographies of the student midwives**

Participant's chosen pseudonym	Age at interview	Stage of education	Experience prior to entering midwifery education	Educational attainment prior to entering midwifery education
Anne	22	2 nd year	School and part time waitress	A levels
Barbara	29	2 nd year	Insurance	College - access course
Debbie	22	3 rd year	School and part-time care home assistant	A levels
Emma	37	2 nd year	Maternity care assistant	College – access course
Grace	30	2 nd year	Ward Clerk and Maternity care assistant	College – access course
Jane	23	2 nd year	School – Gap Year	A levels
Lisa	28	3 rd year	University internship within a pharmaceutical company	Bio-science degree graduate
Lucy	21	3 rd year	Assistant in a home care setting	A levels

4.3 Justification and the process of analysis

As with my own data collection, qualitative data is unstructured and, as such, a structure needs to be employed to allow for a comprehensive sense of understanding. Interpretative Phenomenological Analysis (IPA) involves the comprehensive examination of a participants' 'lifeworld'; their experiences of a given phenomenon, the means by which they made sense of these experiences and the meanings they attach to them (Smith, 2004). The key theoretical perspectives of IPA are; phenomenology, interpretation (hermeneutics) and the idiographic (Smith, 2004, 2007; Smith et al., 2009). IPA promotes immersion in the participant's world, whereby the aim is to try and step "*into the participant's shoes*" (Smith and Eatough, 2006 p. 332), to enter their world and understand their reality. Whilst this offers an empathetic approach there is recognition that IPA is complicated by the researchers' own perspective when accessing another's world. Finlay (2006) notes that the researcher should scrutinise and share their preconceptions and motivations regarding the research in order to help the reader position their analysis.

The interpretative emphasis of IPA draws on the Interpretation (Hermeneutics) theoretical perspectives of Heidegger and Schleiermacher (Larkin et al., 2006; Smith, 2007; Smith et al., 2009). Schleiermacher's adopted position, in respect of bringing together the whole (comprehending the context of a text) as well as the part (comprehending the author), has a contemporary timbre for IPA researchers when conducting the analysis of texts of research participants (Smith, 2007; Smith et al., 2009). Researchers accept that a phenomenon is experienced by an individual in a particular and exclusive way and yet it is lived within a shared context. Schleiermacher's theories form a significant criterion for IPA as he also advocated that an effective analysis, based on both linguistic and psychological interpretation, would disclose meaning beyond the immediate positions of the individual, whereby it would reveal more about a person than that person is aware of themselves (Smith et al., 2009).

Heidegger built upon Schleiermacher's theories of interpretation and fused his understanding of phenomenology with the theories of hermeneutics, adopting the position that human existence is absolutely and inextricably bound up in the world

of individuals, objects, language, human connections and culture. Larkin et al., (2006) assert that it is impossible for anyone to elect to transcend or disengage themselves from these indelible aspects of their lives, in order to reveal some fundamental truth about lived experience. On this basis all investigations start from the enquirer's perspective from the basis of their experience. Therefore, as opposed to setting aside or bracketing preconceptions and assumptions, in advance of an enquiry, IPA researchers work from a Heideggerian perspective, whereby they attempt to identify their rudimentary understandings of a particular phenomenon.

There is acknowledgement that an awareness of these preconceptions may not emerge until work has started in the interview or the analysis stages (Smith et al., 2009). For Heidegger and IPA, phenomenology involves hermeneutics and for IPA researchers this means that what is captured of another's experience, utilising IPA, will always be suggestive and provisional rather than conclusive and absolute because researchers themselves, however intensely they endeavour, cannot completely exclude the contextual basis of their own experience (Larkin et al., 2006). The process of analysis offered by IPA provided, for me, a detailed and logical approach which, paradoxically, aligns with the fact that Smith et al., (2009) stress that there is no right or wrong way of conducting this sort of analysis. As IPA is so akin to the philosophy and theory proposed by Heidegger, it proved to be the most appropriate method of analysis for this study.

There are considered limitations to IPA in the respect that whilst it recognises the importance of the researcher's perspective, criticism has been levelled at the fact that there are no guidelines on how to encompass this reflexivity into the research process; and for not stating how the researcher's conceptions sway analysis. In response Willig (2001) suggests that findings invoke a sense of discovery, rather than construction. However, Smith and Osborn (2008) contend that IPA offers an approach rather than a rigid method. In turn, this allows for flexibility to meet the researcher's need and context. The role of language can be problematic in IPA, with social constructionists arguing that language constructs rather than describes reality. It could be said, therefore, that an interview transcript tells us more about the way in which an individual talks rather than the actual context of the experience.

4.4 Data analysis – saturation

Morse (2000) contends that there are many factors to consider when endeavouring to reach saturation point during data analysis. Such factors include the scope of the study – with the principle being that the broader the scope of the research question the longer the timeframe will be to reach saturation. Another factor to consider is the nature of the topic; in regards to this Morse (2000) suggests that if the topic focus is clear and obvious and that the required information has been obtained easily within the interview stage, then fewer participants will be required. In examining the use of semi-structured interviews, as used in this study, Morse (2000) considers that the number of participants is dependent on the richness and amount of data which is collected at each interview. In order to obtain the richness required then there is the possibility that 30 to 60 participants may be required to allow for analysis depth. However, if participants are interviewed more than once then possibly only 6 to 10 may be required.

Initially, particularly when writing my research proposal, I found it difficult to estimate how many interviews would be required. As Smith and Osborne (2008) identify that IPA studies are undertaken on small sample sizes, where there is thorough case-by-case analysis of individual transcripts, which is very time intensive. The aim of my study is to say something in detail about the perceptions and understandings of my participants, rather than make premature general claims. However, Smith and Osborne (2008) acknowledge that that IPA is not adverse to more general claims for larger populations; rather the process is committed to the meticulous analysis of cases rather than jumping to generalizations. However, even with only eight participants I felt assured that I had reached the point of data saturation when no new themes were emerging.

Smythe (2011, p. 41) offers the analogy of a river to describe this point of 'knowing':

“Already the insights are emerging like a river of thought. To keep pouring in more runs the risk of overflowing the banks which somehow hold the thoughts in a coherent whole.”

4.5 Stages of analysis - Identifying initial ideas and emerging themes

The first interview conducted was used as a pilot study. Yin (2011, p. 37) defines pilot studies as aiming to “*help test and refine one or more aspects of a final study; for example, its design, fieldwork procedures, data collection instruments or analysis plans.*” Interviews, especially, appear to receive particular attention, in part due to their popularity as a generic data collection method, moreover due to the importance of ensuring the interaction with participants is both effective and ethical (Alvesson, 2003; Cassell, 2005). The completed transcript and emergent themes were reviewed by a group of colleagues and discussed with my supervisor. A total of six colleagues were drawn from the Faculty in which I work and from different disciplines from within health care. They were chosen on the basis that some of them had already completed their doctorates and others because they were familiar with phenomenology and with IPA.

It was demonstrated to me that by asking for the participant to define their interpretation of the term ‘inappropriate behaviour’, as opposed to allowing the emergence of the definition through the participant’s narrative, I did not gain the experiences and data which I sought. This became evident as the interview progressed and was addressed through discussion with my supervisor, who examined part of my transcript, which allowed for a change and refinement to my opening question. However, a major component of the interview data was lost due to my naivety. In conducting this pilot study, supported by the scrutiny of colleagues, I was firstly able to reflect on the focus of the study, secondly to learn how to extract the information needed without corrupting data and finally gain awareness into the difficulties of using interviews as a data collection tool (Pritchard and Whiting, 2012).

Ch. 4 – Process of analysis

As soon as possible after each interview, I typed an analytic memo where my first impressions and thoughts from the interview were conveyed. At the same time I also attempted to reflect on the interview and to determine why those impressions were made and where the impressions originated. The interviews were transcribed as soon as possible after the interview and I wrote a brief summary before interviewing the next participant to assist in thematic analysis and distinction between participants.

My starting point for analysis of the full data set was to read and re-read the initial interview to enable me to become fully immersed within the data and to commence a preliminary descriptive version of the participant's inhabited world (Smith, 2009). This initial analysis focused on the resemblances, differences, paradoxes and elaborations. Each recording was personally transcribed, following the interview, and liaising between the transcript and the recording allowed me to become fully immersed in the data with the process being repeated following every interview. I made comments in the left hand margins of transcripts whereby the use of language and sophistication were noted. Initial ideas revealed initial thoughts and statements that became highly evident during the transcribing, reading and re-reading stages. These initial aspects were then sought for validation during subsequent interviews. Notes were also taken during the interview process.

There is a risk, highlighted by Gerrish and Lacey (2013) that writing notes during an interview can result in the participant thinking that the researcher is either not interested or not listening. I was cognizant of these issues prior to the commencement of each interview and so each participant was petitioned that this action would be happening, with the reason behind it. All participants permitted me to take notes during their interview.

On completion of all eight transcripts, I replayed each recording, mapping the transcript concurrently. From this exercise, I was able to highlight the key phrases and interesting issues raised, using a highlighter marker pen. Following completion, the phrases were allocated an interpretive emergent theme, either one or two words which denoted the meaning of the highlighted phrase. This process is what Smith et al., (2009, p. 88) refers to as "*conceptual coding*", whereby an

overarching statement is provided to encapsulate that which each participant has described.

There is, throughout the process of hermeneutic interpretation, a constant 'spiral', sometimes described as the hermeneutic circle, between both the whole and elements of a text as comprehension of the one permits understanding of the other (Smith et al., 2009). This is in accordance with Heidegger's (1962) position in which the image of the whole is reflective of a reality that is situated in the detailed experiences of everyday existence by an individual: that of which it is a part. In doing so it can be posited that this directs the interpretation away from that which the participants have conveyed directly, but since the interpretation has been derived directly from the participant's experience it remains as true an interpretation as possible to the lived experiences undergone by the participant. Table 3 offers an example of a conception of an initial idea and emergent theme, which is the first stage in the IPA process, which Smith et al., (2009, p. 83) refer to as "*initial noting*."

Table 3 Example of the conception of an emergent theme

Emma – 2 nd year midwifery student	Initial idea –emergent theme
Sometimes it is [as] if I am not there. I just get on with it not knowing if it's OK. She [midwifery mentor] only seems to do something if I done it wrong, you know, then I don't know why I ask and she [midwifery mentor] says that she has shown me and that I need to up my game	Feeling invisible

The IPA process concerns the process of "*mapping interrelationships, connections and patterns between exploratory notes*" as a means of developing "*emergent themes*" (Smith et al., 2009, p. 91). Further, Smith et al., (2009) identify that there is no right or wrong way in the decision making process of what is to be commented upon nor that that the text has to divided up or de-contextualised in any manner or that comments have to be assigned to 'meaning units'. The emphasis rather is placed upon the researcher adopting a process of engaging with each transcript as much as with the outcome of doing so, by engrossing oneself in this manner there is, as Smith et al., (2009 p. 83) suggest, "*likely to be a*

descriptive core of comments [that] stay close to the participant's explicit meaning."

It is further proposed by Smith et al., (2009) that there is an element of personal reflection during the process of developing the emergent themes, with the phenomenological interpretation drawing upon my experiences and professional knowledge, which cannot be dismissed from my analytical process; it must be acknowledged. This aspect will be considered further in my reflexivity section (Chapter Six) of the thesis. In completing steps two and three for all eight of the transcripts, the emergent themes were recorded and then cross-examined to show commonalities and dissonance.

4.5.1 Stage 2 – Sub-ordinate themes

In this part of the process the emergent themes were grouped together in recognition of their commonalties, an example of which is in Table 4. Commonalties were composed by the meaning of individual words, sometimes two words, or phrases which held similar implications (i.e. being ignored, feeling invisible) and by interpretation of the meaning of these words which led to the development of sub-ordinate themes.

Table 4 Step 4: Example of one sub-ordinate theme as developed from emergent themes

Emergent theme	Sub-ordinate theme
Being ignored	Invisibility
Feeling invisible	
Left on the side lines	
Lonely	
Sometimes it just like I'm not there	

Within the IPA process, as shown above, the emphasis is placed on the search for connections across the emergent themes. I noticed that on occasion words and phrases located within the emergent themes proved difficult to link together in one sub-ordinate theme. At this point it was important that I did not simply look for a 'best fit' scenario and attempt to place an emergent theme into a sub-ordinate theme just because it did not fit anywhere else.

By involving impartial colleagues as peer reviewers I feel that I was able to discuss and justify my decisions, throughout the process, in order to minimise bias and skewing of the data. The next step involved moving to the next case and repeating all previous steps. Step 6 is concerned with looking for patterns across cases and combining all themes and codes clustered under a particular research-focussed category (e.g. self-doubt) from all participants, in order to identify recurrent themes. Following this, I needed to look for master-themes within each research-focussed category, then, as the master-themes emerged from research-focussed categories, combining them with the earlier provisional themes from all participants that emerged from the analysis of the individual transcripts in order not to miss any relevant themes. Finally, I then gathered all the important and relevant themes together, thereby creating a map of super-ordinate themes, e.g. 'Struggling'. Steps four, five and six of the IPA process have run concurrently throughout the development of the sub-ordinate themes, as their main focus is looking across individual cases and the data set.

4.5.2 Stage Three – Super-ordinate themes

At this stage I had collated 20 sub-ordinate themes which I then revisited and reduced further to produce super-ordinate themes. Within Table 5 I have demonstrated how the terms identified within the sub-ordinate themes heading were fused together and an overarching meaning was addressed to them. Finally, having gathered the themes together, I created a map of super-ordinate themes, e.g. 'Angst and anonymity'.

Table 5 Composition of super-ordinate themes

Sub-ordinate themes	Super-ordinate themes
Self-doubt Loss of self-worth/confidence Negative feelings Will I be a good midwife? Feeling helpless	Struggling
Invisibility Pushed out On my own Feeling second best Trying to be a student Anxiety	Angst and anonymity
Loss of learning/experience Preparation for role of midwife Fear of not knowing Questioning own knowledge base Fear of asking Losing the right to be taught	Loss and bereavement
Conflicting support Lack of acceptable support Subterfuge Poor attitudes and perceptions towards students	Betrayal

4.5.3 Stage Four – Final interpretive themes

The final part of the IPA was to create a grouped ‘master list’ of themes. The sub-ordinate themes were further refined. During this process, I was required to select the predominant higher order themes and, in this particular analysis of eight student midwives, it provided three higher order themes (final interpretive themes). The three final interpretative themes that I identified from my analysis relate to how students midwives make meaning of inappropriate behaviour and the impact this on them.

Table 6 provides the process of obtaining the final interpretive themes.

Table 6 Final Interpretive Themes

Sub-ordinate themes	Super-ordinate themes	Final interpretive theme
Inconsistent support Lack of acceptable support Poor attitudes and perceptions towards students	Struggling	Breaching covenant
Conflicting support Lack of acceptable support Subterfuge Poor attitudes and perceptions towards students	Betrayal	
Loss of learning/experience Preparation for role of midwife Fear of not knowing Questioning own knowledge base Fear of asking Losing the right to be taught	Loss and bereavement	Dispossession
Invisibility Pushed out On my own Feeling second best Self-doubt/questioning if I will be a good midwife Loss of self-worth Negative feelings Anxiety Feeling helpless Trying to be a student	Angst and Anonymity	Liminality

Ch. 4 – Process of analysis

To support understanding, Table 7 offers a synopsis of the analytical process.

Table 7 Synopsis of Analytical Process

Stage	Name of grouping	Comment	Descriptive or interpretive
Stage one	Initial ideas Emergent themes	Initial thoughts from listening, reading and re-reading each transcript were recorded in the LEFT margins of each transcript. I saw these as holistic ideas. Interesting comments and phrases were highlighted from reading the transcripts. Emergent ideas were hand-written in the RIGHT hand margin of each transcript.	Descriptive Descriptive themes. These came from the text, as 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 20 central themes.	Interpretive themes
Stage three	Super-ordinate themes	By considering the commonalities between central themes, the numbers were further reduced to leave three 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

This research study sought to understand the potential impact that inappropriate behaviour had upon student midwives. The three final interpretive themes that constitute the outcome of inappropriate behaviour and the impact identified are: 'Breaching the Covenant', 'Dispossession' and 'Liminality'. 'Breaching the Covenant' encapsulates the fact that both clinicians and midwifery academic tutors have not met their duty of care to the students and the struggles felt by students, which in turn leads to the students' 'Dispossession' of the academic and clinical skills knowledge base they require in order to become qualified midwives. Finally, the personal effect felt by the student midwife is 'Liminality'.

4.6 Chapter conclusion

This chapter has reviewed the biographical details of the participants at the point of interview. The justification and process of analysis has been presented, along with the in-depth audit trail, which has resulted in conception of three final interpretive themes for consideration. These themes merged from the data collected via semi-structured interviews, whereby the participants own words have been used to inform this process. Chapter Five will discuss the findings from the interviews.

Chapter 5 FINDINGS

5.1 Introduction

This chapter offers my interpretation of the lived experiences of the eight participants, whereby the findings are the direct results obtained from the semi-structured interviews having followed the analysis and audit trail as detailed in the previous chapter. The words of the participants have been used verbatim, whereby single words as well as phrases have been included. It is acknowledged that the use of a single word can be as powerful in relaying meaning as that of a descriptive long sentence (Thomas, 2006). The findings are exposed in depth under the three final interpretive themes – ‘breach of covenant’, ‘dispossession’ and ‘liminality’.

The collective experiences expressed by the participants, during the process of data collection, establish the lived experiences of student midwives who have experienced inappropriate behaviour and their description of how it has impacted upon them. Within the process IPA the emphasis is that interpretations which are made are attempts to make sense of the participant trying to make sense of their experiences (Smith et al., 2009), and on that basis I acknowledge that the following account can be viewed as a partial and subjective interpretation, in that other researchers may have identified and focused on different aspects of the accounts. These findings are presented with minimal commentary or academic argument in order to promote the authentic voice and the power of the participants’ words.

Coherent with the hermeneutic circle, each part of the text is “related to the meaning of the whole text and with it the sense of the text as a whole is expanded” (Fleming et al., 2003, p. 118).

5.2 Inappropriate behaviour – not bullying

As discussed previously, there are nuances of inappropriate workplace behaviours which, potentially due to their nature and especially due to their infrequency, will not be classed as bullying and for that rationale have a tendency to be either

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overlooked or treated as part of the rough and tumble of organisational life (Pearson et al., 2001). I acknowledge that inappropriate behaviour is both subtle in nature and subjective, and on that basis presents situations with implications that can be difficult to address. However, as a means of placing inappropriate behaviour into the context of my study I have included vignettes, as described by the participants, to illustrate their evidential support of what they understand inappropriate behaviour to be and, to what extent, the impact the behaviours had had on them.

5.3 Vignettes

5.3.1 Lisa – 3rd year student midwife

Lisa arrived on the antenatal ward expecting to work with her named mentor; however, she was off sick and Lisa was placed with a qualified midwife whom she had met before. Lisa was to work with this midwife in order to support women in the induction of their labours. Lisa and the midwife met with a client, (who was in a four bedded ward) where Lisa offered a full explanation regarding labour induction and gained consent from the client for the intervention to occur. Lisa left the room to collect the required items, in order to carry out the induction process and, as she was about to re-enter the room, she overheard the midwife talking to the client. The midwife was heard to say:

“...Well of course she is only a student midwife, not a trained nurse, which I think they should all be before they start training to be a midwife. They don't know enough. That why I'm here; to make sure she gets it right.”

Lisa described her immediate feelings of being undermined and felt all the knowledge she had accumulated previous to this event, regarding the induction of labour, to be limited. From a skill perspective Lisa found herself taking more time than normal to conduct a vaginal examination and constantly questioning her findings and decision making skills. She felt that the midwife's behaviour was inappropriate and had completely undermined her knowledge base.

