ACTION RESEARCH FOR CURRICULUM IMPROVEMENT IN PRE-REGISTRATION MIDWIFERY EDUCATION

by

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CONTENTS

ACKNOWLEDGMENTS

Writing a thesis would not be possible without the involvement and support of numerous people. For confidentiality reasons many of these cannot be named but I would like to offer my grateful thanks to students, teachers, midwives, clerical staff and the childbearing women who made this study possible. I must also thank all members of the curriculum planning team and staff in the Division of Midwifery for their support and lively debate throughout the study.

A particular thanks must go to the EME evaluation project research team: Roger Murphy, Michelle Worth-Butler and Chris Bexton. The combination of friendship, mutual support and intellectual stimulation made for a cohesive and productive project team. In addition I must thank Roger for providing careful supervision, encouragement and invaluable guidance throughout the study and during the writing up stage.

I am also extremely grateful to the English National Board for Nursing, Midwifery and Health Visiting for having the confidence to give me the opportunity to co-direct two major projects. Members of Steering Groups for these projects helped issues to be clarified and ideas to be developed in a stimulating but collaborative and relaxed atmosphere.

A very special thank you must go to my secretary Caroline Slaney. Her friendship, efficiency and encouragement have enabled me to manage change and development at work alongside meeting commissioned and personal research targets. With patience she has deciphered my writings to produce many drafts before processing the final thesis.

Finally a personal thank you must go to my family. To Ian for his understanding of a home taken over by research papers, to my daughters Shona and Deborah for their enthusiastic encouragement and practical help and to my parents for their enduring support.

ABSTRACT

This thesis examines the effectiveness of a new curriculum for the preparation of midwives. Data were collected over a three year period in seven case study institutions, from women who had their babies in one large maternity unit and from a professional network of experienced midwives whose role is to advise the statutory body regulating midwifery programmes in England.

The overall intention of the study was to improve the pre-registration midwifery curriculum locally and influence national policy and guidelines. Action research provided the framework for the study where a multi-method approach was largely qualitative to attempt to capture the context and complexity in which the midwifery education programme operates.

The research explores and compares curriculum intentions with the perceived experiences of the curriculum as reported by key stakeholders. The development of a holistic integrated model of a competent midwife provided the framework for discourse on curriculum effectiveness, the design of an assessment matrix and recommendations for curriculum improvement. Overall the three year pre-registration route into midwifery was found to be an effective preparation for contemporary midwifery practice as judged against a model of a competent midwife. However there was evidence to suggest that not all students were equipped to practice competently and confidently in contexts of uncertainty and change in the health service. Factors which emerged as influencing curriculum effectiveness related to: recruitment and selection, curriculum structure, appropriateness and robustness of assessment schemes, the preparation of and support for assessors and the role of the midwife teacher in assessment in practice settings.

Diagnosing problems and initiating actions as a collaborative process formed an important part of designing and implementing an 'ideal' curriculum in changing and constrained health and higher education contexts. The need for on-going dialogue, critical reflection and research to facilitate and assess learning more effectively in the 'caring' professions emerged as necessary to ensure only competent practitioners have a licence to practice.

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PREFACE

This study comprises a synthesis of two separate but interwoven research projects. One of these, the EME (Effectiveness of Midwifery Education) project, was a national evaluation study designed to investigate the outcome effectiveness of innovatory three year pre-registration midwifery programme of education. My role was that of co-director for the project. The other study comprised an evaluation of the three year pre-registration midwifery programme in my own institution. Both studies adopted a qualitative research approach and were undertaken to inform curriculum development.

The EME project was commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB) and the final report was published in July 1997 (Fraser, Murphy and Worth-Butler 1997). The areas of data collection and actions for the EME project, with which I was most involved, are woven into this action research study together with all data and actions from the study within my own institution. This synthesis and presentation of data from both the EME and the local studies I believe is justified on a number of fronts. Firstly, as a practising midwife and member of the national group of ENB appointed Approved Midwife Teachers and the ENB's Professional Midwifery Advisory Network I can claim to be directly involved as a practitioner researcher in the EME study. I can also claim to understand the context in which it is located. Secondly I am committed to improving not only my own institutions's pre-registration midwifery programmes, but programmes nationwide. Findings from the EME study could not be disclosed to my own course planning team prior to publication of the final report, but they were used to inform my dialogue with them. In addition preliminary findings were able to be fed back to the case study sites to explore assessment issues more fully and bring about changes to our tentative assessment matrix. Finally, all elements of the commissioned study and the local study have contributed in some way to collaborative actions to improve the pre-registration midwifery curriculum nationally as well as locally.

CHAPTER ONE PRE-REGISTRATION MIDWIFERY

PROGRAMMES

1.1.   INTRODUCTION

This thesis seeks to demonstrate the need for systematic curriculum evaluation to bring about curriculum improvement. Whilst the Quality Assurance Agency (QAA) Higher Education Assessment Exercise is likely to focus the minds of course leaders on curriculum improvement to ensure a continuing supply of resources, those involved in professional education have a responsibility not only to higher education but also to the users of their professional services. Over the years there have been major changes in all forms of professional education and midwifery education is no exception. In 1989 the English National Board for Nursing, Midwifery and Health Visiting (ENB) introduced three year diploma and degree pre-registration programmes of midwifery education. The intention had been for these programmes to be offered in each Region of the country alongside the already well established 78 weeks course for registered nurses wanting to change to a career in midwifery. However, there was an overwhelming response to this new initiative and now the majority of universities offer more places to students as "direct entrants" (a term not now used within the profession) rather than the more traditional shortened route for nurses.

At the start of the 1990's midwife teachers found themselves required to design and develop new pre-registration midwifery programmes alongside mergers into large

colleges of nursing and midwifery and subsequently into universities.

They were therefore faced with adapting to a new academic culture and separating, employment wise, from their health service colleagues. At the same time the purchasers of midwifery education were expecting programmes to be designed at a higher academic level (previously certificate level) which were accessible to students of wide age ranges and abilities.

Given the context and uncertainties about the effectiveness of these new three year pre-registration midwifery programmes, it is perhaps understandable that the ENB commissioned an evaluation study. This three year study, known as the EME (Effectiveness of Midwifery Education) project commenced in October 1993 and the final report was published in 1997 (Fraser, Murphy and Worth-Butler, 1997). This thesis represents a complementary action research project to improve my own institution's pre-registration midwifery programme.

1.2   THE EME EVALUATION PROJECT

The EME project team was required to evaluate the three year midwifery programmes in two phases. Phase one concentrated on the assessment of competence and student ability to fulfil the role of the midwife at the point of registration. Phase two evaluated programme effectiveness in terms of one year in midwifery practice. The evaluation design was based upon an interpretative (Smith 1989) and constructivist (Guba and Lincoln 1989) philosophy, incorporating a multi-site case study approach as described by

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Schofield (1993), Yin (1994) , Hamel et al (1993) and Brewer and Hunter (1989). As with any commissioned study specific outcomes were required in addition to the overall judgements of programme effectiveness. This involved a survey of all institutions offering the programme and an analysis of their curricula (Mountford et al 1995), as well as collecting data from experts in midwifery (Worth-Butler et al 1996) and from childbearing women (Fraser et al 1996).

1.3   THE WRITER AS ACTOR AND DIRECTOR

This thesis provides an account of the macro (national) level in pre-registration midwifery education juxtaposed with a set of contradictory as well as complementary accounts of what happens at the micro (local) level. A particular attempt is made to reflect upon my own role at both these levels. The action research approach also investigates the circumstances within which the project has contributed to attempts to bring about curriculum improvement. Throughout an attempt is made to write a text which has coherence whilst trying to make evident the need to reflect on and respond to the complex and ever changing context being explored.

As one of two directors of the national study I was able, with a co-director expert from education, to propose and manage a research strategy designed to evaluate the effectiveness of pre-registration midwifery programmes. Whilst data from this macro study would be likely to be of value to the curriculum for which I was responsible locally, there was evidence of the need for a systematic evaluation of this local curriculum to inform curriculum development (Fraser 1994, 1996).

Locally it was possible for me to undertake a study similar to the EME case studies, and as actor (researcher) and director (programme manager) I was able to access different kinds of information than had been possible in the national study. This dual role of local actor and director was not without its challenges and dilemmas. These issues will be made evident throughout the text.

In keeping with the complexity of the context being studied this text has no real beginning or ending. The "story" begins with the curriculum in action and ends with curriculum intentions for future student midwives. Evaluation of the effectiveness of this revised curriculum will no doubt be the next cycle in striving to achieve absolute programme effectiveness in preparing midwives: to meet the changing needs of childbearing women, (DoH 1993) the requirements of statute (UKCC 1993), the expectations of employers (Jarrold, 1995) and the standard set by Higher Education (HEQC 1995, 1996).

CHAPTER TWO CURRICULUM INTENTIONS AND REALITIES

2.1   THE NATIONAL PERSPECTIVE

The twenty-three three year pre-registration midwifery programme curricula, were analysed during the study. It is possible that they were written as part of a drive to achieve the ideals of the midwifery profession (Radford and Thompson, 1988), the aspirations consequent upon affiliations and mergers with higher education and the desire to provide high quality midwifery care. As such, the writers were likely to be motivated by professional, political, economic and ideological influences. The curriculum documents were therefore recognised as representing the formalised thoughts and plans of a particular group of diverse individuals, transferred onto paper in a polyphonous style. Midwife teachers and practitioners were being expected to review their established practices of offering only shortened non-academic award bearing courses for registered nurses and design degree and diploma level courses for those who may have no prior health service experience. Given the changing context, many of these curriculum designers found themselves in, it was perhaps surprising that there was a high level of similarity in the curriculum documents.

Phillips (1995) suggests that although some people thrive on change and innovation and the risk associated with uncertainty, others find it threatening and seek out an authoritative voice in a quest for homogeneity and certainty. He is critical of this latter

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group in relation to nurse education as he believes educators should explore diversity and contradiction and "bring about the development of a nurse education curriculum which encourages students to treat knowledge as the beginning of a dialogue" (p.15). At first sight it might appear that the writers of these midwifery curricula are seeking uniformity as a way of coping with uncertainty, but on closer examination there are noticeable differences in emphasis and organisation which suggest an openness to explore diversity. Do these curricula demonstrate therefore a greater tendency to conformity or to innovation?

2.1.1   A hypothesis: the juxtaposition of certainty and uncertainty

All twenty three curriculum documents quote from and refer to common statutory/international reference documents (e.g. WHO 1969, ICM 1972, UKCC 1986) and thus there is a basic agreed description of the midwife. The curricula describe midwives as reflective, research-based,, autonomous practitioners who contribute to the development of their profession and see the need for life-long learning. Midwives work in partnership with women and their families using a problem-solving, individualised needs-meeting approach and have flexible attitudes to care. Even in the context of uncertainty the curriculum writers convey a confidence in this description. Given "The definition of a midwife adopted by the International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO) ..... and later adopted by the World Health Organisation (WHO)" (UKCC 1994 p.3) it would seem unfair to suggest that these similarities arise out of a quest to cope with uncertainty or in response to an external command. Instead it seems more likely that there is a commonly

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held belief amongst midwives about the nature of their role as exemplified by the requirements for membership of the International Confederation of Midwives (ICM 1993).

Uncertainty seems to lie more in the ways in which the programmes appear to be organised, delivered and assessed. Historical influences could have affected curriculum design and could be attributed to the syllabus laid down by the professional bodies. These professional bodies include, initially the Central Midwives Board and now the United Kingdom Central Council (UKCC) and the four National Boards (ENB in England) who approve institutions and courses. The remit of these bodies is to protect the public from unsafe practitioners and hence the curriculum writers must convince the ENB that their programmes will produce safe, competent midwife practitioners. More recent influences could be attributed to the interface with nursing and the need for programme validation at diploma or degree level by higher education.

The interface with nursing has possibly had a two-fold influence. Firstly the majority of midwives are also registered nurses and hence followed a shortened programme as student midwives before practising as midwives. Midwife teachers and practitioners generally have limited experience of teaching and facilitating learning for those who have not been socialised in the health care system. The second element that could influence the midwifery curricula is whether schools of midwifery amalgamated with schools of nursing or other institutions. Pressure could be exerted to economise on timetabled sessions and require pre-registration student midwives to be taught with students nurses or multi-disciplinary groups for specified periods of time.

In seeking approval of a course for the award of a diploma or degree the curriculum planners might have been expected to draw in experts from higher education to participate in teaching, to structure courses in particular ways (e.g. modules, units, semesters) and to assess students in accordance with local regulations. No one can make curriculum planners adopt a particular strategy but there could have been concerns that failure to demonstrate conformity might lead to courses failing to be approved. The following discussion can only hypothesise as to why there might be curriculum variations in emphasis and organisation when there was such similarity about the nature of the role of the midwife. There is of course no guarantee that everyone involved in curriculum implementation will interpret the curriculum in a unified way and hence this hypothesis can only relate to curricula as written.

There is an assumption in all the documents that most women of childbearing age are healthy and childbirth is a natural process. Hence the students initially observe while "normal" mothers are being cared for, they then participate in this care and much later are exposed to caring for women who have or develop complications. It is likely that this progression from normal to abnormal has been influenced by the requirements set out by the UKCC (1990). Content is structured in nearly all these programmes so that it is taught from the simple to the more complex, health before illness and normal before abnormal. Hence theory and practice are arranged serially or progressively, Bruner's (1960) spiral curriculum being the most commonly described. The degree to which the simple are revisited in greater detail as part of the complex (Bruner 1966, Ausubel 1968) is variable.

This organisation of the curriculum is perhaps not surprising given the UKCC and ENB guidelines and influences of Project 2000 programmes (UKCC 1986). Unfortunately this would appear to support the notion of curriculum as 'edict' as the simple to complex model contrasts with the realities of midwifery practice. It is suggested that the uncertain and puzzling situations encountered by midwives would have been better served by a curriculum that enables students to develop the skills for problem framing and re-framing from the beginning.

A second commonly held assumption in the curriculum documents is that taught theory would be integrated or synthesised and there would also be an integration of theory and practice.. Evidence for this was lacking in many of the programmes due to the compartmentalised arrangement of subject disciplines and the timetabling of more hours initially for theory than there are for practice (fig 2.1)

Figure 2.1   The

double-wedge

approach

Clinical
Practice

Academic
Theory

Year 1   Year 3

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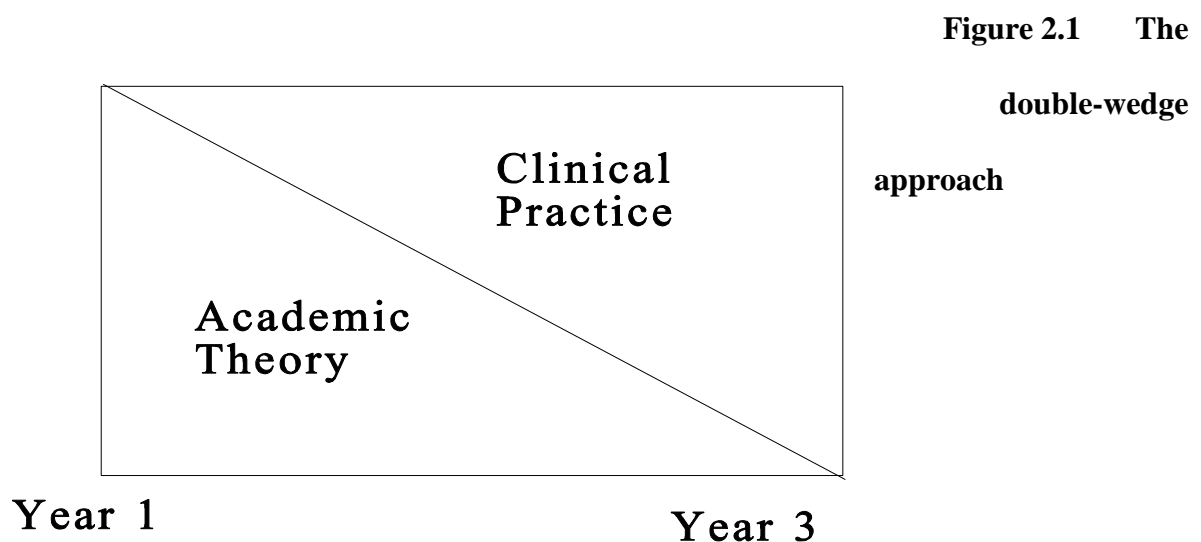
Why then, when curricula propose a philosophy of integration to demonstrate the complex and holistic role of the midwife, do they appear to demonstrate a traditional model of professional knowledge based on positivist epistemology? Schön's view that "the business of university-based scientists and scholars to create the fundamental theory which professional and technicians would apply to practice" (Schön 1983 p.36) might help provide an answer. All curricula have selected modules/units/themes related to specific academic disciplines e.g. biological, psychological and social sciences. In secondary education Ball (1981) found that science teachers were likely to put the needs of their discipline before the needs of an innovation. Many of these curricula draw upon university lecturers to teach the early content of these academic disciplines. It is possible they have little knowledge of midwifery and have different emphases of scholarship in their own field. Involving a large number of teachers, claims Bernstein (1971), makes an integrated curriculum more difficult to achieve since control of the classification and framing of knowledge by midwife teachers is much more problematic. Perhaps in striving to gain academic recognition for their programmes, curriculum planners have had to temper their innovative ideas with, at least on paper, adopting the power and all pervasiveness of the "technical rationality" model of practice criticised by Schön (1983).

The need to adopt a more double-wedge approach to curriculum organisation was potentially initiated by the professional bodies. In their regulations and guidelines institutions are required to assess "theory" and "practice" and to schedule students for 1000 hours "rostered service " (ENB 1996a). Inevitably rostered service will be scheduled for the final year of the programme and assessing "theory" and "practice " implies a university (academic theory) and clinical placement (clinical practice) split in

assessment. It is possible that drawing upon a large number of academic subject experts early on in the programmes could tend to overload the early year with content but could reassure the midwife practitioners that the new type of students, once allowed in practice, would at least be knowledgable if not socialised 'doers'.

A third significant variable in these programmes was the midwife teacher/student interaction in the first year. The variable emphasis on theory as facts and information taught largely as separate disciplines by academic experts or nurse teachers may influence the student's view of knowledge and their learning strategies. This is likely to be greatest in those programmes where students are taught mainly by non-midwife teachers. It is suggested that the first year is the time when students are most vulnerable and experience the greatest influence on their fundamental paradigms of knowledge, teaching and learning and especially midwifery practice. A lack of integration of subject knowledge with meaningful practice is also, suggest Eraut et al (1995 p,205) likely to be "exceedingly wasteful because without linkage to practice is quickly forgotten and has to be repeated later in the course".

Finally, although programmes recognised the variety in student learning style and the ability of students to do well at different tasks, the weight given to traditional methods of assessment, notably unseen exams and essays varied as did the assessment load. Whilst most curricula describe the assessment approach as one of problem solution, none of the curricula explicitly incorporated problem design into the process. Schön (1983) makes the suggestion that problem design is at the centre of practice rather than solution as, "in real-world practice, problems do not present themselves to the practitioner as givens.

They must be constructed from the materials of problematic situations which are puzzling, troubling and uncertain" (p.40). It would seem that the weight of assessment was increased in those programmes that were modularised or unitised and where no credits were given for practice based assessment. It is likely that the move to higher education validation influenced the assessment strategy and midwife teachers were more, or less, empowered to be innovative. Whether these assessment schemes are likely to be more of less effective in identifying those fit for practice (statute), for purpose (employers) and fit for award (universities) could not be deduced from the small number of detailed assessment documents provided for analysis as there were no commonly shared definitions of competence or standard for award.

Summary

Those involved in planning the pre-registration midwifery curriculum and those involved in the approval process cannot guarantee that colleagues will implement the programme as designed. If a new curriculum is to be implemented successfully it is necessary to convince a critical mass of midwife teachers, subject teachers and midwife practitioners to take on the values, organisation, content and outcomes so intended. What seems in doubt is whether some elements of the curricula, as written, do embrace the values and intentions of the curriculum writers or whether certainty to gain approval over-ruled the desire to innovate and propose a curriculum full of uncertainty and uniqueness. The next section seeks to summarise the innovations and compromises made when seeking validation for my own institution's first three year pre-registration diploma in midwifery programme.

2.2   THE LOCAL PERSPECTIVE

Staff in my own institution supported the suggestions, in 1990, that we should develop a three year pre-registration Diploma in Midwifery programme to run alongside the well established 78 week programme for registered nurses. Four schools of midwifery had recently (April 1990) amalgamated with four schools of nursing to form one large college of nursing and midwifery. This re-structuring and rationalisation of courses resulted in an increase in the availability of resources to support curriculum innovation. No additional resources were provided for the college, although a few institutions nationally had been given pump-priming to develop such programmes. Hence additional staff could not be "bought-in" to provide advice to the course team, although it was unlikely that the advice needed was available as so few institutions had experience of similar programmes. This could be viewed as an advantage or disadvantage. The intention was to be innovative rather than repeat what had been offered in the past and too much reliance on those with previous experience could stymie experimentation.

There was however one midwife teacher who had, in her previous post, been involved in direct entry midwifery programmes and was able to provide some indication, based on personal intuitive judgements, of strengths and weaknesses.

Whilst the decision to develop the programme was unanimous, a significant number of midwives had mixed opinions about a "direct entry" route being the most effective way of preparation of future midwives. Added to these reservations were staff uncertainties about their future roles in the recently established college of nursing and midwifery.

Shipman (1974) advises that too much change can choke innovations whereas Nisbet (1975) believes that innovation is the only way to survive "in a rapidly changing environment" (Nisbet 1975 p.6). The latter view was considered the more appropriate for our situation as our competitors were already developing three year midwifery programmes.

It could be argued that developing these programmes was hardly likely to be innovatory because of the constraints imposed by the professional organisation (UKCC 1991) and the validating university. However, as was evident from the national perspective outlined in section 2.1, and my own discussion with colleagues in other colleges, curricula frameworks contrasted quite significantly. This supports the findings of the Radford and Thompson study that nationally "what was meant by such a course (direct entry) may differ widely" (Radford and Thompson 1988 p.173). Hence the curriculum planning team took the view, espoused by Lawton (1975), that provided account was taken of essential policies that could legitimately influence the curriculum they should design an innovatory programme to reflect their beliefs and values and the context in which the curriculum would be operationalised.

The most important challenges for the course team were designing a programme for those with no previous nursing experience and enabling students to achieve the standard required for a diploma in higher education from an "old" university. Given the lack of experience of midwife teachers in facilitating appropriate learning for those with no prior experience in the health service it was agreed that shared learning with Diploma in Nursing students would be advantageous. Both groups of students required some

common knowledge of biological and behavioural sciences as well as needing to develop a range of caring skills. Nurse teachers had already established with the university their expertise to teach the required subjects at the appropriate academic level, this being the result of key nurse teachers studying an academic subject alongside their nursing. This shared learning with nurses seemed to the midwifery curriculum planning team to have a two-fold advantage. Firstly, the nurse teachers would be more likely to make their subject meaningful to students in the health service than academics from a subject discipline. Secondly the costs involved in resourcing the timetabled components could be kept to a minimum by sharing sessions already provided within the college. How much of the curriculum to share was somewhat difficult to determine as decisions had to be made based on the Diploma in Nursing intended curriculum. From a scrutiny of this curriculum it seemed that much was relevant in year one and hence the decision to share taught sessions for just over three fifths of the first year of the programme. The nursing curriculum tended towards a positivist epistemology to satisfy the higher education academics involved in programme validation but the control of the curriculum by nurse teachers sought to ensure subject linkage and integration. The midwife teachers agreed to be involved in the subject group teams that would be developing the nursing curriculum to help ensure the needs of students midwives would be addressed. In addition students midwives would attend timetabled sessions for them alone and facilitated by midwife teachers. Years two and three of the nursing programme did not contain elements considered appropriate for shared learning and therefore these two were designed for student midwives alone. The overall balance of timetabled sessions in the college and in the clinical practice areas looked very much like the double-wedge illustrated in figure 2.1. This was considered necessary if students were to be 'knowledgeable doers' during

their practice experience and able to be part of rostered midwifery teams for 1000 hours towards the end of the programme.

2.2.1   University and ENB Conjoint Validation

The need to appear to adopt a traditional model of professional knowledge based on a positivist epistemology was in part reinforced by the questioning from the university members of the validation panel. However the need for an integrated curriculum designed specifically for student midwives came from the professional members on the panel. This latter group held the views of Morrin (1992) that the philosophies of midwives and nurses are so different that shared learning is not appropriate. They supported the notion that subject specialist academics would be more appropriate teachers of midwives than nurse teachers who would be more likely to be conditioned to an illness model of care. A pragmatic resolution to the difficulties was agreed as there was very little research evidence at this stage to support or confound the differing assertions. The course team adopted the arguments of Somekh (1988) that the experiences and reflections of teachers, practitioners and students are equally of value in identifying and trying to resolve curriculum problems. Hence it was asserted that the programme should be approved as there was also the intention to evaluate it systematically as it was being implemented.

2.2.2   Evaluation of the First Two Years

Learning with and from nurses emerged as being the most contentious aspect of this new

curriculum. Systematic evaluation therefore concentrated on the notion of evaluation described by Beck and Yeoman (1987). This comprised judgements about worthwhileness and effectiveness as they related to shared learning in college and clinical practice supervised by nurse practitioners in non-midwifery placements. Two studies focussing on these aspects of the curriculum concluded that the advantages of shared learning (Marshall 1993) and non-midwifery placements (Fraser 1994) outweighed the disadvantages. There was evidence however that the first year of the programme had significant weaknesses which potentially could cause difficulties for some students achieving the intended course outcomes in relation to fitness for practice and for purpose. At the same time as these studies were reporting there was a requirement for the programme to be modularised.

Mountford et al (1995) suggest that organising a curriculum around pre-selected disciplines makes it more difficult to design and deliver an integrated curriculum Whilst the course team believed that on the one hand sharing a curriculum that had been modularised might facilitate a more appropriate selection of content they were also concerned that the "technical rationality" model described by Schön (1983) might become more embedded. Added to this the university conferring the award required that each module should be assessed separately. The university was also opposed to awarding credits for assessments carried out by non-university employees in practice placements. All these factors contributed to the decision that in order to develop the existing curriculum to improve outcome effectiveness and ensure re-validation was successful research evidence to support actions was essential.

An earlier study of my own (Fraser 1994) provided the catalyst for me and my research supervisor to bid for the EME project. My 1994 study identified important limitations of the evaluation. These included my involvement at regular intervals with the first cohort of pre-registration students which probably influenced the outcomes. I concluded that an outcome evaluation study was a necessary first stage in curriculum development to provide more reliable data on overall programme effectiveness.

With the impending merger into an 'old' university (August 1995) and its heavy reliance on university based essays and examinations, it seemed even more urgent to engage in educational research to support curriculum developments. Ball (1990) argued that reflexivity provides the basis of rigour as the various social relations in qualitative research are related to the more technical elements. It would seem therefore that taking a reflexive view of my different roles and the interface between elements of the national and a local study would help to provide the rigour necessary when producing data to inform educational practice. On-going reflexivity will, it is suggested, become an important part of attempting to:

· evaluate the effectiveness of current three year pre-registration midwifery programmes to inform curriculum development;

· explore the notion of competence in midwifery to develop assessment strategies.

CHAPTER THREE   METHODOLOGY

3.1   INTRODUCTION

This chapter is organised in five sections. These are, firstly a rationale for adopting a qualitative approach when studying the complexities of curriculum evaluation and innovation. Secondly there is a discussion of the appropriateness of action research to achieve my research intentions. The third section provides an overview of the major actions and methods employed for data collection. Further details, including justification for sampling at both group and within case levels, are provided in subsequent chapters. The fourth section seeks to provide the reader with a description of my own roles in the process so that judgements can be made about the extent of my interests and values and their potential effects on outcomes. This need for practitioner researchers, "to situate themselves in terms of the framework of professional imperatives within which they work and in terms of the values which underpin their professional action" (Frost 1995 p.308), is seen by many to be essential for rigour, validity and to give some protection against "self delusion" (Miles and Huberman 1994 p.2). The final section is intended to provide a discussion of the process of data analysis. According to Miles and Huberman, "the creation, testing and revision of simple, practical and effective analysis methods remain the highest priority for qualitative researchers" (Miles and Huberman 1994 p.3). I have therefore sought to demonstrate that the methods of data analysis, the degree of triangulation and extent of cross checking have been sufficient to meet the "hallmarks of high quality research, ... rigour, clarity and systematicity ...." (Murphy et al 1997 p.16), and to justify the actions taken at each stage in this study.

3.2   QUALITATIVE RESEARCH

Like Leininger (1992) I believe that qualitative research has the greatest potential for discovering complex and difficult human problems, yet within the health service there appears to be greater emphasis on a quantitative approach. This may explain why Day (1995) warns would-be qualitative researchers that they will be, "joining a 'tribe' and that this tribe may be seen to be in competition - even at war - with others", (Day 1995 p.365). Day is primarily referring to the qualitative-quantitative argument where, according to Denzin and Lincoln (1994) the opposing 'tribes' challenge qualitative research as being:

> *"Unscientific, or only exploratory, or entirely personal and full of bias ...*
> *It is called criticism and not theory, or it is interpreted politically ....."*

> *(Denzin and Lincoln 1994 p.4)*

As well as encountering opposing tribes from the quantitative paradigm the qualitative researcher has also to contend with opposing tribes from within. According to writers such as Miles and Huberman (1994) and Murphy et al (1997a), qualitative tribes hold a diversity of positions, some of which overlap with those adhering to the quantitative paradigm. These differences within the qualitative paradigm are likely to add to the difficulties for novice researchers in defending their studies. For example Maykut and Morehouse (1994) report problems encountered by classroom teachers in trying to defend qualitative research to their administrators, "because these administrators do not see the research as rigorous or 'scientific'", (Maykut and Morehouse 1994 p.ix). Day (1995) has also found researchers encountering criticisms that their research is 'soft' rather than

'hard' and identified studies disparaged by quantitative researchers as merely descriptive.

Whilst there are those who argue about the greater merits of one approach over another, Corner (1991) suggests that the quantitative versus qualitative debate is constraining. Similarly Miles and Huberman (1994) believe that , "the quantitative-qualitative argument is essentially unproductive" (Miles and Huberman 1994 p.41). I disagree with this view. Like Maykut and Morehouse (1994) I believe that qualitative research, "needs strong defenders" as it is still "a minority voice". (Maykut and Morehouse 1994 p.2). This is particularly true for midwifery with its close affiliation with obstetrics where laboratory research and randomised controlled trials are seen as the 'gold standard' in medical school environments. Whilst randomised controlled trials might be appropriate for determining the effectiveness of, for example one drug over another, I support the view of Parlett and Hamilton (1972) that a quantitative approach is largely deficient for studying educational programmes. Similarly Robinson and Thomson (1991) suggest that a quantitative approach might be necessary when assessing the relative merits of alternative policies and practices, but a qualitative approach is needed to uncover information where little exists. This does not imply that qualitative information will necessarily be sufficient for curriculum evaluation and development, but that a qualitative approach to data collection and analysis is more relevant. This use of different forms of data by qualitative researchers is effectively summarised by Strauss and Corbin (!990):

> *"By the term qualitative research we mean any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification .... Some of the data may be quantified as with census data but the analysis itself is a qualitative one".*
> *(Strauss and Corbin, 1990 p.17)*

This use of both qualitative and quantitative data in no way weakens the arguments for adopting a qualitative approach to the study as a whole. Miles and Huberman (1994) support this as they believe that numbers and words can help to detect and describe patterns in the data more clearly.

Given that there remains a range of tensions and contradictions within and outwith the field of qualitative research, the following three sections seek to demonstrate and justify my own approach within this paradigm.

3.2.1 Validity and Relevance Issues

Qualitative researchers adopt an essentially interpretive, naturalistic approach to try to understand the complexity of situations and people being studied. They are aware of the socially constructed nature of real life and the constraints that influence the collection of empirical materials. In contrast quantitative researchers seek to measure and analyse cause and effect relationships between variables. They see empirical knowledge as objective, verifiable and quantifiable. Little account would appear to be taken of the influence of one subject upon another. These different approaches are a little like some of the differences between a picture created by a jigsaw and by a photograph. Creating a jigsaw could be approached in many ways, the more complex it is, the more time consuming to build up the picture. Different people might tackle the problem in different ways but all seek an understanding of the whole picture whilst accepting that at times pieces are missing. In contrast a photograph is more instant, it represents a single moment in time, once all the variables are arranged it can be replicated easily. Field and

More (1985) create a similar image by describing quantitative research as a 'one-shot' approach.

Researching educational programmes is more like constructing a jigsaw than a one-shot photograph. In taking a qualitative approach to educational evaluation and curriculum development the researcher seeks for underlying patterns or themes and for actors who have opposing as well as similar perspectives. A curriculum cannot be considered effective if it fails one individual. In contrast the positivist approach discounts outliers if likely to skew statistical analyses. In qualitative research there is room for reflexivity and additional lines of inquiry to be pursued if of relevance to emerging themes. Conversely the quantitative researcher is more likely to adopt an analytic approach confined to a small number of pre-specified controlled variables. Although statistical data, such as attrition rates and assessment scores, help to build up the picture when evaluating curricula, they do not help explain the processes involved which might have the greatest effect on curriculum outcomes.

A qualitative approach has therefore more validity and relevance when seeking curriculum improvement than a quantitative approach. This assertion can be summarised by adapting the five points put forward by Becker (1993, cited Denzin and Lincoln 1994 p.5). Firstly, positivisits try to capture and understand what they see as 'reality' whereas in educational research there is a view that reality can only be approximated and hence requires multiple methods to try to discover as much of reality as is possible. Secondly, positivist methods tend to concentrate on one aspect to the neglect of others. Qualitative researchers would argue that this is only one way of telling a story.

Becker's third point does suggest however that both qualitative and quantitative researchers try to capture the individual point of view. Where they differ is that quantitative researchers are more likely to rely on more remote empirical materials, whereas qualitative investigators try to understand why individuals hold their particular viewpoints and how they are influenced. The fourth area identifies the greater detachment of the quantitative researcher. Becker believes this is demonstrated in the way the constraints of everyday life are examined. The quantitative researcher rarely studies life directly. In contrast the qualitative researcher confronts the constraints of everyday life. This is essential when evaluating and attempting to improve the midwifery curriculum where more than 50% of the course takes place in practice areas. Becker's final point identifies the differences of quantity and quality of data. He suggests that the methods of positivism fail to generate rich descriptions. Rich descriptions are essential when attempting to evaluate curriculum effectiveness from the perspectives of all stakeholders.

From this summary it is clear that I believe qualitative research has greater validity and relevance for educational evaluation and development than a quantitative approach. However I agree with Murphy et al (1997a) that qualitative researchers:

> *"should not try (as some have) to treat certain approaches as a 'gold standard' ...... because it implies a prior reality which can control the methods applied to it"*

(Murphy et al 1997a p.4)

Instead I see the qualitative researcher as more of a "bricoleur" (Denzin and Lincoln 1994 p.2) who uses whatever methods are available to secure an in-depth understanding of the situation and people involved in the study.

3.2.2 Differences in data collection and analysis

Even though a qualitative approach is considered a more valid and relevant approach when studying innovative educational programmes, it has been suggested that within the field some approaches are likely to be more valid than others. Not everyone believes researchers should engage in debates about the superiority of one approach over another. Miles and Huberman (1994) express the view that:

> *"At times it seems as if the competing, often polemical arguments of different schools of thought about how qualitative research should be done properly use more energy than the actual research does"*

> *(Miles and Huberman 1994 p.2)*

However if the findings of Sandelowski (1986), who identified problems of rigour in qualitative research, are to be challenged then some discussion is probably necessary. More recently Denzin and Lincoln (1994) cite many good examples of rigorous, systematic qualitative studies. Others, such as Peshkin (1993) urge researchers to explain the 'goodness' of their studies and refuse to let them be denigrated whereas Eisner (1997) provides a longer list of potential "perils" of qualitative research than of its "virtues". Murphy et al (1997a) discuss the most common features of qualitative research which provides a useful framework for explaining the qualitative research approach to data

collection and analysis.

The first feature of qualitative research that forms this framework is the way the perspectives of those people being studied is explored. Although quantitative researchers also seek participants' perspectives they tend to stress the deductive character of questioning where prior theories are tested out and there is little room for surprise or novelty to emerge. However unless qualitative researchers carefully select and test out their methods they might find their data emphasise what people do and neglect why they think and behave in certain ways. Attempting to establish other people's meanings challenges the qualitative researcher to consider the frequency and context for data collection recognising that perspectives might change over time and in different locations. Quantitative surveys do little to acknowledge the mood of the respondents or the political agendae that might be influencing responses.

A second characteristic of qualitative research is the emphasis placed on describing the setting for the study. This is important because, unlike laboratories, settings involving the study of people change from day to day. As Murphy et al (1997a) suggest, "the value of description must be tempered by an awareness that description can never be treated as a direct reproduction of reality .... descriptions are necessarily imbued with theoretical assumptions" (Murphy et al 1997a p.7). However an attempt to describe and not hide the setting is important when considering the context for an innovation and when attempting to create a holistic picture. It is perhaps a weakness of some quantitative studies which fail to describe settings. For example blood pressure recordings are likely to be different according to where and by whom they are taken. By neglecting to emphasise description,

positivist studies involving people can rarely claim to be rigorous or generalizable.

The emphasis on process, which characterises qualitative studies, needs to be seen in the methods adopted for data collection. Longitudinal studies or collecting data over a period of time would appear to be essential when claiming to understand how or why something took place. This in-depth perspective is necessary to justify curriculum change. An emphasis on process does not however preclude the collection of quantitative data if this enables a more holistic perspective of curriculum effectiveness to be built up.

A final characteristic of qualitative research described by Murphy et al (1997a) is the flexibility of design which allows researchers to respond to emerging discoveries. Polit and Hungler (1995) cite examples of studies which required fluidity of design to enable researchers to pursue themes which emerged following interviews with women.

Positivist researchers, who favour prediction and proof suggest that this approach demonstrates lack of clarity, disorganisation and cannot contribute to knowledge. Cormack (1991) has found suggestions that the non-statistical data of qualitative studies are incapable of contributing to knowledge development. Similarly Oakley (1989) described the arguments that randomised controlled trials are the nature of 'real' knowledge. However the following extract suggests that an examination of knowledge is far from straightforward.

> *"....the examination of knowledge can only be carried out by the act of knowledge. To examine this so-called instrument is the same thing as to know it. But to seek to know before we know is as absurd as the wise resolution of Scholasticus, not to venture into the water until he had learned to swim"*

Given the complexity of human perceptions and contextual differences it is essential for educational researchers engaged in curriculum evaluation and development to define their research questions in fairly general terms. By so doing it is possible to explore themes and gain new knowledge and understanding as the story unfolds. However within this flexibility of research design it remains essential to be systematic in selecting, sampling and analysing the data to demonstrate that qualitative research is a rigorous approach.

3.2.3   Ways of interpreting and presenting data

Positivist researchers tend to claim that they interpret and present their data within a value-free framework. In contrast qualitative researchers acknowledge the value-laden nature of their work. This difference might have more to do with hidden versus overt values which I suggest makes the qualitative study more rigorous by the way values are opened up to public scrutiny. Quantitative researchers, in their desire to establish proof might present data in such a way to make it difficult to challenge complex computer calculations with statistical significances and compelling graphical displays. In contrast there is often a, "hesitancy of many qualitative researchers when dealing with claims to truth" (Murphy et al 1997a p.6). This does not imply a lack of confidence in the rigour or validity of their work but that they are acutely aware of the complexity of the issues. Alternatively it might demonstrate that they have ethical concerns about "what constitutes legitimate persuasiveness in qualitative research" (Eisner 1997 p.268). The interpretation of data from multiple sources adds to the complexity for the qualitative researcher. However even this use of triangulation of multiple methods arouses criticism, says

Silverman (1985), as it is viewed by some as merely an attempt to reflect a one truth positivist approach to research.

The large amount of data from a wide range of sources, mainly in the form of words, creates a particular difficulty for the qualitative researcher. This data needs to be managed in such a way as to aid systematic analysis and interpretation. In one sense it is no different from the need of the quantitative researcher to manage large amounts of numerical data. However the processes adopted are likely to be more transparent when managing numbers than when managing text. An assumption is often made that the quantitative researcher will input data correctly, will check a sample for reliability of data entry and will use appropriate statistical tests or correlation tables. This assumption is possible mainly because it is reasonably easy for calculations to be re-checked. The qualitative researcher on the other hand has to make analytic choices during the process. Unless the sample is small and the data is left 'to speak for itself', the qualitative researcher has to make analytic choices to reduce the data before it can be displayed effectively and meanings or conclusions drawn out, (Miles and Huberman 1994). Data displays are an important way for the qualitative researcher to demonstrate that some interpretations are more compelling than others. The strategy of using multiple perspectives, demonstrating thorough searches for negative or differing instances and using a colleague to check for consistency are all important means of demonstrating rigour in interpreting and presenting the data. Without these processes it is suggested that, like quantitative studies:

> *"qualitative analyses can be evocative, illuminating, masterful - and wrong .... reasonable colleagues double-checking the case come up with quite different findings"*

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If reasonable colleagues disagree about findings then it is understandable that qualitative researchers encounter opposing tribes. Miles and Huberman (1994) highlight areas where qualitative researchers need to be aware of the potential for bias. These areas include: interpreting data as having patterns or themes that are negligible, putting more emphasis on responses from highly regarded participants than others, or by becoming so involved and part of the group being studied that a balanced perspective is lost.

Recognising our own values and potential for bias, drawing up ethical guidelines and adopting sound practices throughout the process are all important elements of good qualitative research. The same principles can equally well be applied to quantitative research. The positivist researchers who claim that their studies are characterised, "by a belief in value freedom" (Tubbs 1996 p.43) are, in my view, deluding themselves.

3.3   RESEARCH DESIGN - ACTION RESEARCH

The decision to adopt an educational action research approach for this study emerged early on. Tentative findings from the analysis of curricula and project team discussions about the notion of competence and how to determine fitness for midwifery practice were of particular relevance for my own institution. I had initially considered using my own institution as a seventh case study, alongside the six national case study sites. However, I believed it impossible for me to try to assume the role of detached researcher when I was accountable for the quality of the midwifery programmes in my own university. As issues emerged I would need to discuss them with the course team and formulate action plans as and when required. In this way research and action are integrated, unlike the 2

stage process of the national part of the study where as Somekh (1994) suggests, the knowledge generated from the research will be applied by practitioners when the report is published. Coming from a position where I believe that all those exiting from our programmes should be capable of providing women with a safe and positive experience of childbirth, I could not undertake research into our own course effectiveness in isolation nor fail to take alternative action if that seemed appropriate. There was also the need to re-design the curriculum for 1997 and proposals for change would need to be owned by all participants if they were to be argued convincingly during the validation process.

Action research with its emphasis on diagnosing problems and initiating actions as a collaborative process between researcher and practitioner had relevance for my own areas of concern. Noffke (1994) asserts that it is also concerned with "ethical issues as well as technical ones" (p.14) which for me is of vital importance in vocational education, the more so now universities are responsible for conferring the academic/professional award. However, like Prideaux (1993), my department is located in a largely "positivistic and quantitative" (p.375) Faculty of Medicine and Health Science and representatives from medicine would be members of our course planning team. Hence they would be the major players in the validation process. Given that there appear to be a large number of interpretations of action research, it seems sensible to try to locate my own unique interpretation and approach to action research within this plethora. This should better enable me defend the credibility of our findings and actions when exposed to sceptics from both qualitative and quantitative paradigms, and those who value theory more highly than practice. Like Titchen and Binnie (1993) I need to be able to demonstrate, to medical colleagues in particular, that action research is an appropriate and rigorous

strategy when evaluating and improving innovative curricula.

3.3.1 History of action research

Most writers appear to attribute the concept of action research to Kurt Lewin for his pioneering work in the 1940's amongst factory workers and immigrants in the USA (Adelman 1993, Gitlin 1993, Hart and Bond 1995, Holter and Schwartz-Barcott 1993, Kemmis 1993, Noffke 1994, Somekh 1994). However Altrichter and Gestettner (1993) draw upon the work of two German writers who argue that "not Lewin but J. L. Moreno should be seen as the founder of action research" (p.332). As these German writers, Petzold and Gunz, have written in their own language I am unable to critique their arguments, but as Lewin and Moreno knew each other, it is possible that their thinking was very similar. The lack of references to Moreno suggest that Lewin is the more worthy of being credited with coining the phrase "action research".

Lewin's quasi-experimental work is more likely to appeal to my medical colleagues than the empowering, enhancement and emancipatory approaches described by Hart and Bond (1995), Holter and Schwartz-Barcott (1993) and Kemmis (1981) respectively. However Lewin's work did not fit a conventional quantitative research approach. Adelman (1993) described Lewin as a scientific pragmatist who adopted a methodology which was,

> *"a dialectical process seeking best fit or concordance and an interpretative (of many social perspectives) epistemology melded to a quasi-experimental orientation. Lewis did not work by hypothetical induction....."(Adelman 1993 p.12)*

Although Lewin's work has, according to Somekh (1994), been criticised as technicist and positivist, he emphasised the importance of democratic participation and believed action research could be carried out in four different ways. Adelman (1993), drawing upon the work of Marrow (1969) described these as experimental action research when investigating the relative effectiveness of different techniques; empirical action research involving the accumulation of evidence in day to day work from similar groups; participant action research when investigating a problem locally and finally, diagnostic action research where external change agents would intervene to produce a needed plan of action. These four different approaches have, according to Kemmis (1993), "presaged three important characteristics of modern action research: its participatory character, its democratic impulse, and its simultaneous contribution to social science and social change" (p.179). It would seem to me that these variations in approach, but with their unifying characteristics, helps to explain the interest and differences in action research across the world in education and health services. Noffke (1994) suggests that whilst action research is gaining in credibility in many, if not all, countries it has also developed "multiple meanings" (p.13).

In Britain the curriculum development work of Lawrence Stenhouse (1975) brought about the teachers as researchers movement. Somekh (1994) asserts that John Elliott had an influence upon Stenhouse's thinking in the Humanities Curriculum Project and has now established a tradition of curriculum action research which has been adopted elsewhere. Although Elliott and Stenhouse both believed that teacher involvement in research is an essential part of curriculum development, Somekh (1994) identifies differences between them:

"Elliott's concept of educational action research differed from Stenhouse's concept of the teacher as researcher, because he doesn't see the development of understanding as preceding the introduction of changes in practice. For Elliott, educational action research is a hermeneutic process of movement back and forth from the particularities of practice to the theories of interpretation"

(Somekh 1994, p.9).

Although some might suggest that the work of Stenhouse, coupled with Elliott and Adelman's directing of the Ford Teaching Project between 1973 - 1976 has been the catalyst for the resurgence of contemporary interest in educational action research throughout Britain, Elliott (1996) himself suggests otherwise. He cites the work of "Eraut at Sussex and of Whitehead and Lomax at Bath and Kingston" as having "developed relatively autonomously from the influence of Stenhouse" (Elliott 1996, p.5). This perhaps goes some way to explaining why McNiff (1988) suggests that "there seems to be a polarisation between those working on action research in Cambridge and East Anglia, and at Bath" (McNiff 1988 p.xvii). The relevance of this apparent polarisation to my own study will be returned to later.

The influence of Stenhouse and Elliott in other countries appears more apparent than that of other British action research advocates. In Australia the collaborative curriculum planning of Kemmis (1982) and McTaggart (1991) has some features of Stenhouse's work but also appears to have been influenced by the critical social sciences and the framework described by Habermas (1974) for the mediation of theory and practice.

According to Altrichter and Gestettner (1993), "Austria has developed a new strand of

action research based on work of Stenhouse and Elliott" (p.349). This they say is in contrast to the decline in action research in Germany, the former home of Kurt Lewin. This decline they believe could have been arrested if German action researchers had made allies with other research programmes. The proponents of action research in Germany appear to have been unable to confront their critiques and were, according to Gestettner (1976, cited in Altrichter and Gestettner, 1993), also engaged in role conflicts within their teams. Critics in Germany argued that "the basic terms and methods of action research remained unclarified and that its objectives were characterised by vague terms, unclarified preconditions and contradictions" (Altrichter and Gestettner 1993 p.342). Hart and Bond (1995), Holter and Schwartz-Barcott (1993) and Lathlean (1994) believe that there is also confusion in the nursing literature where action research has gained in popularity. This suggestion that there is confusion and vagueness of terms warrants further discussion before being able to clarify my own position in this study.

3.3.2   Characteristics of action research

Many advocates of action research have adopted Stenhouse's view that action research must be systematic and made public, but this alone does not distinguish it from other forms of research (McNiff et al 1996 p.12). According to the founder of action research, Kurt Lewin, it requires democratic participation resulting in action for greater effectiveness or improvement (Adelman, 1993 p.1). More recently, Elliott (1995) has found that the term, action research:

"is being used to legitimate any form of methodological deviance from

the traditional paradigm. It is the buzz word which is appealed to when
any researcher wants to promote the practice relevance of their work to
teachers and administrators"

(Elliott 1995 p.1).

Perhaps because of this misappropriation of the term some writers have constructed typologies to clarify (in their view) the processes of action research (e.g. Hart and Bond 1995, Holter and Schwartz-Barcott 1993). Others describe action research as having a list of characteristics, features or embodying certain principles and processes. Somekh (1988) offers a definition which encompasses the main themes that seem to occur in most people's interpretation of action research:

"Action research is the study of a social situation, involving the
participants themselves as researchers, with a view to improving the
quality of action within it"

(Somekh, 1988 p.164).

Whilst there might be general agreement that action research is context specific and involves action by those directly involved in the situation, there is a diversity of opinion surrounding collaboration and the nature of the action or processes involved. The relative merits of the differing perspectives will be discussed alongside the views of those who are sceptical of the value of action research.

Collaboration in action research

Elliott (1996) described the early forms of action research in which there was collaboration and negotiation between professional researchers from higher education and

practitioners committed to improving their practice in schools. In this situation the experts from higher education spend time as outsider researchers working with practitioners in schools as insider researchers. In an earlier paper Elliott identifies "the power struggles going on within the collaborative, as part of a continuing process of negotiating and re-negotiating power-relations" (Elliott, 1994, p.135). The forms these power struggles might take are defined in different ways but appear to hinge upon the role adopted by the outsider researcher. Day (1991) talks about the researcher evaluator whereas Holter and Schwartz-Barcott (1993) describe a technical collaborator who plays a key role in identifying the problem and the required change intervention. At the other extreme the outsider researcher acts more as a facilitator or critical friend (Somekh 1994, Kemmis 1993, Walker 1993, Elliott 1996).