5.3.2 Anne – 2nd year student midwife

Anne is fully cognisant of her learning style. She listens, takes brief notes and then writes her notes up in full at home. She described an incident when she did not fully understand an aspect which had been discussed in the classroom. She undertook supplementary reading around the subject but she felt she needed further clarification. On return to the classroom the tutor asked if there were any issues which had arisen from the last session. Anne raised her hand and asked for further clarification on the particular matter. At this point the tutor said, *“If you bothered to take notes then you would know.”* Anne felt that she was in a position where she could not then ask for any further information, as well as feeling humiliated. She tried to discuss this with her tutor but it was put to her that the academic was only trying to support Anne’s learning style. Anne felt dismissed and unable to seek guidance from the midwifery team as to her whether she was ‘doing well’ or not. She began to question her own knowledge base.

5.3.3 Debbie – 3rd year student midwife

Debbie offered insight into a situation whereby her named mentor, with whom she had a good relationship, failed to support her during an event which had happened during their shift. Debbie was caring for a client in labour and the fetus was showing signs of distress, resulting in a lowering of its heart rate. Following discussion with the client, the decision was taken to apply a fetal scalp electrode, a process which Debbie had undertaken on numerous occasions. She discussed the procedure with her mentor and then, during gaining the client’s consent, the client questioned Debbie’s ability to undertake the procedure. At this stage Debbie was about to explain her level of competency when her mentor said;

“Don’t worry, that’s what I’m here for. She’s [Debbie] talked it through with me but there is always a big gap between what they say and what they can actually do sometimes; I blame the University for that.”

(Debbie, 3rd year).

Debbie explained that she felt that she could not confront her mentor in front of the client, as it would be unprofessional. She felt that what she had discussed with her mentor, to show that she fully understood the process, counted for nothing and

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was not sure now if what she had said was correct. Following this she found herself constantly checking with other midwives that what she was doing was correct as she no longer trusted her own knowledge.

5.3.4 Barbara - 2nd year student midwife

Barbara discussed her experience of working with her named mentor in the community in her first year of training. They had worked virtually all of the shifts together and Barbara felt that they had a really good relationship. She recounted an experience in which she felt her mentor had exhibited inappropriate behaviour towards her which she believed had impacted on her learning:

“I was allowed to conduct the booking interview and we had discussed it all in the car before we went in. I must admit I was excited, sounds silly doesn't it, but anyway I was talking to the lady and her husband and it got to the bit where we discussed the scans. I had practiced this in my head and read up on the new bits and so I was in the process of telling her when my mentor suddenly said “oh no Barbara that's not what we do let me explain.” She wasn't rude or anything and said it really nicely but I felt that the woman had lost confidence in me and I completely questioned my knowledge base. I really distrusted what I knew.”

5.3.5 Emma - 2nd year student midwife

Emma discussed an experience during a delivery where she felt that her midwife who was supervising her.

“For example we were [she and another midwife] in the delivery room and I had been with this lady and her husband all night and she was making all the right noises, you know, like she was fully and the midwife said do a VE to make sure was fully. Now we are taught not to do that so I said very quietly to her so the mum couldn't hear that I did not feel it appropriate to do that and said why - you know the guidelines and stuff. I felt really confident in what I knew about when to do VEs as I had worked with other midwives who practice like that and also in uni they taught us the same thing. Anyway she [midwife] then said quiet like you

don't really know anything at this stage just do as I ask please. I felt that I couldn't say anymore and went ahead with the VE. I know I was right there was no reason to do a VE and she made me feel like I knew nothing."

5.3.6 Grace - 2nd year student midwife

Grace discussed an experience with her tutor when she was presenting to her peer group. When following her tutor's comment she felt that she lost confidence.

"We all had to look up stuff on the topic we had picked and I choose breech, silly really now I look back, asking for trouble really, but anyway I was talking about the breech trial and how it was critiqued and that the findings are flawed and how we are still basing our discussions on the best way of delivering them on poor evidence. I had spent ages looking at new findings since the Breech trial and how we can support breech women in delivery virginally. I began to talk about the Australian and Canadian studies which have shown that vaginal breeches can be safe when she [tutor's name] suddenly jumped in and said "Grace can I just stop you there we can only use the evidence we have and that has to be Hannah's trial findings." I tried to debate with her I was polite and so was she but I felt that I couldn't finish my presentation because A she didn't agree with what I was saying and B my group may not have believed me. She shouldn't have behaved that way I lost face and confidence in my critiquing skills."

Jane described an experience where she had initially felt secure in her knowledge base and with her clinical skills and to an extent in control of the situation however, described her loss of confidence following the actions of the midwife she was working with.

5.3.7 Jane - 2nd year student midwife

"We were in the pool room and this was going to be my first pool birth. The lady delivered and it was so lovely she collected her baby turned

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around and just put him to the breast. I was drying the baby and just checking him – you know Apgar scores and then the midwife said “ok out you get now so that we can deliver the placenta”. The lady said that she didn’t want to get out and that she wanted to deliver her placenta in the pool I knew it was safe for that to happen and I quietly said to the midwife that it was OK for this to happen and said about the guidelines she then just looked at me and said “it’s not safe to deliver the placenta in the pool” and that I wasn’t to say that it was to the mother. I was only a first year then and I really felt that the way she behaved towards me was wrong but she was a really experienced midwife so I believed that she must be right. I really lost confidence that day.”

5.3.8 Lucy – 3rd year student midwife

Lucy described her experience of what she believed to be inappropriate behaviour from a midwife which led to feelings of anxiety (about her final grade award) and negative feelings towards the midwife.

“....yeah well a lots happened over the three years and as I said at the beginning I don’t think I was ever bullied you know when people are really unkind to you all of the time [pause] I think that some people just don’t know that they are being inappropriate. I wouldn’t put up with it now but when I was a first year we did this thing where you worked with different staff on the ward you know ward clerks maternity assistants so that you got an understanding of what they did - well during our lunch break I talked about it with my mentor and said that I thought it was a shame that maternity assistants did the baby baths as I would find it a valuable skill to have. She then went off on one not shouting or anything but saying that it wasn’t my place to comment on how the ward was run and that it had very well before I arrived and what did I know as a first year and that I had a lot to learn and who would be doing midwives work if they had to do the baths - she ended up saying that I was here to learn to be a midwife not a maternity care assistant all of that in front of the others who were in the staff room. Like I said now I wouldn’t put up with it I would ask to speak to her away from the staff room and explain how inappropriate I felt her response was but as a first year I couldn’t

do that, I was worried that it might affect the grade she gave me at the end – the way she behaved that to me is inappropriate behaviour”.

5.4 Breaching covenant

A breach of covenant is a legal term and comes into play when an individual or company, which has entered into a contract, refuses to perform a duty or refrain from doing said duty in a particular manner. This rider encompasses a duty under a contract which is implied, or ones which are incorporated within a written agreement (law.yourdictionary.com/covenant, 2013). A midwife’s practice is governed in accordance with the code and standards set by the NMC, (2012, 2013 and especially by the Standards to support learning and assessment in practice (NMC, 2008), which informs midwifery mentors of their responsibilities when supporting student midwives in clinical practice. Equally, academic midwifery tutors must abide by the aforementioned Nursing and Midwifery standards and codes; however, in addition they must adhere to the quality assurance framework (NMC, 2013), by which all AEs are governed. By not abiding by these standards and codes both clinicians and faculty can be seen as breaching these covenants.

There was a consensus among the participants about the main roles of a clinical mentor being a support person, teacher, advocate, guide, expert and evaluator. The participants felt that overall their relationships and communications with mentors were good. However, two participants described their frustration at the lack of what they perceived to be consistent support from mentors:

“He’s [mentor] sometimes happy to teach or he just leaves me to just get on with it, no 'how it is done' or 'do you want to tell me how you would go about this' [care procedure]. I’m sure he doesn’t mean anything by it. I’ve just started my second year so all the complexities are new to me, that’s what he’s there for to teach me; I felt I learnt nothing that day.”
(Grace, 2nd year).

“My mentors have been great, but on this one day I had to work with someone else; she was just not interested. [Lucy shakes her head as she relays this piece of information] I’m in my third year now and I know

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the government pays my fees, but I deserve to be taught, I don't want to make mistakes.” (Lucy, 3rd year).

The participants described that they worked hard at academic studies within the university arena; however, four of the participants offered at least one example each regarding the lack, or inconsistency, of support from Faculty:

“I began to think that she [lecturer] didn't like me, so I got the courage to ask her she said I was imagining it, but other students get quizzes from her and hand-outs; so some she helps and some she doesn't. I spoke to my tutor and she said oh probably [name of lecturer] had misunderstood what it was I wanted... [raises eyes and head to the ceiling] What are you supposed to do, where's the learning?” (Anne, 2nd year).

“...fed up being told 'oh, that's just the way [name of lecturer] is.” (Grace, 2nd year).

“I get on all right with [lecturer], but I can see how she can come across as not supportive. I really don't think she realises she behaves like that; it's not bullying, it's just inappropriate, but even I come away some days from class thinking, 'what have I learnt?’” (Barbara, 2nd year).

“Sorry for sounding bitter, but I don't think [lecturer] would know what support is if it sat up and begged in front of her.” (Jane, 2nd year).

Three participants, early in their narratives, relayed experiences of poor mentor attitudes and the following excerpts show how this was important to them:

“I sometimes wonder why [midwife] is given a student if she really doesn't want to teach you? [shakes her head] It certainly seemed to me that I wasn't wanted. I know I was only with her for that one shift, how I am supposed to know what I've learnt, if anything? I'm glad she isn't my proper mentor.” (Barbara, 2nd year).

“Sometimes it is if I'm not there. [pause] Nine times out of ten it's okay, but on this occasion I just got on with it, not knowing if it was okay.

Turned out it wasn't the right way to do it. [Mentor] asked why I did it that way and I explained that was how [Midwife] had done it; she just raised her eyes and tutted. That put me off who's right; you can't learn like that." (Anne, 2nd year).

"This one midwife, not my mentor, really didn't want me around she wasn't nasty or anything. It's like I'm too much trouble, even asking questions brought nothing. How was I supposed to learn? She knows what she is supposed to do, so why doesn't she do it? She's not unkind, you know; I think it is just her..." (Lisa, 3rd year).

Despite some good experiences in the clinical arena, two of the participants felt at times like they were an inconvenience.

"There are some [midwives] that just don't like having students. I know everyone is busy and they don't pick on you or anything... But sometimes I felt like I was just an inconvenience. It pretty much ruins your day, in the sense that why would I bother even being here if you don't even want to teach me? I felt I have lost a whole day of learning." (Debbie, 3rd year).

"It was as if I wasn't there. When it came to working, she [mentor] wasn't rude or unkind or anything, she just kept going without me. It's like... I can't think of the word... it's like she just expected me to learn, but I did not know what I should be learning, so did not know what I hadn't learnt. Do you know what I mean?" (Jane, 2nd year).

Frustration, about how their mentors' distribution of work showed inappropriate behaviour, was highlighted. Debbie described an encounter with a midwife, who was not her named mentor, when working on the labour ward and looking after a wealthy client:

"Throughout the shift she [midwife] kept giving me silly little jobs. It seemed she wanted to keep me away from the lady; she wasn't nasty about it, I know midwifery involves everything, but I wanted to

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consolidate my skills by attaching the FSE that was needed. But she made some excuse that it should be a trained midwife who did it. I know I'm a third year and should be sourcing my needs, but I spent all day with this midwife and I can honestly say I learnt nothing." (Debbie, 3rd year).

"At times I think that we [student midwives] are just an extra pair of hands when it suits them [midwives], not students. We can be given the cleaning jobs, or taking the bags to the collection points, then the next minute we are expected to behave like third years. You don't know if you are coming or going. This is what happens when they don't seem to know what to do with you. I know that they aren't purposely dissing you, but giving you jobs which really do nothing for your learning isn't appropriate behaviour." (Lucy, 3rd year).

There was a noticeable difference in midwifery staff expectations and reactions to students' clinical abilities, dependent on their year of training:

"It's so frustrating. I'm nearly at the end of my second year and [mentor] gives me the most basic clinical stuff to do whereas others really let me fly; it's difficult to learn when you seem tied to someone's apron strings." (Emma, 2nd year).

"At times after handover, I'm shipped off to a bay and told to get on with it because as [mentor] says, 'you will be a third year soon'. I'm happy with my skills, but there's no feedback; I'm unsure what I've really learnt at times." (Barbara, 2nd year).

"As a third year, I'm normally considered by most staff to be able to work on my own and report back. However, this one time it went against me; I was on labour ward, looking after a women and I found myself conducting a delivery on my own, waiting for someone to answer the bell. Afterwards [mentor] said 'well-done, that's what it's like in the real world,' no debrief or nothing." (Lisa, 3rd year).

“When I came on shift, I was allocated a labouring lady and so I went in to say hello. Immediately, the midwife I was working with called me outside and asked me what I was doing. She was nice about it and I explained and then she said that as I was only a student I had to stay with her and not wander off doing my own thing... from then on she just didn't let go; it was as if she had to be by my side all the time. I wouldn't mind but she really didn't spend time actually teaching me anything. That's not appropriate; as a third year, I need to be able to start practising with a little more autonomy.” (Debbie, 3rd year).

This frustration regarding workload distribution was not limited to the clinical arena as three participants described their experience within academia:

“It just seems that I always get the biggest amount of feedback to bring back to class when [academic tutor] is taking the session. She doesn't pick on me and maybe it's due to the fact that I always sit at the front. I don't know it's got to the point where others have noticed; I get so stressed about it that none of it [teaching] goes in.” (Emma, 2nd year).

“She wasn't nasty about it, but on this one occasion she kept on asking me and seemed to ignore others hands, even when I hadn't put mine up. That's a lot of pressure; I kept on making stupid mistakes with my answers. Then you question yourself about what was the right answer.” (Lucy, 3rd year).

“This one time [lecturer] just focused on me, with things like 'come on, you know this' and 'what are you going to do in practice?' He wasn't aggressive, but he didn't do it to the same extent to the others in class. You end up thinking so fast that you don't take it in.” (Anne, 2nd year).

It is apparent that the participants clearly considered that aspects such as inconsistent support, lack of acceptable support, poor attitudes and perceptions towards them as being inappropriate behaviour.

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5.5 Dispossession

Midwifery knowledge is the process by which the whole purpose of caring for women and their families is achieved, as it underpins what midwives actually do. It is what defines a midwife as opposed to similar professions, such as nursing, medicine or dentistry, further it helps to differentiate the profession from a lay carer, such as a doula or a maternity care support worker. Knowledge is basically what classifies midwifery as a profession because having a 'unique body of knowledge' is one of the hall marks that define a profession in society (Mensik et al., 2011, p. 259). A definition for the term dispossession is "*the act of putting out of possession; the state of being dispossessed*" (Webster-dictionary.org). The covenant set up between the participants, mentors and the faculty staff had been breached and the consequence became one of dispossession of knowledge on behalf of the participants:

"The way she treated me on that day wasn't appropriate. I'm a third year and I need to be getting ready to qualify. I came away not knowing if I was right or wrong. She should know what her role is as a mentor."
(Lisa, 3rd year).

"With this one lecturer, it felt that communication was sort of non-existent; she took ages to answer emails and phone messages and as for asking questions... well, she seemed not to want them, you just felt stupid whenever you did." **(Jane, 2nd year).**

Barbara described, whilst working in antenatal clinic, her difficulties in accessing learning opportunities with her mentor and how uncomfortable she felt in asking questions and so developing her knowledge and skills:

"On this placement, whilst [mentor] was nice enough, she didn't want to know what skills I had already or what other high risk stuff I had done; she just didn't seem to care in general. It got to the point where I didn't ask anything." **(Barbara, 2nd year).**

Similarly, both Debbie and Grace felt uncomfortable asking questions and this seemed to impact also on their ability to learn:

“[The mentors are] nice enough women, just little or no teaching and absolutely no inspiration. In the end, I just got on with it; asked a few questions and it’s like ‘learn yourself, [use of own name]’.” (Debbie, 3rd year).

“It’s like [mentor] ran away from questions to the point that it became quite uncomfortable. I’m still not sure what I got out of that week’s placement.” (Grace, 2nd year).

Three of the participants, who were close to qualifying, discussed clinical staff members’ inappropriate behaviour and how it impacted on their confidence in preparing for the role of qualified midwife:

“[Mentor] asked me about CTGs in front of the woman and the answer just went; then I couldn’t believe it, she was so inappropriate, she just stood there and said, ‘well thankfully you’ve got a few months before you qualify’. You begin to think if you are really safe to become a midwife.” (Lisa, 3rd year).

“I was taking the unit, you know acting as co-ordinator and this doctor came up and completely ignored me. He knew my role that day and talked to the midwife and when she referred him back to me. He said ‘oh, but you’re just playing at being in charge. I need someone who knows what they are doing at this point.’” I thought, ‘what the hell, what do I really know, am I ready to qualify?’” (Debbie 3rd year).

“I’m qualifying this year and I dread making a fuss, but it doesn’t help me when [mentor] says she’s ‘teaching by example’; I can’t learn that way.” (Lucy, 3rd year).

Four of the participants discussed what they saw as their rights in regards to being taught and how the act of inappropriate behaviour made them feel:

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“I know we are seen as adult learners in university, but it’s different out in practice: Here you can doing something that might harming a mum or baby and at times the midwives are nice, they just don’t seem to want to teach.” (Grace, 2nd year).

“I know the wards are busy at times and that [mentors] can’t be with you all the time and they shouldn’t, but when you ask something someone should at least take the time to tell you, even if it’s briefly. It was important to a woman [in labour], you know, that she had an answer, so she went on worrying because someone couldn’t be bothered to tell me.” (Emma, 2nd year).

“This was when I was a first year: God you need so much support then and I tried so hard to get feedback from [mentor], but it just didn’t happen; it would be a quick ‘well done’ or ‘that could have been better’. I needed to be taught. I lost so much in my first few weeks...’ (Anne, 2nd year).

“Someone taught her, has she forgotten?” (Barbara, 2nd year).

This sense of deserving to be taught was not just present in practice as two participants’ highlighted issues in academia:

“I asked the lecturer to explain a little further during class, but she just said ‘read about it’. How do you know what it is you don’t know? That’s her job, surely, to teach me?” (Jane, 2nd year).

“I deserve to be taught. I don’t want to make mistakes.” (Grace, 2nd year).

Losing motivation to learn as a result of experiences such as inconsistent support, lack of acceptable support, poor attitudes and perceptions was identified by three of the participants:

“As I said before, she was a nice enough person, but she just didn’t offer the support that day. You end up losing the will to learn. It was just easier to do the jobs.” (Emma, 2nd year).

“You just can’t get motivated, some days. I worked with this nursery nurse in the cool nursery; she was looking after me for the shift, but it was obvious to me that she didn’t want to be there. She talked to me and made me tea, but she obviously didn’t seem to enjoy her job, there was definitely no teaching that day.” (Grace, 2nd year).

“I was so looking forward to the induction unit, but I ended feeling like the women were on conveyor belts; the midwife I was working with just saw the women as a process, she did not really interact with them, or me. Maybe she lost her motivation and love for the job; I know I did.” (Barbara, 2nd year).

As discussed previously, motivation is a key element when engaged in the learning process and these participants offered experiences of loss of learning through lack of motivation due to the inappropriate behaviour of the practitioners with whom they were working.

5.6 Liminality

One of the ascribed definitions of liminality is:

“The transitional period or phase of a rite of passage during which the participant lacks social status or rank, remains anonymous, shows obedience and humility and follows prescribed forms of conduct, dress, etc” (Dictionary.com, 2013).

The action of liminality can be seen as the final consequence of the participants’ covenants being breached; and dispossession. It can be considered that the students have lost their rite of passage through which they gain both a degree and be admitted to the professional register as a midwife. Three participants described themselves as invisible to clinical staff with whom they were working in practice,

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where invisibility to them was seen as being ignored or forgotten, resulting in students being marginalised or not acknowledged as individuals.

Emma recounted:

“I think the main thing was that they [theatre staff present at the time] just didn’t see me as a person; they just saw the student, saw my student scrubs and just ignored me. They weren’t nasty about it; I felt I had no real persona.” (Emma, 2nd year).

“Sometimes it’s just like I’m not there. I swear she thought that if she [nursery nurse] couldn’t see me, then she didn’t have to teach me.” (Grace, 2nd year).

“Sometimes I felt like saying, ‘hello, I’m here!’” (Jane, 2nd year).

Developing their feelings of what invisibility meant, two participants discussed the issue of how this led to feeling anxiety:

“It’s bad enough, being made to feel that you’re not there: I’m sure it wasn’t done on purpose, but that made me feel so anxious. Who was I going to go to, who was going to teach me? NICU was so new to me.” (Lucy, 3rd year).

“I tried to involve myself in everything without getting in the way. I was desperate to learn, but they really didn’t acknowledge me. This made me anxious, you only get to go to gynea for a week and I wondered what I was going to do in the future if I met women with the same problems: What would I say to them?” (Emma, 2nd year).

These feeling also manifested themselves whilst the participants were in academia:

“I put my hand up and [lecturer] never comes to me. It may be where I sit, but it makes me anxious, like, am I right or wrong?” (Anne, 2nd year).

“She [described as a tutor] has her favourites, but she definitely acts towards me differently. She isn’t a bully or anything, nor is she unkind to me; I can’t explain how, but she makes me anxious to the point where I question if I really know anything.” (Debbie, 3rd year).

This sense of anxiety manifested itself in other terms, with two of the participants considering self-doubt and questioning if they would make a good midwife:

“I had spent another shift wondering what I had learnt. There’s a difference between wanting to experience autonomy and being left on your own completely. A few months to qualification and I’m scared to think that I’m going to have all this responsibility. I sort of have self-doubt that I’m not going to be able to be a good midwife.” (Debbie, 3rd year).

“I don’t know if what I am doing is correct half the time; she [Mentor] just doesn’t give me the feedback I need. I’m nearly qualified and I wonder if I really do have the knowledge to become a midwife.” (Lucy, 3rd year).

Three participants recounted how clinical staff members’ lack of attention gave them feelings of loss of self-worth and being second best:

“Just when I started my second year, my mentor wanted me to let a doctor know about a client. My first hand-over as a second year in high risk... I found the registrar and said that I needed to let him know about Mrs [client's] situation. He just kept saying 'uh-huh' and 'yep', while looking through the notes. It was obvious he wasn’t listening to me. I don’t know if it was because I was a student, but he made me feel worthless.” (Grace, 2nd year).

“I asked the registrar if he could explain the diagnosis in more detail. He just looked at me like I was something that had crawled out of somewhere. It made me feel worthless and inadequate...” [participant began to cry at this point]. (Barbara, 2nd year).

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Feelings of being 'on my own', leading to helplessness, were addressed by three participants:

"When you feel that no one is supporting you in practice, you feel that you are on your own. It makes me feel like I can't do anything on my own initiative in case I get it wrong. At times it made me feel really helpless".
(Debbie, 3rd year).

"It's like when you are not accepted in an area; they're not unkind, just indifferent. I don't think they even know they are doing it. You do really feel on your own, you stick to what you know and leave new stuff to others, but I did feel a bit helpless at times." **(Anne, 2nd year).**

"When you don't feel you can ask, you end up feeling that you're on your own, helpless. Then you think should 'I know this already'. It's unsafe."
(Lisa, 3rd year).

Ultimately, the participants described feelings of being pushed out:

"At times she made me feel as if shouldn't be in the profession. She wasn't nasty just, being her, I suppose." **(Grace, 2nd year).**

"I really tried, but it took me a long time to get my VEs right. One day [mentor] said to me, not nasty, you know, "do you really think midwifery is for you?" Felt like she was pushing me out." **(Jane, 2nd year).**

During their narratives some participants offered experiences whereby they had encountered inappropriate behaviour without a negative impact upon them:

"Yeah, I have had that type of behaviour, but I think now, because I'm a third year that I let it wash over me. It doesn't affect me anymore, as it did in the beginning." **(Lisa, 3rd year).**

"I know I've talked about what experiences I had from mentors who acted inappropriately, but now I'm going to the third year, I think it will be

different. I hope I can challenge them and not let it affect my learning opportunities.” (Barbara, 2nd year).

‘As I told you, I know what it did to me when those mentors behaved in the way they did. But now I think I can recognise it and in the future not let it get in the way of what I need to know.” (Anne, 2nd year).

5.7 Chapter conclusion

Within this chapter, I have presented my interpretations of the lived experiences of eight student midwives, who had experienced inappropriate behaviour, provided via three final interpretative themes. These are ‘Breaching Covenant’, ‘Dispossession’ and ‘Liminality’, all of which the participants described as contributing to the cause and effect of being subjected to inappropriate behaviour. These interpretations covered narratives of both individual and collective experiences during the semi-structured interviews. This chapter has demonstrated the complexity of interlinking points that have been identified within the findings.

Chapter 6 DISCUSSION OF ANALYSIS AND SYNTHESIS OF FINDINGS TO THE WIDER LITERATURE

6.1 Introduction

Eight participants were involved in individual semi-structured interviews during which they provided narratives of their experiences, as student midwives, who had been exposed to inappropriate behaviour and how they described the impact upon them. The rich descriptive data was analysed and the key findings presented with interpretive themes in Chapters Four and Five. In this chapter I offer a wider understanding of these themes by situating them in a discussion of the literature. From the findings of my study it would appear that unlike the definitions and required recognition of acts to be cited as bullying (the requirements that they are repeated acts; (Einarsen 1999, for example) the participants described only single acts of inappropriate behaviour which caused an impact.

Each participant was asked to only share experiences where they felt inappropriate behaviour had been acted towards them, which resulted in descriptions of off one-off events. Some participants described different occasions by different staff where inappropriate behaviour had occurred; but always as a single entity. The following discussion of findings has been considered under the three final interpretative themes: 'breach of covenant', 'dispossession' and 'liminality' and, in order to aid the focus of the discussion, the super-ordinate themes (as per Table 5) will be used to guide my discussion. Overall, the findings have shown how the influence of inappropriate behaviour manifests itself for each participant.

6.2 Breaching covenant

According to one definition a breach of covenant is violation of an express, or implied, condition of a contract to do or not to do something (businessdictionary.com).

Mentoring and teaching is a vital process in midwifery, whereby qualified midwives and lecturer support and teach students and facilitate the acclimation to their role.

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Both the mentor and student become engaged and committed to nurturing and fostering the relationship, which may be described as a covenant between the mentor, one who shares their experience and expertise, and the student, who looks to the expert for knowledge to enable personal development and the acquisition of clinical skills (Blauvelt and Spath, 2008; McCloughen et al., 2009; Mijares et al., 2013). This bidirectional relationship is complex and composed of trust and respect and when, through whatever means, the trust and respect is removed the covenant becomes breached. Further, as discussed previously, midwives and lecturers are bound by regulation in regards to supporting students (NMC, 2008, 2009, 2012) and failure to adhere to these regulations can be constituted a breach of covenant.

6.2.1 Betrayal and Struggling

During their training, a student midwife has the right to expect to be treated accordingly to enable her/him to achieve the requirements of their program. The creation of a contract made between academic staff and clinical staff can be seen as a means to support the student in attaining both the required knowledge and skills, in order that they may qualify (Chien et al., (2002). Written learning contracts are one form of partnership which can be created between faculty staff, mentors and students that encourage students to actively learn, therefore, acting as a vehicle to achieve program requirements, both clinical and academic. Thus students are able to take increased responsibility for their own learning in both academic courses and clinical education (Tsang et al., 2002). Conversely a psychological contract sits within the formalized written contract however, it is the unspoken expectation of a student in regards to the people with whom she/he works with in an organization, with its importance to the tacit cognitive and behavioural expectations of a learning relationship, both implicit and explicit (Rousseau, 2001, Jarvis, 2015, Charlton et al., 2007).

It is contended by Wade-Benzoni et al., (2006), that students perceive psychological contracts as a method of mutual exchange in their education process, whereby the interface between a student and an instructor are both central and revealing about continuing perceptions of commitments. However, this relationship becomes muddled due to low cultural and social understanding which

leaves some students unsure of the rules of engagement when socialising into the clinical arena. A psychological contract is an implicit part of this relationship and violations of elements of a student psychological contract negatively impacts on the quality of the learning relationship and invokes a sense of betrayal by the student (Robinson and Rousseau 1994).

Through data analysis one of the themes, which emerged, from my study, was betrayal and the rationale for examining the role of psychological contracts, in the context of this study, rests on that when a written learning contract is breached it allows the student to seek redress through the AEI's appeals processes, whereas the breach of a psychological contract does not offer this mode of recourse, leaving the student with the choice to refrain from contributing or withdraw from the relationship.

Rousseau (1989, p. 123) defined the psychological contract as an:

“Individual’s beliefs regarding the terms and conditions of a reciprocal exchange agreement between the focal person and another party. Key issues here include the belief that a promise has been made and a consideration offered in exchange for it, binding the parties to some set of reciprocal obligations.”

The beliefs constituting Rousseau’s (1989) above account are obligations arising from the exchange of perceived promises, whereby two types of promises are relevant to the contract. The first being promises which are expressed in words which focus on modes of speech to convey promises, which can be described as explicit promises, whereas the second type are promises that are communicated through non-verbalised perceptions that stem from the understanding of actions or indirect statements which can be seen as implicit promises.

It is possible to see how the notion of the psychological contract can apply to midwifery students both in university and the clinical arena, as they face a great deal of uncertainty, especially those who are unable to draw on any existing experiences.

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Both Jones and Wylie (2008) and McClelland and Williams (2002) undertook qualitative studies which explored student midwives' and student nurses', respectively, in regards to stress and learning experiences. Their findings were complimentary in regards to adult learners, located in a health-care setting, which demonstrated that there was a vulnerability to feelings of both a lack of confidence and disempowerment when confronting the challenges within the clinical environment.

The need for both academic and skill knowledge is immense and the students have many gaps to fill, which are accommodated by academic tutors, mentors and the student themselves, so failure of the mentor and academic tutor to uphold their part of the contract will lead to dissolution of the psychological contract.

Although Robinson and Morrison's (2000) qualitative study examined a management sample, their findings indicated that the breach of a psychological contract was associated with reactions such as fear, frustration and betrayal. For the participants of my study this seemed to lead to disenchantment, dissatisfaction, a decline in academic/clinical performance and for some conceptualizations of the contract, the stronger feelings of betrayal, anger and moral injustice. However, the key feature of breakdown of the psychological contract is loss of trust. It is also worth remarking that psychological contracts vary along a dimension between the transactional and the relational. Whereby relational contracts contain terms that may not easily offer monetary values and largely concern the relationship between the employee and the organisation, and transactional contracts are considered to be based on specific exchanges that pertain to a limited range of behaviours over a limited time period. These types of contracts tend to emphasise on financial rewards in exchange for a rather tightly defined sets of employee behaviours (Guzzo and Noonan, 1994).

From the findings of my study it would appear that the participants' betrayal came from the perspective that psychological contracts were breached due to them not being seen as an individual; being categorized; disrespectful interactions actioned against them; not being recognised as a student; and unfair treatment.

Jones and Wylie (2008) explored reasons that caused stress to student midwives in the clinical and academic areas, whereby they concluded that lecturers' support was at times unsatisfactory and that a number of mentors failed to offer a positive environment for experiencing clinical skills. The findings from their study sit well with the issues raised by my participants.

Chamberlain's (1997) ethnographic, grounded-theory study explored the factors that affected the learning of clinical skills by student midwives who had previously trained as nurses: Key findings of the study identified that the student midwives' former socialisation in nursing had a major bearing on their learning. The anxieties of being thrust into learning new skills, without prior preparation and training, together with exposure to midwives who had communication difficulties, inhibited student midwives from taking advantage of experiences offered to them. In respect of the academic environment Cooper et al., (2011, pp. 1 to 21) contend that:

“While faculty may not intentionally behave in ways to demean or embarrass students, their negative behaviours contribute to a hostile learning environment that has negative consequences.”

Leading to the theme of betrayal and struggling and ultimately a breach of covenant, my participants identified the issues of inconsistent support, lack of acceptable support and poor attitudes and perceptions towards them. Gray and Smith (2000) conducted a longitudinal cohort study, using Grounded Theory, to discover the effect(s) of mentorship on student nurses, whereby findings identified that poor mentors lacked the skills, knowledge and attitudes of good mentors.

Also using grounded theory as their methodology and interviews as the means of data collection, Licquirish and Seibold (2008) explored eight student midwives' views of what they perceived to be both helpful and unhelpful preceptors (mentors) when entering their final clinical placement. Findings indicated that unhelpful mentors gave limited hands-on practice and offered limited explanations for students, furthermore the participants reported mentors to be poor communicators, who did not provide support and lacked interest and encouragement. Midwives were identified as unwilling to have students working with them, who also exhibited negative behaviours which were reported to lead to the student feeling

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incompetent. Further data findings suggested that where unhelpful mentors were more likely to function in a hierarchical setting, the student became disempowered.

Licquirish and Seibold's (2008) findings offer some concordance with Begley, (2002). Begley (2002) undertook a literature review of 122 studies which enquired into whether pre-registered final-year midwifery students were influenced by the traditional, non-evidence-based, practices of their clinical mentors. Findings derived from the review identified that both professional and organisational constraints prevented students and practitioners from using evidence in practice, with some studies identifying inconsistencies between what students were taught in practice and what was taught in university, which Begley (2002) concludes this may have contributed to widening the theory practice gap.

Clinical midwives need to be aware of the effect their acts of inappropriate behaviours may have on the future mentoring role of student midwives. These rudimentary aspects of care and support, which should exist as a theme throughout the midwife-student midwife dyad are notably absent in the view of my participants. Further the way in which students are supported by academic tutors in their academic studies is noted to be inconsistent where, while it may not be academic lecturers' intention to humiliate or demean students, their inappropriate behaviours have consequences and contribute to an inimical environment.

Kolanko et al., (2006) describe some of those consequences as student frustration, anger and a sense of powerlessness, furthermore, they noted that disrespect was often felt by the students and that they became caught in a power struggle where the faculty would be the winner. Due to power imbalance, students believed that they stood to lose too much if they tried to defend themselves or confront staff.

Both Litchfield (2001) and Gammon and Morgan-Samuel (2005) suggest that academic demands are enhanced by tutorial support, whereby students are enabled to become familiarised with the conditions of an academic undergraduate programme and thereby reduce stress, foster feelings of control, autonomy and promote more effective coping.

Returning to Heidegger, he provides an interesting view on the student-teacher relationship:

“Teaching is even more difficult than learning. We know that; but we rarely think about it. And why is teaching more difficult than learning? Not because the teacher must have a larger store of information and have it always ready. Teaching is more difficult than learning because what teaching calls for is this: to let learn.” (Heidegger, 1954/2004, p. 15).

Of course it could be argued that what Heidegger is suggesting here is merely the contemporary view of teaching as we know it, even though this was written in 1954.

Returning to Heidegger in respect to ‘being-in-the-world’, it is reflected here the fact that the student midwife, faced with inappropriate behaviour within the learning environment, remained within that situation all the time he/she occupied that space. Discussion and debate about the difficulties associated with providing students with support in the clinical area is on-going (Papp et al., 2003; Brown et al., 2005; Hutchings et al., 2005; Mannix et al., 2006).

The complexities and demands of providing sufficient support for learners in the clinical area are well documented with factors such as increased workload, shortage of clinical staff and the training shortfall of newly qualified staff identified as having a negative effect on this role. This in turn can lead to impeded social transition and reduce the sense of belonging buy students (Chamberlain, 1997; House of Commons Committee of Public Accounts, 2014, Hutchings et al., 2005).

Secret et al., (2003) identified a ‘sense of belonging’ to the clinical environment and to the nursing team as a particularly important aspect in enhancing the learning experience. According to Levett-Jones and Lathlean (2009a), students who feel part of a team become motivated to learn, struggle less, show less anxiety and develop the ability for self-directed learning with confidence to ask questions.

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The theme of struggling was also identified whereby aspects such as self-doubt, negative feelings, anxiety and the feeling of helplessness were experienced by my participants. The sense of feeling helpless is supported by Celik and Bayraktar (2004), whereby the responses to a questionnaire by nursing students indicated helplessness having experienced abuse.

According to Gilbert and Brown (2015) student nurses often complain of feeling out of place or of being invisible and of being treated as an outsider when attending a new placement, with Melincavage (2011) suggesting that any new learning experience, particularly that of moving from novice student to expert, is likely to trigger anxiety.

Corwin et al., (1961) Taylor et al., (2000) and Takase and Maude (2006) all offer the opinion that in general disillusionment with the role of student results from inconsistency between their perceptions of reality and their actual experience of it, whereby this anticipatory anxiety accelerates once the student is in practice and when acts of inappropriate behaviour heightens the student anxiety. Thomas et al., (2015) acknowledges that learning in clinical practice remains a cornerstone of preregistration programmes and a lack of supervision is inapposite when it is recognised that a decrease in anxiety and an increase in self-esteem are seen in student nurses who are received warmly into the clinical setting (Chesser-Smyth, 2005). Linnenbrink and Pintrich (2003) suggest that learner anxiety, general worries or other negative affective responses to learning will seriously detract from motivational engagement by students, with those who are anxious possibly experiencing cognitive difficulties with such aspects as recall, memory or misinterpretation of information (Suliman and Halabi, 2007).

Anxiety in the context of learning has been described by Santrock et al., (2010) as a vague, highly unpleasant feeling of fear and apprehension, and as students experience such feelings of tension, in a learning situation, their response to learning and their sense of believing they can achieve may be impacted. While feelings of anxiety may present as a challenge to learning, issues such as inadequate supervision, the absence of supportive relationships and access to teachers have been described by nursing students as situations where anxiety and stress were increased in clinical learning (Carlson et al., 2003, Cook, 2005; Levett-

Jones et al., 2009b, Reid-Searl et al., 2009). This findings were evident from my own participants.

Melincavage's (2011) phenomenological study findings identified themes which related to students' anxiety as experiencing inexperience, being demeaned, being exposed, unrealistic expectations, being abandoned, sensing difference and being uncertain about ability. Zupiria et al., (2003) supported and enhanced these findings in revealing that contributors to feelings of anxiety were lack of competence, self-efficacy relationships with tutors, classmates and workmates and uncertainty in the clinical setting. Self-efficacy affects how a person thinks, feels and acts and Bandura's (1997, 1986) description of self-efficacy is an individual's belief in their ability to perform well on a specific task or behaviour, in turn it is the individual's judgment of whether they have the capability to carry out a course of action required to deal with a situation.

Further Bandura (1997) contends that an individual's perception of self-efficacy is made up of two components, those being efficacy expectations and outcome expectations, whereas an outcome expectation is a person's estimate that the behaviour will lead to a specific outcome and an efficacy expectation is the belief that one can successfully perform the behaviour required to achieve an outcome. For an individual to successfully perform a task, both components of self-efficacy must be present. From the literature discussed it is suggested that anxiety may have a direct impact on nursing students' clinical achievements and self-efficacy, where the degree of trait anxiety will influence reaction to a given situation and the overall ability to be successful in the encounter.

Providing support for students both in the clinical and academic arena is a challenge for midwives and midwifery educators. When given the required support, students should be able to translate their theoretical knowledge and integrate it into practice.