Winter (1989) and Schratz (1993) describe working collaboratively in a more mutual way where each partner provides a resource for the other and a multiplicity of views is welcomed. Each of these roles has the potential for a conflict unless a clear set of ethical principles is adopted (Kemmis 1982, Wallace 1987). Unless these are agreed in advance there is the potential for the academic researcher to dictate the data collection methods, the structure of the verbal and written reports and what will be published by whom (Elliott 1996). Another problem encountered by Prideaux (1993) when moving between being an outsider and an insider researcher concerned access to information. At times he was treated as outsider and was given information of a confidential nature that would not have been provided to an insider. However because other groups treated him as an insider he was expected to report on his findings. These dilemmas might well have been lessened if he had considered ethical issues in advance, a situation similar to a previous

one of my own (Fraser 1997a).

Whether there is a need for active support from an outsider researcher in action research appears to be challenged. Day (1991) believes it is necessary if dialogue, challenge and systematic self-reflection by practitioners is to be effective. This is supported by Elliott (1996) who saw his role as the academic researcher to develop "teachers' capacities to reflexively and discursively transform their own practice" (p.4). However there has more recently been a significant change in the role of many academic researchers engaged in action research to that of supervisors of practitioners higher degree studies (Elliott 1996. McNiff et al 1996, O'Hanlon 1994). This form of collaboration between practitioner researcher and academic supervisor is seen by some practitioners to give them more autonomy (Meyer 1995, Waters-Adams 1994) and recognises the reality of the classroom where teachers work alone and lack opportunities to collaborate (Johnston 1994).

Whilst on the surface it might appear that the outsider researcher working in the situation with insider researchers is more likely to exert control than the academic supervisor based in the university, I do not believe this is necessarily so. I support the view of Holter and Schwartz-Barcott (1993) that it has more to do with each individual's philosophical orientation to action research. Both professional researchers and practitioner researchers are equally likely to want control or learn from the other. Kemmis (1993) has found that some outside facilitators have forgotten the origins of action research and use practitioners to collect data for them, a situation not unlike that faced by midwives who might be data collectors for academic obstetricians. Midwives are however, like teachers

in schools, increasingly undertaking research into their own practice and using university based academics as supervisors of their project. However, although Elliott (1994) suggests that the academic in such a situation might become the supplier of theoretical resources for the teacher, with the teacher as the "ultimate arbiter" (p.137), it is still possible for the academic to exert considerable control over the practitioner researcher. The practitioner researcher might tend to rely heavily on the academic supervisor for advice and direction in a dependency way. The supervisor is possibly seen as the controller of the academic award and therefore their ideas could dominate those of the practitioner. This is potentially dangerous as unlike the outsider going into the situation as collaborator, the academic supervisor has only limited insight into the situation portrayed by the practitioner. With less and less experience of the practice situation the academic becomes less and less of an expert. Can academics therefore sustain even a role as process facilitator (Elliott 1996) or are outsiders in any form becoming unnecessary as collaborators in action research (Kemmis 1993)? My answer is both yes and no, depending upon the problem and the change expected. Like Walker (1993) I agree that practitioners are constrained by the expectations of the organisation and time to undertake research is likely to be limited. Whilst I also have some empathy with McIntyre (1994) that it is "simply unreasonable to demand of teachers that they be researchers as well as teachers" (p.132), unless teachers have some ownership then change is less likely to come to fruition. This ownership might not however require them to collect data, instead it could require the practitioners to be part of a critical community of researchers where all have different but equally valued roles. The catalyst for change must, in my view come from within, a view not necessarily shared by Waterman et al (1995). But the internal instigator of the action research is likely to need the support of an

external researcher to "sustain an inquiring environment" (Day 1991, p.545). Whether this external researcher becomes a collaborator as an authentic participant such as that described by McTaggart (1989), or a critical friend must depend on the situation requiring change or improvements. If academics are now having less opportunity to form collaborative partnerships with practitioner researchers, then maybe the blame lies partly at their own feet. If as, Hammersley (1993) suggests, "outsiders have to negotiate access and teachers could fail to co-operate" (p.221) why might they choose not to co-operate? After all Day (1991) asserts that a partnership model is "practical and emancipatory for all participants" (p.545). From my review of the literature I see only a few examples of academics wanting to be equal partners with practitioner researchers. Elliott (1996) believes that collaborative action research projects have enabled academic experts and researchers to be "sensitised to the significance of *context, language* and *reflection in action* (his emphasis not mine) as they worked alongside teachers". Why then do these academics use language which, according to Ebbutt (1994) in his review of Winter (1987), "incrementally disables (his audience) by cloaking his ideas in prose of irredeemable opacity" (p.296). As a novice practitioner researcher I was however reassured when another academic, Donald McIntyre, in a critical response to a number of position papers at the 1994 BERA conference, said that he found Jack Whitehead's (1994) "living theory" incomprehensible.

On balance I believe that an outsider academic researcher does have an essential role in action research projects. Adelman (1989) believes there is a paucity of high quality accounts of teacher case studies and it is possible that this is the result of lack of collaboration with academics whose very existence is dependent upon publication output.

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Without this sort of collaboration, practitioners might be content to bring about change locally and not recognise the importance of going public. Day (1997) has found that "conditions of service do not allow for regular professional dialogue about teaching which goes much beyond anecdotal exchange, implementation planning and the trading of techniques" (p.197). Unless the practitioners have been exposed to a critical community of researchers the validity of their actions could be questioned and publication could prove difficult. However the critical community needs to form co-operative relationships if it is to be emancipatory rather than serve the interests of "the oppressors" or "the oppressed" (Elliott, 1993 p.181). With these potential tensions in mind it is now useful to consider the different approaches to constructing a framework for action research.

Frameworks for Action

If action research is about making research accessible to those concerned with day-to-day situations at work and closing the gap between theory, research and practice (Somekh 1994), then the processes involved need to be relevant and comprehensible to practitioners. Complex structuring I suggest, detracts from what ought to be a practitioner-friendly research approach. Hart and Bonds (1995) action research typology is meant to clarify what is intended by action research but in my view it is more likely to confuse or diminish practitioner enthusiasm for action research. Although they suggest that the "typology is a guide to practice rather than a prescriptive device", I feel that they have lost more than they have gained by sacrificing "something of the fluidity and dynamism of action research" (Hart & Bond, 1995 p.44).

Winter has succeeded in making his professional ideals more of a reality in his later book, "Learning from Experience: principles and practice in action research" (1989). His six principles (Appendix 1) for the conduct of action research are now more comprehensible than when expounded in an earlier book (Winter 1987). In coming to this conclusion Winter is conscious of colleagues' concerns (cites Somekh 1988) that there has been an emerging exclusive ivory tower image of action research. But when re-affirming that it belongs to teachers, he believes it is essential to re-define the key processes of observation, reflection and implementation. He is not suggesting that specific methods are necessary but is advocating a set of methodological principles. Unless practitioners have this clear framework he believes:

> *"They will not be able to refute the criticism of those who cast doubt upon the value of small-scale inquiry carried out with minimal resources by people actively engaged in the situations they are investigating"*

> *(Winter 1989, p.38)*

One danger, of particular relevance to those working closely with medical colleagues, is to ensure that "methods do not depend on 'positivist' assumptions; otherwise it (action research) will be open to attack as being like conventional research, but incompetent" (Winter 1989 p.27). Instead Winter advocates a range of working methods, based on much of the work of Elliott (1987) and Kemmis et al (1982). This triangulation of different viewpoints, he believes, is needed for "comparisons and contrasts to be illuminating and to allow conclusions to be drawn" (Winter 1989 p.22). Of particular

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importance, whatever the data gathering methods, is that the practitioner researchers will be involved in new sets of relationships with colleagues and others and therefore ethical guidelines are essential (Winter 1989, Somekh 1994, Elliott 1988, Day 1991, Fraser 1997, Kemmis and McTaggart 1982, McNiff et al 1996).

Principles rather than methods appear to be well supported by those offering a framework for action research. For example, Lomax (1994) also offers six governing principles of action research (Appendix 2) and Somekh (1994) suggests that it is a broadly defined methodology although Whitehead (1994) emphasises the need for originality. He believes that offering a methodology could tend towards a technical approach and damage the practitioner's capacity to analyse and synthesise. In spite of these ideals, Whitehead, in collaboration with McNiff and Lomax succumbed to write a basic guide to educational action research (McNiff et al 1996). In this book they say that "a significant feature of action research that everyone agrees about is that it operates in cycles. Its essential features are the cyclical moments of planning, executing and fact finding" (McNiff et al 1996 p.22), and several variations are offered to guide the novice practitioner researcher. However I agree with Somekh (1994) that cyclical models have a danger in that they can be interpreted too literally, the more so by the less experienced researcher, and if a model is to be used it should demonstrate "broad stages in an integrated process" (Somekh 1994 p.6). If a model is felt to be necessary then the one in Table 3.1 given by Altrichter, Posch and Somekh (1993 fig 3.1) is a simpler way of

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┌─────────────────────────────────┐
│                                 │
│   A  Finding a starting point   │
│                                 │
└─────────────────────────────────┘

┌─────────────────────────────────┐
│                                 │
│   B  Clarifying the Situation   │◄──┐
│                                 │   │
└─────────────────────────────────┘   │
                                      │
┌─────────────────────────────────┐   │
│                                 │   │
│   C  Developing action strategies and │
│      putting them into practice │───┘
└─────────────────────────────────┘
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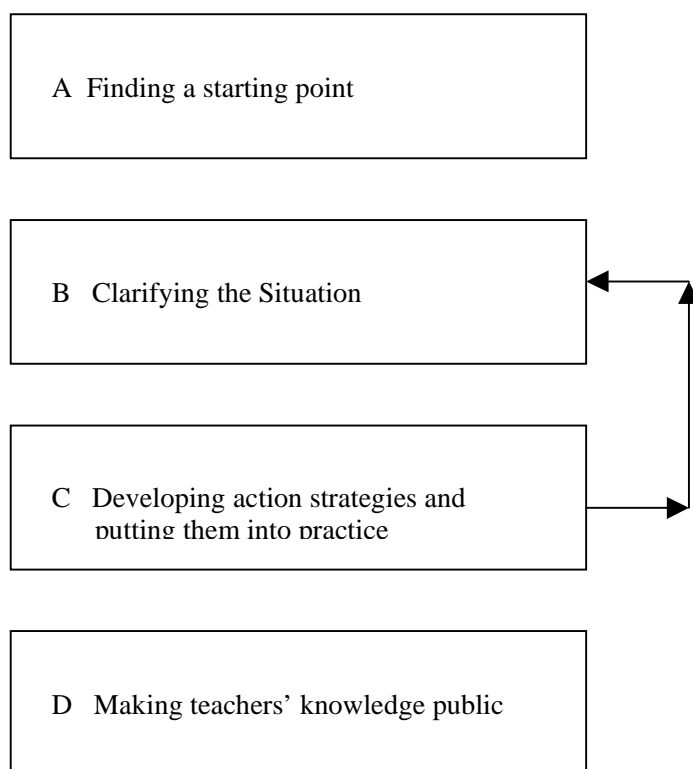
┌─────────────────────────────────┐
│   │   **Table   3.1.   The   Action**
│   D Making teachers' knowledge public │
│   │   **Research Process**
└─────────────────────────────────┘

conceptualising the approach than the models comprising numerous intersecting lines and spirals offered by McNiff et al (1996).

Although there are variations in interpretation of the best way to formulate a framework for the process of action research there are notable similarities and differences. Whatever models, frameworks or methods are adopted, all appear to emphasise the importance of reflexivity and dialectical critique in a democracy. Self-reflective enquiry is seen by Lomax (1996) as an important part of continually critiquing one's own values. Whitehead (1994) adopts a similar position when stating that it is essential to place "I" in an educational enquiry in an attempt to embody one's own values in professional practice. McNiff (1988) is critical of Kemmis and McTaggart (1982) Elliott (1981) and Ebbutt's (1985) failure to "map their own imagined frameworks onto their own practice" (McNiff 1988 p.34) She argues that the teacher-practitioner must be kept at the centre of the

enquiry at all stages in the process. The school of action researchers in Bath and Kingston is, says McNiff enabling teachers to recognise the importance of dialogue in their educational development and are enabling them to present their action research case studies in terms of dialogue.

Whilst the need for reflexive and dialectical critique and collaboration are supported by the action researchers from East Anglia and Cambridge, their approach is criticised by McNiff (1988) for failing to be "intrinsically educational" (p.35). She asserts that they fail to "encourage teachers to account for their own personal development" (p.36). According to McIntyre (1994) the differences between these 'schools' lies in their different views of 'self' in action research. Since the change in roles of academic collaborators to higher degree supervisors it might appear that the differences have disappeared. It would seem that personal development is an intrinsic part of action research for an academic award. However, from his study of practitioners following award bearing courses, Elliott (1996) found the tutorial styles of academics varied markedly. In some universities the focus was on questioning the practitioner's "thinking processes rather than on the objects of thought" (Elliott 1996, p.6). Elliott believes that personal and professional development are limited if academic supervisors fail to challenge and question the creation and testing of solutions to the practitioner's work based problem. He found little support for this view as those practitioner researchers participating in his study found action research to be a "process of self-discovery and of justifying the product of that process: self-knowledge" (Elliott 1996, p.9).

My own educational ideal is closer to that of the Elliott than the Whitehead camp. Whilst I believe that all research will bring about personal and professional development, the

catalyst for my own study is my passion for achieving the educational ideal of ensuring all students who are eligible to practise as midwives are competent to meet the expectation of contemporary midwifery practice. Like Day (1995) I prefer research which is "useful and useable" (Day 1995 p.2) and gives "a sense that it is moving forward, that we seem to be getting somewhere" (Eisner 1997 p.268).

My approach to action research in attempting to change the world of midwifery education 'out there' has therefore to take supremacy over changing the self 'in here' (Elliott 1996, p.10).

3.3.3   A personal approach to action research

The national evaluation part of the study produced evidence early on that not all students completing their programmes were equipped for contemporary midwifery practice. If this was the situation across six different case study sites in England, it would be naive to assume that my own institution was likely to be any different. The effectiveness of the programme therefore needed to be systematically investigated locally so that changes could be made to improve outcomes.

The starting point for the investigation was a multiple case study evaluation of students on a particular pre-registration midwifery programme. Each student due to complete the programme in 1995 was treated as a separate case. Data collected from this evaluation were analysed and reflected upon at different levels. These included a reflexive critique and a dialectical critique. Comparisons were made between the local and national data at

a personal level and at a collaborative level. Collaborative discourse involved the research team, the course planning team for the new curriculum locally and senior colleagues only when an action strategy was needed for a potentially borderline student. Findings from all seven case studies demonstrated the need for further clarification in relation to defining and assessing competence.

Throughout these interwoven cycles of data collection, analysis, reflection and actions, reflexive critique has been essential. Within the study my role changed according to the situation needing investigating or action. The following summary of the range of research methods involved should assist the reader in making judgements about the effectiveness of my assumed roles during the lifetime of this study.

3.4   RESEARCH METHODS

Stufflebeam (1991) suggests that it is often beneficial to include multiple methods to increase validity and robustness. As discussed in the previous section, action research advocates, such as Winter (1987), advise multi-methods for triangulation purposes. Wolf (1987) also suggests using a combination of approaches for evaluation studies. However, of more importance than adopting a multi-method approach is the necessity to select research designs appropriate to context (Cronbach 1982). The complexity of educational research in midwifery appears to fit most with the "swampy lowlands" described by Schön (1983, p.42). Parlett and Hamilton (1972) advocate a qualitative research paradigm for investigating innovative educational programmes and this approach has largely been adopted throughout this study. Where more quantitative data

have been required, questionnaires have been used but these would not necessarily have provided valid and reliable data if they had been relied upon alone.

The research approaches and methods used for the different cycles in the study are outlined in the following five sections. Details are provided in subsequent chapters as the various elements of data collection and actions are woven into this action research story.

3.4.1 Students as case studies

A multiple case study design was adopted for the study. This is based upon an essentially interpretivist (Smith 1989) and constructivist (Guba and Lincoln 1989) philosophy. Alongside the popularity of case study for evaluation studies in schools has been the more recent rise in its popularity in health service research (Bedford et al 1993, Kent et al, 1993). In spite of this popularity Yin (1994) and Stake (1975) advise their readers that alongside its advantages there are also disadvantages and case study is not without its critics (Atkinson and Delamont 1985). Hamilton (1980) and McNiff (1988) have found that critics see case study as a soft option, but generally they are considered difficult to do well.

In all case study sites a wide variety of data were collected involving interviews, observation and documentary analysis to provide a balanced perspective of each student as an individual case within a case study site. Hamilton (1980) emphasises the unique nature of each case, but others are critical if there is not potential for the generalisation of findings (Atkinson and Delamont 1985, Mitchell and Kerchner 1983, MacDonald and

Walker 1977). Atkinson and Delamont believe the case studies should bear some sort of "systematic relationship to each other" (1985, p.39). However Bassey (1984) sees the merit of each case lying.

> *"not in the extent to which it can be generalised, but in the extent to which a teacher reading it can relate it to his own teaching"*

> *(Bassey 1984, p.104).*

Both of these aspects of generalisation are of importance for action research for course improvement. It was anticipated that by treating each student as a separate case similarities and differences would emerge. According to Winter (1987) dialectical critique should enable the collaborative team to investigate the contradictions within apparent unity and the unifying context in spite of differences.

A particular dilemma for researchers when treating each student as a particular case, whether as part of insider or outsider research, surrounds issues of confidentiality . Descriptions must of necessity be incomplete to protect the identify of the participants. Some of these necessary omissions can therefore affect the ability of the critical community to validate some of the claims that are made. An attempt is made therefore to expose the basis upon which I made my judgements as claims are made.

Once analysed, reflected upon and presented to the collaborative teams further investigation of some of the issues seemed necessary. Whilst some numerical data was presented from the case studies, it was recognised that this had to be reviewed in the light

of using semi-structured interview schedules where issues emerged rather than a rigid framework being imposed. A decision was taken to design a questionnaire to use with the cohort completing in 1996. This would enable tentative theories to be subjected to "further elaboration and test" (Norris 1990 p.134)

3.4.2   Interviews with childbearing women

My earlier study (Fraser 1994) concluded that views of the users of the maternity services were necessary when designing and developing the pre-registration midwifery curriculum.   Research team discussions about the issues which emerged from some exploratory work demonstrated the value of more systematic investigation of women's views (Fraser et al 1996). I saw undertaking my own investigation of women's views locally as having a three-fold advantage.

Firstly it would provide me with a greater insight into the quality of our local midwifery practices than could be gleaned from someone else's written report. Issues might emerge which I would be unable to divulge for fear of implicating individuals but I could follow up in more indirect ways if necessary.

Secondly I believed I was more likely to be seen as an influential outsider by the women. They would see me as an academic capable (many assumed) of bringing about change in the maternity services but not actually involved in delivering the care. In this way I anticipated greater honesty and openness during the interviews in hospital and in the women's homes following the birth.

The final advantage I saw was in relation to collaboration between the university and the National Health Service Trusts. Access had to be negotiated and ethical approval obtained from the participating Trusts. I believed that the trust I had built up over the years would enable access to be given. Knowing the gatekeepers, can, according the Murphy et al (1992) prove invaluable. Ethical approval proved somewhat more difficult but was obtained once the panel understood why written information was not appropriate - non-English speaking women were to be recruited. The promise of a written report and presentation to staff, as well as the course planning team, were important elements in securing approval for the investigation.

The major disadvantage of doing the data collection myself was one of time and hence necessitated recruiting an opportunistic sample for the study. I do not believe this in any way detracted from the outcome. The wide dissemination of findings has provided extensive opportunity for dialectical critique and raised questions for investigation at a later date.

3.4.3   Questionnaires to midwives

Following an analysis of curriculum documents and exploratory work with practitioners in my own institution it was evident that there were wide variations about what makes an effective assessment strategy. As a member of a group of over 50 midwives drawn from educators, researchers, clinical experts, managers and supervisors to advise the ENB, it seemed to me that this was an ideal group of experts with which to consult. A

questionnaire survey seemed the only practical first stage to find out the views of this group.

During the construction of the questionnaire there was a time when it appeared impossible to design one that was appropriate. Midwife teachers in my own institution assisted us by completing two pilot versions and making critical comments. The final version was agreed following critical debate with the project steering group. Their advice to use the questionnaire as part of a two stage approach proved invaluable. The group work undertaken with the Professional Midwifery Advisory Network (PMAN) members enabled us to establish the problems for them in completing a questionnaire which included unfamiliar educational language (Worth-Butler et al 1996). Definitions for terms had done little to alleviate this problem. This has similarities with Ebbutt's (1994) concern that difficult language can disenfranchise "hard-pressed professionals" (p.298).

Data from the questionnaire and group discussions did provide important evidence to assist with project outcomes. However a further advantage of this data collection method was the way in which it helped my own practice. The questionnaire to PMAN has provided an invaluable learning tool and has therefore been "intrinsically educational" (McNiff 1988, p.35).

3.4.4 Focus groups

Although the national part of the study was a more traditional evaluation study, the processes that resulted in the use of focus groups have some similarities with the stages

of action research processes. It became evident that a critical forum was needed to consider and contribute to the development of an assessment matrix. This assessment matrix was a requirement for the commissioned part of the study. As my own course planning team was at the stage of reviewing the assessment strategy for the new curriculum, I believed it essential that it should be a useful tool for curriculum designers and not just lost in a final report. One of Lomax's (1994) six governing principles for action research is the need for "continuous validation by 'educated' witnesses from the context it serves" (p.3). McKen (1996) also sees the importance of using "all viewpoints as a collaborative resource, not to gain consensus but to look at the differences between them as to focus on the contradictory elements" (p.63-64). Similarly Gitlin et al (1993) suggests that "one way to facilitate the scrutiny of prejudgements for both researchers and participants is to seek out alien or contrasting views within dialogical encounters" (p.205).

The value of dialogical encounters appears to be supported by Posch (1993) who found that a "deeper understanding for a situation can be gained if different perceptions are identified and confronted with each other" (p.453), Morgan (1988) has found focus groups to be a particularly useful method for obtaining participants' interpretations of results from earlier studies. The six national case study sites provided the majority of data from which an assessment matrix was first drafted. If this was to be useful nationally and to me locally it seemed essential to involve more participants in the validatory process. The project team agreed that the case study sites should be invited to participate in focus group work.

We were aware that some writers suggest that most meaningful data from focus groups is provided if the group is homogenous (Axelrod 1976, Merton and Kendall 1956, Basch 1987). However we agreed with Hoffman (1959) and Kitzinger (1994) that for our purposes heterogenous groups are more likely to produce a varied dialogue and higher quality solutions. In facilitating the six focus groups I had to be aware of the greater difficulty in heterogenous groups of ensuring every person was enabled to contribute and all opinions were valued. Following a review of the literature the procedures outlined by Morgan (1988) were drawn upon. As outsiders we were aware of the need to avoid power differential between the researchers (group facilitator and scribe/assistant) and the participants. I therefore used strategies to encourage high levels of involvement from all participants with relatively little direct input from myself. The focus groups provided a friendly but challenging way of testing out our ideas for an assessment matrix. The tape recorded and written data were then used to re-design the matrix and test it with colleagues locally and documentary materials from 23 pre-registration midwifery programmes.

3.4.5 Towards teacher consensus - The Delphi Technique

The need for action to investigate teacher perceptions arose late on in curriculum development. Changes to the curriculum had been agreed as educationally sound and more likely to close the gap between "the ideal and what actually happens" (Lomax 1994 p.1). However I had perhaps been guilty in my passion to improve our midwifery curriculum of not remembering, as Whitehead (1994 p.7) advises, "to bear each other in mind" sufficiently. Although midwife teachers could not all be involved in curriculum

planning I did recognise the importance of the whole team owning the curriculum. When one teacher said concerns had been expressed about the feasibility of teachers resourcing the innovations, it became apparent that another cycle of action was required.

Action had to take account of difficulties for teachers being available at the same time and the way in which messages can be distorted when passed from one to another. Tensions were evident between teachers and opinions seemed polarised between believing workloads were too heavy already to consider anything new, and those who were excited by the change and prepared to work round the difficulties.

Following reflection about the range of actions open to me I adopted a three stage Delphi technique approach. The first involved individual interviews with each midwife teacher. From this I constructed a questionnaire listing all the issues that had been raised. Questionnaires were then used to establish as close a consensus as possible to the actions that would be appropriate for facilitating the implementation of the new curriculum. The Delphi technique, according to Goodman (1987), can be an effective way to obtaining honest responses without excessive peer group pressure. The details of this process and the outcome are discussed in Chapter Five.

3.5 REFLECTION UPON THE INFLUENCE OF MY OWN VALUES AND OPINIONS

Although my roles as both actor and director were outlined in chapter one, I believe a more detailed description is required to assist the reader make judgements about my

actions, adequacy of collaboration and "truth claims" (Norris 1997 p.172). I have previously asserted that by having my work supervised by an educationalist from outside the institution, "my strategy would be challenged if personal bias tended to predominate" (Fraser 1997a p.163). Since the completion of that work my position has changed. I am now an academic colleague in the same institution as my supervisor and was also co-director with him for the three year EME study (1993-1996).