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6.3 Dispossession

As discussed previously because the covenant set up between the participants, mentors and the faculty staff had been breached, the consequence became one of dispossession for the participants

6.3.1 Loss and bereavement

For some of my participants loss was described through experiences such as the loss of learning/experience opportunities, questioning their own knowledge base, the fear of not knowing and of asking. For others they discussed this in terms of concern in regards to their preparation for role of qualified midwife.

The literature favours exploring healthcare students acquisition of skills e by focusing on the clinical environment, which accounts for 50% of a student midwives' education. Longworth (2013) identifies that student midwives welcome frequent opportunities, in the clinical setting, to practise skills and that a supportive mentor was important to ensure the integration of theory to practice and adequate transfer of the newly acquired skills. Practicing within the clinical arena is unpredictable and constantly changing, so fostering optimal learning in such an environment is challenging (Papp et al., 2003). Demanding workloads, insufficient time for learning and high anxiety may lead students to adopt a superficial approach to learning during a period of clinical education. This can result in lack of personal connections, memory and of reflection (Fräsineanu, 2013).

Students may even fear failure in practice (Löftmark and Wikblad, 2001; Myall et al., 2008), with Hjalhmult (2009) and O'Brien et al., (2014) identifying that interaction between the learning environment, preceptors, students and faculty teachers, influences what and how students learn. Findings from my study have shown that with experience of loss came feelings of decreased competence and confidence and increased anxiety, vulnerability and stress. These findings are comparable with Celik and Bayraktar (2004) who examined nursing student abuse in Turkey.

Relationships with mentors are considered fundamental for midwifery students' confidence, whereby confidence was considered an integral component of

relationships and reduced anxiety (Jordan and Farley, 2008; Licquirish and Seibold, 2008). Brunstad and Hjälmhult, (2014) identified that the participants, from within their longitudinal study, wanted feedback from their mentors after learning situations; and when the feedback was vague, the students became insecure. Further, with this feeling of insecurity in their relationship with the mentor they withdrew from the situation. These aspects were described across the participants of my study.

Finnerty and Pope (2005) support the notion that fear and ambiguity hinder students. Astley-Cooper's (2013) findings identified what it meant for her participants to be denied access to the community of practice (clinical learning environment) and to be on the outside. This had a detrimental effect on the participants' sense of belonging, whereby they expressed feelings of being alone and confused; being alone held a measure of connotations including being invisible, isolated (working on their own without another colleague), separation, loss and loneliness. These findings concur with the outcomes of my study. Conversely, Atherton (2011) theorises that whilst ineffective learning might be attributed to lack of motivation, lack of aptitude or poor teaching, it could instead be as a consequence to the psychological 'cost' of learning. He proposes that, for some students, the process of learning necessitates significant changes, wherein they not only have to undertake 'additive learning' but also have to replace existing knowledge or attitudes in order to take on new ideas.

Although Fraser et al., (2013) found that student midwives valued midwife teachers for their unique and crucial role in supporting the application of knowledge to midwifery practice, further that good midwife teachers selected content and applied theory to practice according to what students needed at that time. In reviewing my methodological framework the position of relating to loss can be seen as, from Heidegger's perspective, *Das Suchen* – the seeking. For Heidegger every inquiry is a seeking, like a groping in the dark, in which an answer is sought.

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As a means of an example consider:

Question - Where is the learning?-*Das Suchen* – the seeking.

1. A seeking for the learning location;
2. The learning is asked about;
3. Locations are examined;
4. We want to know the learning's location.

Therefore, in order to seek *Dasein*, Heidegger refers to *Befragten*, which is the interrogation of a person. *Befragten* always requires a 'someone' to be questioned, in this case student midwives, in order to understand the meaning of the impact of inappropriate behaviour.

6.4 Liminality

Turner (1974, p. 237) describes liminality as:

“...representing the midpoint of transition in a status-sequence between positions, outsiderhood refers to actions and relationships which do not flow from a recognized social status but originate outside it, while lowermost status refers to the lowest rung in a system of social stratification in which unequal rewards are accorded to functionality differentiated positions.”

Rites of passage employs the concept of liminality to explain the process of transition between roles or positions in society (Van Gennep, 1960; Turner, 1967, 1969), also applying it to the entry into a 'new achieved status', for example, membership of a certain group (Turner, 1967, p. 9), in this instance the role of student midwife. Liminal people are structurally '*invisible*' – they are "*no longer classified and not yet classified*" (Turner, 1967, p. 96), therefore, do not belong to one or the other classification.

According to Cousin (2006, pp. 134 to 147):

“The idea that learners enter into a liminal state in their attempts to grasp certain concepts in their subjects presents a powerful way of remembering that learning is both affective and cognitive and that it involves identity shifts which can entail troublesome, unsafe journeys.”

6.4.1 **Angst and anonymity**

In relation to my study findings, the participants were indeed in the ‘outsiderhood’ (Turner, 1974) as their status as students was not at times recognised by clinical staff (invisible) and the un-equal rewards refer to, in this instance, the un-equal access to teaching opportunities. For my participants Cousin’s (2006) description of ‘unsafe journeys’ involved issues such as invisibility, being on their own, negative feelings, anxiety and working out how to become students and student midwives.

Findings from Vallant and Neville’s (2006) descriptive interpretive study revealed that the student nurse participants described themselves as invisible to the nurse clinician with whom they were working in the clinical setting. For them invisibility was being ignored or forgotten, also descriptions of invisibility in the relationship were seen in the interactions with the nurse clinician, resulting in students being marginalised or in failure to be acknowledged as individuals. It was the nurse clinician's attitudes, in these interactions toward the student nurse that were seen to be rendering the student invisible in the relationship.

The effects of clinical training experiences on healthcare students' self-esteem are brought up frequently, with Randle (2003) drawing attention to social interaction as having the capability to either build up or damage self-esteem. According to James and Chapman (2009) good self-esteem can be considered a prerequisite for students with a good outcome resulting from positive support. (Bradbury-Jones et al., 2010). Levett-Jones et al., (2009b) contend that students' self-esteem also seems to connect with their sense of security and empowerment. Furthermore, students' confidence, their motivation and career decisions can be influenced by

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their experiences of belongingness in clinical training (Levett-Jones et al., 2007; Levett-Jones et al., 2009b).

Belongingness also forms part of socialisation into a profession with Anant (1966 p61) defining it as a '*sense of personal involvement in a social system so that persons feel themselves to be an indispensable and integral part of the system*'. The inability to socialise into a profession through inappropriate behaviour has been shown to found to lead to low motivation, demoralisation and decreased patient care (Kramer, 1974).

Becker and Neuwirth (2002) contend that anxiety serves as a significant obstacle to achieving in the clinical setting, with consequences for the potential of students being unable to perform (Schmeiser and Yehle, 2001). Comments on students' impaired cognition while trying to perform in the clinical setting has been discussed by Meisenhelder (1987), supported by Kleehammer et al., (1990), following the exploration of anxiety-provoking situations for student nurses on clinical placement. Beck, (1993) also examined student nurses' initial clinical experience and found that a receptive environment from staff increased students' self-esteem and decreased their anxiety level over the course of the clinical placement. These findings relate to my participants' experiences.

6.5 Breaching covenant

This interpretive theme was developed through the sub-ordinate themes of inconsistent support, lack of acceptable support and poor attitudes and perceptions towards students, from the experiences of the participants.

Buante et al., (2012), within their study of experiences of student nurses' interaction with the staff nurses during clinical duty, found that that when students experienced relationships with clinicians as not being positive, this inhibited their achievements. Further they discuss the issues of the respondents having a hard time communicating with the staff nurses because most of them were not approachable and lacked interest in communication. And as a result of this,

student nurses lacked self-confidence and they hesitated to approach whenever they wanted to ask questions.

6.6 Dispossession

Clinicians and academic staff have long been aware that when, students are motivated events go more smoothly, communication flows, anxiety levels decrease and creativity becomes more evident (Wlodkowski, 1999). The findings from my study indicate a correlation with previous study outcomes. My participants offered experiences of questioning their own knowledge base in preparing for the role of qualified midwife as a consequence of being subjected to inappropriate behaviour. Fear was also highlighted. Heidegger distinguished between anxiety and fear declaring that *“We become afraid in the face of this or that particular being that threatens us in this or that particular respect, further identifying that fear, in the face of something, is also in each case a fear for something in particular”* (Heidegger, 1962, p. 140). For my participants’, the action of inappropriate behaviour brought about the fear of their loss manifesting in the fear of not knowing and fear of asking.

6.7 Liminality

Anxiety was highlighted and identified by my participants as often interfering with their practice placements and for some it and prevented them from taking advantage of practice opportunities. Researchers, such as Jarvis (2015), found that anxiety interferes with the process of thinking, ultimately impairing performance, which was the case from the findings of my study. Chamberlain (1997) described student nurse anxiety as due to inadequate instruction, supervision, role of transitioning to student, and poor communication, which interfered with students, leaving them feeling ill prepared to function as midwives, all of which were experienced by my participants. **Transitioning from different roles such as being a university student to being a student midwife in practice, potentially impacting on their socialisation role was also raised by some of my participants.** From Heidegger’s, (1962, p. 234) perspective, anxiety is probably best understood as a strong feeling of unease, where the individual no longer feels

'at home' within the world. This fits well with my participants' narrated experiences of being pushed out, self-doubt and loss of worth.

6.8 Hermeneutic circle

Heidegger developed a three-fold structure he called 'the fore-structure of interpretation': fore-having, fore-sight and fore-conception. Fore-having, according to Heidegger, (1962, p. 191), is where in every case the interpretation is based on 'something we have in advance', the background context in 'which *Dasein* knows its way about'... in its public environment (Heidegger, 1962, p. 405).

For example, a student midwife may already know from her/his background knowledge that inappropriate behaviour will have an impact upon her/him. Foresight is concerned with the fact that one always enters a situation, or experience, with a particular view or perspective. Fore-conception is the anticipated sense of the interpretation which becomes conceptualised.

As the researcher I had my own pre-understanding of the phenomenon I was investigating and, to unfold this understanding as experienced by my participants, I used the hermeneutic circle, as described by Heidegger, (1962), to grasp the existential issues involved in my participants' descriptions. The process enabled me to address the ways in which two people in dialogue, or myself reading a transcribed text, mutually transformed each other's notions through maintaining on-going interaction. As an individual 'in-the-world' my background practices allowed me to share my experiences with what I encountered in the world of my participants and to interpret in a circular movement.

The hermeneutic circle, when interpreting a text, requires a circular structure where the process of understanding encompasses somewhat that which is already understood. The hermeneutic circle relies on movement in circles from the whole to the parts, whereby deconstruction followed by reconstruction of the text occurs, from which shared understanding ensues (Ortiz, 2009).

Therefore, interpreting is a matter of reinterpreting. In examining this fact, Dreyfus, (1991, p. 36) explains that

“...in interpreting a text one must move back and forth between an overall interpretation and the details that a given reading lets stand out as significant.”

Consequently, each discrete detail revealed offers the potential to alter the interpretation by revealing new elements in a circle that enriches the comprehension of the whole text.

6.9 Summary of main findings

This study set out to explore the lived experiences of student midwives who had been subjected to inappropriate behaviour and to what extent any impact it had on them. I wanted to learn about what their perceptions of inappropriate behaviour were and in interrogating and analysing the data it became clear that they saw these acts to be single episodes carried out without malice or with intent to harm, primarily by clinical mentors. At the outset of this study I stated that I deliberately used the term ‘inappropriate behaviour’ in a broad manner, for the purpose of taking account of events and interactions that the participants themselves described. I choose this unrestricted definition because it was important to the purpose of my exploration that the student midwives themselves indicated what inappropriate behaviour meant to them and the potential impact it had on them. Ultimately, the participants provided a rich description of their perception of what an inappropriate behavioural act meant for them. From this I believe it is possible to consider, at this stage, a definition for inappropriate behaviour based on the findings of this study:

“Single acts which are perpetrated without malice or intent to harm but can have significant personal impact on the recipient.”

6.10 Reflexive account

Frosh and Emerson, (2005) explain reflexivity as a means of testing one's interpretations and taking accountability for the ways by which the researcher arrived at a particular 'understanding' of the data; in other words, making explicit the process by which we came to know. This explanation is fitting in regards to Heidegger's philosophical stance whereby I, as the researcher, am not disassociated from the research project but an active participant. Trustworthiness within phenomenology relates to whether the researcher has truly presented the essence of a phenomenon, as the researcher I cannot be a neutral observer, and on this basis reflexivity and self-awareness can be exploited and used as insight, thereby reducing subjectivity (Lipson, 1991).

The phenomenological researcher focuses on the way subject and object are enmeshed in pre-reflexive existence. One important route to understanding is to reflexively interrogate my subjectivity as part of investigating how the subject is present in the object. The phenomenologist uses the term reflexivity to characterise the way in which constituent dimensions serve as both foundation and consequence of all human projects. The task, then, of phenomenology is to make obvious the incessant tangle of reflexivity of action, situation and reality in the various modes of being-in-the-world (*In-der-welt-sein*).

Through the process of development and delivery of this thesis via writing, supervision and debates with my colleagues, I have learned much. I have enhanced my existing knowledge surrounding qualitative research in general and, especially, that of phenomenology to a point where I can contend that this methodology was appropriate for this study. My intent was to explore the lived experiences of student midwives' and had, therefore, developed the question and design to fit the research approach. I maintain that phenomenology remains the appropriate approach to allow me to investigate what it is like to be an individual and experience the phenomenon.

If I had not gone through my journey I believe I would have found great difficulty in communicating the justification for my research project. As the individual, I am a midwife, midwifery tutor, a nurse, a mentor and in the past a manager, whereby my experiences, within these roles, led me to make many assumptions as to

where midwifery practice and academic teaching is related to current student experiences. I have also been that student (and qualified midwife) experiencing the inappropriate behaviour. Due to this my experiences have aided the contextualisation of the interpretations of my participants' experiences.

A note of caution surrounds aspects of my experiences as they are of an historical nature, where issues such as societal, political and professional attributes have altered over time; and this caused me to think that my interpretations need to be wholly explicit in an attempt to undertake my study effectively. I have taken the findings of this study and applied them to my academic work both as a learner and as a teacher and, as a consequence, I have re-examined my approach to students in order to hopefully remove any aspect of inappropriate behaviour. In regards to myself as a learner, I will be more astute in not allowing any of the traits or acts as described in the findings to be endowed upon me as a means of limiting or impacting on my personal learning.

In adopting reflexivity into my journey I have acknowledged four key areas that have caused trepidation for me. Primarily, it was ensuring that I conducted the interviews appropriately; secondly, it was listening to student midwives' experiences and remembering that I am part of the profession that acted towards them in inappropriate ways, resulting in the outcomes discussed; thirdly, I realised that at times I could verbally articulate what I wanted and needed to say but had not been able, for whatever reason, to put it into words; and finally, the belief that I could achieve my Doctorate.

6.11 The interview process

I have worked as a nurse and midwife for over 30 years and as a midwife, manager, tutor and admission tutor. I have garnered a wide range of experience in interviewing and my confidence continues to increase with exposure. I have also conducted previous phenomenological studies and used semi-structured interviews as a means of data collection but for some reason this study made me very apprehensive regarding interviewing. On reflection, and after talks with colleagues, I believe it was because my Doctorate is so important to me, from a

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personal journey perspective that I did not want to do any injustice to the participant's words and experiences. My reflexive diary entry prior to my first interview detailed worries such as: will I lead instead of listen; will I remain conscious of the fact that I am seeking experiences and feelings and not what the participant thought?

After I had completed the initial interview, I returned home and transcribed it immediately, paying attention to my worries. Following transcription I listened again to the digital recording to reassure myself that I had captured appropriately the participant's experiences and that I had only asked for elaboration on aspects that had been raised and not what I thought had been said. In doing so, I was able to reassure myself. I used this technique for every interview as a marker of good practice.

6.12 Student midwife experiences

I have always been proud of being a midwife and never forget the privileged position I occupy in society. As a nurse and a midwife I have been a mentor to students, as well as being an academic tutor for students within the university arena. Whilst I have never had any complaints levied against me, I still reflect on my behaviour and mode of speech towards students. Whilst listening to the participants narrating their experiences, in regards to clinical practice and the academic arena, I came to realise that I was a member of a profession whereby I could be seen as part of the problem as well as part of the solution. Listening to some narratives made me feel ashamed, at times, of my professional colleagues both from within clinical practice and within faculty.

Remembering to remain a researcher and not to become a counsellor or comforter during these moments was very hard for me. By nature I am a very caring person and it went against all my personal beliefs not to reach out to these particular participants. My values and beliefs about my role in midwifery have been really challenged to the point where I considered if 'midwifery' was still right for me. I honestly believe that I have changed as a result of taking my research journey, not

just as an academic or midwife, but also as a person, which I find difficult to express.

Post-interview, I was able to remind students of where they could seek support if they wished to discuss the issues raised within the interview further. What surprised me was that having switched off the digital recorder some of the participants became more vocal about their experiences; on reflection, I considered that possibly the participants no longer saw me as a researcher at this point but more of a professional colleague. Even though I was taking some field notes at the time, I decided not to use the information given to me as part of the data set as I, morally, could not convince myself that it was told to me in my remit of 'researcher'. For myself, I was able to utilise my Supervisor of Midwives (SOM) and my doctoral supervisor to debrief. This worked well as my SOM gave me counsel regarding professional practice and my supervisor, who is not a midwife, could look on in a more pragmatic and practical manner and prompt me to place aspects into context.

6.13 Reflexive diary

During my journey I maintained a reflexive diary so that I had a record of where I came from and where I had arrived on completion of my thesis. As an individual, I have never really had an enormous amount of confidence in myself but give me a role such as midwife or academic and then I am fuelled with confidence. As explained previously, I have been that student and midwife who has experienced inappropriate behaviour which, in turn, had a major impact upon me. As I have progressed through my journey of study I have learnt that no amount of letters after your name can change how you feel about yourself; however, since starting my doctoral thesis I have had to challenge myself and really look at me. From the outset my journey was about me and I soon understood that in essence whether, or not, I achieved my doctorate was not the point of the journey; it was never about the cap and gown. For me it was about personal discovery. I look forward to my viva, where I will have the opportunity to celebrate and discuss my research. I recognise that my findings may never change the world but at the end of the day it

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was my journey – and I intend to embrace the end. Excerpts from my diary are included in Appendix 9.

6.14 Chapter conclusion

This chapter provided a discussion of the study's findings in relation to contemporary literature and their application to practice. The three interpretive themes, resulting from analysis, have been discussed and examined from Heidegger's perspective in regards to the action of inappropriate behaviour and the impact on the participants'. Through the exploration of reflexivity I have demonstrated my ability to discuss my relationship, as the researcher, with the participants during the interview process, acknowledged my influence on stages of the research process, evidenced my self-awareness and insight and finally provided, in the form of extracts from my reflective diary, the effects of the research on me (Appendix 9).

Chapter 7 CONCLUSION AND RECOMMENDATIONS FOR PRACTICE

7.1 Introduction

The research question:

What is the lived experience of student midwives subjected to inappropriate behaviour, within their practice and academic environments?

was set to examine the lived experiences of student midwives who had experienced inappropriate behaviour and describe any impact it had had upon them. A hermeneutic phenomenological approach was adopted incorporating an interpretive mode for data analysis. I believe that I have established a credible positive response to my question, in that my participants were able to articulate and offer personal meaning to the term inappropriate behaviour and further bring meaning to the impact this had had on them.

Having scoped the literature, it is apparent that there is a plethora of evidence which examines bullying and the physical and psychological effects that it manifests. However, there is, at the time of this review, no evidence available to address the issue of the effect of firstly inappropriate behaviour, as a unique concept and secondly any impact that it may have on student midwives. This project aimed to address this deficit. This chapter presents the main conclusions that have emerged from the study.