This changed relationship has, I believe, enabled me to avoid a dependency relationship with an academic supervisor, such as that described by Elliott (1996). Instead we developed a collaborative partnership in which we agreed ground rules and areas of responsibility. Within the project team we learned to value each others perspective and challenge each others assumptions from positions of equality. Ethical guidelines were agreed at the outset and shared with all participants. This agreed need to adopt ethical principles was carried through into my local case study work.

Hammersley (1993) is critical of the view "that being an established participant in a situation provides knowledge that is not available to an outside researcher" (p.219). He appears to believe that insider researchers might have a tendency to deceive themselves but the outsider is more likely to view things from a wider perspective. Similarly Nisbet (1988) suggests that those with accountability for programmes are in a powerful position as "gatekeepers". Both Hammersley and Nisbet could be implying that ethical dilemmas for insiders will influence data collection, processing and reporting from a negative perspective. Kemmis (1993 p.183) assets that it is "illusory" to believe that outsider researchers will be less influenced by their own values than insider practitioners. I would

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argue that research involving people must not disregard values and consequences. Outsider researchers who fail to acknowledge the need for ethical principles to influence their activities are more likely to be denied access to information and will probably make access more difficulty for future researchers. Of the "two camps" described by Pring (1984 p.279), I believe that it is necessary to "judge the value of what is done much more by reference to the consequences" rather than value the activities "irrespective of the consequences". Reflection on the potential consequences of all aspects of the research enabled me to enter into informed dialogue with participants and agree data that could and could not be collected and reported. Like Prideaux (1993) I appeared to move between being an outsider and insider researcher at different points in the studies. This was influenced by relationships with the participants involved as well as the context.

I believe that our status as project directors for an ENB commissioned study (the professional validating body) and my role as Head of Midwifery in the University, facilitated access. National networking meant that I was known to people in other universities and maternity services and as the national study was considered to be important to the profession, access to people and information was rarely denied both in the national and local study. Does this mean I was an insider or outsider? Perhaps quasi-insider would be the most appropriate description of the role during most cycles of activity. On the other hand I has likely to be perceived as quasi-outsider by some participants as they did not see me as actively involved in day to day teaching at pre-registration level or actually employed by their institution. The cycle of action where I believe I have most claim to being an insider is in relation to the actions involving teachers. Resource management and in particular human resources is an activity for

which I am clearly responsible and therefore sought to encourage teachers to be open and share critical responsibility with me (Simons 1985)**.**

Collaboration was relatively extensive throughout and took place at different levels. There were only two people collecting the majority of data, the national project research assistant and myself. The research assistant was totally immersed in the data, I was partially submerged and my co-director was able to consider issues from a wider context. Team discussions enabled us to analyse and synthesise data from the "judicious combination of involvement and estrangement" advocated by Hammersley (1993 p.219). In my own institution I was the only person immersed in the data. I was also the chairperson of the course planning team. These roles of researcher and director could have been used to limit critical discussion. However the nature of the project and knowledge of issues emerging from the national part of the study helped me to develop more effective reflexive powers and, I suggest, enabled me to facilitate democratic course planning team meetings. The outcome was a shared body of midwifery knowledge about education practice and use of evidence and research to inform the new curricula. The new curricula (three year and shortened [78 weeks]) were validated for 5 years with no conditions or recommendations. Mc Niff et al (1996 p.108) in discussing validation write "unless other people agree with you (that you have brought about improvement) your research will not be regarded as credible". A validation outcome such as this is rare and indicated that the actions and collaborative efforts of all participants had produced two much improved written curricula for the preparation of future midwives.

If I have a personal position on these matters it is my passion to improve midwifery

education. This personal position, I believe is ethically acceptable in a study such as this. I do not accept Hammersley's suggestion that insiders have a greater tendency to self deception. All of us are susceptible to self deception, whether an insider or outsider researcher. Outsiders whose sponsors expect a particular outcome are just as vulnerable. Perhaps I am naive in believing the ENB and the midwifery profession wanted us to report "the truth". I do not think so,. The roots of legislation in midwifery, supervision in midwifery and the current climate of woman-centred maternity care have altruistic values. My enthusiasm for initiating these studies stems from my commitment to improving care for childbearing women. The way I am able to contribute to that improvement is through educational research. I believe that adopting roles as quasi-outsider, quasi-insider and true insider are acceptable approaches in an action research study such as this.

3.6   ANALYSING AND PRESENTING THE DATA

Considerable thought was given to how data might be collected, stored, managed and analysed before each activity in the process. Lessons learned from managing the large amount of data collected from the six national case study sites proved valuable in indicating where systems might be repeated or changed. In particular the use of a computer programme (TEXTBASE ALPHA) was necessary for manipulating large amounts of data following semi-structured interviews. The need to anonymise data was considered in advance to ensure that no replication of codes occurred between those of us collecting data simultaneously.

These studies generated a wealth of data and hence difficulties for ensuring adequate analysis (Hamel et al, 1993). Yin (1994, p.102) suggests that the ultimate aim when analysing data is to "treat the evidence fairly, produce compelling analytic conclusions and rule out alternative interpretation". I believe that I have treated the evidence fairly and drawn sound conclusions for our purposes locally. It would however be inappropriate to suggest that there might not be alternative interpretations as, like Altrichter et al (1993 p.131) I believe "every finding can have only a tentative status".

3.6.1   Data Analysis

The main method of data analysis involved constructive and critical stages. Dilemma analysis, as described by Winter (1982) , was used on occasions to enhance our discussions through juxtaposing different views. In this way minority views, which could have an important impact on curriculum processes or outcomes, were debated more effectively.

Tape-recorded interviews were transcribed verbatim as soon as possible. This was achieved quite quickly for the first few, but the pace slowed as it soon became apparent that this was a lengthy procedure. Field notes became particularly important when there was a delay between data collection and analysis, as well as helping to capture emergent thoughts.

Interviews and observations recorded by notes were processed onto computer disk within a few days of the event. Details of contextual information were included to compensate

for the lack of verbatim recording and assist in data analysis. Documentary information was also recorded onto computer disk alongside other data but source documents were returned to during analysis as necessary to check reliability, or otherwise, of evidence.

Analysis did not commence until all data from one group of participants were entered on computer. Both deductive and inductive methods were used to code the data. Deductive coding was carried out first to identify the passages that fitted the categories arising from my existing knowledge of midwifery education. Inductive coding proved more time consuming. All information entered on computer was read and re-read to become immersed in the data (Perkins 1986) and to allow themes to emerge. Whilst this was possible and necessary for the local part of the study, I could only become partially immersed in the data for the six national case studies. Instead both I and my co-director scrutinised the list of themes and samples of transcripts to agree/disagree themes and apply codes. Coded segments were then retrieved and themes re-viewed to agree categories.

Discussion between myself and the research assistant took place regularly, not quite in the way Altrichter et al (1993 p.126) see its value "to become aware of any blinkered assumptions", but more to cross-check our interpretations of the data. We both had different sorts of knowledge of midwifery education to bring to bear on the data. The research assistant from a relatively recent student user perspective and me from an experienced education provider perspective. Together we were able to search for evidence to substantiate or refute our claims for describing different categories. Research team meetings, steering group meetings and my own staff and course planning

team meetings provided further critical analysis to enhance reliability of findings and ensure unusual perspectives were included as advocated by Miles and Huberman (1984).

As some of the data analysis was deductive and arose partly from the semi-structured questions, quantification also seemed appropriate. In addition, it was found that "intuitive counting" (Altrichter et al 1993 p.127) was helpful in developing the categories and finding supporting and conflicting evidence. Whilst quantification for inductive analysis proved helpful, we were less convinced of its value when reporting to others. Readers could be too influenced by seeing numbers and forget the context and the qualitative approach to data collection. However, on balance, where quantification was likely to give a better insight into the perspectives of participants it seemed important to include it.

Another method of critical analysis was through triangulation. This took a variety of forms according to the stages in the study. Perceptions of different participants were compared with each other and documentary evidence and observation helped to demonstrate whether explanations appeared plausible or suspect. Workshops, focus groups and conferences provided further opportunities for interpretations to be challenged by different, larger and relevant audiences.

Sufficiency of data for analysis in a qualitative study should ideally be influenced by "saturation". This says Altrichter et al (1993 p.132) (and members of our steering group) means that it is acceptable to stop collecting any more data when it appears that it "would yield nothing new in either a positive or negative sense". As comparisons were made across the multi-sites used for data collection and nothing new emerged in one that was not found in another, it is suggested that "saturation" was achieved for this part of the

study. However, it is possible that the requirement to re-validate my own institution's curricula by a fixed date set a pragmatic limit in relation to work with women and with teachers.

3.6.2   Data presentation

Action research, by its dynamic nature, is difficult to present in written form to those who were not involved in the process. Whilst there are those within my own institution (but not my own department) who were critical of the dialectic process adopted for the conjoint university and ENB validation of the midwifery curricula, I believe that it provided the only context in which we could achieve such a successful outcome.

Although McNiff (1988 p.45) has found diagrams like her "three-dimensional spiral of spirals" (Appendix 3) aids clarity, definitive curriculum documents do not, I suggest, enable the audience to engage with the process very effectively. Action research enables the researcher to provide the reader with evidence and dialogue to capture the processes more effectively. I hope my dialogue is sufficient to enable an understanding of my reasons and values in undertaking this study. The following order of presentation of the study is for me a coherent story. Readers will have to decide for themselves whether this story enables them to judge my ability to use self and others in an ethical, systematic and trustworthy way to bring about an improved curriculum.

CHAPTER FOUR   CURRICULUM EVALUATION

4.1   INTRODUCTION

This chapter draws upon the following three main sources of evidence:

·   the 6 national case study sites (which focused on 39 students who qualified
      between September 1995 and March 1996)

·   case studies of all 22 students in my own institution (who qualified in August
      1995)

·   questionnaires sent to all 28 students in my own institution who qualified in
      August 1996

As the main purpose of this study was to improve the curriculum in my own institution, it

was felt necessary to include and treat each student as a separate 'case' to avoid missing

any potential anomalies. The multiple case study design had similarities with case study

designs seen in evaluation studies in schools (Stenhouse et al 1982, Powney and Watts

1987, Simons 1987, Worthen and Sanders 1987, Clift et al 1988, Norris 1990). In

addition each participating student within a case study site was treated as a separate 'case'

within the case study institution. Ragin and Becker (1992) describe many competing

definitions of a 'case' and the different uses of 'case' within this study are compatible

with some of those so described. So complex and various are the activities in midwifery

practice that it could be argued that one student's experiences cannot be compared with

that of another even within the same institution. An additional complexity is the multi-

site nature (6 Hospital Trusts and their surrounding communities) of practice placements even in my own institution. Hence it is possible that comparisons of case study institutions and the case study students within them are likely to result in such complex patterns that no coherent picture is likely to emerge However, given the commonly held view of the role of the midwife and the requirements of statute that have to be fulfilled, there was an assumption that interrelated categories would emerge. Whilst I would expect my own institution to exhibit some characteristics not evident in all the national case studies, there was an expectation that all 7 institutions might have some features in common in these new programmes of preparation for midwives.

The process of data collection and analysis adopted the "theoretical sampling" approach described by Glaser and Strauss (1967). The curricula analysis provided a broad theoretical framework for the first stage of data collection through semi-structured interviews with students. An analysis of this data informed decisions for subsequent data collection. This included interviews with the assessor midwife for each student at the final summative assessment point, the student's personal tutor and the course leader in each institution. In my own institution, whilst I am accountable for all programmes of midwifery education, the senior teacher responsible for implementation of the three year programme across the 7 sites was interviewed for the purposes of this evaluation.

The major source of data for curriculum evaluation was obtained from interviews (table 4.1) and observation of formal and informal course evaluation discussions and Board of Examiners meetings. This was supplemented with a scrutiny of written evaluations and student profiles. In addition the 39 case study students from the six national sites were

Table 4.1. Sources of Interview Data

Institutions number of students	Student Interviews	Assessor Interviews	Teacher Interviews	New Midwife Interviews	Mentor/ Preceptor Interviews	Midwife at end of one year (telephone)	Supervisor of Midwives/ Managers Interviews	Total
EME site 1 (9)	9 x 2	9	3	9	6	9	7	
EME site 2 (4)	4 x 2	4	5	4	4	4	3	
EME site 3 (7)	7 x 2	7	3	7	7	7	6	
EME site 4 (9)	9 x 2	8	3	8 x 1 1 x 2	7	8	7	
EME site 5 (4)	4 x 2	3	4	4	4	4	4	
EME site 6 (6)	6 x 2	6	4	5 x 1 1 x 2	5	5#	5	
SUB TOTAL EME	78	37	22	41	33	37	32	280
Own site A (4)	4 x 1	4	1					
Own site B (5)	5 x 1	5	1					
Own site C (4)	4 x 1	4	1					
Own site D (4)	1*	2	1					
Own site E (3)	3 x 1	3	1					
Own site F (2)	4 x 1	4	2					
SUB TOTAL OWN	21	22	7					
TOTALS	99	59	29	41	33	37	32	330

*   Two students on this site, one never available to interview
\#   Traumatic personal circumstances for one student meant she did not feel able to talk at this point
        Some interviews related to more than one student/midwife

followed up and interviewed on two occasions (one face to face and one by telephone) during their first year as midwives. Their perceptions about the effectiveness of the 3 year programme in preparing them for practice was compared, through interviews, with that of the midwife each new midwife worked most closely with in the early months. Finally interviews were arranged with their supervisors of midwives (or manager) at the end of one year.

An alternative follow up strategy was adopted for my own institution's August 1995 qualifiers. This involved providing each student with a written summary of the analysis of the case study interview data and asking for their comments and evaluation of the course in the light of six months practice as a midwife. The response was poor, both from those employed locally and those who were working further away (30%). It is possible that those employed locally assumed that their informal feedback by chance or deliberative encounters would suffice. None of these chance remarks added to or contradicted the themes that emerged from the systematic collection of data, a sample of responses can be found in Appendix 4.

One particular problem with course evaluation is the changing nature of the course with subsequent cohorts. In an earlier study (Fraser 1994) I identified potential problems associated with "firstness" (p.226). This is not just to do with first intakes in a particular institution but also the newness of the pre-registration diploma/degree in midwifery nationwide. It is possible that early cohorts of students are atypical, teachers support them too much or too little, midwife practitioners have prejudices based on anecdote not experience as well as overall curriculum design having some flaws which are remedied

prior to the next intake of students. In cognisance of these issues, for the national study we selected a mixture of first and second cohorts of students. Those from my own institution represented the second cohort for sites A-C but the first cohort for sites D-F. A further complexity was to be the introduction of a seventh site (5 students) in the cohort that commenced the programme in 1993. An initial intention had been to replicate the case study work with this 1993 cohort of students. However, in keeping with an action research approach this was not undertaken for two main reasons. Firstly when mapping out the interconnections between the seven case study sites many similar issues emerged. It therefore seemed unnecessary to generate any more data of a similar nature and to use busy practitioners time unless really justified. A second reason was that a replication would not be entirely possible as some of the same 'actors' would be involved. Instead, and in order to try to confirm or contradict the emerging theories a largely statistical sampling technique was employed in relation to students due to complete their programme in August 1996. A questionnaire (Appendix 5) was designed and distributed to all 28 students with an 89% (n=25) response rate. The questionnaires were not coded to encourage an honest response and hence the only way reminders were sent was via their teachers, asking any who had "forgotten" to return their questionnaire as soon as possible. All sites were represented in the sample returned (envelopes had been left with a member of each group) and several respondents had added their name. This was particularly helpful in the case of the student who was subsequently discontinued for failure in the practice based assessment. All of this data is now drawn upon in the discussion that follows.

4.2   INTENDED AND ACTUAL CURRICULUM OUTCOMES

Throughout the period of data collection there appeared to be a general consensus that the pre-registration midwifery curriculum should have the following outcomes:

1.   students should feel confident and competent to practice as midwives;

2.   students must have achieved the statutory requirements before being entered on the professional register;

3.   students should be committed to undertaking the whole role and responsibilities of a midwife, working in partnership with women to provide holistic, flexible patterns of care;

4.   students must be equipped to take responsibility and be accountable for their actions;

5.   students must be knowledgable, reflective practitioners, using evidence to inform their practice and recognising the need for career long learning.

These goals were achieved to varying degrees and by focusing on the factors that facilitated or inhibited their achievement it has been possible to put forward suggestions for future strategies. Whilst there is some overlap between each of these five areas of course outcome, there is an attempt to address each in turn.

4.2.1 Student feelings of competence and confidence

The two cohorts of students in my own institution had similar perspectives about the effectiveness of the course in preparing them for their future role as midwives. In answering question 1 on the questionnaire (Appendix 5) 100% (n=25) of respondents found the programme had either prepared them very well or satisfactorily for their future role. This included one student who was subsequently discontinued for failure to achieve the required standard in practice by the end of the course. Of the intake of students who were interviewed (n-20), 10% did not feel well enough prepared although these 2 students formally completed the course at the same time as their peers. Both of these students were from site F, one was single and aged under 20 and the other was over 30 and had young children. Academically they had experienced some difficulties, but eventually succeeded, and both their midwife assessors felt they had the potential to be good, competent midwives. The views of the midwife assessors and course leader contrast with that of the teacher on site F who was less confident of their abilities and did not relate well to them.

The reasons given by these students for not feeling confident for their first post were markedly different. The younger student thought it could be because she was taking a job in a much larger inner city maternity unit away from her home and thought the staff might have unreal expectations of a three year pre-registration route midwife. The older student thought the course was in some way partly to blame:

"....I expected when I finished the course I would feel more confident .... maybe not feel like I needed somebody as much as I feel like I do to ask questions and to tell me yes what you're doing is right. ..... if we'd been allowed to do things earlier in the course and sort of achieved our numbers (EC Midwives Directive minimum requirements of experience) earlier we could have concentrated our practice on caring for women ourselves .... building our confidence .... had more abnormal cases...."

(Local student)

A few students felt that although the course had prepared them to feel competent for their first post they were somewhat nervous.

".... excited, a little bit nervous about the responsibility that I am going to have now, but I am really looking forward to it.... I feel well prepared now to actually go and practice as a midwife, because I know I am going to have the backing of other people ...."

(Local student)

These feelings of students locally reflected the national picture where the majority of students interviewed just prior to course completion felt well prepared for the role of the midwife. The aspects of the course that appeared most instrumental in assisting students to prepare for their first job were the assessors and the student's own personality. It was evident that assessors varied in the degree to which they directly or indirectly supervised students at the end of the course. Some assessors appeared reluctant to give the students, even in the last few months, additional responsibility whereas those who did, helped to build student confidence.

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"…. I've been allowed to be all by myself and to take caseloads by myself …. its been a good experience because we are coming now to the end of the course and we should be able to take on responsibility, there's no point in getting to the qualifying (date) and we're not ready so…. I've coped alright and I feel really good about it…."

<div align="right">*(EME student)*</div>

It would appear from an analysis of curricula documents and from knowledge of my own institutions curriculum that the intention is to allow students to consolidate learning by being given small caseloads. It is evident that the degree to which this is successful is extremely variable even within an institution . For some, inhibiting factors could be the need to complete outstanding numbers of normal deliveries whereas others had "over-protective" assessors and a minority were particularly anxious students. A few respondents were concerned that some assessors and teachers could undermine a student's confidence.

"…. if you've got someone always popping in …. to check on them all the time …. its going to undermine their confidence and they are going to start doubting that they can actually care for the woman…."

<div align="right">*(Assessor local site)*</div>

There appeared to be minimal evidence that the assessors or the students used their assessment in practice documentation to agree when or if the student should be given more or less responsibility. Interviews with all participants identified the extensive dialogue that took place throughout the practice based parts of the course but perhaps the lack of documentation made midwife assessors reluctant to delegate responsibilities in case the student made mistakes. Fear of litigation was however only rarely mentioned in formal data collection but in my own experience it is a source of concern expressed by

several practitioners. Although books have been written to assist midwives understand their legal responsibilities (e.g. Dimond and Walters 1997, Jenkins 1995) midwives might find it difficult to apply famous relevant judgements in negligence cases to themselves. It would however seem that the case of Rosen and Edgar 1986 and the judgement of Lord Denning in the case of Roe v Minister of Health 1954 referred to by Jenkins (1995 p.101 & 104 respectively) could provide some guidance. In the Rosen and Edgar case the court held that the consultant could not be held responsible for the senior registrar's operation that went wrong. In other words a more senior employee cannot be held vicariously liable for the actions of a more junior colleague except in the case of actual supervision and training. It would seem possible that if a midwife has adequately trained and supervised a student and delegates responsibilities to her, then the midwife could not be held responsible for negligence on behalf of the student. If however the midwife has no evidence on which to make decisions about delegation, then she could be held negligent for failing to teach and supervise the student adequately.

It could be argued that as student midwives are not employees then the Rosen and Edgar case law does not apply. Lord Denning's judgement helps to clarify this by stating that hospital authorities are responsible for all staff working there, except when selected and employed by the patient themself. Student midwives fit into this category as confirmed in a joint statement by the NHS Executive and the Committee of Vice Chancellors and Principals (CVCP 1995) - that is, the provider of the service is vicariously liable for those involved in providing care. Midwife assessors who appear to hide behind the law as an argument for not giving students increasing responsibility could themselves be unable to cope with puzzlement and uncertainty or have had inadequate assessor preparation.

Alternatively they might be concerned that there is a lack of evidence in the assessment in practice documentation to establish the culpable party if a case went to court. These issues will be considered in more detail in subsequent sections of this chapter as lack of feelings of confidence could impact upon capability to take on the full role of the midwife.

Feeling competent for their role as a new practising midwife appeared to be influenced by their own expectations of whether they should be able to provide all the care for a woman (normal pregnancy and childbirth) themselves or whether it was reasonable to learn some skills post registration. Most institutions, including my own, did not expect for example all students to have developed suturing skills by the end of the programme although they would expect this skill to be practised in simulation. In spite of students being aware of this, a few students felt they would not be prepared fully for the role of the midwife until they could suture and carry out other skills normally carried out by midwives. There were variations between institutions and between individual assessors as to whether some skills must be learned prior to registration and which could be developed later. It is possible that these conflicting views could have influenced student feelings and self-assessment.

The majority of students felt they would be competent in their first post as they had a comprehensive knowledge base and had received a lot of teaching and experience in caring for women in normal pregnancy and childbirth. This would enable them to be safe practitioners as they would be able to recognise deviations from the normal and seek help from someone with more experience. This point is made in the following extract from a

student interview.

> *".... I've got a very sound basis in normal midwifery and understand what normal is .... have a feeling for that .... not scared to make decisions on my own em .... and em ... I think its having the particular skills .... being able to know when to do a vaginal examination and understand what you're feeling .... to be able to do palpation and understand exactly what that's telling you .... and what I was saying about being able to see the woman as a whole ...."*

> *(Local student)*

There were however some students who felt that although they believed competence had more to do with decision making and knowing your own limitations there were midwives who viewed competence differently.

> *"There's a slight tendency in midwifery as seeing competent as being dextrous .... how quickly you can set up a drip or get ready for their epidural or how quickly you can do some other technical procedure ...."*

> *(local student)*

Nowhere in the curricula documents was there support for this apparent over emphasis on psychomotor skills and it would seem therefore that some students experienced a mismatch between curriculum intentions and practitioner expectations. It did not however appear to have influenced the majority of students in their feelings about whether the course had enabled them to feel confident and competent for midwifery practice. Where there were most discrepancies in curriculum intentions and actual outcomes these lay in caring for women with complications. Many students felt that they had insufficient experience in caring for women who were ill or had a health problem and had limited opportunities to administer drugs other than analgesic and oxytocic agents. It is possible

that this lack of experience related to lack of learning opportunities and could, as explored in my earlier study (Fraser 1994), be accounted for by the reluctance of some institutions to provide student midwives with placements in acute hospital wards.

4.2.2 Achieving the statutory requirements for midwives

The United Kingdom Central Council for Nurses, Midwives and Heath Visitors is the statutory body regulating the registration of midwives in the United Kingdom. It draws upon the legislation in this country and in the European Union to draw up Midwives Rules. Rule 33 (UKCC 1993) outlines the "outcomes of programmes of education leading to admission to part 10 of the register" (Appendix 6). This rule was used as the basis for establishing whether the case study students and those completing the questionnaire (appendix 5) had achieved the requirements of statute.

In all case study sites the interviewees were provided with a copy of Rule 33 to avoid researchers making assumptions about knowledge. The students given a questionnaire were advised to use their student handbook and portfolio to help them answer the questions on the requirements of the EC Midwives Directive, Activities of a Midwife (question 3, appendix 5) and the UKCC Rule 33 (question 4, appendix 5). There was greater familiarity with the numbered learning outcomes (i) to (xi) than with the first part of the rule relating to enabling the student midwife to be able to "accept responsibility for her personal professional development". However interviewees were aware that this was a requirement for all practitioners as it had been made explicit through the UKCC Post-Registration Education and Practice legislation (UKCC 1994). The framework for the

semi-structured interviews in the national and local case study sites took a slightly different focus in identifying achievement in this area. In the six national sites we drew upon interviewee perceptions at registration and in the light of one year's practice, whereas in the local site I was looking for evidence from the players about whether the curriculum had enabled us to assess whether the statutory requirements had been achieved. This was felt to be important when developing a new curriculum to establish the match between the expectations of the curriculum planners and validation panels with the realities of interpretation.

All of my own case study students, assessors and teachers identified the assessment in practice document as providing evidence of achievement of the activities of the midwife. There had been limited opportunities for many students to become involved in family planning, breech delivery, carrying out and suturing episiotomies and taking an active role in emergency situations. However simulation, role play and written work had played a part in making judgements about capability potential. Only a small number of students completing the questionnaire identified emergencies generally (n=2) as being areas of weakness, but a larger number (n=5) believed they had inadequate experience in receiving and resuscitating babies at birth. As the EC Midwives Directives (EC 1980, 1989) specifically expects midwives to be able to carry out an episiotomy, and resuscitate the newborn when necessary, it would seem that more attention might need to be given to the adequacy of our simulation sessions in determining achievement of competence in these areas. Evidence from the six national sites did not specifically identify any inadequacies in preparing students to resuscitate the newborn and it must therefore be assumed that our own programme has weaknesses in this respect or we have students

who have higher expectations of themselves than students elsewhere. What was in common with other case study sites was the lack of experience of episiotomies which is probably a consequence of the reduction in the number of episiotomies generally.

> *".... because they're done so infrequently (episiotomies) she hadn't actually performed one ... "*

> *(EME study Supervisor of Midwives)*

> *".... I find it amazing that we're actually getting girls through now .... that have never infiltrated perineums, have never done an episiotomy.... "*

> *(EME study Assessor)*

Given the concerns in my own and other institutions about the lack of actual experience in carrying out episiotomies, this seemed to be an important consideration for curriculum development. Although there was agreement that less episiotomies are being carried out by midwives, the availability of alternatives needs to be explored.

Assessment in relation to UKCC Rule 33 outcomes (i) to (xi) appeared easy for interviewees to identify. They were aware of the cross reference code on the assessment in practice document and the students and teachers were generally quite clear about which other assessment methods tested each outcome. Whilst the majority agreed that more than one assessment method was appropriate for some of the learning outcomes, there was also a strength of opinion that over half of the outcomes could only be effectively assessed in the practice areas. The area where most uncertainty existed in relation to assessment was outcome (xi), "the assignment of the midwife of appropriate duties to others and the supervision and monitoring of such assigned duties". A few interviewees

were uncertain what this meant and two of my own students did not think there was any evidence to confirm achievement of this outcome. Nationally assessors felt it was unreasonable to expect students to be able to fulfil this outcome prior to registration but in most cases were able to give an indication of student potential. However it could be argued that if students had been given a small case load or group of post natal women to care for, they could have delegated and supervised the work of more junior students or health care workers.

4.2.3 Commitment to the role and responsibilities of a midwife

Data from all sources found that pre-registration student midwives were very committed to the ideals set out in Changing Childbirth (DoH 1993) and were keen to work in integrated midwifery teams or group practices. They saw the importance of developing good communication skills and working in partnership with women and their families to provide individualised holistic care. This was an important aim in all curricula documents and appears to have been achieved in terms of commitment to childbearing women and to the midwifery profession. The assessors in my own institution were asked to describe the qualities in their student that were most evident and demonstrated commitment to contemporary midwifery practice. Table 4.2. provides a summary of the qualities identified during the one to one interviews.

Table 4.2   Qualities identified most in own case study students

	n = 19 Assessors	n = 5 Teachers	Lacking
a) knowledgeable	17	-	1
b) enthusiastic	13	-	1
c) initiative	16	-	1
d) good communicator	17	-	-
e) high standard of care but do not always see need to balance priorities when busy	9	-	-
f) unreal expectations at times - measures self against experienced midwives	12	-	1
g) learned quickly in last 6 months	10	4	-

Knowledge, enthusiasm, initiative and good communication skills emerged as the most evident and important qualities with one student being described as lacking these qualities. Nearly half of the assessors observed that students were so concerned to provide for women's individual needs and choices that they had difficulties in prioritising competing demands for care. They were aware however that maybe the students were not always given sufficient opportunities to develop in this way.

> *".... very rarely the students manage more than one woman or one confinement at a time .... we are looking at ways of developing that even now .... (local site assessor)*

This ability to prioritise care or take charge of a ward also appeared to be lacking during the case study midwives first year of practise as described below:

> *" .... she needs to be fully exposed to all the knocks and up and downs and the stresses .... constant interruptions .... how to be a midwife and act on your own .... plan care for a ward full .... "*
> *(EME study Supervisor of Midwives)*

It seems that the notion of "time and speed in professional work", as described by Eraut

(1994a p.149) has not been fully explored in midwifery curricula nor juxtaposed against the ideals of Changing Childbirth (DoH 1993).

Another theme that emerged as needing further exploration related to unreal expectations of students and some of their assessors. All curricula, and my own institutions was no exception, emphasised pregnancy being a normal physiological event. This should enable students to detect deviations from normal, seek assistance and participate in caring for women with complications. The degree to which students should be able to provide care for women who were ill or developed a complication lacked consensus. On the whole teachers were of the opinion that students would develop expertise in these areas following registration and it was unreasonable for students to be expected to care for women with significant complications as soon as qualified. Assessors had mixed views on this issue but in my own institution assessors generally agreed that this sort of expertise only comes with experience.

> *"... she would know who to call for help .... very few would be able to deal with that but she would know who to turn to and do the necessary things while waiting ...."*

> *(Local site assessor)*

> *".... although you've got the management of your own women .... we work in little teams and you've always got a senior member within that team to seek advice or assistance"*

> *(Local site assessor).*

Of more concern to assessors were students who were anxious about being unable to care

for women with more serious complications. They felt that these students were comparing themselves with experienced midwives which was almost as unrealistic as a junior doctor in her/his first appointment expecting to have the expertise of a senior registrar or consultant. Helping students to develop the right level of self expectation proved to be particularly important in the case of one student who said at interview:

> *".... what scares me is that as soon as you're a midwife you don't think you can ask anybody .... you think you should be able to do it .,... you feel the others will think its because you're pre-reg ...."*

(Local site student)

This student's assessor was very impressed by her capabilities but felt she was a perfectionist and became worried about the things she did not know or could not do. She resigned from her first post as a midwife within a month although colleagues had tried to support her through the period of transition. It is possible that this student's self expectation that she should be able to provide quality midwifery care in all circumstances did not enable her to cope with the responsibilities and accountability that can reasonably be expected of new midwives.

4.2.4 Responsibility and accountability

There was general agreement that three year programme students were as well equipped as shortened programme qualifiers to take responsibility for women in all stages of normal pregnancy, labour and the postnatal period. No one believed it was appropriate for new qualifiers to work as independent midwives as they believed that new midwives

need to have more experienced practitioners easily available to discuss care and seek advice appropriately. This notion of 'appropriately' appeared to be a key issue in relation to whether the student was adequately prepared for her/his role. In my own institution all but one assessor believed the students were equipped to assume the level of responsibility and accountability expected from new practitioners. The response from teachers was similar but three students from each of the interview cohort and the questionnaire cohort felt they were not quite ready to assume responsibility themselves and hoped they would be given a good preceptor for the first few months. Reasons given by students for feeling uncertain about whether the programme had prepared them to assume responsibility and accountability included the following:

> *" …. not allowed on labour ward to have a 'confidence case'"*
>
> *"I do not feel it is possible to prepare someone in a classroom situation for taking responsibility …."*
>
> *"…. it is impossible to learn to take responsibility and accountability as a student. Not only are you constrained by hospital policies/protocols but by the midwife supervising you. Its perhaps likely on community but we only have 4 weeks out there at the end …."*

From a synthesis of all the case study data from my own institution, nine student midwives emerged as demonstrating significant capabilities as future midwives (Appendix 7). The qualities that were used to describe these students are listed in Table 4.3.

Table 4.3   Qualities/Capabilities of Most Effective Students

a)   Confidence is evident, not over-confident
b)   Initiative demonstrated
c)   Excellent potential as a midwife/exceptional student
d)   Calm, demonstrates confidence to women
e)   Predict would cope well/safely with emergencies
f)   High or above average academic standard
g)   Good decision making abilities
h)   High level of motivation demonstrated
i)   Assertive and articulate
j)   Good personality/good interpersonal skills

These students came from four of the five possible sites for practice and tutorial support and their ages on course entry ranged from under 20 to over 40 years. As there appeared to be a good comparison between achievement in written work and capability in clinical practice, there might have been an assumption that all of these students had similar academic abilities on entry. This was not however the case, four of these nine students had below average academic qualifications for the cohort as a whole.

Unfortunately only a minority of these students responded by giving written feedback about their first few months as a midwife although others provided more informal feedback. The issues identified in the following extracts from ex-students helped inform the subsequent deliberation of the course planning team.

> " .... I commenced as a 'core' midwife for 5½ months .... (then) moved into a team (or Group Practice as they call them here) of 6 midwives - hospital based .... The idea of working as a core midwife when newly qualified is to 'break you in gently' before becoming a fully-fledged team

midwife. Incorporated into my time on 'core' was meant to be 4-6 weeks labour ward experience. However, due to the chronic under-staffing which appears to plague the whole of London it was not a gentle introduction - I was frequently left as the only qualified member of staff on a 27 bedded ward and was only actually given 2 weeks labour ward experience. So it was a great relief to get on a team. My experience of being thrown into a <u>very deep end</u> during my first few months as a qualified midwife did make me feel acutely under confident and competent. I don't think that was inadequate training but rather inadequate staffing and support of newly qualified staff here. I have seen 6 or 7 newly qualified 'post-registration' midwives go through the same process as me and they seem to have all felt at least, if not more, under-confident that myself. Also I think you need quite a bit of labour ward experience when you're newly qualified .... after the first 8 weeks I did begin to feel a bit more confident .... but its only now that its really 'coming together'"

(one of local site "exceptional" students)

" .... felt confident and competent. Managed postnatal ward with few staff (28 beds). On delivery suite more confident than other midwives in allowing mobility to women, not monitoring throughout labour, delivery in different positions .... less confident with pre-eclampsia and pre-term labour (didn't get this experience on my training site)... thanks for such a good training .... getting promoted to F grade ...."

(Local site student who "made excellent progress")

Both of these students took up first posts in London and described short-staffed situations which meant they had to immediately assume responsibility and accountability and appeared to cope well although lacked confidence in some situations. This finding is similar to that of the midwives from the six national case study sites and the Department of Health study "Getting a Job and Growing in Confidence" (Maggs et al 1995). All case studies identified new midwives who coped well with the transition from student to practitioner but there were a few who appeared to have real difficulties in accepting responsibility and accountability. The peaks and troughs of work in the maternity services

inevitably makes it difficult to guarantee being able to "break (new midwives) in gently".

These new midwives appear capable of assuming responsibility for providing individualised, holistic care to women without complication, but unreasonable expectations were made in relation to expecting them to take responsibility for delegating and managing the work of others and providing care with insufficient support in unfamiliar contexts. These issues became an important focus when developing the pre-registration curriculum in 1996.

4.2.5   Career long learning and development

Unlike nursing, where mandatory post-registration education and practice was only introduced form April 1995, midwives have been required to undertake statutory midwifery refresher courses since the third Midwives Act came into operation in 1936. Curricula all include considerable content on legislation and the Midwives Code of Practice (UKCC 1994). Skills of reflection, no doubt promoted by the frequent references to the work of Schön (Schön 1983), were evident from interview data and course documents. Similarly my own institution promotes the use of learning journals and reflective diaries in the pre-registration curriculum. When interviewing my own institution's students, all recognised the need to continue with their own development and career long learning:

> *".... you have a responsibility to ensure your practice is knowledge based and research based and that you can't sit back once you're qualified because its part of your responsibility as a practitioner to further your knowledge .... "*
>
> *(local site student)*

"…. you've just got to continue (learning) …. you just can't stop …. you've got to carry on for your own good because things are changing so much, and for your own competence …"

(local site student).

The subsequent cohort of students who completed the questionnaire all confirmed that the programme had prepared them for career long learning and development. The midwife assessors also agreed that students were highly motivated to continue learning and increase their knowledge and abilities.

"…. there's no stopping her …. everything you put on study days for midwives she attended … in her own time…. "

(local site assessor).

" …. she is very keen, very academic, she is just not going to be happy just sitting on her laurels, no never, she is a perfectionist … "

(local site supervisor).

"… I mean with the practice as well, she will want to know, she will want to go and find out about that weird and wonderful condition that lady had or whatever …. she will want facts as well …. she is inquisitive, very knowledgable and will say to junior doctors if its not good enough … she'll suggest we think about it …. find out what others say … "

(local site assessor).

Generally all students seemed well able to identify their areas of weakness and gaps in learning. Those who appeared to lack self insight will be discussed separately in section 4 of this chapter. When asked about priorities following registration as a midwife the majority view (Table 4.4) was that they needed to consolidate their learning and develop their skills.

Table 4.4   Priorities following registration as a midwife

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Develop skills, consolidate learning	25	14	9	2
b)	Concentrate on normal midwifery initially	18	5	12	1
c)	Take on larger workload and develop management and prioritising skills	13	3	9	1
d)	Work as a member of a midwifery team	13	11	1	1
e)	Gradual development of caring for complicated pregnancies	9	2	7	-
f)	Work in a hospital initially	7	4	3	-
g)	Worried about job opportunities	5	5	-	-

Assessors thought it was particularly important for students to develop their confidence in normal midwifery before becoming involved in complications Although this might have been the intention of employers it can be seen from the extracts in Appendix 4 that ideals do not always match reality. New midwives appear to have little time for consolidation in their first post and are likely to need to develop very rapidly. As one midwife commented:

> *"These days new midwives need to hit the ground running .... we're so short-staffed"*

4.3   CURRICULUM EFFECTIVENESS

From the data obtained it might appear that these three year pre-registration midwifery programmes have proved to be effective in terms of outcome. How far this claim can be made will be considered under the three commonly cited dimensions of :

·   fitness for practice

·   fitness for purpose

·   fitness for award

4.3.1 Fitness for practice

The professional body requires each student and the institution's approved midwife teacher to sign a training record (ENB MID 5 - Appendix 8) to say that the statutory requirements for entry onto the professional register have been met (UKCC 1993, Rule 33) It might be reasonable to assume therefore that students whose forms are submitted to the ENB must be fit for midwifery practice. There are however two fairly important flaws in this argument. The first is the assumption that the approved midwife teacher is totally confident in the validity and reliability of assessment evidence drawn upon when signing these records. The second is the assumption that everyone has the same understanding of what is meant by fitness for practice.

There does appear to be a wealth of evidence that these new programmes are effective in preparing students to provide woman-centred midwifery care, this being a reasonably universal accepted requirement of fitness for practice. (DoH 1993). Similarly there was evidence to support the statutory requirement that new qualifiers had the capability to be the named midwife for a woman throughout pregnancy and childbirth provided all was normal. However there was also evidence to suggest that not all students had been equipped to practise independently because the range of learning opportunities during their programmes had varied. There was a view that new midwives should consolidate their learning by working in a well staffed maternity service where assistance and advice would be readily available. If however practice was more isolated, even though these midwives might be aware of their own limitations (a measure of 'safety' often quoted) help might not be readily available. There was evidence that quite a number of students

had not developed sufficient skills to feel confident to carry out episiotomy, catheterisation or vaginal examination without supervision. All of these skills might be necessary during normal childbirth in a woman's home. It seems that neither students nor assessors believed that simulation was sufficient experience for carrying out these skills unsupervised. Although simulation helped and programmes provided students with a good theoretical understanding of how, when and why to carry out these procedures, actual practice had been lacking.

Evidence of dexterity and understanding about these skills in real rather than simulated instances appeared to be important to all interviewees. Whilst there was acceptance that simulation only and knowledge testing were adequate learning opportunities to equip students to "take the necessary emergency measures in the doctors absence" (EC 1980) for example in a breech delivery, interviewees did not extend this adequacy to what were seen as core midwifery skills. Determining fitness for practice therefore appears to lie in attempting to define what should be the scope of normal midwifery for a new practitioner. This search for a definition of competence to practice required additional lines of enquiry which are reported in chapter six.

Given that there are likely to be situations when most practitioners will have to carry out an activity that they have not been able to practise under supervision, there must be some indicators of whether students can be predicted to be safe in these situations or not. I have argued previously (Fraser 1994) that student qualities and characteristics are key in this respect. Students who showed maturity, initiative and the right level of confidence appeared to not only make the most appropriate decisions in a variety of contexts but also

sought out more learning opportunities for themselves. Hence these students would probably be less likely to find themselves in an unfamiliar, unsupported situation than some of their more anxious or over-confident colleagues.

Those students who demonstrate lack of knowledge are likely to be discontinued before the end of the programme if the assessment strategy is sufficiently rigorous. However it is possible that the anxious student who is nurtured throughout the programme (the degree could be significant) might succeed whilst well supported and the over-confident or manipulative student could succeed if the assessment strategy is insufficiently robust. These are some of the issues that make 'failing students' problematic.

4.3.2　Fitness for purpose

In this context fitness for purpose is used to consider whether students undertaking the three year pre-registration midwifery programme meet the expectations of the commissioners of the programme, the employers and most importantly the needs of childbearing women. There was evidence from all case studies that students who successfully completed their programme were committed to the philosophy of care of Changing Childbirth (DoH 1993), a report which drew heavily on the expectations of childbearing women. However it was evident that busy maternity units left a few new midwives disillusioned that they were unable to meet every woman's individual needs. The reality of present day maternity services also appeared to expect new midwives to commence their career 'running' with very little time to consolidate learning. Managers expected these new midwives to be able to manage wards and did not expect to have to supervise them gaining experience in what they saw as fairly basic skills.

The massive swing from the shortened route of preparation of midwives to a three year 'direct entry' route is only likely to be sustained if the commissioners of education programmes can be convinced that these programmes are providing the required outputs. It is significantly cheaper to prepare a midwife via the three year route than the shortened (although technically at leat 4½ years in total) route. Whilst attrition during the shortened programme was relatively low (3% locally), retention in midwifery following qualification has traditionally been poor. However if attrition during the three year programme remains high (29% in 1991/92 and 19% in 1992/93 - ENB database), purchasers of education may wish to revert to the shortened programme. At present, from the EME data, it would appear that retention in midwifery following the three year programme is good with 95% (n=37) remaining in midwifery posts. However if there is disillusionment when midwives are faced with the realities of practice in very busy and short staffed maternity services, it is possible that retention patterns could change.

From this evidence issues emerged which needed further consideration by my own institution. Firstly why do students leave and secondly how can they be equipped more effectively to meet the realities of their first job as a midwife. Both of these issues were presented to the course planning team but prior to this the personal files of those that have left the programme were scrutinised (Table 4.5)

TABLE 4.5 PRE-REGISTRATION MIDWIFERY ATTRITION MONITORING

FIRST COHORT	INTAKE TOTAL	NO OF LEAVERS	MATURE LEAVERS	LEAVERS WITH DEPENDENTS	REASON				LEFT			% ATTRITION
					FAMILY	ACADEMIC	MIDWIFERY	FAILED ASSESS	YEAR 1	YEAR 2	YEAR 3	
SITE A	5	0	0	0	0	0	0	0	0	0	0	0
SITE B	5	1	1	1	[1]	0	[1]	0	0	1	0	20%
SITE C	5	0	0	0	0	0	0	0	0	0	0	0%
TOTALS	15	1	1	1	[1]	0	[1]	0	0	1	0	6.%
SECOND COHORT												
SITE A	6	1	1	1	[1]	[1]	0	0	0	1	0	16.7%
SITE B	5	0	0	0	0	0	0	0	0	0	0	0%
SITE C	6	3	2	1	0	[1]	3	0	2	1	0	50%
SITE D	2	0	0	0	0	0	0	0	0	0	0	0%
SITE E	3	0	0	0	0	0	0	0	0	0	0	0%
SITE F	5	1	1	1	[1]	[1]	0	0	0	1	0	20%
TOTALS	27	5	4	3	[2]	[3]	3	0	2	3	0	18.5%
THIRD COHORT												
SITE A	6	0	0	0	0	0	0	0	0	0	0	0%
SITE B	5	0	0	0	0	0	0	0	0	0	0	0%
SITE C	6	0	0	0	0	0	0	0	0	0	0	0%
SITE D	2	1	1	1	1	0	0	0	1	0	0	50%
SITE E	3	1	0	0	0	0	0	0	1	0	0	33%
SITE F	5	0	0	0	0	0	0	0	0	0	0	0%
SITE G	5	2	1	0	1T	[1[	0	1P	0	1	1	40%
TOTALS	32	4	2	1	1	[1]	0	1	2	1	1	12.5%
3 YR TOTALS	74	10	7	5	4	[4]	4	1P	4	5	1	13.5%

[ ] Partial
T = transfer to Midwifery elsewhere
P = Practice
W = Written

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Of surprise was the low attrition from the first cohort of students. It is possible they were given additional support by their tutors to compensate for the newness of the course and I interviewed and met with them at regular intervals throughout the programme as part of my previous study. Even for subsequent groups the attrition is lower than that nationally, but failed to match the 0% and 1% attrition in case study sites 6 and 4 respectively. As well as students who chose to leave the course there was one student who failed to achieve the required academic standard and therefore was not eligible for her diploma or licence to practice.

4.3.3   Fitness for award

During the programme a small number of students failed to achieve a pass standard in summative assessments and therefore their programme was terminated. A number of anecdotal comments were made to the effect that potentially competent midwives were discontinued for failure in written work and examinations. Case study data found no evidence to support this suggestion. As well as the exceptional students described earlier, there was a very good comparison between achievement in university based assessment and assessment in practice placements. On analysing the data to describe the academic profiles of my own case study students there were two surprising outcomes. One student who had above average ability, excellent references and demonstrated high motivation achieved below average marks in written work and had a barely satisfactory standard in practice outcomes.. The other surprise was five students who started the course with minimum academic achievement but ended with above average marks in written work and good practice reports. The five very successful students and the one under-achiever

all appeared to be highly motivated and aware of their own capabilities. What did appear to be different was that the under achieving student had problems with her personal teacher, expressed anxiety about exams (no evidence of additional support was found) and lacked continuity of assessor in the practice placements. She did achieve a satisfactory standard to receive the award, but had she not done so it is possible that the programme could have been at fault.

Judging whether students have achieved a satisfactory standard is said to be problematic and appears even more so when trying to identify graduate standards across universities (HEQC 1996). Students suggested that the requirements for a diploma in my own university were:

> *".... higher than that required for my honours degree ..."*
>
> *(Local site graduate student)*

Evaluations of the current assessment strategy by the case study cohort (Appendix 9) and the cohort who completed the questionnaire provided important data for improving the assessment strategy for subsequent intakes and the new curriculum.

4.3.4   Summary

An assumption has been made that sound judgements were made in determining fitness for practice and fitness for award. Evidence would suggest that 'borderline' students are given the 'benefit of the doubt' and the possible reasons for this and the implications of

doing so are discussed in the following section.

4.4   FAILING STUDENTS

In the knowledge that practitioners find 'failing' students difficult (Ilott & Murphy 1997) at the outset of the local study I had to be aware that I might find evidence that 'borderline' student(s) had been given the 'benefit of the doubt' and been 'passed' in all assessments. This required careful reflection about the ethical implications of recruiting my own institutions students into the study as individual cases. I believed that two principles had to be addressed. Firstly the students must not be disadvantaged by participating in the study. I therefore informed the students that none of the data would be analysed until after the meeting of the Board of Examiners when the pass list would be signed and the ENB would be informed that they had completed the programme successfully.   I assumed this information reassured the students as all agreed to participate.

The second principle to consider was my professional accountability for the quality of the programmes. To fulfil my responsibility, if had evidence to suggest our assessment strategy had flaws, the students were told that if I identified any areas of concern the student concerned would be offered additional tutorial support or study packs post-registration. This additional support became necessary for one student. In order to preserve anonymity, further details are not able to be provided.

Data overall from my own institution case study work showed varied responses in

relation to perceptions about the robustness of our assessment strategy. What was evident was that there was no room for complacency. Tables 4.6 and 4.7 provide a summary of responses from case study interviews.

Table 4.6   Reasons for suggesting we have a robust strategy

·   there is good teacher/assessor liaison
·   we do not use poor midwife assessors
·   the supervisors of midwives know the assessors
·   we all know each other and poor students do not go unnoticed
·   documentation provides a progressive record
·   assessors accept responsibility for students entering the profession

Table 4.7   Reasons for suggesting we have gaps in our strategy

·   we don't assess attitudes
·   there is sometimes lack of continuity of assessors
·   some assessors give the benefit of the doubt
·   assessors have not all got critical assessment skills and find it
       difficulty to fail students
·   we don't know what they'd be like in emergencies

In the light of the suggestions in table 4.7 the students asked to complete the questionnaires were specifically asked whether they thought an incompetent student could pass all elements of our assessment scheme. Their responses are presented in Figure 4.1.

Figure 4.1   Could an incompetent student pass?