7.2 Study conclusions

For the participants', inappropriate behaviour was seen as single acts most commonly perpetrated by mentors, without a sense of malice or intention to cause harm. It is important that the difference between bullying and inappropriate behavioural acts become known by of all those involved with student midwives' education and a concerted effort in changing attitudes is made to enable the development of both clinical and academic environments, where inappropriate behaviour is strongly contested and vigorously opposed.

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During data collection, the participants were asked to recount a significant experience or experiences they had had with behaviour that they felt was inappropriate. Initial themes highlighted experiences of struggling, being out of sight out of mind, loss and bereavement; and betrayal. The final themes emerged as experiences of breaching covenant, dispossession and liminality, were predominantly associated with participants.

From the findings, inappropriate behaviour was seen as single acts most commonly perpetrated by mentors, without a sense of malice or intention to cause harm. For them, there was clear distinction between their perception of bullying and inappropriate behaviour. This perception sits well with the literature that indicates that acts of non-bullying, as opposed to bullying, can be extremely damaging and should be considered equally unacceptable (Pope and Burns, 2009). As identified inappropriate behavioural acts, as described by my participants, were subtle in nature and, therefore, could be considered by onlookers or by whom the behaviours are discussed with by the student as subjective, in turn proving difficult to both challenge and contest. More over its subtle form makes it more difficult to detect (Lim and Lee, 2011).

On this basis it is hoped that the same attention will be given to those who are subjected to acts of inappropriate behaviour as are given to bullying, in respect of support for the victim and recognition of the impact.

7.3 Recommendations

Primarily, there needs to be a conservative effort in changing attitudes of all those involved with student midwives' education to enable the development of both clinical and academic environments where inappropriate behaviour is discussed strongly contested and vigorously opposed. It is important that the difference between bullying and inappropriate behaviour becomes known. My study's findings showed it was not the persistent acts of what could be termed bullying which impacted on the participants, it was just single acts of what has been described as nuances of inappropriate workplace behaviours which, potentially due to their nature or infrequency, may well not be classed as bullying and for that

rationale have a tendency to be either overlooked or treated as part of the rough and tumble of organisational life (Pearson et al., 2001).

Dissemination needs to occur to all who are involved in midwifery education, including stakeholder colleagues. Midwifery curricula, be it undergraduate or post qualifying, need to be developed which clearly discuss inappropriate behaviour in its own frame of reference and not as a part of bullying education.

The undergraduate curriculum needs to support the student midwife to be able to recognise acts of inappropriate behaviour and develop and action leadership when dealing with clinical, or faculty staff, who portray inappropriate behaviour towards them. Rees et al., (2013) analysed narratives from medical students who described common professional dilemmas in clinical practice, which involved conflict between their own learning and that of students experiencing abuse and the emotions experienced at the time. One of the responses to verbal abuses adopted by participants was to challenge the perpetrator; however, there was recognition of the potential risk for retribution, such as impact on future job prospects.

My participants described experiences and meanings of inappropriate behaviour, within this thesis, that are factual. However, the initial inability to have labelled inappropriate behaviour acts, as such, potentially impeded any real action being adopted to wipe this out. Although discussing bullying, I believe Hadkin and O'Driscoll's, (2000) comment that by not having a label it becomes difficult for victims to understand what is happening to them, as well as onlookers, to be just as pertinent to the acts of inappropriate behaviour.

Recommendations:

1. A **philosophy** needs to be established and embraced in which the practice and academic arenas have a heightened awareness of inappropriate behaviour and its differing attributes to bullying, whereby it is challenged and positive behaviours endorsed.

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2. Initially, this awareness needs to be addressed by healthcare and education providers, who have the power to prevent and manage acts of inappropriate behaviour and to challenge culture.
3. Whilst it is acknowledged that there are existing policies and procedures which address ways of educating healthcare staff in acceptable behaviour, greater emphasis needs to be placed on the characteristics of inappropriate behaviour, as a unique concept, and incorporated into such policies and procedures to support provider's strategic commitment to dealing with inappropriate behaviour.
4. Focus on curricula within student midwife education in order to develop insight into their own behaviour and its impact on others; creating a shared understanding of what is acceptable and unacceptable behaviours.

These recommendations in some way meet with the findings of the Francis Report, (2013, p. 105), recommendations surrounding the selection of recruits to the healthcare profession whereby they need to evidence the possession of the appropriate values, attitudes and behaviours. This can hopefully ensure that future students can support a culture whereby inappropriate behaviour is challenged.

The NMC, (2009) advocated the involvement of student midwives in the design of curricula and this could be an opportunity to embed insight into their own behaviour, behaviours experienced and impact on others; creating a shared understanding of what is acceptable and unacceptable. Student midwives and qualified midwives and faculty need be advocates for change by actively participating in changes geared toward eradicating inappropriate behaviour. Collaboration with all sectors, such as policy makers, hospitals, stake holders and healthcare professionals, should be invoked to ensure that all appropriate resources are available to address this issue.

7.4 Possibilities for further research

In this phenomenological study, the richness of the collected data can never exhaust the option for more interpretations but continuously leaves open doors to be explored. Furthermore, an existential interpretation of an individual is a process

of becoming; thus, research needs to be done in this area where complementary studies could enlighten different meanings in the living experience.

Having investigated from the perspective of student midwives, insight into the impact that inappropriate behaviour may have upon qualified midwives may provide greater understanding of the phenomenon.

7.5 Evaluation of study and limitations

The findings of this study should be considered in light of its limitations. At the outset of this study the term inappropriate behaviour was an amorphous concept and I could not guarantee equivalence of understanding between myself as the researcher and the student participants.

I acknowledge that I commenced this study with the firm aim of discovering if inappropriate behaviour, and not bullying, had an impact upon the participants. It was vital that I had not intentionally or unintentionally influenced the participants in their perception of what inappropriate behaviour meant for them. I reflected on this point, following comments from my supervisor, and reviewed the transcripts again. I listened to ensure that I had not led the participant, nor that I used any form of inflection in my voice, when asking the initial question.

Geographically, the study was confined to the UK, which does limit any transfer claims however, there is no reason to believe that experiences of midwifery students in this study might differ significantly to other students, which makes transferability to other contexts a possibility.

The interviewing of only eight participants could be seen as a limitation to this study, in respect of the quantity of data collection in order to offer both credible analysis and reporting. I have offered my justification on using eight participants in Chapter 4 and I believe my sample size has enabled me to gain an insight into the lived experiences of the participants.

Finally I am honoured and privileged that my participants gave of their time and trusted me with their narratives, which enabled me to give them a voice.

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'Voice is the overlapping of the four parts of our nature: our body, our mind, our heart, and our spirit'.

Stephen R. Covey

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Appendix 1 - Literature Selection – incorporating key texts identified within pre and post data analysis

Study	Sample	Country	Methodology	Findings	Considerations
Björkqvist et al 1994 Aggression among university employees	N = 338 University employees N = 19 interviews	Finland	Employed WHS* and other factors e.g. style of communication in work group, experienced reasons for harassment, gender. Applied scales to measure depression and anxiety. Clinical interviews also conducted. (*Work Harassment Scale)	Victims experienced significantly more depression, anxiety and aggression than non-victims NB Interviews with victims, victims claimed feelings of depression etc. were a direct result of harassment. Also reported other ill health e.g. insomnia, apathy, lack of concentration, melancholy, various nervous symptoms and sociophobia.	Cross sectional. Recall bias of victims.
Leymann 1996 The content and development of mobbing (also known as bullying in some countries) at work	N =2400 (representative sample)	Sweden	Interviews. Bullying measured using LIPT* (*Leymann Inventory of Psychological Terrorization)	3.5% were mobbed 10-20% of mobbing victims seem to contract serious illness or commit suicide.	Self-reported ill-health. Difficult to estimate cause of suicide. Latent mental health problems.

Appendix 1

Study	Sample	Country	Methodology	Findings	Considerations
<p>Leymann and Gustafsson 1996 Mobbing at work and the development of PTSDs</p>	<p>2 studies: N = 2428 N = 64 Swedish workers</p>	<p>Sweden</p>	<p>a) Interviews with people (representative of Swedish population) using LIPT and stress symptoms b) Patients at a rehabilitation clinic. Used lots of psychological tests e.g. Beck Depression inventory</p>	<p>Study a 14.4% subject to mobbing Symptoms reminiscent of PTSD or Generalised Anxiety Disorder eg., memory disturbances, chest pains. Classified into groups: Cognitive effects of stressors leading to psychological hyper-reactions; syndrome with psychosomatic stress symptoms; symptoms associated with production of stress hormones and activation of autonomic nervous system; muscular tension; sleep problems.</p> <p>Study b Confirmed diagnosis of PTSD with 92% of patients. Conclusion: Bullying can lead to certain PTSD symptoms as severe as those experienced by rape victims, and worse than those experienced by train drivers who hit people on the tracks.</p>	<p>Study a Use of LIPT (item generation very subjective) Cross sectional</p> <p>Study b Sample –potentially skewed (i.e. bullied targets being rehabilitated at time of study), difficult to extrapolate whether bullying caused symptoms. Debate over PTSD</p>

Study	Sample	Country	Methodology	Findings	Considerations
Niedl 1996 Mobbing and wellbeing: economic and personal development implications.	N = 368 Austrian hospital staff	Austria	Postal questionnaire. Used revised version of LIPT and Mohr's scales for psychological impairment and well-being	Bullied significantly lower on anxiety, depression, irritation and psychosomatic complaints (but not self-esteem) than non-bullied	LIPT = low response rate (29%) possibility that data skewed. Cross sectional
Einarsen and Raknes 1997	N=64 Male employees in Norwegian marine engineering industry	Norway	Questionnaire survey Used NAQ* and measures of job satisfaction and a six item scale to measure psychological health and well-being *Negative Acts Questionnaire)	Those who experienced bullying behaviours, particularly when experienced consistently and systematically had significantly health consequences. Poor psychological health was particularly associated with persona; degradation type behaviours.	
Hoel and Cooper 2000 Destructive conflict and bullying at work	N = 5288 from over 70 different organisations across occupational life.	United Kingdom	Postal survey. Provided definition of bullying and enquired whether respondents believed they were bullied. Enquires independently about being exposed to negative social acts. Management style, work environment, using standardised tool, also explored	Health outcomes measured using General Health Questionnaire and Occupational Stress Indicator. 1 in 10 prevalence (10.6%) identified having been bullied within the previous six months, rising to one in four (24.7) when the period was extended to the previous five years. Almost one in two (46.5%) had witnessed bullying taking place within the previous five years. Particular prevalence was found in the: prison service (16.2%), post and telecommunications (16.2%), teaching (15.6%) and the dance	Cross-sectional study. Use of norm-referenced health measures.

Appendix 1

Study	Sample	Country	Methodology	Findings	Considerations
				<p>profession (14.1%). A greater proportion of women bullied compared with men, 11.4% for women as opposed to 9.9% for men. This difference increased when the period was extended to five years (27.7% for women against 22.0% for men). Compared to general population norms, there were much higher levels of mental and physical ill health for currently bullied people. Regular exposure to bullying associated with higher levels of ill health than occasional exposure. Experience of bullying related to higher scores of negative management style, such as autocratic, divisive, laissez-faire and non-contingent.</p>	

Study	Sample	Country	Methodology	Findings	Considerations
<p>O'Moore et al 1998 Victims of bullying at work in Ireland</p>	<p>N = 30 Variety of occupations</p>	<p>Ireland</p>	<p>Sample consisted of the first 30 people who referred themselves to the Irish Anti-bullying research and resource centre One-to-one interviews (average of 3 hours in length)</p>	<p>All had experienced direct verbal aggression and felt humiliated by belittling remarks, and had experienced indirect aggression (e.g., rumours, criticism of work, unrealistic work targets, and isolation). All had experienced psychological symptoms because of bullying e.g., anxiety, irritability, depression, withdrawal, lowered self-esteem etc. 93% had experienced physical symptoms: most common disturbed sleep, lethargy, stomach disorders, and headaches. 87% had taken sick leave because of bullying. 90% reported leadership to be autocratic, 83.3% found environment was competitive, 77% said work environment was strained and stressful, and 40% were satisfied with feedback about work that they received.</p>	<p>Small sample. Potential for skewing of data as participants' self-referred. Self-reporting Possibility that participants reflected experiences of a single group of people who may be seeking redress for being bullied or as a cathartic process.</p>

Appendix 1

Study	Sample	Country	Methodology	Findings	Considerations
Quine 1999 Workplace bullying in NHS Community Trust: staff questionnaire survey.	N = 1100 NHS Community Trust staff	United Kingdom	Anonymous postal survey 20 item inventory of bullying behaviours (have you experienced these in past 12 months?) including various other scales e.g., HAD scale, job satisfaction, support at work. (*Hospital Anxiety and Depression scale)	1100 employees returned questionnaires 421(38%) employees reported experiencing one or more types of bullying in the previous year. 460(42%) had witnessed the bullying of others. When bullying occurred it was most likely to be by a manager. Two thirds of the victims of bullying had tried to take action when the bullying occurred, but most were dissatisfied with the outcome. Staff who had been bullied had significantly lower levels of job satisfaction (mean 10.5(SD 2.7) v 12.2(2.3), P<0.001) and higher levels of job induced stress (mean 22.5(SD 6.1) v 16.9(5.8), P<0.001), depression (8% (33) v 1% (7), P<0.001), anxiety (30% (125) v 9% (60), P<0.001), and intention to leave the job (8.5(2.9) v 7.0(2.7), P<0.001	Cross sectional. Good response rate (70%). B measure: no information on frequency of behaviours experienced

Study	Sample	Country	Methodology	Findings	Considerations
Quine 2001 Workplace bullying in nurses	1100 completed questionnaires (Response rate of 53% - n=778) Nurses reporting Bullying	United Kingdom	Anonymous postal survey Scales measured occupational health, support at work, propensity to leave, Hospital Anxiety and Depression Scale, perceptions of the organisational climate and experience of bullying behaviours.	Respondents were asked whether they had persistently been subjected to any behaviours over last 6 months. 26% reported bullying affected health. Key symptoms included misery and depression, increase in stress levels, feeling you don't want to go to work. Statistical findings showed, bullying was identified with significantly: lower levels of job satisfaction higher inclination to leave more probability to suffer depression increased days off work through sickness Qualified nurses more likely to have been subjected to bullying as opposed other staff.	Worth noting that perceptions of the work environment may well be mediated by various factors, including negative affect and other personal variables.

Appendix 1

Study	Sample	Country	Methodology	Findings	Considerations
<p>Zapf et al 1996 On the relationship between mobbing factors, and job content, social work environment and health outcomes</p>	<p>N = 50 N = 99 Non-random, participants derived from adverts in publications (newspaper etc)</p>	<p>Germany</p>	<p>Used LIPT N = 50 questionnaires of which 19 also interviewed., N = 99 questionnaires. Other scales measure health outcomes e.g., Mohr's scale. Compares mobbed and control group. Work and job factors were measured: Complexity Control over tasks Variability Control over time Communication possibilities Co-operation requirements Social climate</p>	<p>Confirmed Niedl' s (1996) results: All mental health variables (psychosomatic complaints, irritation, depression and self-esteem) showed significant differences between control and bullied group. Attacking private person is the key behaviour linked with poor health. Bullied had significantly higher control over tasks (than worker samples, but not control group), cooperation requirements (ie, being forced to work together) and social stressors. They had lower control over time and lower supervisor and colleague social support.</p>	<p>Small sample size Large number of variables can inflate some correlations. Self-selected sample.</p>
<p>Robinson and Morrison's (2000)</p>	<p>147 employees who had recently earned their MBAs and begun new full-time jobs</p>	<p>USA</p>	<p>Postal Survey sent at the beginning of new job and 18 months later</p>	<p>Perceived contract breach at 18 months was more likely when: •organizational performance and self-reported employee performance were low, -•the employee had not experienced a formal socialisation process, •the employee had little interaction with organizational agents prior to hire,</p>	<p>Reneging, incongruence, and vigilance not actually measured therefore not possible to draw conclusions regarding the mediating process linking the</p>

Study	Sample	Country	Methodology	Findings	Considerations
				<p> <ul style="list-style-type: none"> ▪the employee had a history of psychological contract breach with former employers, ▪the employee had many employment alternatives at the time of hire. Perceived breach associated with more intense feelings of violation when employees both attributed the breach to purposeful renegeing by the employer and felt unfairly treated in the process significantly related to stress after other work environment factors had been controlled for. </p>	<p> independent variables to perceptions of contract breach. Psychological contract breach, focused on employees who had recently begun new jobs therefore unable to conclude that the same results would be found for employees in longer employment. Potential that by measuring perceived contract breach by asking employees to determine how well their psychological contract had been becomes subjective in nature, and hence open to error. Cross sectional. Self-report. </p>

Appendix 1

Study	Sample	Country	Methodology	Findings	Considerations
					Only used a limited number of work environment measures. Single item measures.
Begley 2002 Are student midwives influenced by the 'traditional' (non-evidence-based) practices of their clinical mentors?	122 studies		Structured literature review. 122 studies were retrieved for detailed evaluation via electronic to access midwifery, nursing and educational journals. Textbooks and governing health professional websites were also accessed. Key words were typed into the search engines. Data that matched the inclusion criteria were scanned and, where relevant, the evidence was critically appraised to assess the study's validity.	Both professional and organisational constraints prevent students and practitioners from using evidence in practice. Some studies identified inconsistencies between what students were taught in the university and what was taught in practice and this may have contributed to widening the theory practice gap. However, there is limited published data making specific reference to the influence of clinical mentors or student midwives' practice.	Majority of studies investigated explored the experiences of pre-registered nursing students and nurse practitioners and many used a qualitative approach. Therefore it is not possible to make generalisation of how student midwives may behave.

Study	Sample	Country	Methodology	Findings	Considerations
<p>Licquirish and Seibold, 2008 Bachelor of Midwifery students' experiences of achieving competencies: The role of the midwife preceptor</p>	<p>8 Bachelor of Midwifery students completing their final clinical placement.</p>	<p>Australia</p>	<p>Grounded theory methodology using in-depth interviews for data collection</p>	<p>Categories: hands-on practice; reflecting on practice; building confidence; gaining knowledge; working with midwives; and constructing a sense of self as a midwife. Only one category explored - working with midwives, which encompassed the therapeutic, interpersonal and clinical characteristics of the preceptor and impact on student learning. Preceptors identified as helpful and unhelpful, and students indicated preference for working with caring midwife preceptor, Also felt that they benefited from opportunities for responsibility for care under supportive supervision, hands-on learning and debriefing. Midwife preceptors described as unhelpful poor role models.</p>	<p>Small group of student midwives sampled from one university Lack of interview data from midwife preceptors.</p>

Appendix 1

Study	Sample	Country	Methodology	Findings	Considerations
Budden et al., 2015 Australian nursing students' experience of bullying and/or harassment during clinical placement	Undergraduate nursing students' (N=888)	Australia	Prospective cross-sectional survey	50.1% of students indicated they had experienced this behaviour in the previous 12 months. Younger students were more likely to be bullied/harassed than older students ($p=0.05$). Participants identified perpetrators of bullying/harassment as registered nurses (56.6%), patients (37.4%), enrolled nurse's (36.4%), clinical facilitators (25.9%), preceptors (24.6%), nurse managers (22.8%) and other student nurses (11.8%). The majority of students reported that the experience of being bullied/harassed made them feel anxious (71.5%) and depressed (53.6%). Almost a third of students (32.8%) indicated that these experiences negatively affected the standard of care they provided to patients with many (46.9%) reconsidering nursing as their intended career.	Possibility that the title of the survey attracted only those participants who felt they had an experience to report, therefore biasing the sample. Title may have deterred those who did not wish to revisit a prior negative experience. The decision not to define the terms bullying or harassment may have proven constraining for some respondents.