- Yes
- No
- Unsure
- Missing data
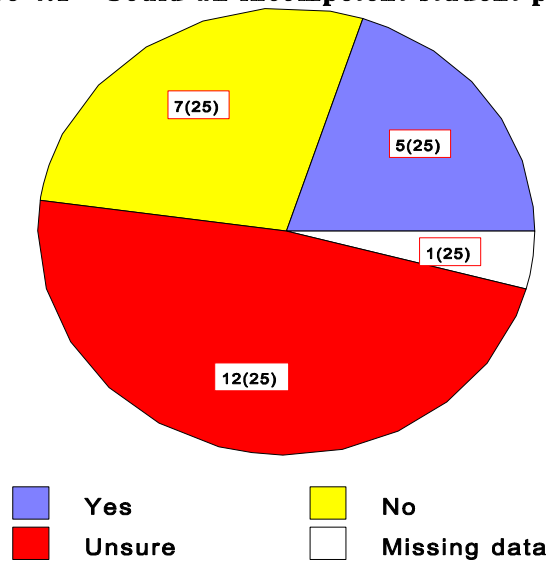
The main reasons given for being sure or unsure that an incompetent student could be entered on the professional register included the following:

- One off marking of assessments are no indication of ability in different contexts and at different times in the course

- Poor preparation of assessors

- Students who give an air of competence/confidence

- Students who seek out weak or generous assessors

- Poor monitoring of the process

In response to these findings and similar issues emerging from the six national case studies I decided that data had to be presented not only to the course planning team for the programmes to be validated but also the current course management team. It seemed

necessary to address the major areas of concern identified through these evaluations, that of the potential for borderline students being given the benefit of the doubt, so that interim improvements could be made.

4.5   AN INTERIM STRATEGY

A dilemma existed for me as 'director' and 'actor' when presenting information to my own course management team. Data collection and analysis from the six national sites had raised some important issues in relation to assessment, but these were not yet in the public domain. However, data analysed from the case study work locally had identified similar issues. Where there was a strong association between the national and local data it seemed reasonable to stress those issues in particular . The two main issues that focused discussion were the problems in adequately preparing and updating midwife assessors and the support that was needed when students were having difficulty achieving the required standard.

4.5.1   Preparation and updating of assessors

There was general agreement that the findings presented in section 4.4 of this chapter were reasonably representative of situations in all sites at some point. The midwifery service managers on the course management team require all midwives to be able to teach and assess students but recognised that some were more motivated than others to attend preparation and updating sessions. The high levels of maternity leave amongst midwives sometimes added to the problems of providing students with continuity of assessor and

hence less well prepared assessors might be required to work with students. Although a sample assessment document and guidelines for completion had originally been provided in each practice area, knowledge of its whereabouts was variable. To compound the problem it was suggested that students did not always carry their whole assessment profile with them, but just brought the sheet they wanted signing at the time. This could prevent the assessor drawing on "evidence contributed by more than one accredited witness" as advocated in the ACE report (Bedford et al 1993 p.166) and our own assessment strategy. It could perhaps be implied from table 4.5 that because "we all know each other" evidence from others would be drawn upon in team discussions. However when the questionnaire responses were analysed it was suggested that students themselves could manipulate the process especially if there were inadequately prepared assessors. This potential manipulation of assessors was also alluded to in data from other institutions.

It was agreed following discussion of the difficulties in regularly sending all midwives for up dating sessions that a pocket book for assessors should be produced. Two members of the team agreed to produce a draft booklet containing:

· the principles of effective assessment

· roles and responsibilities of those involved in assessment

· expectations of what students should achieve and when

· how to assess and record their decisions correctly

This pocket book was drafted, amended slightly following team discussion and

distributed to all assessors of students on current pre-registration midwifery programmes. Additional updating sessions for assessors were provided on each site and link teachers scheduled one to one meetings with those unable to attend.

4.5.2   Support for assessors when students are 'cause for concern'

There is evidence from many studies as well as that identified in table 4.7 that assessors find it difficult to fail students (Bedford et al 1993, Ilott 1993, Fraser et al 1997). Members of the course management team believed that midwives would be prepared to fail students if they were not suitable to enter the profession. This view supports the respondents that contributed to table 4.6. However they were concerned about the stress involved in failing students and the potential consequences if students appeal. This concern was not unreasonable as now there is, says Hocking (1997), ".... a rising tide of litigation in the world of higher education .... by students that (claim) their course or the teaching they received was not up to the mark". Although maybe less concerned with the prospect of litigation than the potential for an unsuitable student qualifying, it was agreed that clearer guidelines and support in decision making were necessary. The course team agreed and implemented with immediate effect the procedures, to be taken in the event of students having difficulties in practice/failing in practice (Appendix 10). These procedures clearly set out the roles of the midwife teacher, supervisor of midwives and external examiner in supporting assessors through this difficult period of teaching and assessing students who give "cause for concern".

4.5.3 Summary

It was agreed that assessment of students in practice was one of the most difficult aspects of the assessment strategy and would need considerable development when the programmes were re-designed. The studies with the first three cohorts of students had however helped to identify other areas that needed improvement and which are included in the next chapter.

CHAPTER FIVE   CURRICULUM DEVELOPMENT

5.1   INTRODUCTION

Evidence from this study went someway to convincing even the sceptics on the course planning team that the three year pre-registration route was a worthwhile and mainly effective programme to prepare future midwives for practice. However there was also evidence to suggest that the programme has deficiencies. This evidence includes attrition information (table 4.5), reasons given by new qualifiers for leaving the profession after minimal practice and weaknesses in the programme identified following systematic evaluation. Research evidence, set alongside normal course evaluations indicated that initially there were four areas that needed particular consideration in terms of development. These four areas included: recruitment and selection strategies, designing an integrated curriculum, making teaching and learning more effective and identifying the best ways to assess learning.

The planning team formed a collaborative group, as advocated by Somekh (1988), so that the experiences and expertise of students, midwives, teachers, obstetricians, GP's, university academics, the ENB and users of the service could be drawn upon. The university vice-dean responsible for the Faculty's undergraduate programmes and the ENB education officer, who were to be co-chairpersons for validation of the programme, were not invited to the team meetings until half way through the curriculum development process. The reasoning behind the strategy could have been to avoid what Phillips (1995) described as, "wanting to resist a dependency type of relationship". That is, the planning

team potentially responding to these representatives as the voices of ultimate authority. Not that it has ever been the style of my own department's course teams to bow to the voice of authority if it was likely to stifle innovation. There was instead a belief that if arguments could be articulated effectively and reflected the team's beliefs, values and the context in which the curriculum would be operationalised, innovative ideas would be accepted. This proved to be less easy than writers in the 1970's might have led one to believe (Lawton 1975, Skilbeck 1973, Stenhouse 1975). Conformity and audit appear to be features of the current decade with unfamiliar or different course designs being thwarted by individuals (outside the planning team) who adhered rigidly to particular interpretations of ordinances and regulations. What follows is perhaps an over-simplification of what appeared at the time to be a tortuous and exhausting route to achieving, at least on paper, a curriculum which best operationalises the vision of those most closely involved in its implementation and outcome. Without the evidence from this and other relevant studies (Appendix 11) the written curriculum might have looked more like the authoritative voice of someone else's preferred design.

5.2   RECRUITMENT AND SELECTION

The planning team drew upon attrition data to consider whether recruitment and selection strategies needed to be revised. It had been agreed that the programme leading to registration as a midwife should carry the award of Diploma in Midwifery. However, in keeping with the current shortened programme for registered nurses, the last period of the programme would include 60 level three (degree level) credits. The decision to keep the programme as a diploma with the option to complete a further 60 credits post-registration

for an honours degree was based on a variety of factors. These included: loss of non means tested bursary if it became an undergraduate programme and hence potential exclusion of post graduate students, change of entry profile to favour school leavers with "A" levels , weight of assessments for 60 more credits potentially detracting from developing competence to practice and no support from employers and current and past students to offer it as a degree after only three years.

There seemed to be sufficient evidence to suggest that academic potential and personal qualities should be equally weighted when reviewing the scoring system for applications. A previous study (Fraser 1994) and this study (tables 4.2 and 4.3) all demonstrate the importance of personal qualities in determining competence for midwifery practice. There was no dissention on these issues from planning team members but there was a division of opinion about the relative weight given to academic achievement and life experiences. A few thought that age and academic attainment should be considered together, with life experiences providing a substitute for the more mature applicant who was more likely to be a parent. The bar charts (figures 5.1 and 5.2) of ages and academic entry qualifications of the local case study cohort facilitated discussion.

Figure 5.1. Age Profile on Entry of Completers (2nd cohort)
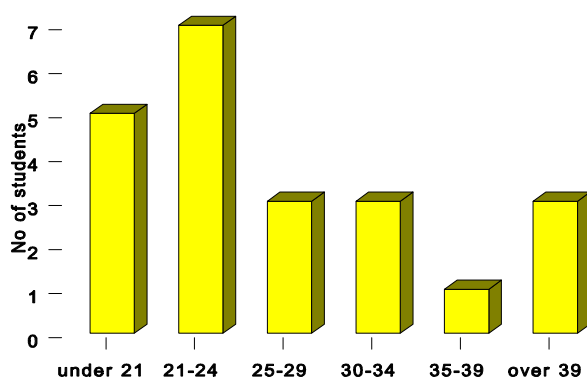
Figure 5.2 Academic Profile on Entry of Completers (2nd cohort)
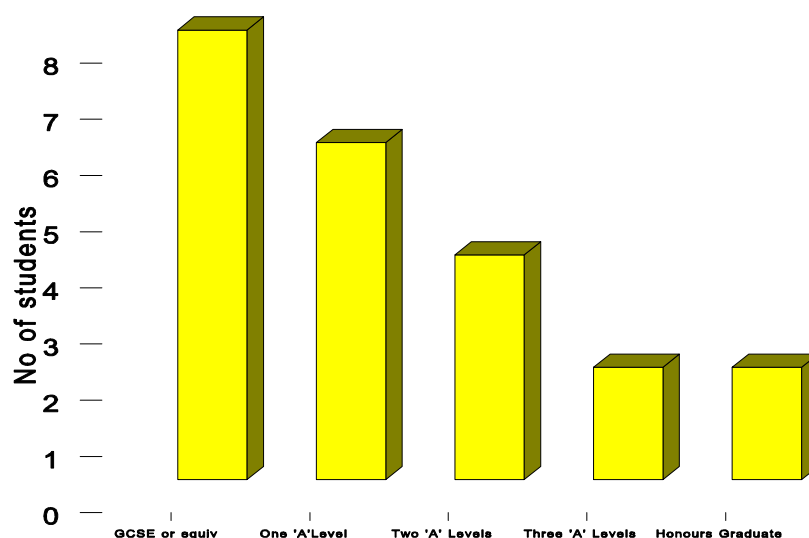
Numbers were small but even so no correlations were evident between age and achievement on the course as the nine students who were identified as showing significant capabilities as future midwives were spread across the whole age range of under 21 to over 39. Similarly for academic entry correlations, although the two graduates did particularly well (a third graduate left the course in the first year), four of the exceptional students were in the minimum academic entry group.

Whilst it seemed appropriate from the evidence available from successful students to retain a broad entry gate and weight personal qualities and motivation as equally important, profiles of those who left over the last 3 cohorts and the one student who gave some 'cause for concern' also influenced the debate. In particular it was found that the majority of those that left their programme were described in a reference or by the interview panel as: quiet, nervous, lacks initiative/confidence, reserved, works hard. Some of these characteristics emerged in the interview transcripts of the 'successful'

student who apparently also gave 'cause for concern'. It is possible that even at interview these applicants were given 'the benefit of the doubt' if their academic profile showed potential. In the light of these findings a review of interview panel preparation was put in place.

As can be seen from table 4.5, 50% of those that left the course had dependent children. Four students cited family responsibilities as contributing to their decision to leave. When those with family commitments also found difficulty with course work and irregular hours in practice placements they always put their family first. It is not clear how much the partner contributed to the decision as those exiting from the programme only occasionally alluded to others contributing to their decision. This is in marked contrast to the information on their application forms where three of these applicants stated that their husbands totally supported their career aspirations.

Those who left the programme because of family responsibilities had generally demonstrated high levels of motivation at interview and had been studying part-time in preparation for the programme. The planning team concluded that there are likely to be peaks and troughs of attrition from amongst this group of students and the only possible recruitment development might be to offer 'taster courses' as already in place to improve recruitment from minority ethnic groups (Clarke and Fraser 1996).

The four who left their course because they felt a wrong career choice had been made, revealed very different profiles. Two were mature, intelligent women with young children. They left at the mid-point in the programme having found that whilst they

enjoyed being with women, teaching and supporting them, the responsibilities they would

have as midwives were much too daunting. As one explained:

> *"Its not the fault of the course, it couldn't have been made easier for me*
> *.... it is personal, my reasons for leaving are my own .... I couldn't*
> *possibly have known that I couldn't handle it until I tried doing it and I*
> *probably wouldn't have recognised it as my own personal limitations*
> *without the education that I have had over the last 18 months .... to stand*
> *back and look at myself and my situation and realise ... I was blaming it*
> *on other things ... the family ... pressures of work and the studying ... but*
> *they weren't the reasons that I was unhappy ...."*

A third student failed to offer a reason for leaving and a fourth (a graduate who married

two weeks before the course started) blamed the heavy theory load and insufficient

experience in practice during the first year. None of these factors provided any further

insights into developing the recruitment and selection strategy. The success of those with

some of the lowest academic attainments at course entry provided sufficient grounds for

securing agreement for retaining the broad entry gate.

5.3   AN INTEGRATED CURRICULUM

The existing curriculum had not been constrained by the introduction of the modular

scheme to which the new design had to conform. However, even without the existence of

a modular scheme, the intention to implement an integrated curriculum was not entirely

effective. Integration was intended both in relation to taught subjects and in relation to the

integration of theory and practice.

Chapter 2 highlighted the potential weaknesses in the design of pre-registration

midwifery curricula nationally and the factors which influenced the original design of our own curriculum. Year One emerged as the part of the programme that failed to achieve satisfactory integration at both levels, caused most dissatisfaction for students and possibly affected the availability of learning opportunities at the end of the course. The case study interview data identified suggestions for course improvement which were circulated to members of the course planning team (table 5.1).

Table 5.1   Suggestions for course improvement

	n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a) Learn basic skills earlier in course	29	14	10	543
b) Reduce theory/shared learning in year one	18	14	-	
	17	10	4	
c) Increase contact with midwife teacher in year one	17	5	12	
d) Give greater responsibility towards end of course				

The suggestion that shared leaning with nurses was unsatisfactory had been raised in all earlier evaluations but it was hoped that modularisation of the nursing programme would enable us to be more selective. Whilst multi-professional education is frequently advocated, not everyone is clear about its purpose. Barr (1997) argues that it is more appropriate to consider whether the aims are for "multi-professional education" where different professions learn side by side or "inter-professional education" where different professions learn from and about each other to promote collaborative practice. If the

latter then collaborative groups potentially have more flexibility to timetable sessions for the convenience of all concerned. If however the intention is to share content and hence presumably reduce resourcing costs, timetabling becomes more difficult. This was the prime intention for my own students when sharing with nursing students. Inter professional learning was a more secondary aim. It was therefore difficult to achieve integration as any attempt to do so was normally directed to the majority group, students of adult nursing. To compensate for this, student midwives from three sites joined together fortnightly for sessions facilitated by their cohort midwife teacher. Unfortunately the groups missed different sessions on their base sites to attend the midwifery sessions. These factors, the evidence from table 5.1, Mountford et al's (1995) recommendation for more attention to developing skills of problem design as well as problem solving earlier, Eraut et al's (1995) evidence that knowledge needs to be used to be effective and retained, all pointed to the responsibility of midwife teachers to facilitate more practice based learning early in the course. In this way the planning team believed learning opportunities could be grasped more effectively in a safe teacher facilitated context.

The planning team agreed that during the first year of the programme the student midwives should spend one day per week with their personal teacher facilitating midwifery praxis. In these weekly sessions praxis will have some similarities with the "informed, committed action" of action research praxis (Kemmis 1993, p.182). Students will be enabled to integrate theory and practice in a structured way using their theoretical knowledge in practice with the intention of practice also informing and transforming their understanding. Teachers will also assist students in the development of practical skills in

both laboratory and clinical settings. According to Eraut et al (1995) and case study data (Table 5.1) it is essential for students to have some basic clinical skills early on so that they can concentrate on more complex aspects of learning during their longer practice placements.

This strategy is intended to have a three-fold advantage . Firstly students should develop the skills to problem frame, re-frame and problem solve form early on. Secondly, by learning and improving a range of essential psycho-motor skills they will be better equipped to capitalise on the more complex learning available in practice placements. The third advantage will be to give the midwife teachers a greater presence in the practice areas. This will give them additional opportunities to liaise with and support midwife assessors as well as informing their teaching of midwifery, vital suggest Day et al (report pending 1998) for teacher credibility and effectiveness.

Whilst the planning team agreed that these curriculum changes were necessary, midwife teachers expressed concern about the potential difficulties of resourcing these changes, given existing workloads. As has been suggested by Phillips (1995) no curriculum planners can make colleagues adopt a new way of teaching by persuasion alone. Reflecting upon the agreed need for this type of curriculum change, set alongside the views of some midwife teacher that human resources were already stretched, another action cycle seemed necessary. If implementation of the new curriculum was to be successful it seemed evident that a systematic investigation of teachers' views was required. Teaching and learning issues forms the focus of the next stage in the process.

5.4   TEACHING AND LEARNING

The debate surrounding the need for curriculum change took place largely within the curriculum planning team meetings, which involved only a small number of the team of midwife teachers. If the new curriculum was to be implemented successfully, all teachers needed to support the philosophy underlying the revised teaching and learning strategy. With the rapid pace of change in midwifery education and recent appointments of new teachers, it emerged that there was no evidence to establish whether the team held such a shared philosophy and commitment to the new strategy. Midwifery, where the variables are great and predictions uncertain, requires multiple ways of knowing if learning is to be effective. It is suggested (Barnes 1976, Eisner 1990) that ways of knowing influence teaching and the student-teacher relationships. In the current curricula there is a heavy reliance on the transmission of knowledge as facts and information in the early months, the majority of this teaching being within groups taught by nurse teachers. Very little attention is given to recognising differences in students' learning styles or to the importance of encouraging students to develop different learning styles. Marton (1976) observed that students adopted a surface or deep level of processing information according to context or content. Laurillard (1979, 1994) and Miller et al (1994) believe that it is important to encourage students to vary their learning style according to context or goal and this would seem essential when learning to become a competent midwife practitioner. There will be times when the student midwife needs to adopt a serialist, step-by-step, logical, analytical, convergent learning style. On other occasions the

learner will need to conceptualise the task as a whole using anecdote and synthesis to develop a divergent, cognitive style. Over the years in midwifery and nursing education, there has been perhaps a heavy reliance on the work of Pask (Pask and Scott 1972 and Pask 1976). From their experiments they suggested that learners are disadvantaged if they are not taught in a style that matches their normal learning strategy. This possibly explains why the curricula examined by us generally sought to match teaching with learning styles and why nurse teachers in my own university used the Honey and Mumford learning styles (Honey et al 1982) to inform their teaching strategies for different groups.

It is possible that some students might find it difficult to learn in different ways and at different depths, from early on in the new midwifery curriculum. The midwife teachers will therefore need to facilitate this learning. Laurillard (1994) and Eraut et al (1995) stress the importance of helping students with mapping strategies and integrating subjects. This was seen as a key role for the student's personal teacher. Those entering the programme have a broad range of educational abilities and it could therefore be anticipated that some would find it easier than others to cope with a problem-design and problem-solving approach to learning from the beginning. Teachers were also likely to have anxieties in adopting a different approach to teaching in year one, especially if they were unaware of the theoretical concepts underlying this change initiative. These factors, alongside concerns expressed about resourcing issues meant that more action was needed to find out each teacher's perspective.

The strategy adopted arose out of considering a range of alternatives. Firstly it was

evident that all teachers needed to be aware of the theories on which the changed teaching/learning strategy in year one was based. Secondly they needed to be given an opportunity to argue against those theories. Thirdly it was necessary to identify any factors that might inhibit students' personal teachers from facilitating the new sessions and finally to try to identify agreed possibilities for development. Whilst those teachers who were members of the course planning team agreed to feed back to colleagues and report on their comments, it was likely that there could be a filtering of information or the most forceful responses being reported back.

5.4.1 Delphi technique: an overview

Adopting a Delphi approach to investigate teachers views about the proposed curriculum changes and their implementation appears to have several advantages. Beech (1991) and Williams and Webb (1994) have found that as a method it encourages participants to give their opinion without feeling intimidated or inhibited by others. This I felt was an important advantage as new members of staff could be reluctant to challenge the opinions of colleagues in group discussion or committee meetings. A second advantage lies in the cyclical approach to the dissemination and amendment of individual opinions to try to reach a group consensus. If a consensus can be reached then curriculum implementation is more likely to be successful. From Delphi studies reported elsewhere, consensus appears to be poorly explained (Williams and Webb 1994). In my own study I believed that even if a consensus, in terms of 'majority view' (Oxford Dictionary 1984) was not achieved there would be an advantage in teachers knowing the range of views of their peers. This knowledge might play a part in achieving compromise if not consensus.

The Delphi method was a technique used in defence research in the USA in the 1950's (Helmer and Rescher 1959). Since then it has gained in popularity amongst health care professionals (Loughlin and Moore 1979, Reid 1986, Beech 1991, White 1991). Goodman (1987), in her critique of the Delphi technique, identified four characterising features, although she also found a range of differences in interpretation. The first of these is the guarantee of anonymity. This was adhered to in the second and third round in this study but possibly contributed to the poor response rate and difficulties in claiming a high level of consensus.

The second feature of the Delphi technique involves "iteration with controlled feedback" (Goodman 1987, p.730). This is normally achieved through the use of successive questionnaires which incorporate information and opinions from one round into the next. The value of this process enables all participants to be informed of respondents opinions, whether or not they responded themselves. The third characterising feature is to enable a group response on specific items to be represented statistically. The final feature is the use of experts rather than a random sample of the population. For my purposes, it was important to include all midwife teachers in the sample. There four characteristics are evident to varying extents throughout my own Delphi approach which has been used in an attempt to guide group opinion towards a critical mass decision (Sackman 1975, Loughlin and Moore 1979, Lyons 1981, McKenna 1994).

5.4.2   Delphi technique: one-to-one interviews

One-to-one interviews with midwife teachers appeared the logical first stage in my Delphi approach to gathering information and working towards a consensus. The interviews gave me the opportunity to provide each teacher with the same information about why the curriculum changes were to be made. There were no objections to the theoretical and philosophical basis on which the curriculum had been developed but there were concerns about the feasibility of resourcing such a change. On further probing teachers told me what they saw as the problem areas in the Division of Midwifery. Several of the teachers offered ways in which they thought these problems might be solved. A total of 32 problem areas were identified following interviews with 18 midwife teachers. Sometimes teachers were unable to suggest ways in which these problems could be resolved but in other instances up to five possible ways for their resolution were put forward.

It was evident following an analysis of data from the interviews that potential problems and solutions were sometimes viewed differently. It was also possible that because this stage in the Delphi process was not anonymous, midwife teachers might have been reluctant to give me their honest opinions. The data obtained was used as the basis for the second round of the process.

5.4.3 Delphi technique - Questionnaire One

From an analysis of the interviews with teachers all of the issues considered to be problem areas were listed in a questionnaire and each was followed by the suggestions for improvement as applicable. Alongside each item teachers were asked to identify whether

they: agreed, disagreed or were unsure (Appendix 12). A total of 18 questionnaires were sent out to teachers. There was no attempt to code the questionnaires as it was felt that honest answers would be more likely if they were anonymised. A total of 11 were returned, giving a response rate of 61%. Had it been possible to send reminders, then a higher return rate might have been possible. In the circumstances it was assumed that if teachers had not bothered to complete and return their questionnaire, then they might be less likely to disagree with the outcomes as it would mean admitting non-participation in the process.

As it was possible that midwife teachers could have felt inhibited in suggesting to me as Head of Division that the Division could be managed better, the questionnaire allowed for a free response on any issues of relevance. A total of 24 different issues were raised in this free response area of the questionnaire.

5.4.4   Delphi technique - Questionnaire Two

Responses to the first questionnaire were collated and used to construct a second questionnaire. In this second questionnaire (Appendix 13) teachers were asked to rank each item on a scale of 1 (not important) to 5 (very important). Although the Delphi technique had been explained, one teacher expressed the view that she did not like being aware of the responses of colleagues. She was concerned that their responses could influence her response. She remained unconvinced when advised that the purpose of the exercise was to achieve a consensus to facilitate implementation of the new curricula.. This teacher appeared concerned about the potentially manipulative effect of the feedback

mechanism, a concern similarly expressed by Goodman (1987). Again the questionnaires were not coded and no follow up questionnaires were sent out. A 100% response was hoped for but there was only a marginal improvement on the first questionnaire as a 67% response rate was achieved. Poor response rates appear to be a problematic feature of Delphi investigations, especially in relation to the final round (Farrell and Scherer 1983). However McKenna (1994) found that if face-to-face interviews were used initially, then response rates to questionnaires improve significantly. I think it unlikely that the two were necessarily connected in the response rates for this study. In trying to preserve anonymity at the second and third rounds in the process there was no way of knowing whether the original 11 had all responded to the second questionnaire or not. It is possible that teacher responses could be influenced by: objections to the Delphi technique, pressure of work, forgetfulness, apathy, or a wait and see approach. The latter might be particularly relevant as teachers were aware that the findings from the questionnaires would be discussed at an in-service session for teachers (INSET) in a months time. On receipt of the completed questionnaires each item was rank ordered to provide the agenda for the teachers' INSET day.

5.4.5   INSET day discussion

The data from the second questionnaire were analysed question by question in such a way that the total score for each question was calculated. In addition the number of respondents at the two extremes of the continuum were identified. Once this analysis was carried out each question was rank ordered in importance according to the responses (Appendix 14). The 30 most important issues were then identified and grouped

according to the similarity of themes. From this grouping, four major categories emerged

that formed the focus for discussions at the teachers' INSET day.

Teachers' Base

In contrast to many other universities offering pre-registration midwifery programmes,

teachers are based on the same site - as far as possible - as their personal students are for

practice placements. This strategy was likely to facilitate the changes proposed in the

new curriculum but it had to be set against concerns that teachers spend a lot of time

travelling from their base site (7 sites in total) to one of the two main teaching sites. It

seemed to me that I could not make an assumption that teachers agreed with my own

philosophy that they should be close to their practice link areas and work and teach in

practice for at least the equivalent of one day per week as expected by the ENB (ENB

1996). The responses to the Delphi technique questionnaire did however strongly support

basing teachers on all seven sites (table 5.2).

Table 5.2   Teacher Base Site

Q.19   Teachers should be based where their personal students are based.

Questionnaire One: Agree   =   8
Disagree   =   0
Unsure =   2

Questionnaire two: Rank   =   1
Respondents   =   12
Rated 4 or 5*   =   12

* 1 = not important, 5 = very important

The responses to questions 17 and 16 (relating to intake leader and personal students) also supported this strategy even though it meant teachers would have to travel to teach in the university setting.

With a move to greater centralisation of activities in the university it was helpful to have data suggesting that it would be a retrograde step to centralise teachers' base site. By being on the student's base site, the teachers would be in a better position to facilitate the new curriculum. However I recognised that a third of the teachers had not completed the questionnaire and dissent amongst such a number could potentially affect the working environment. Alternatively, it was possible that non-respondents accepted the status quo. In order to encourage discussion at the INSET day all teachers were provided with a copy of the findings from the Delphi technique questionnaire. To provide an alternative option for discussion I acted as devil's advocate and opened the debate by highlighting all the disadvantages of teachers being scattered around all seven sites. I asked teachers to consider the improved patterns of communication that would be likely if we were all together. There was no support for the suggestion of teachers moving to just one or two base sites. There was an acceptance of the need to travel for class teaching sessions and a willingness to work at improving communication.

Communication

In large organisations communications can often be problematic. When interviewing teachers I had pressed those who cited communication difficulties to offer ideas for overcoming the difficulties. In relation to operationalising the curricula it became evident that teachers needed to have greater understanding of courses when it became their

responsibility to manage an intake. Teachers roles are made more complicated by them all being involved in teaching both three year and shortened pre-registration midwifery programmes as well as continuing education programmes for midwives. Although when interviewing teachers I asked whether they would prefer to concentrate on a smaller number of teaching activities they all preferred to retain their current variety of activities. As the new three year curriculum would make more demands on personal teachers in year one it was agreed that it was important to look at ways to improve communication and reduce time wasted.

Teachers were concerned that although they might be knowledgeable about each curriculum when it is first approved, if there was a delay before it became an individual's responsibility then they were likely to forget issues. The meeting discussed the responses on the questionnaire to improving information and were supportive of implementing the pre-course briefing of intake leaders proposed in question 11a (table 5.3).

Table 5.3   Briefing of teachers by course leader

Q.11a Course leader to brief cohort intake leader 4-6 weeks before each start date.

Questionnaire One:	Agree	=	9
	Disagree	=	1
	Unsure	=	0

Questionnaire Two:	Rank	=	6
	Respondents	=	11
	Rated 4 or 5*	=	8 respondents
	Rated 1 or 2*	=	0 respondents

* 1 = not important, 5 = very important

Other questions relating to the need for better updating of teachers and more forward planning had similar support from teachers. Following these discussions the course leader for the pre-registration midwifery programmes agreed to meet with the two intake leaders (one for each major circuit) for each cohort at the time suggested.

In order to assist teachers remember what procedures should be followed for which programme, a Guidelines folder had been compiled. However there was a suggestion that keeping these folders on the two main teaching sites was inadequate. The preferred alternative was to send a copy of this folder to each of the seven sites (table 5.4).

Table 5.4   Division Guidelines Folder

Q.18c Copies of Division guidelines should be at each site

Questionnaire One:	Agree	=	10
	Disagree	=	0
	Unsure =	0	

Questionnaire two:	Rank	=	6
	Respondents	=	10
	Rated 4 or 5*	=	10

* 1 = not important, 5 = very important

During discussion it was suggested that the document should be available, for print only, on computer. Both suggestions were implemented as not all teachers had easy access to a university networked computer.

Although only a third of teachers had suggested on the first questionnaire that they did

not always feel party to decision making, 50% agreed with this suggestion on the second round (table 5.5).

Table 5.5   Involvement in decision making

Q.10   Teachers do not always feel party to decision making

Questionnaire One: Agree   =   6
                        Disagree   =   0
                        Unsure =   0

Questionnaire Two: Rank   =   9
                        Respondents   =   10
                        Rated 4 or 5* =   9
                        Rated 1 or 2   =   0

* 1 = not important, 5 = very important

I considered these views to be significant when trying to introduce a new curriculum as many others have found that difficulties arise if a critical mass is not convinced about the innovation (Skilbeck 1973, Shipman 1974, Nisbet 1975, Stenhouse 1975, Hoyle 1976, Sockett 1976, Phillips 1995).

At the time of this study teachers were represented on course planning and management teams and three teachers attend monthly Division meetings on a rotational basis. It became evident during discussion that these teachers did not feedback to their colleagues as effectively as had been anticipated. A range of alternative strategies were discussed but the meeting concluded that the best option was to open the Division meetings to all teachers. Not all would be able to attend but all teachers would receive an agenda and minutes. In this way it was up to the individual who could not attend to seek further

clarification of issues for themselves and to send items for discussion if necessary. The

meeting was scheduled to be held on each site in turn which should, theoretically,

facilitate each teacher attending twice per annum without incurring additional travelling

time. This change meant that it was not necessary for individual sites to hold teachers

meetings, unless there was a local issue to discuss, and valuable time could therefore be

saved. Open Division meetings should result in more corporate decision making but the

effectiveness of this change, it was agreed, would be reviewed in twelve months time.

Staff Development

A considerable number of changes had taken place in the previous five years. One that

appeared to still concern teachers was developing a fair and consistent marking standard

at diploma and degree level. Generally teachers had become more used to coping with

change, and uncertainty, but in relation to marking students' work there was a clear

indication that teachers were seeking greater certainty about the appropriateness of their

decisions (table 5.6 and 5.7).

Table 5.6   Feedback to Markers

Q.26	Feedback to markers when grades are changed is inadequate		
Questionnaire One:	Agree	=	9
	Disagree	=	0
	Unsure	=	1
Questionnaire Two:	Rank	=	2
	Respondents	=	12
	Rated 4 or 5*	=	11
	Rated 1 or 2*	=	1
* 1 = not important, 5 = very important			

Table 5.7   Comparison of marking standards

Q.27   Teachers need to compare marking standards with each other

Questionnaire One: Agree   =   8
                      Disagree   =   0
                      Unsure=   1

Questionnaire Two: Rank   =   3
                      Respondents =   11
                      Rated 4 or 5* =   9
                      Rated 1 or 2 =   1

* 1 = not important, 5 = very important

Only one teacher of those responding to the questionnaires felt satisfied that their feedback was satisfactory and did not feel the need to compare marking standards with colleagues.

Prior to 1990 none of the pre-registration midwifery courses had been validated by higher education. Midwife teachers only experiences of diploma and degree level marking had been in relation to their own professional and academic studies. These studies had taken place at a variety of 'old' and 'new' universities in England and according to a Higher Education Quality Council Report (HEQC 1996), were likely to have different standards in relation to classifying their degrees. On the side of consistency, all midwife teachers had taken a similar advanced diploma in midwifery course which would have been marked and moderated by their peers. However it seemed possible that teachers were justified in believing there might not always be consistency in marking.

The INSET day discussions were particularly helpful in identifying areas in need of development. It was agreed that new teachers should continue to 'shadow' mark with their mentor, but experienced teachers needed to have more sight of their colleagues marking. The current marking by one teacher with sample moderation of scripts was preferred for diploma level work as was the double marking for the first few students who opted for degree level studies. The new programmes would include degree level work for all students which meant a much larger individual teacher's workload if all this work was to be marked by two teachers.

The final consensus was that one teacher marking followed by moderation by a panel should be the norm for diploma and degree level work for the new programmes. A marking workshop was arranged to enable teachers to mark samples of work with their peers and the composition of the moderation panel was reviewed It was agreed that more teachers should be given the opportunity to be part of moderation panels with more experienced colleagues. When, following moderation, grade changes were made then individual feedback to the teacher(s) concerned would be provided by the chairperson of the panel. The university was in the process of introducing a revised appraisal system and it was hoped that this would give individual teachers a further opportunity to identify any specific needs for personal development that had not been met by the marking workshop and changes to the moderation panels.

Administrative Issues

The final group of issues that formed the agenda for the INSET day related to the many

administrative tasks undertaken by teachers and problems caused when a colleague is absent unexpectedly. Teachers were reluctant to cancel sessions when colleagues were absent as they were aware that students had travelled from outlying sites. A range of strategies were suggested, many of which could not be universally applied. One practical outcome resulted in reviewing the list of module convenors and identifying a reserve teacher where possible. It was agreed that teachers who were not equipped to teach a particular module should not feel an obligation to attempt to do so, but should instead brief students about the circumstances. It did not appear however from course evaluations that this was a common occurrence. Teachers welcomed 'permission' to not feel obliged to teach subjects for which they were inadequately prepared.

5.4.6   Teacher effectiveness

Universities normally recruit the majority of students from amongst school leavers who have three good 'A' level GCE grades. The profile of our own students is somewhat different as can be seen from that of the case study cohort in figure 5.2. earlier in the chapter. Students on sites A-C had the higher academic profiles (table 5.8) and were taught separately from students on sites D-F.

Students on sites A, B, C all had a change of intake leader and personal teacher on their base site early on in their course This was a cause of difficulty for some, especially one student on site B who felt it "affected my exam mark as she (the teacher) didn't help me much".

Table 5.8   Academic Entry Profile of Case Study Cohort according to Base Site

Academic Level on Entry	No students	No on each site					
		A	B	C	D	E	F
Students with GCSE standard	8	1	1	0	1	2	3
Students with 1 'A' Level	6	1	1	2	0	1	1
Students with 2/3 'A' Levels	6	1	3	1	1	0	0
Students with Honours Degrees	2	1	0	1	0	0	0

However by the end of the programme all students were very impressed by the support received and achieved a standard at or above the average for the cohort as a whole. There was no movement of intake leader during the three years for students on sites D, E and F, but students on site D did have a change of personal teacher. Complaints were expressed by six of the students from these three sites about the support received from one teacher. All but one of these six students entered the course with the minimum academic level accepted. Although students on other sites demonstrated achievement in excess of what was anticipated from their entry profile, none of these six students matched their achievement.

From the limited evidence available it is not possible to suggest reasons for the better overall performance of students on sties A, B and C as compared with D, E and F. It is possible that the presence of more academically able students lifted the less academically able ones. However, only those who expressed dissatisfaction with the support received on sites D. E and F did less well, the rest of the group achieved a better standard. These

dissatisfied students might have, for example, been seeking a more teacher dependent relationship and had a convergent learning style whereas the teacher might have expected them to be less teacher dependent. Whatever the reason, it has to be accepted that there was a mismatch between student expectation and reality of experience. It is hoped that the curriculum changes for year one of the programme will enable teachers to assess student learning needs more effectively. By doing so, it is anticipated that all teachers will be more supportive in facilitating students develop the wide range of learning styles put forward by Laurillard (1979, 1994) and Miller et al (1994) as necessary for effective learning in varied and complex contexts.

5.5   ASSESSMENT OF LEARNING

The course planning team reviewed assessment of learning by first considering the case study evaluation data. There was a general consensus that where assessment was working well, it should be continued. Account had also to be taken of the university's guidelines for consistency in relation to assessment and concerns of the professional body and data from the seven case studies that over-assessment could result in an assessment driven curriculum. Such a curriculum might detract from other important aspects of learning.

5.5.1   Value of written work for students

When case study students locally were asked how important the written work had been in enabling them to achieve the outcomes of the course, they all (n=20) responded that it had

been of value. The aspects which were felt to be most important included: increasing depth and breadth of knowledge and understanding and use of research in informing practice. The majority of students felt that the good feedback they had received enhanced learning and saw assignment tutorials as more important formative assessment than suggesting they did additional work. A very small number of students (n=3) felt that the timing of the examination was wrong but could not offer a better alternative. Students generally found that the written work was of most value if it related to midwifery practice. This latter point was seen as added confirmation of the need for an integrated curriculum.

Although these students had not been following a modular programme they had a similar number of pieces of written work and examinations as that proposed in the new curriculum. This was only possible because of an intention to cluster modules for integrated assessments and to award credits at levels two and three (diploma and degree) for assessments in the practice placements. Both of these intentions, particularly the latter, it was agreed would need to be well argued to gain approval by the university's undergraduate studies committee.

5.5.2 Assessment in practice

Following an analysis of case study interviews it emerged that students, assessors and teachers found the assessment documents reasonably clear to know what to assess during the final year, but rather complicated to use early on. There was a general view that good dialogue between students and assessors took place but was not always recorded very

effectively. It was thought that this was partly due to the documents not providing sufficient space but partly because some students and assessors were unclear about what was expected. These findings were similar, but more positive in relation to the clarity of the documents, to those of the other six case studies and the Bedford et al (1993) study. Apart from improving the assessment documents, comments were made about the preparation of and function of assessors (table 5.9) and the role of the midwife teacher in practice (table 5.10).

Table 5.9.   Preparation of and function of assessors

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Failing students is difficult: - helped by talking to each other - contact teachers if a problem - with diploma courses realize it is their responsibility too	19	2	12	5
b)	Better preparation needed	13	3	7	3
c)	Most assessors very rigorous but others are less effective	11	6	5	-
d)	Documentation difficult at first but understood at end:	8	4	2	2
e)	Lack of continuity of assessors caused problems	7	3	4	-

Table 5.10   Teachers in clinical practice

		n =44 Total	n =20 Students	n = 19 Assessors	n = 5 Teachers
a)	Teachers always involved when there is a problem	25	1	19	5
b)	Teacher should be involved with all students	22	2	15	5
c)	Teachers should monitor assessment process and support assessors	20	1	14	5
d)	Teachers should work in clinical practice	14	-	12	2
e)	Assessors, not teachers, should make assessment decisions	9	-	9	-
f)	Teachers should work with students if a problem	7	-	6	1

This data from the case study evaluations indicated the need for a working group to review the assessment in practice documentation and the procedures to be followed in making assessment decisions.

The working group comprised teachers, midwife assessors and supervisors of midwives. It was agreed that more information from students was needed to inform the deliberations of the group. The third cohort of pre-registration student midwives in the institution was at the end of their programme and would therefore be in a good position to comment on the issues emerging from the case study data. These issues were included on the questionnaire this cohort was asked to complete. Over half of those who responded to the questionnaire thought there should be some changes to the assessment in practice strategy. These suggestions included: better preparation and continuity of assessors, more involvement of midwife teacher in decisions about student capabilities and changes to the wording of some of the competencies.

Preparation of assessors in practice placements

Although 9 out of the 25 students responding to the questionnaire thought that course improvement required better preparation and continuity of assessors, most of them (22) were satisfied with their own assessors. However the working group believed that if there were problems for just one student then improvement was called for. It seemed that some assessors were still unfamiliar with the assessment documents and had unreal expectations of student capabilities. None of these issues were new and supported the

need for an assessors pocket book and a review of the documentation to be completed by them and the students.

As the case study evaluations had demonstrated variability in completion of assessment documents, it was helpful to the working group to have student comments about how assessment decisions were made. Table 5.11 provided an overview of student perceptions about these judgements.

Table 5.11   Student views on how assessors make judgements

(Total number of students who completed questionnaire = 25)		
1.	On-going discussion between student and assessor	n = 16
2.	Observing students in practice	n = 15
3.	Questioning students to test knowledge and understanding	n = 9
4.	Talking to other midwives about your abilities	n = 5
5.	They make intuitive decisions	n = 4
6.	Talking to women you have cared for	n = 3
7.	Assessing your ability to reflect	n = 3
8.	Unsure	n = 3
9.	They just sign things off	n = 1

Most students offered more one than opinion as to how assessors judge that students have achieved the required standard. The majority of respondents (22) indicated that discussion or questioning was an important element. This matched the findings from the case study data interviews and demonstrated that the majority of assessors were testing students' knowledge and decision making abilities. The student who failed to achieve the required standard and was discontinued at the end of the course also indicated that assessment judgements were made on the basis of her being observed in practice and

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questioning her about her practice. The response that caused most concern for the working group was that from the student who wrote "some just sign things off". It was agreed that revisions to the assessment documentation must ensure that adequate evidence is drawn upon and documented so that the rationale for assessment decisions is clear to internal and external examiners.

The midwives on the working group agreed that there was a need for evidence to be documented but would not want excessive demands to be made on the assessors. Given the case study evidence that maternity units are often short-staffed this had to be recognised as a real constraint when re-designing the assessment instrument. There was also a view that assessors would need more support from teachers in recording the sort of evidence required. Involvement of teachers in all assessments attracting the award of credits was also a requirement of the university. Determining the feasibility and appropriateness of teacher involvement was not straight forward.

Teachers role in clinical practice

The professional body, the ENB, require assessment of practice to be equally weighted with assessment of theory. The course team agreed that as the intention was to offer an integrated curriculum, all assessments would draw upon theory and practice. Whilst this was relatively straightforward when devising marking grids for written work and briefing markers who were all trained teachers, it was evident from the case studies and the ACE project (Bedford et al 1993), that there were variations amongst practice based assessors. It was likely that the majority of assessors made sound judgements but there was

evidence to suggest that there was the potential for students to 'pass' before they were competent. The notion of competence became an important issue for the working group to clarify and is addressed in detail in the following chapter.

How much the teachers should be involved in assessments in the practice placement was informed by both the case study data and the data from the questionnaire to the third cohort completers. The case study data (Table 5.10) indicated the issues of most importance to the interviewees.

It would appear from this data that the students were less concerned about the teachers' role in clinical practice than the assessors and the teachers involved in the study. However as the interviews were semi-structured it is possible that responses might have appeared different if direct questions had been asked. To test out this theory, direct questions were put to the subsequent cohort of students who were asked to complete a questionnaire (Appendix 5 questions 9-11). Of those who responded (n=25) 72% had worked with a midwife teacher either occasionally or quite often in clinical practice. Comments about the value of this were made by 21 of the respondents. Over a third of these believed teachers had an important role in *"making judgements....", "helping assessors who are unsure ....", "identifying standards....", "judging reliability of assessors ....", "identifying areas for improvement....", "teaching assessors"*.

A quarter did not think it was important to work with a midwife teacher especially if *"assessors are good and experienced"*. One student said she felt threatened if she worked with her personal teacher but found her knowledge and confidence improved

after working with the teacher linked to the labour ward.

The majority of students supported teachers working for some of the time in the practice placements, mainly to contribute to their teaching and assessment in practice, although a few (n=3) said it would *"keep teachers up to date"*. All but one student agreed that teachers should monitor the assessment process in the practice placement areas, unfortunately the one who disagreed did not comment in any of the free response sections of the questionnaire.

On the basis of the data presented to the working group it was agreed that the role of the teacher in contributing to the assessment of learning in the practice placements had to be formalised. In the current curriculum teachers were required to be involved for students having difficulties achieving the required standard. Evidence surrounding the difficulties of failing students (chapter 4.4) and data from case studies and questionnaires all convinced the working group that teachers must be involved at designated assessment points for all students.

5.6   SUMMARY

Curriculum development drew upon, in the main, evaluation data from all seven case study sites and questionnaires to recent course completers. As the design of the new curriculum unfolded it became evident that the midwife teachers would need to take on additional activities and change some of their teaching and learning strategies if the curriculum was to be operationalised as intended. This required new data which was

obtained through individual interviews with teachers and use of the Delphi technique in an attempt to achieve consensus. From a synthesis of all these research findings, supported by literature and other studies as appropriate, the overall framework for the new curriculum emerged.

No evidence was found to support raising the minimum academic entry requirements but better preparation of short listing and interview panels was needed. The planning team agreed that an integrated curriculum both of subject disciplines and of theory and practice was necessary from the outset. This required a significant change to the way the first year of the programme was structured. Midwife teachers would need to have a key role in facilitating activities for their personal students in year one. They would be expected to help students develop a range of learning styles according to context and goals within a supportive learning environment. By so doing it was anticipated that students would learn to use theory in practice more effectively and develop skills of problem framing and re-framing from early on. The new curriculum would make heavier demands on teachers in this first year but should have benefits later on as students became less teacher dependent and able to cope with degree level studies. Commitment of teachers to these innovations was secured through collaboration and consensus to address the practices and procedures most in need of improvement.

Of most complexity for curriculum development was designing an assessment scheme that emerged from the aims of the course[1] and met university and ENB regulations. An

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[1] "The course will enable students to become competent practising midwives. Diplomates/Graduates will be able to practise midwifery to a high professional standard in any area of the maternity services or as an

essential aim of the course is to ensure that students leaving the programme develop the

right blend of knowledge, skills and attitudes to be competent to practice as midwives .

The next chapter discusses the evidence that was drawn upon to define and understand

professional competence to develop a model of competence for the pre-registration

midwifery curriculum. This was a vital first step before constructing a framework for

assessment.

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independent practitioner" (Course Submission Document 1997)

CHAPTER SIX   DEFINING COMPETENCE TO PRACTICE

6.1   A REVIEW OF THE LITERATURE

A review of the literature on competence in education, industry, midwifery and nursing provided a theoretical framework to identify the aspects that need to be taken into account when seeking to define competence in midwifery (Worth-Butler et al 1994 and 1995). Two major issues of relevance to the pre-registration curriculum were firstly, to investigate how competence, performance and capability are interrelated and secondly whether Benner's (1984) application of the Dreyfus model (Dreyfus and Dreyfus 1986) to professional work could help in discriminating the competent from the non-competent midwife.

A detailed critique of the literature led us to reject the atomistic and reductionist approaches as they would fragment midwifery competence into a list of tasks or skills with little acknowledgement of the role of underlying knowledge, understanding, personal characteristics and qualities. Instead the concept of capability, described by Eraut and Cole (1993) as the potential to perform consistently successfully and across a variety of contexts, helps to encapsulate the complexities involved in competence in midwifery.

The work of Benner on novice to expert in clinical nursing had been drawn upon in many of the pre-registration midwifery curricula that were analysed. However the definition of competence as the mid-point on this continuum seemed unsatisfactory in defining

competence to register as a midwife practitioner. Eraut (1994a) argues that:

> *"it is extremely unlikely that any students will have progressed to the same level of competence right across the range of roles and tasks included in the qualification"*
>
> *(Eraut 1994a p.168).*

This would support the notion that professional practice is strongly contextual and influenced by background as well as development within a programme of study and we should expect students to be at various points on the continuum for various activities. This would not however be accepted by those favouring a competency-based system of training where a binary scale is used to measure outcomes or by employers who expect new qualifiers to be fit for purpose in their organisation.

Both the binary scale adopted by Jessop (1991) and the variable matrix suggested by Eraut (1994a) have some relevance in defining competence to practice in midwifery. Newly registered midwives are entitled, by statute, to be responsible for the total care of women in normal pregnancy and childbirth, therefore clearly defining the scope and quality of a midwife's professional competence at the point of registration is essential. Cash's (1995) critique of Benner is partly based on Benner using mainly non-nurses to describe expertise in nursing. Cash believes that the "status of the person who codes the material" influences the credibility of the outcome. It seems imperative therefore that the opinions of women must play a major role in defining competence in midwifery practice.

6.2   THE PERSPECTIVES OF WOMEN

There are a variety of ways in which parents' views about midwifery care can be collected.   An initial exploratory study used three different approaches..   These approaches used questionnaires, diaries and open-ended interviews and it was concluded, as had Oakley (1991) in her work, that open-ended interviews provide the most meaningful data (Fraser et al 1996).   The course planning team was aware of the published work by the National Childbirth Trust (NCT) (Hutton 1994) and the many patient satisfaction surveys.   However it was agreed that patient satisfaction surveys raise problems in defining "satisfaction" (Bramadat and Driedger 1993) and NCT studies do not adequately represent women from different ethnic, social and educational backgrounds.   Membership of the course planning team included representatives from the local branch of NCT and the Community Health Council but their views would not necessarily be representative of the local community. It was agreed by the team that a more systematic investigation of the expectations and experiences of women from a wide cultural and socio-economic community would prove invaluable in defining and assessing competence to practice as midwives.

As the perceptions of women had not informed the definition of competence in the current curriculum, this research data played an important part in developing the model of competence and the assessment framework in the re-designed curriculum.

6.2.1 The sample population

Qualitative studies provide such rich data that the number of participants is less important than for surveys or experiments (Parlett and Hamilton 1977). What was important for this study was to select a reasonably representative group of women from the local community and to recruit until no new issues emerged. The time taken to carry out interviews inevitably is a constraint and an initial aim was 30-40 women. Midwives provide care throughout pregnancy, labour and the post natal period and therefore it was important to enable the women recruited to describe all aspects of their care. Many studies concentrate on care during labour and delivery (e.g. Kirkham 1987, McIntosh 1988 Bluff and Holloway 1994) but Wilkins (1993) advocates a longitudinal study that goes beyond experiences of labour to consider the postnatal period in the community. A longitudinal study also enables a comparison of anticipated and actual experiences and triangulation of data by cross-checking with maternity records. It was felt that these techniques might help provide a check against the assertion of Porter and MacIntyre (1984) that "women tend to say they like whatever they receive".