Study	Sample	Country	Methodology	Findings	Considerations
<p>Vartia 2001 Consequences of workplace bullying with respect to the well-being of its targets and the observers of bullying</p>	<p>N = 949 Variety of occupations from municipal sector</p>	<p>Finland</p>	<p>Used revised LIPT and items measuring psychological health symptoms, mental health and psychological work environment. Single items measured psychological work environment. These included: Haste Goal clarity Excessively difficult tasks Amount of joint meetings at workplace Changes at work anticipated</p>	<p>Targets and observers experienced more general stress and mental stress reactions Targets more likely to report low self-confidence sense of fear. Stress reactions were predicted by bullying, haste, excessively difficult tasks and poor goal clarity. Particular forms of bullying = ill health: Judging a person's work performance wrongly/in an offending manner linked to general stress; assaulting private life and judging work wrongly = mental stress; meaningless tasks and restricting possibility to express opinions = low self-confidence. Features of work measured (psychological work environment and characteristics of work e.g., haste at work, work tasks that are too difficult) were a significant explanatory factor for being a target of bullying: 20-25% of variance of reported stress. Bullying alone = 5% of variance. Bullying remained significantly related to stress after other work environment factors had been controlled for.</p>	<p>Both single-item measures and sum scales were used in measuring psychological health and well-being. While sum scales are generally considered more valid than single-item measures, validity research has shown that single-item stress measures can be valid on the group level. Long-term conclusions about stress on the individual level cannot be drawn on the basis of only 1 question (26).</p>

Appendix 2 - Ethical Approval

Student Research Project: Ethics Review Checklist - Form CH2-Student

This checklist should be completed by the researcher (with the advice of the research supervisor/tutor) for every research project which involves human participants. Before completing this form, please refer to the Ethical Guidelines in the School's Research Student Handbook and the British Educational Research Association guidelines (<http://www.bera.ac.uk/guidelines.html>).

Project Title:

Inappropriate behaviour within midwifery practice: impact on continuing professional development

Researcher(s): Jane Johnston Student ID number: 21906289.....

Supervisor: Dr F Maringe..... Email: Felix.Maringe@soton.ac.uk

Part One	YES	NO
1. Does the study involve participants who are particularly vulnerable or unable to give informed consent? (e.g. children with special difficulties)		X
2. Will the study require the co-operation of an advocate for initial access to the groups or individuals? (e.g. children with disabilities; adults with a dementia)		X
3. Could the research induce psychological stress or anxiety, cause harm or have negative consequences for the participants (beyond the risks encountered in their normal life and activities)?		X
4. Will deception of participants be necessary during the study? (e.g. covert observation of people)?		X
5. Will the study involve discussion of topics which the participants would find sensitive (e.g. sexual activity, drug use)?		X
6. Will the study involve prolonged or repetitive testing or physical testing? (e.g. long periods at VDU, use of sport equipment such as a treadmill) and will a health questionnaire be needed?		X
7. Will the research involve medical procedures? (e.g. are drugs, placebos or other substances to be administered to the participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?)		X
8. Will financial inducements (other than reasonable expenses or compensation for time) be offered to participants?		X
9. Will you be involving children under sixteen for whom additional consent will be required?		X
10. Will you have difficulties anonymising participants and/or ensuring the information they give is non-identifiable?		X
11. Will you have difficulty in explicitly communicating the right of participants to freely withdraw from the study at any time?		X
12. Will the study involve recruitment of patients or staff through the NHS?	X	
13. If you are working in a cross-cultural setting will you need to gain additional knowledge about the setting to be able to be sensitive to particular issues in that culture (e.g. sexuality, gender role, language use)?	N/A	
14. Will you have difficulties complying with the Data Protection Act (e.g. not keeping unnecessary personal data and keeping any necessary data locked or password protected)?		X
15.		
16. Are there potential risks to your own health and safety in conducting this research (e.g. lone interviewing other than in public space)?	X	

11 Feb 08

Appendix 2


To be completed by the Supervisor (PLEASE TICK ONE)

Appropriate action taken to maintain ethical standards - no further action necessary. This project now has ethical approval.

The issues require the guidance of the School of Education's Ethics Committee. This project does not yet have ethical approval.

COMMENTS:

Signed (supervisor on behalf of SoE Research Ethics Committee):

Date:  24 MARCH 2010

There are aspects to research governance that lie outside 'ethics', but which are important for you to consider. These include data protection, insurance, and health and safety issues. You should seek advice re same from your Supervisor in the first instance, and then if necessary from your Programme Director.

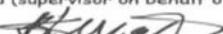
To be completed by the Supervisor (PLEASE TICK ONE)

Appropriate action taken to maintain ethical standards - no further action necessary. This project now has ethical approval.

The issues require the guidance of the School of Education's Ethics Committee. This project does not yet have ethical approval.

COMMENTS:

Signed (supervisor on behalf of SoE Research Ethics Committee):

Date:  24 MARCH 2010

There are aspects to research governance that lie outside 'ethics', but which are important for you to consider. These include data protection, insurance, and health and safety issues. You should seek advice re same from your Supervisor in the first instance, and then if necessary from your Programme Director.

From: Edwards R.S.
Sent: 15 February 2012 17:02
To: Johnston J.D.T.; Boak S.L.
Subject: RE: Ethics Submission

Under these circumstances, we are able to give ethical approval to your amendment. Sarah will send you a formal email in due course.

Best wishes

Ros

Rosalind Edwards (Chair SoE Ethics Committee)

Professor of Sociology

Sociology and Social Policy / Social Sciences

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Appendix 3 - Consent

(On School of Education headed paper)

CONSENT FORM – Part 1

Study title:

The lived experience of student midwives subjected to inappropriate behaviour: Their stories depicting issues of learning deficit

Researcher Name: Jane Johnston

Lecturer in Midwifery,

School of Education

University of Southampton

Highfield,

Southampton, SO17 1 BJ

Ethics reference:

Please initial in the box if you agree with the statement(s):

I confirm that I have read and understood the information sheet for the above study (date/version no.). I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.

I understand that I do not have to take part and that I am free to change my mind without giving any reason (even if this is part way through the interview) without my legal rights being affected

I agree to take part in this research project and for my interview to be recorded and agree for my data to be used for the purpose of this study

I agree to the confidentiality policy set out in the information sheet

I agree to the storage of information about me as set out in the information sheet

Appendix 3

I agree to the use of direct quotes in research reports and publications

I confirm that I have been informed of where I can obtain support, should I require this.

Name of participant (print name).....

Signature.....

Date.....

Part 2

I understand that I will be able to choose a pseudonym for use in the study to protect my identity.

My real name is:

The name I have chosen is:

NB This part of the form will be shredded once your chosen name has been recorded. Once this is done, your chosen name will not ever be stored in the same place as your real name.

Suggested support mechanisms

Named Academic Tutor

Named Pastoral Tutor

Cohort appointed Supervisor of Midwives

Student Support Services

Student Pastoral Services

Student Counselling Service

Appendix 4 - Thank you letter

(On School of Education Headed Paper)

Dear

This is a follow up letter to thank you for taking part in my research study.

Please be reminded of the following, should you require any support following your participation:

Named Academic Tutor

Named Pastoral Tutor

Cohort appointed Supervisor of Midwives

Student Support Services

Student Pastoral Services

Student Counselling Services

Regards,

Jane Johnston

Appendix 5 - Participants' Information Sheet

(On School of Education headed paper)

Participant Information Sheet

Study Title: The lived experience of student midwives subjected to
 inappropriate behaviour:

Researcher: Jane Johnston

Please read this information carefully before deciding to take part in this research. Should you consent to participate you will be asked to sign a consent form.

I would like to invite you to take part in a research study. Before making your decision you need to understand why the research is being undertaken and what it would involve for you. Please be kind enough to take time to read the following information carefully. Discuss the research with other people if you wish. Take time to decide whether or not you want to take part.

- Part 1 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 contact me if there is anything that is not clear or if you would like more information (telephone Jane Johnston 07855565685 or email jdtj@soton.ac.uk).

Part 1: What is the purpose of the study?

The purpose of this study, being undertaken as part of an Educational Doctorate, is to explore the lived experiences of student midwives who have been subjected to inappropriate behaviour, within clinical practice or the academic environment.

The term 'bullying' is well recognised and there is legislation in place in order to protect individuals however, there are nuances of inappropriate workplace

Appendix 5

behaviours which, potentially due to their nature or infrequency, may well not be classed as bullying. Due to this there is a tendency for this type of behaviour to be either overlooked or treated as part of the rough and tumble of organisational life, therefore, these issues are not normally seen to fit the criteria warranting investigation. It is possible that these incidents are just as important and deserve recognition, in order to highlight the potential outcomes for student midwives either in the clinical or academic environment.

What are the possible disadvantages and risks of taking part?

You may find it upsetting to talk about what the outcomes of certain types of behaviour have had on you and you will be able to say that you do not wish to talk about a particular aspect of it or withdraw from the discussion at any time. I will give you details of sources of support you can contact if you do feel upset afterwards.

What are the possible benefits of taking part?

I cannot promise that the study will help *you* but I hope that the information gained will help inform practice and or the academic environment of what inappropriate behaviour is and identify the effects that impact on the ability to learn.

Will my taking part in the study be kept confidential?

Yes. I will follow all required ethical and legal practices and all information about you will be handled in the strictest confidence. The details are included in Part 2 of this information sheet. No one else will know that you have taken part in this study, unless you choose to say.

What happens after our meeting?

I will contact you after our meeting to thank you for your participation in the study.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. The details are included in Part 2 of this information sheet.

Thank you for taking time to read this sheet.

This completes Part 1 of the information sheet.

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

(On School of Education headed paper)

Information about the research.

Part 2

Will my taking part in the study be kept confidential?

All the information which is collected from you, during the research, will be kept strictly confidential.

How will you protect information about me?

The reply slip that you return to me will be stored in a locked cabinet within a locked office. One copy will be taken and placed in a sealed file in second secure location. The name that you choose, for identification purposes for this study, will never be stored with your real name or personal details.

I am overseen throughout this research study by my supervisors.

I will take personal responsibility for the transcription and analysis of the interview data. Interview recordings and transcripts will not be identified with your real name. Once the study has been completed, records of all your personal details will be destroyed. You will be given a choice as to what happens to the recording. The usual research practice is that the recording is securely stored at the university for 15 years. If you do not wish for this to happen, I will personally destroy the recording once my Doctorate is completely finalised, however, if that method is adopted then one of my supervisors will be required to listen to parts of the recording in order to verify that I have transcribed what you said accurately. The transcripts will be kept for 15 years, at the university, in a locked place with limited access and will then be disposed of securely.

If you are willing to participate I will need you to give written consent to these arrangements.

Who is organising this research?

This research forms part of a Doctorate in Education and is being organised through the University of Southampton and developed in collaboration with the School of Education.

Who has reviewed the study?

All research is examined at by an independent Research Ethics Committee to protect your safety, rights and dignity. This study has been reviewed by the School of Education Ethics Committee at the University of Southampton.

What if there is a problem?

If you have any concerns regarding any aspect of this study, please contact my Supervisor at the University of Southampton:

Dr Felix Maringe

School of Education

Email: Felix.Maringe@soton.ac.uk

If you feel that your concerns remain unaddressed and wish to complain formally, you can do this in writing to:

School's Research Director

School of Education,

University of Southampton,

Highfield,

Southampton S017 1 BJ

The letter should specify:

- the title of the research project
- the nature of the complaint

Further information and contact details

For any further information about the research contact:

Jane Johnston

Lecturer in Midwifery

University of Southampton

Highfield

Southampton

S017 1 BJ Telephone: 07855565685

Email: jdtj@soton.ac.uk

Appendix 6 - Reply slip

(On School of Education headed paper)

Reply Slip

I am willing to be contacted

I have some questions I would like to ask about your research

My name is.....

The most convenient way to contact me is

By telephone – My number is.....

If I cannot answer the telephone I happy for you to leave a message

YES

NO

(Please be aware that I would only identify myself by my name if I left a message for you)

The most convenient time for you to contact me is

Email – my email address is.....

Other – please give details

Appendix 7 - Prompt sheet

- Welcome participant
- Offer the participant the opportunity to choose/confirm own pseudonym for the research.
- Check that participant has signed the consent form.
- Check that participant has consented to semi-structure interview being tape recorded.
- Ensure that participant understands that they may withdraw consent.
- Ensure that participant is comfortable.
- (If not in their own home offer refreshment)
- **Opening Question**
- Can you describe or walk me through a significant experience or experiences you have had with behaviour that you define as inappropriate?
- **Continuing prompts**
- To elaborate on responses:
- What did you mean...?
- Can you give more detail...?'
- Do you have any examples?'
- Could you say more about...?'
- What happened when you said that?
- What did he/she next say next?'
- How did you feel right after the event?
- Did you react to the event?
- Did you have any other feelings, emotions, or reactions that you would like to discuss with me about this experience?
- What effect have you experienced personally from this event?
- What came from that experience?
-

As suggested by Bluff (2006) the following prompts may be employed if required:

- Are you saying that...
- What do you mean by that?
- Silence

However, as advised by Hollway and Jefferson (1997) care will be taken not to interrupt the narrative as far as possible. This may mean simply nodding or repeating the last words used by the participant by way of encouragement

Appendix 8 - Full Transcript of Interview – ‘Debbie’

Clean transcription of interview with initial notations where appropriate.

(FIRST RUN)

‘Debbie’

JJ – Thank you Debbie for coming today and taking part in my research.

Debbie – You’re welcome.

JJ – So before we start can I just confirm that before I turned on the recorder that you agreed for this interview to be taped?

Debbie – Yeah you did ask and I’m fine with it.

JJ – Thank you - I just need to go through a few things before we start the actual interview – is that OK?

Debbie – Yeah that’s fine.

JJ –Thank you.

Debbie –I’ve been looking forward to it actually I just hope it’s what you need.

JJ – Please don’t worry I am sure that whatever you choose to talk about will be useful. So can I confirm that throughout this conversation you will be referred to as ‘Debbie’ and that you chose that name for anonymity purposes?

Debbie – yep that’s right.

JJ - Also that you have signed the consent form and that you know you can withdraw at any time from this interview?

Debbie – Yeah I did sign the form and you spoke to me about being to stop the interview I know I can stop this at any time.

JJ –Thank you. Debbie I would to write some notes as we go through the interview and I would not want you to think that I am not interested in what you have to say it’s just that I would like to capture such things as your body language or facial expressions – things like that, which will help me when I am transcribing this interview – is it acceptable to you for me to take notes?

Debbie – Of course I don’t have a problem with it.

JJ – Thank you – so if you are comfortable is OK to start the interview?

Debbie – yeah let’s go for it.

JJ - So - can you describe or walk me through an experience or experiences you have had with behaviour that you define as inappropriate?

Appendix 8

Debbie – [pause] I've been thinking about this since you came to see us at Uni and like I said I'm not sure if it's what you want but thinking about it there have been incidences you know behaviour that's been a bit off throughout my three years [pause] is it just about practice by the way or can I talk about Uni?

JJ –What do you mean?

Debbie – Well some stuff went on in practice and other stuff was in Uni.

JJ – Oh I see what you mean no please just talk about whatever you feel you want to it doesn't matter where it happened.

Debbie – Oh OK I just wanted to know – didn't want to go off track. Um OK so in my first placement um well it was a bit worrying at the start I was so sure that I was going to make mistakes or do something wrong, silly now looking back as a third year – you know what I mean?

JJ – Yes – I can remember being a new student.

Debbie – Well the midwife who I worked with was a nice enough women but her skills as a mentor were not so good – although I didn't know that at the time as I was new – you know what I mean? So we start off in the community and I was excited to get stuck in – we had had skills teaching in Uni so I knew how to do BPs, urinalysis and palpate and auscultate you know?

JJ – Yes I do

Debbie - So I wondered should I take the initiative or should I just stay beside her and wait for her to tell me what to do but as time went on she just didn't seem interested ...I'd do stuff but nothing really happened.

JJ – Can you explain what you mean?

Debbie – Well by the end I felt that there are some midwives that just don't like having students I know everyone is busy and they didn't pick on me or anything but sometimes I felt like I was just an inconvenience it pretty much ruins your day in the sense that why would I bother even being here if you don't even want to teach me? She wasn't unkind you know she would bring in cakes and we would go to the sea front for lunch if we had time it's just like ..like I felt I had lost a whole day of learning on more than one occasion at times I felt like I wasn't there or perhaps she didn't remember I was there I don't know.

JJ - Could you say more about how that experience made you feel?

Debbie – Well I dunno possibly being invisible does that sound silly?

JJ – No if that is how it made you feel at the time.

Debbie – Yeah um invisible is probably the best word sounds silly as I was actually there but I genuinely felt that she just went through the motions with me I mean she always included me in things and she passed me at the end but I did wonder at the time if I deserved to be passed or if she just signed me off – worrying isn't it?

JJ – Can you explain what you mean by worrying?

Debbie – Well were my skills up to it? Did I deserve to pass or was it easier for her just to tick the box – sort of questioned my abilities what I knew you know I thought I was doing OK but was I? [Long pause] Wow haven't really thought about this in much depth til now [pause] I suppose looking over my past grades and feedback that I did deserve to pass up to now as I have had really good reports as I've gone on in practice. But still [long pause].

JJ - Could you say more about how you felt about that experience?

Debbie – Well the placement was in a team of midwives you know they all look after you and the midwives were are nice enough women, just little or no teaching and absolutely no inspiration for me in the end, I just got on with it asked a few questions and in the end I thought well it's like learn yourself [use of own name] made me feel like I don't know will I be a good midwife It's like one minute you're at school and then you're a student at uni trying to figure how to deal with that and the next thing you're in placement that's a lot to get your head around... ..I do know I was lonely at times. That sounds stupid doesn't when I just told you I had a group of midwives looking after me.

JJ – Not at all

Debbie - At the time I didn't really feel like I learnt much but I must of as I passed but that takes me back to did she just tick the box ...gets complicated doesn't it? They well most of them had very strange attitudes towards us students.. me I can't say they were nasty or anything they would bring in cakes and stuff for us but when I got back to uni others that had been in the same team said the same things so at least I knew it wasn't just me ..sad really.

JJ – What do you mean by strange attitudes?

Debbie – Umm not sure how to describe it - well like you'd be in clinic and we would be with a woman and it would be like you do this and I'll sit back and watch you and then when the woman came into the room she would suddenly take over – no explanation you know no nastiness and when I said I thought you wanted me

Appendix 8

to do the appointment it was oh sorry I'm so used to being on my own. Or we could be in the car travelling between visits and no conversation it would be stuff like can you remind me to check Mrs so and so's results - no chat about where we were going next or reflection or testing my knowledge you know? Like I said I mostly worked with the one midwife I don't know if she was shy or something but very little came my way – I sort of learnt by watching. I did do some stuff if she was off and I worked with other midwives. I'm probably over dramatising this but six weeks is a long time don't get me wrong she was nice and all and I must have learnt stuff you know.

JJ – Do you have any other feelings, emotions, or reactions that you would like to discuss with me about that experience?

Debbie – Well I do know that when I qualify I won't be behaving like that I want my students to feel welcome and I want to teach them. Sometimes I've come across midwives not even my mentors who really are inappropriate in the way they behave.

JJ – Can you give me any examples?

Debbie -. Um [pause] OK – so [name of mentor/midwife spoken] oopps sorry shouldn't have said that.

JJ – Please don't worry no names will be identified.

Debbie – Oh OK so I was working with her and we'd worked nearly all my shifts together one way or another. She was a brill teacher and we did get on well. Oh this was in my second year by the way and we were on Labour Ward so we were caring for a lovely lady and she was doing really well but listening in with the Pinnards baby's FH started to slow down and we tried moving her you know on all fours on her side but the FH still decelerated. So we discussed with the woman about putting on a FSE her waters had already gone and she said yes so I went to get the stuff ready. I'd put on a quite a few FSEs while I was on Labour Ward so I felt OK doing it. When I came back I was about to tell the woman about the procedure again and to make sure she was OK and gave her consent you know – the woman wanted to know if I had done it before and I told her that I had when all of a sudden she said to the woman something like don't worry that's what I'm here for she's looking at me at the time 'Debbie' has talked it through with me but there is always a big gap between what they say and what they can actually do sometimes; I blame the University for that. Well what could I say I think I just smiled at my lady and she gave me one of those sorry for you looks I couldn't

confront [name of midwife] oops sorry said her name again sorry ...as I was saying I couldn't confront her, how professional would that have been even though the her actions were not appropriate ..you just don't say things like that. Do ya know I talked it through with the midwife before I went out to get the stuff ready so she knew that I could do it I felt like that counted for nothing and I ended up thinking well was I going to do it right? It really knocked my confidence I spent quite a few shifts after that just checking in with other midwives on duty that I was doing things right I really started to doubt myself you know.

JJ – 'Nodded' - Can you explain what you mean by doubting yourself?

Debbie – mmm I dunno - its just that I remember how useless I felt then you know as a second year everyone is looking at you to up your game and here was I feeling helpless well definitely my confidence levels dropped after that I can tell you .I definitely remembering thinking that perhaps I didn't know what I should know does that make sense."

JJ – Yes.

Debbie – She'd never done anything like that before maybe she thought she was giving the woman some confidence I don't know but [long pause] at times I was I know this is going to sound silly but I was really frightened of going to work after that. One shift there was just was two of us, another midwife and myself we were quiet lovely lady, she just let me sit there and let me cry it out. I felt so exhausted and tired and by the end of it and all that I felt drained, she said how do you feel I said I feel shattered, it really took it out of me, the actual crying. After I finished work I just sat in my car for a bit and when I got home to my Mum's house I was picking up my nephew for my sister anyway he got in the car looked at me and said what we gonna have for our tea and he's like, he said are you alright aunty [real name] and I said yeah.

JJ - What were you frightened of?

Debbie - I'd never experienced anything in my life like this not even at school I was so frightened after that of making a mistake and then it grew into what happened if I did – someone mum or baby could die. I got myself in a real state.

JJ - Could you say more about that experience?

Debbie - You know most midwives seem quite happy to have students um there's been very few people who haven't wanted to have a student but I've found that um people who've have been midwives for quite some time sometimes they might

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query how you are working you know, you learn the evidence in Uni and then it's not done in practice and so when you do it the right way they question it not nasty you know as if you are doing something wrong. When that happens I really start to question myself and you think but this is the right way but how do I tell you that as you are more senior than me. Then I think I remember becoming panicky you know anxious about going onto shift in case I made a mistake and that all started after that midwife behaved towards me in Labour Ward that day...one thing and my confidence just went puff. Like I said that was inappropriate I know there are different ways of doing things you know everyone has got their way of doing things but they generally work with the guidelines and evidence you know and the women.

JJ - Did you speak to anyone about how you felt?

Debbie – Oh yeah I spoke to my tutor she was lovely and she did understand and she said did I want to set up a meeting to speak with that midwife and let her know how I felt – I did think about it but in the end I thought that really it wasn't worth it as she probably wouldn't of remembered it. But I have got over that now I sort of found that the midwives who are newly qualified are really good in letting me do things in my scope of practice and that really helped my confidence grow, my named mentor wasn't newly qualified the one on Labour ward with me but I did get to work with others and that helped my confidence. They were happy to let me ask questions and challenge stuff you know not all midwives are like that. Do you know another time in Labour ward just recently I came on shift and I was allocated a labouring lady and so I went in to say hello and almost immediately, the midwife I was working with called me outside and asked me what I was doing. She was nice about it and I explained, and then she said that as I was only a student I had to stay with her and not wander off doing my own thing from then on she just didn't let go; it was as if she had to be by my side all the time. I wouldn't mind but she really didn't spend time actually teaching me anything. That's not appropriate; as a third year, I need to be able to start practising with a little more autonomy.

Confidence is everything I think you need confidence I think to develop your autonomy you know? I remember coming off nights once having started off with a midwife but then sort of getting lost in the crowd do you know what I mean? no one seemed to take responsibility for me and thinking that I had spent another shift wondering what I had learnt. There's a difference between wanting to experience autonomy and being left on your own completely. A few months to qualification

and I'm scared to think that I'm going to have all this responsibility. I sort of have self-doubt that I'm not going to be able to be a good midwife. Still my grades are good so I think maybe that proves that my confidence is getting there, go to be really as I qualify in September.

JJ – Sounds like it. You said that not all midwives were happy with you asking questions or challenging – could you elaborate on that?

Debbie – mmm well I think the difficulty is what we're taught in Uni is the best way of doing things so we're taught a lot of..... I think initially you are taught a lot about the stuff about becoming a midwife, rules, inter-professional learning A and P that kind of thing like I said before we learnt skills as well but not really what is what going to be like in practice actually working with women and mentors. We were really encouraged to not only ask questions by the tutors but to question in the right way why things are being done you know how, we sort of question things. When I did ask things like I thought we weren't supposed to do that or I thought it was better if we did it like this and you got back stuff like it's down to cut backs or there's not enough staff on or we always doing like this they were genuine comments not said rudely or anything you know it was just the way things were. But when that is said to you... you end up being um fearful of asking or challenging. You don't really challenge when you are a first year but in my second year I started to cause in the back of your mind you know what or how it should be. The tutors say to us ask the midwives questions, ask them why they do what they do, and if they've got any evidence behind the practice that they do – do you know what I mean as a tutor?

JJ – Yes I do

Debbie -So I have asked questions and I hope professionally challenged and I remember one midwife saying to me she wasn't rude or anything I shouldn't ask so many questions and that she was the qualified midwife I thought that was such a poor attitude to have.

JJ – How did that make you feel?

Debbie – mmm like I suppose I felt a little helpless where can you go from there really short of making yourself unpopular I didn't feel supported um fobbed off you know?

JJ -.Have you met other poor attitudes or behaviours as you perceive them?

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Debbie - mmm let me think [long pause] yeah so take community for instance you know midwifery is midwifery doesn't matter where you are hospital community, birthing centre but there are some midwives who work on what's called high risk who think that if you work in the community setting you are the feeling is that you are less of a midwife because you are doing low risk. I came into the unit from the community to look after one our ladies the midwife and I had to work with another midwife to carry on caring for this lady I didn't really know her which probably didn't help but anyway she said to me something like so you've only been in the community well this is now high risk so we will need to take over now I mean she said it nicely but she didn't ask me nothing about what year I was or how much experience I'd had like I said she wasn't nasty or rude it was just like she was stating a fact – do you know what I mean? This lady we brought in had been labouring at home and it was going great but the FH started to go down you know decelerate during contractions...she was eight centimetres. We had looked after her for about five hours and I had known her since booking but the FH definitely wasn't happy anyway we ended up in the unit and like I said we met this midwife who said what she said urmm what I'm getting at is ...you know I find it actually empowering to be able to help woman stay at home, you know in their own environment, I mean that is very, very positive um and my midwife and I had supported her with all of what she wanted - midwifery is midwifery it shouldn't be about high risk low risk hospital and community and whose doing the better midwifery you know do you know I felt really second best and that that midwife had judged me without knowing me ..my urm my mentor did have a word with her but she didn't apologise ..now that was inappropriate on her part the midwife on labour ward not my mentor sorry that sounded confusing any way the labour midwife's behaviour was definitely not appropriate. Another time just recently I was taking labour ward you know acting as co-ordinator my first go at it, my mentor was co-ordinator that day so she thought it would be good experience for me anyway this doctor came up and completely ignored me. He knew my role that day and talked to the midwife, and when she referred him back to me he said oh, but you're just playing at being in charge I need someone who knows what they are doing at this point I thought, what the hell what do I really know, am I ready to qualify? His attitude was very poor and his perception of me was wrong.

JJ-. How did that make you feel?

Debbie – I must admit I did feel second best you know and again that feeling of being invisible you know I want to be prepared to be a qualified midwife he did knock my confidence you know and I was a little bit angry about being ignored by him.

JJ – Did you speak to the doctor about your feelings?

Debbie – oh yeah as much good it did ...I was professional and I said to him that I found his behaviour to be inappropriate towards me ..his reply?.. well when you're qualified you will need to be tougher so I then said to him that that comment was not appropriate either and he looked at me and walked away ...I just thought any further discussion would be pointless and besides we had to work together for that shift. You know over time I've got used to being around people who don't know what I'm capable of and so when you first work within them you tell them where you've worked and things. This one team I worked in already knew me which was so nice and we used to meet up for team meetings and other students were there and you could talk and you'd learn that others had varying degrees of struggles and it was nice to know you're not the only one that was struggling. The team leader was really approachable which I think is important and I certainly felt I could ask if I wasn't sure about anything I could go to her with whatever problems I had you know that made one hundred percent difference in terms of the support I felt you know I felt I could progress more easily because I had time to ask questions and have things shown to me stuff that I wasn't so sure about. You know at times she'd stay after a clinic and take the time to listen to me which was really nice you know rather than just trying to squeeze things in between visits she was a really good mentor. [pause] midwives know that they've to be mentors but if it's not really up their street then they've not necessarily got the interest there or the inclination to make the time ..I think if you feel that where you work is supporting your learning, you are perhaps more happy about attending and your focus is better. When you feel that no one is supporting you in practice, you feel that you are on your own. It makes me feel like I can't do anything on my own initiative in case I get it wrong. At times it made me feel really helpless.

I think some midwives just want to get on with their job and don't want to teach. Some want to teach some don't. I think there is that expectation now I'm more senior and I don't know if I put it on myself or what [pause] but there is the expectation by some midwives that I should be able to do it, and there are some

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things I just haven't experienced or seen as a student yet that I need to learn about. One of the midwives who assessed me she was the only sign off mentor in the team wasn't really interested and didn't ask what I'd done already or what it is my learning needs at the beginning of the placement were and even though it was in my practice portfolio she wasn't really bothered about finding out for that practice assessment I never got the time to actually sit down and properly go through it, you know, it was a very quick process the midwife who assessed me gave me back my portfolio already signed now that was not appropriate behaviour that's not how it's supposed to work. So at times you end up with conflicting support or a lack of support it just depends on who you get I think. I know I keep saying it but there are some [midwives] that just don't like having students no one has ever been nasty to me you know but at times the behaviour they show is just not appropriate and that becomes very wearing. As I've gone on I'm not taking it so personally anymore I've seen others been spoken to inappropriately so it's not just me ...maybe those midwives just don't realise what they're doing or saying is not the right type of behaviour to have you know..... I know it's not my fault ... It does sound like I'm moaning doesn't it?

JJ – No it's important that you say what you want to say please do not feel that I'm judging you in any way.

Debbie – Thanks... you know you don't really realise all the things that've gone on I've probably chatted about some of them to different people but it sounds a lot when you start talking about stuff at the same timemind you I can talk for England [Laughs].

JJ – [Laughs] Is there any other experience or experiences you would like to talk about?

Debbie – Is it alright to look at my notes I wrote some stuff down to remind me?

JJ – Of course.

Pause in conversation while Debbie looks at her notes.

Debbie – Urm so I wrote something about when a midwife ...well I thought she didn't behave towards me appropriately or the lady come to that. So it's about breastfeeding I really enjoy supporting women who want to breast feed and I was on night duty and we had a few breast feeders that night. So one of the midwives I was working with that night was an agency midwife who felt that it was perfectly okay for babies to have bottles so that the mums could sleep ..anyway I didn't know this in the beginning and I was with a mum who'd had problems during the

day ..you know getting baby to fix. I remember that the ward was busy but this lady was so close to giving up you know going to give the a baby a bottle so I really wanted her to have a good experience so that she would hopefully keep on breast feeding. Anyway I was really encouraging this lady and telling her about all the goodness of breast milk you know what I mean and I really felt that she trusted me to help her anyway so baby fixed on and was just getting into a good pattern when this midwife came into the room and said don't you think she should have a good night's sleep let the baby have a bottle it won't make any difference, give the baby a bottle. Do you know what I felt ..so undermined and worthless that midwife did not show me or the woman any support the lady saw a qualified midwife saying one thing and a student saying something else and I remember thinking that the trust that I had with that women was broken. I must admit I was cross as well. The lady asked if me what I thought and I thought what should I say ..so I said something like well the evidence does show that breastmilk is best you know the benefits etcetera anyway I stayed with her until she'd finished and then tucked baby down. When I came back out onto the ward the midwife said that we were busy and that there wasn't always the time to spend with the breast feeders as there was other things that needed doing.

JJ – Could you say more about how you felt about that comment?

Debbie – mmmm how did I feel? [pause] I suppose I was still a bit cross after what she'd said and if I'm honest I wanted to have a go at her but you can't do that can youI supposed I felt let down and a bit on my own fighting for the woman but with no support.

JJ – Can you elaborate on what you mean by fighting – it's a very powerful word.

Debbie - I don't know [pause] I think it's about how we are taught you know evidence based research so I suppose we cope OK as students you know to practice changing as findings come out you know whereas there're still some midwives out there who seem stuck so to speak ..we know what the evidence is and yet women get treated in the wrong way because the midwife says so just because she's not practicing using the evidence and there I am beating the drum for the woman advocating for her. If you end up working with a midwife like that it is a struggle because you feel like you are fighting so hard to make sure the woman comes first. Mind you that doesn't always make you popular [smiles].

JJ – Can you say more about that?

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Debbie – Yeah so um the co-ordinator caught me one day on labour ward and said nicely like that a midwife had said that I'd come across as a bit forceful in the way that I'd asked her some questions... I said to the coordinator that I was sorry if that's how I'd come across and that I thought I knew who she was talking about . I said to her that I'm eager to learn and when I ask questions I would like satisfactory answers and for me that didn't happen on that day and I kept questioning because that's the way I am and I wasn't satisfied with the midwife's continuous response of well that's the way I was taught. For me it's important to know why and stuff you know I mean the situation when this happened was during a break so it wasn't as if I was asking when we were busy. So the coordinator said she understood what I meant and said about me finding out for myself but she also said certain people don't like to be questioned why and how they do somethings and just to be aware of how I asked questions and that here were some midwives who were more open to that than others. After that I thought so some will support you and other aren't so happy.. I felt a little fearful of asking questions for a bit after that. I know you can read around stuff but I need to ask question I need to put things in context especially as midwives practice in so many different ways. You know it's amazing the different practises that go on at times it's really confusing.

JJ – Can you elaborate that for me?

Debbie – Oh ...well so in labour ward some midwives sort of lie about where their women are in labour - like saying there're not fully when they are so that no one interferes you know - I don't think that's appropriate to be showing to students I get why they do it but it's still not OK you know? I think that causes trouble cause the evidence says you can leave a women whose fully for up to an hour but you've got to let the coordinator know about your woman so they keep quiet about it. Another thing some of the senior midwives you know the older ones come out with one thing and they tell you off well not tell you off you know what I mean because you're not doing it their way ...then you work with another midwife and they tell you off you know what I mean because you're not doing it their way. This type of behaviour makes me so frustrated you end up as you walk in a room trying to remember how that particular midwife works. I've tried toI do still ask loads of questions, and um I always try and say why and things like that, but sometimes it's very difficult to have a discussion with some midwives especially the sisters you know the band sevens they don't really want to have to justify themselves to you.

JJ – Can you elaborate on that for me?

Debbie -well ..like you know I know that you don't have to guard the perineum and yet I worked with a band seven at a delivery and she guarded the perineum and really didn't seem happy that I didn't anyway she told me her reasons for doing it. She even put my hand there so I couldn't move it .So after I asked her why and was told it's clinical experience, it's what I've learned through my years of experience. She wasn't rude or anything, so I said OK fair enough and then the next midwife I worked with was a junior anyway when I said what do you think about this you know guarding the perineum she said no you shouldn't touch it ..some places they don't even put their hands on at all they kinda of stand and watch. But then the next person says guard it. So you end up going round in circles I suppose it's some sort of learning in a way but there's so much evidence to support not doing it you know, and yet there are still people doing. Seems to me ...oh it's just so frustrating.

JJ – So can you give more detail about how you coped with that experience?

Lynne: Um wellyou ...I just get on with it because that's all you can do when you're a student you can't really practice autonomously as you're always practising under someone else's PIN so really you have to do as they say. So for example if you are delivering a baby and that midwife likes to have the woman on her back to deliver then that's the way it's done it doesn't matter what the evidence says. You can't really practice the way you want til you're qualified I think. Um but really it's I feel more about keeping your eyes open evaluating what's going on I've worked with different midwives and that's good like I said frustrating at times but you get to see how diverse practise is and what's good and what's bad. You know for some midwives they can be so passionate about one thing and they'd go the whole hog for what they believe in, but for another midwife it's completely wrong. You end up feeling at times like ..like the support you get is so conflicting. I know as a student what the ideal way to practice is you know EBP that's how I want to practice but at times I know it's never going to happen like that, there's little things that I do to make it better. I believe that I can change practise when I'm qualified but I know it's going to be an uphill struggle and it really is frustrating. It strikes me at times that some staff just want a student who will meekly follow around and do the job and get on with it and they don't want you to start trying to change practice like you're supposed to and start questioning what's going on and.. and things like that.

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I think I think some people just don't realise that their inappropriate behaviour does have an effect on my experience I don't think they mean any offence it's more about poor communication skills you know not thinking before they speak or thinking that what they are saying is the best way to provide feedback.

JJ – Can you elaborate?

Debbie – [Pause] ...well yeah um [pause] OK so on this occasion I was actually palpating a ladies abdomen in clinic and the midwife intervened and said something like oh no you don't do it like that in front of the woman which I didn't think was appropriate. Ok I get the fact that I needed to know the proper way to do it and I'm sure that the midwife didn't realise that by doing what she did actually made me feel anxious and my confidence was knocked. [pause] another time I can't really remember what I had done but I asked the midwife for some feedback and she replied something like it was OK but I think maybe you could have done it this way which would have obviously been better. Do you see what I mean? Also it depends on who you are working with you know midwives and sisters. I want to learn but at times I think that there's some sort of power struggle with the midwives you know band sixes and band sevens and whose going to take a student it's not so bad in the community cause the band seven is the team leader and still has their caseload but on the ward ..labour especially ..some of the band sevens are sometimes just too busy cause they're usually the coordinator so you end up trying to find someone to work with. I really understand that it's difficult having a student when you're coordinating but it's so frustrating they do try to include you and get some teaching in but normally it just doesn't happen and then you get disjointed support because you end up working with people here and there and there's no real continuity so then you're back to at times conflicting support cause you're not with your mentor. The band seven then says oh so so will look after you and then the band six says oh I've got a student already ..it's not good but it's not their fault I'm not sure why we're put with the band sevens on Labour Ward cause you can't really work with them especially when you are a first year. You're just learning how to be a student and stuff let alone figure out what a coordinator does. The problem is at times cause labour ward's so busy there's no one really taking responsibility for you if your mentor is the band seven and at times you can end up being forgotten you know You end up feeling on the sidelines not really knowing what to do or who to work with....yeah very frustrating. Then your work becomes so

disjointed and that's annoying cause you can't get your teeth into anything and you end up with silly jobs.

JJ – Can you say more about that Debbie?

Debbie [pause] Ok so I was on Labour Ward working with another midwife as my mentor was the coordinator for the shift anyway the lady we were looking after was well off and it seemed that this midwife wanted her all to herself and throughout the shift she [midwife] kept giving me silly little jobs. It seemed she wanted to keep me away from the lady; she wasn't nasty about it, I know midwifery involves everything, but I wanted to consolidate my skills by attaching the FSE that was needed but she made some excuse that it should be a trained midwife who did it. I know I'm a third year and should be sourcing my needs, but I spent all day with this midwife and I can honestly say I learnt nothing. It seemed every time I did what she wanted doing I was sent off to do something else silly like checking the board to see who else had been admitted ...it was like she was pushing me out.....you know I've had that happen to me before. I was on call for one of my case loading ladies and it was all over her notes to call me when she went into labour and the lady also had my details. Anyway my lady went in but I didn't know cause she didn't phone me but when I eventually got to see her she told me that she had said to the midwife don't forget you've got to call [Debbie's real name used] apparently she asked the midwife twice during the time she was in labour that night. So another student got the delivery. Anyway my lady called me after she'd had the baby and I went in. I spoke to the midwife and she said oh well I forgot who was looking after her and I said but it was on her notes and she asked you to call me she did say sorry but they'd got busy ... I was cross and felt I'd been ignored ...ifas if I didn't count . You know it's the same when you are in the room with a lady I get so fed up with people who just walk on in without knocking and ignoring me cause I'm a student and go and talk to the midwife I end up feeling second best I find that it's very intrusive because when I'm providing care for a woman I know what's going on... obviously along with the midwife I'm working with I'm the one who's been talking to her and caring for her [pause Debbie is obviously upset]...sorry

JJ – Please don't apologise - do you want to stop?

Debbie – No it's alright I'm OK..... it's just that feeling of helplessness you know – oh well.

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JJ – Take your time....do you have any other experiences you would like to talk about?

Debbie – [long pause] you know I was just thinking it's not all bad you know I remember a shift where I was working with some younger midwives and we had a good laugh we were busy but somehow it was fun – do you know what I mean. You really do learn when people are ...well the mood is good you know. Some of us had the same break and we had a damn good chat - nothing about midwifery I really loved thatI love talking to the ladies as well in the same way you know chit chat particularly if they are in really early labour and the partners keep popping in and out you've got that luxury as a student -it's great because you can really build up a rapport. I was working a junior midwife one day and she was happy for me to do that but sometimes you feel you can't do that with the band sevens cause they're watching what you're doing. Sadly I have been told things like you shouldn't be that familiar with the women cause you've got to act as a professional. Personally I don't agree I think it's important to build a rapport you know. it helps develop trust. You can talk to women partners grandmas you know about everyday stuff and still be professional. I think by saying things like it's all right or how you doing and make it really nice and relaxing I think it's a better experience for everyone. The women and dads feel happy to talk to you if you are approachable that works well especially when the docs do their rounds ..they say to a women so do you have any questions or they start discussing her case and they say no. But you can bet your boots that soon as they've gone the woman says I wish I'd asked that or what did they say. So then you end up answering their questions or explaining stuff you know and it's because they're too scared to ask because the docs are standing around looking at her lying on the bed, and I just think that's not good.... I think it's much nicer to be able to have a friendly chat with them. I know that's not always possible but keeping a rapport going is so important. Sometimes the midwives are so busy that they don't have time to really talk to the women it becomes more of getting stuff done then spending quality time with them now I not sure that that is so professional.. you know some midwives talk about being professional but they don't act that way at times towards women or students.

JJ - Do you have any examples of that Debbie?

Debbie – [pause].....well with the women it's about like I've said already or they just literally say the least they have to in order to get the bloods taken or to take

their obs it's like get in and get out. For me personally sometimes I feel there could be more communication between staff and tutors things like what we were expected to do and how much we could do... um things like that. I ended up getting caught in the middle, when I was working with my mentor we had a tripartite with my tutor when my tutor was asking questions and my mentor saying well I don't think she should be doing that yet and my tutor saying that I needed experience in putting in prostin, so after my tutor had gone my mentor said it's different in practice your tutor isn't in practice so she doesn't really know what it's like... that was so unprofessional don't you think? I remember being on postnatal and I know we were busy but one of the midwives said to me go and do those obs and after that you can start the discharge for Mrs so and so and I remember feeling like saying to her please but I didn't she made me feel like a servant rather than a student her attitude was very poor... poor communication... when that happened I felt our relationship had broken down. Most of the midwives say something like could you help me out with this or can you do this while I'm doing the drugs or you say do you want me to do this for you. That kind of relationship is totally different. I was a first year then and I think that's how I acted at the beginning you know submissive but I think it's how you act as to how you are going to get treated at times...no ones been nasty or anything well not yet but at times it's just easier to be submissive.

JJ -. Can you explain what you mean by being submissive?

Debbie – [pause] Well at times I found it much easier to go with the flow you know rather than trying... um than make a fuss about how some of them acted towards me [pause] yeah I got to a point when it was better to go with the flow. I think I realised that there're just some midwives who just say stuff or do stuff which I found find hurtful but I don't think they know that they're doing it ..they just don't realise and the problem is I now know that going with the flow was..is dissatisfying because I know my work my practice wasn't as good as it could have been.. it's frustrating. It did grind me down but as I said I've stopped doing it now I'm not frightened to speak up and let them know that what they've just said or done to me isn't appropriate. I know it's a two way street but like..well like I said I just don't think they realise how they come across at times. You know I think in the beginning I got judged on my personality... I know I was enthusiastic maybe over the top at times who knows but some midwives were great and others ..well

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they're the ones I'm talking about. At that time I felt like I was putting on a face like if I did say something someone might just jump at me or if I did speak then I have had a look which said you're still a student and you're not supposed to speak now. And I think that's bad because you should be able to feel comfortable wherever you are practice or uni. I'm actually a nice person I do my bit I'm polite and I know that I'm professional because I've been told so and do try and think before I speak and as a third year I am very aware of what the newbies are going through so I make sure that what I do and say to them I hope is supportive and not a put down. OK I'm lucky cause I'm still a student and I don't have all the stress that the qualified staff have so I can take time to talk to the new students and work with them... I do really hope that being qualified doesn't change me but I think that politeness and professionalism should be the same if your qualified or not don't you? Maybe the midwives that I've come across who done and said stuff to me are always like that you know even as a student - I'm not sure you don't really know do you? Anywayyou know other midwives are great and they restore your faith ..my community team were great, they made me feel so welcome. By the end [of placement] I felt like one of them. My confidence was so much better.

JJ - What did you experience personally from that do you think?

Debbie – mmm well I figured out that not everyone you know midwives act the same way [pause] those midwives really helped me to realise my worth and what I would and I wouldn't put up with [pause] thinking about it I supposed I felt valued and strong. As I've got more experienced I think I now ask more relevant questions you know rather than just asking questions which I'm sure must of drove some midwives mad when I first started I remember asking a lot of questions [laughs] yeah so the answers I get are now much much more supportive and I'm now getting more questions right that I'm asked. Mind you there's a couple of times in class where that's not happened.... we were doing emergency stuff one time and he .. my tutor kept on giving me ..you know the skills drills bits to do anyway like I said this one time [lecturer name] just focused on me, with things like come on, you know this, and what are you going to do in practice? He wasn't aggressive, but he didn't do it to the same extent to the others in class. You end up thinking so fast that you don't take it in I came away from that lesson with my head in a right spin I'm not sure what his motives were but the way he acted towards I felt wasn't appropriate.

JJ- you said a couple of times are there other experiences you would like to share?

Debbie – Yeah so we..ah I can't remember what session it was but anyway she [described as a tutor] has her favourites, but she definitely acts towards me differently. She isn't a bully or anything, nor is she unkind to me; I can't explain how, but she makes me anxious to the point where I question if I really know anything. Oh I remember now we were revising for our exam and everyone was uptight in class you know you never think you know anything anyway the favourites were getting their worries sorted but when it came to me she was like.... oh I can't explain it but I get anxious in any of her lectures she just has that way about her. I know I'm not the only one who feels like this and the class rep did speak to the midwifery head but that was useless cause the reply came back like we know but she doesn't mean anything by it.. what help is that? You... as students if we don't behave you know what I mean we get called in so why's it some get away with poor behaviours? It's really disheartening walking into a classroom or on the ward knowing that a certain midwife or tutor just doesn't know how to behave towards me or like waiting for them to say something... maybe I'm over sensitive I don't knowit's like waiting to be... I was going to say picked on but it's not that .I don't knowthere's still that little number of people in practice and uni that ..it doesn't matter how good my work is or how hard I try it's never going to be good enough. I know my work is good my grades are good but these few just don't seem to take any of that into consideration at all.

JJ – how did or does that make you feel Debbie?

Debbie – Um ..really.. truly... it makes me angry. I'm not the kind of person that talks about my private life I do share some stuff with the other girls in my group but never with people I just work withI think that might be a part of the problem with me. There's midwives who don't know me other than as a student they've never really had a conversation with me and I sense they've made a conclusion about me. I did go and speak to a band seven once on the ward I was working on I just want to find out if I came across unfriendly or slightly pushy as a way of explaining why I thought some of the midwives acted or spoke inappropriately to me. She took me seriously she said that I came across as intelligent hard working and friendly but said that it's human nature to want to know about other people and that if no information was forthcoming from me then opinions would be made....she

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said that I had every right to keep my private life private and that I should never be pressured to talk about anything I didn't want to ..she didn't agree with opinions being formed on limited info but said again that it was human nature. I get it that some midwives might not like me but I thought we were supposed to be professionals so I shouldn't be judged mmm that's probably not the right word .anyway I should be evaluated on my abilities and qualities as a student.. just because someone doesn't know my private life doesn't give them the right to use that to treat or speak to me inappropriately. Maybe I'm different from what they expect me to be I can't change who I am ,. I'm not going to be change who I am ...I can't ...I have reflected on things that have been pointed out to me and where needed I have moderated my behaviour or approaches but I haven't changed anything else I've figured out it's the little things that makes a difference. I've changed somethingslike my confidence has grown so much that I can talk to a lot more people especially consultants. But I haven't changed myself I've just make the effort to talk to people who may have intimidated me in the beginning you know when I was a first year and in my second year to an extent. Mind you I've come to think that it doesn't matter what or who you are it's just one of life's things people making unfair opinions of you ...probably comes from working with a lot of women - you get a lot of bitching and gossiping and I find that very inappropriate behaviour.

JJ- Can you elaborate on that Debbie?

Debbie – Mmm well I suppose you can gossip and you can be nice about it, you know just pass a comment but there're some midwives and MCA's who just lay into people, they even do it the doctors. I don't know why they do it there's no excuse... you know that's not how professionals should behave is it? [pause] maybe they've got an inferiority complex or just passing the time of day.. who knows?. Personally I think some of them are really frustrated or miserable. I've been on shift when we've been really short staffed and the senior midwife has come on looked at the state of the ward moaned about the lack of staff and then is in a mood all day. I think that being short staffed doesn't help attitudes you know...some midwives seem to cope OK when we're short but others just get ...well nasty. I've been in the in the office when the staff start having a laugh when someone tells a joke but the joke is crude...I'm quite a laid back person not snobby prude or anything I'm cool with others having a laugh or telling a joke but not when the women can hear behind the curtains or the public can hear. Oh God

I do sound like a prude...that's not how I mean to come across ...it's just that as a professional you shouldn't do that in my eyes. You know I've witnessed other midwives being inappropriate towards other midwives, not just talking behind their back, but talking inappropriately to them ... things like why did you do it that way or that's the wrong way to do it and in front of others.... I do think that because people aren't aware of what they are doing or saying it can lead to more serious things you know ..the whole midwife backstabbing bitching thing eating their young whatever you to call it ..it's not good to work like that and it definitely impacts on women's care... I've seem midwives really upset and then they're in a bad place and I think that must impact on their practice.

JJ – How does that make you feel?

Debbie – angry and a little worried – I'm frightened that's what happens when you qualify. I knew one of the midwives when she was a student and she wasn't like that then. I think a professional relationship is important you know and when that's not there that's when things go wrong – you know? I think some mentors go overboard with their students ...almost treating them like a child and that's not appropriate behaviour.

JJ – Can you explain that comment about treating them as a child Debbie?

Debbie - yeah ..so they say things like oh I've missed you so much or loved your post on Facebook things like that and then their student replies with oh I missed you too or I'll PM you . In my mind acting like that is inappropriate behaviour. I wouldn't ...in fact I haven't accepted being treated like a child. [pause]Ok that might sound like I'm jealous but I'm notI'd rather be treated like someone who is learning. I think if a mentor or midwife starts treating a student like a child the relationship becomes difficult. I think respect goes out of the window and I personally wouldn't have any confidence in my mentor if they saw me or treated me as a child. Yeah I think a mentor has to look after you as a student cause you're still learning but that has to be on a professional level. I think you have to maintain a student/mentor relationship cause at the end of the day they are senior in the fact that you're in a learning situation....you're the student and they are the qualified midwife. It does depend on the midwife and the student really. The majority of the mentors and midwives I've met have treated me like a student who is learning and needs to be taught and supported. The odd midwife has tried the childlike approach and I must admit I did get annoyed...I'm not a child I am a

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student midwife and I want a professional relationship. Gosh that sounds very aggressive doesn't itsorry it's just that I believe in being professional at all times.

JJ - Can you give me any more detail?

Debbie – Well professionalism is everything isn't it? I think inappropriate behaviour has a lot to do with being unprofessional. You know I think when you are nice or polite to someone they respond in the same way and it does make a difference.

JJ – Can you elaborate on that?

Debbie - I mean, if I'm not happy,.. sometimes I'm not happy ..and I walk on to labour ward for example and I'm miserable because of other things, then that can affect how the day goes for me...so I put a happy face on....sometimes the environment can get me down but if I put a smile on my face I find that the midwives see me or even act towards me more positively.., it seems that if you look happy than others around me seem happy you know they act happy and I think that's good for everyone. It's like when you work with people that are happy everyone is on the same wavelength and everyone just supports each other ...you can have a good laugh.....so even if someone is having a bad day we can... you know keep their chin up... Do you get what I mean?

JJ – yes I do I like working in a good environment it lifts my own spirit.

Debbie – yer that's it ..it does lift you doesn't it? It's a shame that some don't get that ...there's a couple of places that you know have a.. can I say where?...

JJ – If you would like to.

Debbie – so specially like NICU and theatres well they've got a reputation for urm...for not always being supportive to students ...it's sort of when you're there there's definitely a load of negativity a lot of us have noticed it. Some of the midwives and nurses just behave ...well you couldn't call it bullying but when I was in NICU ...urm ..I can't put my finger on it but certain behaviours were inappropriate the culture never made me feel comfortable. I found it exhausting and it really undermined my confidence. I do think everybody has to make an effort to get along especially as a student cause when you go somewhere new everybody whose already there you know there're' already a team so I think to get on with you've got to make the effort. I thinks that some midwives...um I just think that they ..well they look at what other students've done before and if the they haven't really made the effort then it's like all the students are like that instead of looking at each student as an individual...I don't know why they do it maybe it's

their personality. I suppose when you've got groups of people they're not always going to get along ...lots of personalities and then you get clashes and sometimes I've got caught up in that. Problem is like I said as a student going in somewhere new you don't know like the inner workings ..so then it's difficult ...other students tell you about the staff you know what I mean but I like to make up my own mind so I think it takes me longer to bed in. I don't think making your mind up before you work with someone works well for me or my mentor. It's much better though this year cause I'm a third year ..I've worked most places already so I've started to work more on my own so I'm more part of the team you know so ..for example I can look after my lady do the delivery and upload it to the computer with minimal support from my mentor and that really helps.

JJ – That sounds good - are there any further experiences you would like to discuss Debbie?

Debbie – mmmm let me look [pause while Debbie refers to a piece of paper] seem like I've been talking a long time ...I did say I could talk for England [smiles] well probably only a couple of things if that's Ok?

JJ – of course

Debbie – I just wanted to say something about a situation when I was on antenatal it's just in my mind cause of the way we've been talking ...my allocated mentor was lovely made going to work a real pleasure she supported me took time to teach me never made me feel anxious or helpless but after a couple of weeks she went off sick and I was given another midwife. Her approach was very different and I suddenly went from being able to do stuff you know feeling confident to becoming extremely stressed. She would hover over me without saying anything which was off putting it..... she literally watched over me the whole time we were on shift. I'd only just gone into the second year and wasn't at the stage I am now when I would say something. She didn't criticise me but I knew if I did something she didn't like...she would raise her damn eyebrow... the left one and just look at me. I felt under constant pressure ..helpless to do anything really about my situation cause she was quite senior you know... I never knew what she was thinking even when she gave some feedback there was no emotion. You know I wondered if I was good enough at the time.... that's not appropriate to behave like that...I've met her since and she hasn't changed. But like I said I'm not putting up

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with anything anymore....everybody deserves to be treated properly not just professionally –someone said to me once we're human first and students second.

JJ - That's very true. [long pause] Is there anything else you would like to talk about?

Debbie – I don't think so [pause]....I'm just thinking you know what we've been talking about you know when people read itit might sound trivial or petty to them what do you think?

JJ – Debbie you have been kind enough to describe your experiences to me there're personal to you just the same as they are for my other participants and you have helped me in gaining understanding what inappropriate behaviour means for you and I am very grateful.

Debbie – yer I suppose you're right it's just that when you're on the receiving end it's like a drip drip drip effect you know? Anyway ..was that OK?.. I can't think of anything else.

JJ –If you're sure there's nothing else you would like to say then I would like to just say thank you very much for your time.

Appendix 9 - Excerpts from my Reflexive Diary

“It is difficult at times to remember that I am seeking experiences and not thoughts from the participants. I was almost tempted to ask today ‘what do you think about that? Another anxiety is to ensure that I am not asking questions during the interview which could lead the participant to answer what I wanted them to answer rather than encouraging them to give free range responses and then probing their responses further to get a richer description of their experience. I think it is best if I talk to a colleague tomorrow who is going to be part of my peer review of the data findings and ask them to check out a transcript for me”.

“Just spent time with [peer-review colleague], she is an experienced researcher and I trust her judgement. She read through one of my transcripts and has put my mind at ease regarding my worry of leading the participants by asking them the questions I wanted answering as opposed to giving them the free range and then probing if I wanted more”.

“Had my last interview today. A lovely girl who just oozes passion for midwifery. As she described her experience it became apparent that just this one incident had really affected her. As she continued it became more apparent to her just how much she had missed out on that day in practice and what had happened to her confidence. It took all my concentration to remain focused and not lean in and comfort her. I came away almost ashamed that I was part of the midwifery profession”.

“Spoke to my supervisor today and ended up crying – I thought that the participants would be the ones who might need support after talking about their experiences, I thought I would be OK but not so. I really challenged my own thoughts and beliefs about midwives and midwifery in general. It saddens me that there are practitioners who do not seem to be aware of what their actions or words do to students. Here I am 30 plus years later and still hearing about the same traits that midwives have that I experienced when I was in training and when qualified. It’s good that [supervisor] is not a midwife as she offered me support without the insider knowledge which helped me deal with the situation”.

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"I am experiencing the inability to find the written word. I seem perfectly capable of verbally articulating to my supervisor but then sat back at the computer. I am lost. I find this so frustrating as I have limited times when I can write due to my work load and I end up feeling as if I am wasting time. However, [supervisor] reassured me that writing isn't everything when doing a doctorate. She encouraged me to take time out to think".

"Took [supervisor's] advice today. Took a notebook, pen and written thesis to date and went for a long walk and spent the time just thinking about 'stuff'. I went over my themes and the final themes and decided that out of 'sight out of mind' didn't sit well. In thinking about it I have changed it to 'angst and anonymity' and now it flows so much better".

"[Supervisor] has just sent me my feedback and agrees that 'angst and anonymity' is a much better encompassing theme."