Inclusion and exclusion criteria

Initially a stratified random sample of forty women attending the hospital antenatal clinic was considered. However the study was being carried out alongside my full-time job and therefore an opportunistic sample was decided upon provided certain criteria were met as follows:

(i)   Attending the antenatal clinic for booking or first referral on the day researcher present

(ii)   Sixteen years of age or over

(iii)   Address on the local A-Z map

(iv)   Referral letter from GP indicated an intention to proceed with the pregnancy.

I ensured that some women were recruited from each of the six consultant obstetrician clinics, but there was no attempt to select equal numbers from each. By the time 30 women had been recruited, there was a good cross-section of ethnic and socio-economic groups but one of these women subsequently had a termination for fetal abnormality. In case other women dropped out of the study it seemed appropriate to continue with the initial plan to recruit a total of 40 women for the longitudinal study.

6.2.2   Conduct of the study

Ethical approval and permission for the study was sought from the local Ethics Committee, the Obstetrics and Gynaecology Directorate and from the Senior Midwifery Managers in the two participating Trusts. The women were invited to participate after registering their arrival at the antenatal clinic. At this first meeting they were advised that if they agreed to participate they would be asked about six questions at this stage in their pregnancy.   They would also be interviewed soon after the birth of their baby - if they were in hospital long enough - and then a longer visit at home when the baby was 2-3 weeks old. They were assured that all information would be anonymised, were told that all interviews would be conducted by me and that the purpose was to find out what is

important to women to assist in the re-design of midwifery programmes. Some women wanted reassurance that they would "not lose their turn in the queue" and this assurance was given. On occasions this meant asking questions in two sections - before and after one of the procedures carried out in the clinic. Of all the women invited to participate only one declined. The reason given by this woman was her involvement in a research study in her previous pregnancy. The interpreter accompanied women who did not speak English. All women were advised that they could withdraw from the study at any time and would be contacted in advance of visiting them at home.

A total of 41 women were interviewed antenatally using a semi-structured interview schedule. Some of these women were accompanied by their husband or partner and they also contributed to the discussion. Two women were not interviewed subsequently, one because of a termination for Down's syndrome and one who had an intra-uterine fetal death in late pregnancy. Following discussion with colleagues and my research supervisor, both of these women were sent a note of sympathy and offered a visit if they would find it helpful. Understandably neither woman responded. The decision to use data from notes was obviously essential in these two instances as well as providing medical and midwifery perspectives of maternity care.

The intended second interview, shortly after labour, was only partially successful. Although a label was fixed to the front of the notes asking for me to be contacted by labour ward staff, this was rarely carried out. Women themselves sometimes asked the ward staff to ring me. The most effective method of finding out when some of the participants had given birth was to scan the computer at regular intervals. Some women

(15) remained in hospital for less than 24 hours and only a small minority of these were interviewed on the postnatal ward. Of a possible total of 39 women, 20 were interviewed whilst in hospital. These ward interviews were again semi-structured but much more open-ended than those antenatally. The length of interview varied from 15 to 60 minutes, many women appeared to welcome the opportunity to talk about their feelings and experiences. Whilst not all information was of relevance to the study they were encouraged to talk without interruption.

All 39 women agreed to be interviewed in their homes postnatally. Some were prepared to have the interviews tape-recorded but it either became apparent that for the majority it would not have been welcomed or it was not convenient. Instead detailed notes were taken - verbatim where of particular significance for the purpose of the study. All women were extremely welcoming and the interviews lasted from 45 to 90 minutes. Those who did not speak English arranged for an English speaking member of their family to be present.

6.2.3   Data Analysis

The interview notes and tapes were transcribed in a pre-coded format for the structured questions . The less structured questions of a more open-ended format were entered onto computer under the broad headings of: antenatal care, intrapartum care, hospital postnatal care, postnatal care at home and general points about midwifery care. Information of relevance to the study from the hospital notes/client held records were also entered onto computer. Data were then transcribed (as for the case study interviews) in ASCII format

to enable each of the 41 files to be analysed using the TEXTBASE ALPHA computer programme. Computer analysis was however only used for responses to more structured questions. According to Murphy et al (1997a) software packages are not without their risks in qualitative studies as the researcher can become distanced from the data. This was my view and to aid theoretical sensitivity in the analysis process, each data set was sorted manually.

Each woman's interview data were read through three times to gain a feeling of entirety. On the third reading all essential emerging themes were listed. After reflecting upon these emerging themes they were then organised into three categories according to the best ways in which the different themes related to each other. A code was then given to each theme within its category although there were some overlaps between the three.

6.2.4. Profile of the Participants

The biographical details of the 41 women demonstrated a wide cultural and socio-economic sample, representative of those whom student midwives could reasonably be expected to care for once practising as midwives. Ages ranged from 16 to 44, the largest group being in their 20's (fig. 6.1)

Figure 6.1   Age Profile of Pregnant Women
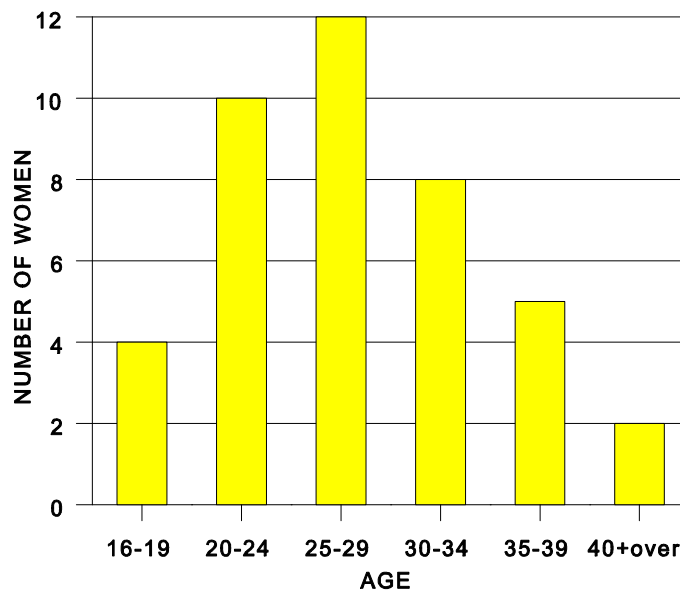
Socio-economic profile

Some other researchers (e.g. Downe and MacIntyre 1996) have suggested that it is difficult to attribute valuable meaning to occupational classifications and educational attainment might be a more effective way of grouping research participants. Given the small sample size in qualitative studies, it can be more useful to group participants according to findings. As in this study, almost a third of couples/single women were unemployed it seemed appropriate to classify these groups. From an analysis of data, six categories were used to group the participants. They were placed according to the highest socio-economic category of the couple (Table 6.1). Twenty-eight women were married, six were living with their partner. The remaining seven were single, living on their own or with a relative.

Table 6.1   Socio-economic profile of sample group of pregnant women

Occupation/Education	Employed	Unemployed
Academic/professional/managerial (14)	11	3
GCSE's/skilled (17)	14	3
Low educational attainment/unskilled/manual (10)	4	6
	29	12

Ethnicity

The local population of the city where the study was conducted is multi-cultural and multi-ethnic of which approximately 10% are Asian or Black African Caribbean. Many studies exclude those whose first language is not English. If midwives are to be educated to assess and provide for the individual needs of each woman, then it was essential to include all groups in the study. Of the 41 women recruited, 8 spoke very little or no English, Punjabi being the first language of five of them (Table 6.2)

Table 6.2   Ethnic Profile of sample group of pregnant women

English	26	Indian	5 (1 born in England)
Gaelic	2	Pakistani/Bangladeshi	6 (1 born in England)
North American	1	West Indian	1
Total White	**29**	**Total Black/Asian**	**12**

Fairly equal percentages of the two groups were in employment and all of the socio-economic groupings comprised white and black/Asian.

Parity and delivery outcomes

Of the 39 women who gave birth to a live healthy baby, a third were primigravida and the woman who had an intrauterine fetal death was also a primigravida. As a whole group there were a variety of previous experiences of the maternity services and a variety of outcomes of their pregnancies (Table 6.3).

Table 6.3   Childbirth experiences profile

PARITY		DELIVERY OUTCOMES	
Primigravida	14	Normal delivery	25 (4 primigravida)
Para 1	15	Forceps delivery	2 (2 primigravida)
Para 2 or 3	7	Ventouse delivery	4 (2 primigravida)
Para 4 or 5	4	Ventouse and forceps	1 (primigravida)
Para 8	1	Elective LSCS	3 (2 primigravida)
		Emergency LSCS	4 (2 primigravida)
		Termination	1
		Intra-uterine death at term	1 (primigravida)
41		**41**	

6.2.5   Women's Expectations

Apart from their biographical details, women were all asked when they first met the midwife during their pregnancy. There were also asked how much they expected to see the midwife and the doctor during their pregnancy. Other questions included: what their

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care had been like so far, whether they had any particular requests or expectations for the pregnancy and what personal and professional qualities they expect to see in midwives. All but two primigravida met a midwife in the first 3 months of pregnancy. The two who did not see a midwife until they were 5 months pregnant were Asian, and in the unemployed socio-economic groups. Both women were scared that they might die in childbirth, one did not speak any English but through an interpreter explained that her mother had died when giving birth to her second baby. The second, had received most of her education in England, was only a teenager and had not seen her husband since their arranged marriage in Bangladesh. None of her relatives had died in childbirth but she felt unhappy with her body changes and was terrified about giving birth.

The majority of women seemed to expect that their care would either be provided by the midwife most of the time (18 women) or they would alternate visits to the GP and the midwife (19 women). Reasons for preferring to see the midwife more than the doctor included the following:

> *"you can talk to the midwife and can't so much to doctors"*
>
> *"it would be better to see the midwife more as she deals with pregnancy all the time"*
>
> *"I feel more comfortable with the midwife than the doctor and it is often a different doctor which I don't like"*

Personal and Professional qualities expected in a midwife

The women were advised that their descriptions of midwives could help in the recruitment and selection of students and assist with the development of the midwifery

curriculum. They provided twenty three different descriptions of their ideal midwife.

Their descriptions were then clustered into three overlapping categories.

Figure 6.2   Most important personal and professional qualities hoped for in their midwife
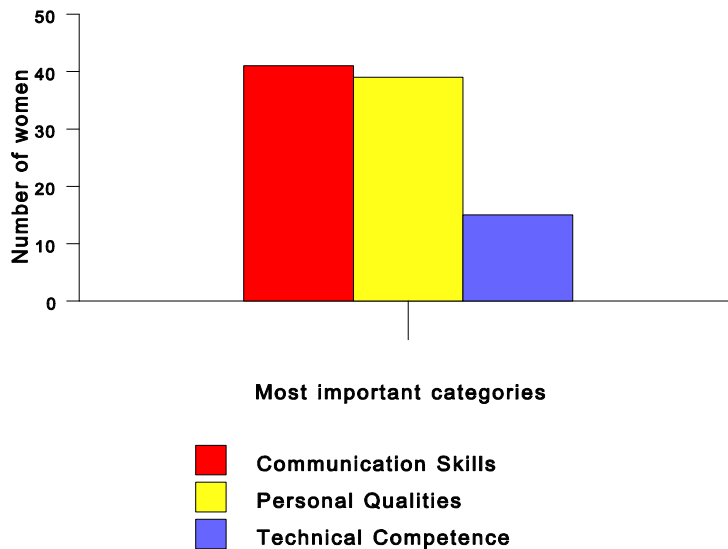
All women wanted their midwife to have good communication skills; *"being a good listener", "able to ask her anything", "able to explain things step by step", "intuitively knowing what is needed".* The personal qualities that seemed to be important included: *"being personable", "friendly", "smiling and cheerful", "puts you at your ease", "caring", "outgoing".* The one women who could not think of any important qualities was expecting her fourth child and said that she expected:

> *"..... to look after myself mainly, so can't really think of anything that would be important".*

However, after spending six weeks in hospital antenatally, she changed her mind and said:

> *".... its especially important for midwives not to have bad attitudes. They*

must be pleasant and to have time for you..... attitudes are what matters ...... to put you at your ease......"

Only 15 women explicitly mentioned the need for midwives to be technically competent and able to fulfil their role confidently. By implication there was an assumption that all midwives would know how to do their job efficiently and when they would need to involve a doctor.

6.2.6   Findings from a synthesis of all data

A constant comparative method was used to analyse the data. Following a sorting and re-sorting of themes, three broad categories emerged as follows:

The Carers

Individualised Approach to Care

Clinical Competence

6.2.6.1 *The carers*

In this category the list of relevant themes were clustered into four sub-categories:

i   communication styles

ii   gender

iii   inter-professional relationships

iv   personal qualities

(i)   <u>*Communication Styles*</u>

Communication abilities continued to be of paramount importance throughout the childbirth period and hence is evident in all three categories to some extent. In this category the themes relate to the communication style of the carer, predominantly the midwife, and the midwife's ability to empower the woman, to enable her to feel special, to help her to relax, be in control and when necessary to be the woman's advocate with the doctor. The majority of women (32) found they preferred the midwife as carer to the doctor because:

> *"the midwife has time for you, the doctor checks you and you're out"*
>
> "*midwives are more supportive than doctors"*
>
> *"feel more comfortable with the midwife.... she knows me..... the doctor doesn't.... he doesn't listen or talk to me......"*
>
> *".... prefer the midwife, I'm more at ease..... its her subject"*

Eight women expressed dissatisfaction with the communication style of some of their carers, for example:

> *"She [the community midwife] didn't relate to me naturally"*
>
> *"staff on the ward knocked my confidence..... made me anxious....."*

(ii)   <u>*Gender*</u>

Although there was an assumption that midwives are always women, when this was explored further the majority of women said they would not like a male midwife even though they would accept a male doctor. Their reasons included some of the following:

> *"..... men don't understand, you need to relate as a woman......"*

> *"..... you're not as open with a man ..... only tell a woman personal things"*

> *"...... men are not interested"*

> *"...... my partner wouldn't like a male midwife"*

> *"..... I'd feel embarrassed with a man"*

> *"...... the dynamic between us was because we are women...."*

Almost half of the participants (19) would prefer to have only female carers but most realised that if there were complications a male doctor might need to become involved in their care.

(iii)   <u>*Inter-Professional Relationships*</u>

The majority of women saw midwives and doctors as having very different roles in childbirth, and also identified what was, on occasion, unnecessary duplication.

> *"unless you have a problem you don't need to see a doctor"*

> *"midwife care is fine ..... there is duplication between midwife and GP"*

> *"midwives are so much more knowledgable than GP's about childbirth"*

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> *"its good that midwives are trained to tell the doctors when they're needed"*

Women had mixed views about the GP visiting then postnatally. A few women found it reassuring that the GP examined their baby but others felt that GP's are busy people therefore:

> *"..... don't see why my midwife shouldn't check Katy [baby], ... it would save the GP coming...."*

On the whole women found that the most appropriate professionals provided their care and liaised effectively. However three women were upset by what they saw as inappropriate attitudes between professional groups. The following examples highlight their concerns:

> *"the student was tactful when she phoned the surgery.... but I think the student and doctor had a bit of an argument.... the doctor did prescribe the antibiotics though...."*

> *".... I was aware of a conversation between doctor and midwives and this was inappropriate as I could hear their disagreement.... my impression was that the midwives were being given a hard time..... there is no way the midwives' competence can be questioned"*

A few women found the GP's receptionist to be the barrier in seeing the midwife and would have liked it to be easier to make an initial appointment.

> *".... had to push the GP's receptionist to make me an appointment with the midwife..... "*

(iv)   <u>Personal Qualities</u>

In line with many other studies, the women in this study clearly articulated the qualities in the carers that enhanced the childbirth experience. They were equally capable of identifying those incidents that left them dissatisfied or angry with their carers. The majority of comments were positive, but sometimes it can be more helpful to examine the negative as well as the positive comments to bring about improvements in the recruitment, education and practice of maternity service staff.

Most important personal qualities and attitudes in midwives (figure 6.3)

Of most importance to women was having midwives who were nice, caring, understanding, pleasant and reassuring. However three quarters of women wanted more than this from their midwife.

No of women who expressed preference for certain qualities

Postive Personal Qualities of Midwives

☐ nice, caring, empathy, pleasant, reassuring	☐ had time, remembered, at ease
☐ friend, friendly	☐ outgoing, bubbly, sense of humour, smiles, happy
☐ listened, explained, informative	☐ calm, professional, open, honest, commonsense
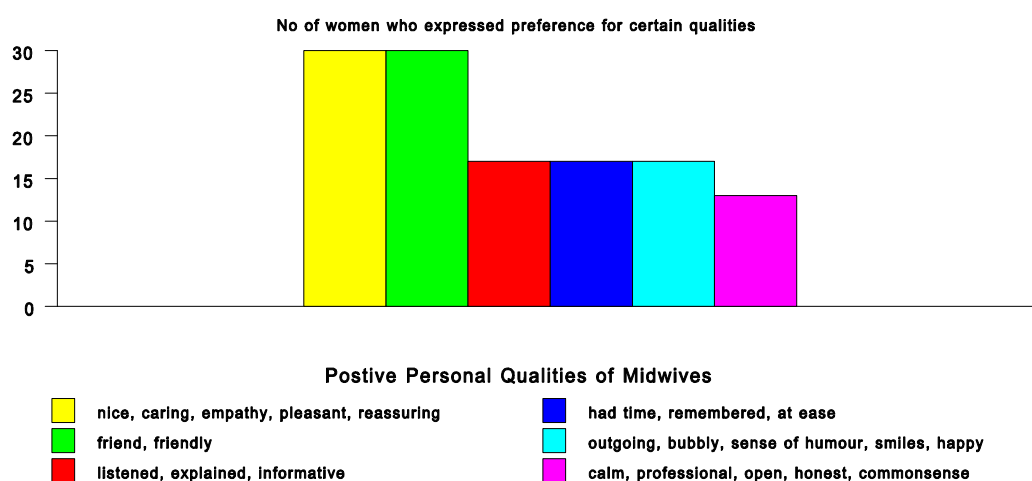
Figure 6.3   Most important qualities of midwives identified 2-3 weeks postnatally

Like the findings of Wilkins (1993) they wanted a more special relationship with their

midwife and saw her as friend as well as a knowledgeable professional practitioner. Interpersonal skills were also important and those who were most appreciative of the midwives described them as having time for them *"being there for me"* and listening to them and what concerned them. Personality characteristics seemed to fall into two groups that were equally appreciated, that is:

· the outgoing, bubbly midwife who is happy in her work and smiles a lot and

jokes with you

and

· the calm, open, professional approach of midwives who inspire trust, demonstrate commonsense as well as sound knowledge.

Age of the midwife did not seem important. One woman had thought antenatally that she would like her midwife to be motherly but postnatally she was really pleased to have a young midwife as they became good friends.

Negative comments about maternity service staff

All but one of the women were impressed overall by the midwives involved in their care, but 14 women encountered examples of personal attitudes or qualities they did not like from one or more midwives. Six women described a community midwife they had met (mainly relief midwives) as: *"unhelpful", "insensitive", "lacked intuition", "in a rush", "abrupt", "snotty .... made me feel uncomfortable", "treated me like a naughty child", "only did what she had to"*. Seven women described a few postnatal ward midwives, 3

of whom were on night duty as: *"older one was officious", "having a bad attitude and miserable", "rude and shouted at me", "unhelpful", "did what she had to do and nothing else"*.

There was very little criticism of midwives involved in care on labour ward but one professional woman expecting her first baby found one of the midwives insensitive and did not smile at all. Of the 14 women who made these comments, 5 were primigravida, all socio-economic groups were represented and all but one is white.

6.2.6.2 Individualised Approach to Care

In this second category the themes were grouped under three headings:

i)   continuity of care

ii)   individual needs and preferences

iii)   informed choice

(i)   Continuity of care

The majority of mothers (22) stated a preference for one or two known midwives throughout pregnancy and childbirth. However, of these, 8 women felt it was somewhat unrealistic to expect their community midwife to be available to care for them in labour. Although women would prefer to be cared for by the same midwife, they felt that being good at their job and being nice and friendly was a good enough alternative. There were

women who were cautious about having the same midwife throughout in case they did not like them. What was of particular importance to women was that all the midwives caring for them should know about them, including detailed reading of their notes and being briefed by their colleagues. It was essential for many women that midwives told them when there was to be a change of midwife and to introduce her if possible. A few women and their partner found it irritating when carers did not read their notes and "each time there was a change of midwife we had to repeat everything...... I didn't feel they'd read my wife's notes". This couple found the student midwife to be the best as "she read the notes". A large number of women (18) found that if they developed a good rapport with their midwife on the labour ward, they did not like a change of midwife. To change midwife made women more anxious and as labour progressed they found it difficult to communicate with someone new. A few women commented on the value of the student providing continuity of carer for them. If the midwife changed, or their community midwife did not accompany them to hospital, to have the known student midwife was reassuring.

Only a small minority of women (3), all multigravida, said continuity of midwife carer did not matter. One of these women particularly stated that she did not want her community midwife with her in labour as she had developed such a good relationship that she did not want to risk embarrassing herself in front of her midwife.

(ii)   *Individual needs and preferences*

Those women who had been pregnant before, but a few years ago, were impressed by the

changes they saw in their maternity care. Almost half of those interviewed commented that they felt as though they were really treated as individuals and were involved in decisions about their care:

> *"...... on the ward in early labour I was given time to make the decision....."*

> *"..... the midwife picked up that I was agitated and asked me if I would like to move to a side room....."*

> *"...... midwives treat you as individuals....."*

However 7 women cited examples of auxiliaries, doctors and midwives who appeared to be more rules orientated than concerned to meet individual needs. Three of these women felt some of those they encountered treated them as having no intelligence or views of their own.

> *".... they assumed all Asian women don't eat meat and didn't speak English...."*

> *"..... my legs were weak, they hardly came to me.....I was forced to get up and then I fainted...."*

Some women who had epidural anaesthetics or Caesarian births felt that very little allowance was made for them. There appeared to be an assumption that their legs would be back to normal once they were on the ward. Primigravida were particularly anxious when they found they could not reach their baby easily as they were unable to get out of bed. Of great surprise to women who had had a Caesarian birth was that they were expected to carry their meal tray on the second postnatal day. Having been told not to lift or carry anything heavy, they had anticipated the meal tray being carried for them.

The majority of women found the atmosphere on the postnatal wards to be a big improvement. They liked being allowed to *"do their own thing"* and found that the staff provided good support and advice when needed. Several women commented on the good team work, and at shift change over the next midwife seemed to know all about them.

Not everyone was happy with their time on the postnatal wards, but these were in the minority. Most complaints related to shortage of midwives and care being provided by *"nurses with less knowledge and patience"*. Two Asian women felt they experienced racial prejudice from staff but another Asian woman commented that the West Indian staff in particular had empathy for her individual needs. Two white women commended all staff, *"even the black ones"*.

A third of women said that their midwife negotiated the pattern of visiting at home with them and this worked to their satisfaction. Four women felt that the midwife visited for too long a period of time but two of them recognised that it was for their own good. A small number of women would have liked the midwife to visit for longer rather than transferring them to the care of the health visitor.

Women failed by the maternity services

There appeared to be two women in particular whose individuals needs were not met, although antenatally there was evidence that they were anxious and had very little support. The interpreting service worked hard to encourage these two primigravid Asian women to attend parentcraft classes which they did occasionally. However, these women

did not find they received enough information about what to expect on the postnatal ward. They both felt that no one in hospital had explained baby care to them and hoped it would be better when they went home. Unfortunately this was not the case. Both women had lots of different midwives, generally a different one each day. They found the advice they were given confusing and by the time they were discharged by the midwife they were still unsure about how to care for their baby. Not surprisingly both women had given up breastfeeding at the time of interview.

(iii) <u>*Informed choice*</u>

Many of the women interviewed felt they were given sufficient information to be able to make decisions about their care. A few thought that too much information was given at the first meeting with the midwife and this caused confusion. Almost half of the women commented specifically that midwives are really knowledgeable now, more so than some of the doctors they had met. They found that generally all their carers involved them in making choices.

However, there were six women who were dissatisfied with the information they were given and felt that decisions were made for them. These women cited community midwives, hospital doctors and GP's as either having insufficient knowledge or deliberately withholding information.

> *"..... the GP had no literature on it and couldn't tell me about the tests....."*

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"..... the doctors just didn't keep us informed...."

"..... I was angry, they talk a lot of rubbish about choice......"

"..... my midwife didn't tell me much, she just did things".

6.2.6.3 *Clinical Competence*

For the purposes of this part of the study clinical competence is used in relation to knowledge and skills as well as dexterity. The themes that emerged in this category were clustered under the following five headings:

i)   Communication Skills

ii)   Knowledge and ability to inspire confidence

iii)   Psycho-motor skills

iv)   Infant Feeding

v)   Parent education

(i)   Communication Skills

Good communication skills were seen as essential for effective care. A large number of women found that midwives and doctors were very good at explaining everything to them, but ten women were less satisfied on one or more occasion.

"I felt fobbed off by the doctors and midwives"

"..... there was one stage when I would have like to have known what the midwife was doing....."

> *".....why didn't they explain that the drip would not cause the problem I had last time....."*

Listening skills were noted as the most variable communication skill difference between doctor and midwives. Midwives were usually described as being good listeners whereas there were complaints that:

> *"..... the doctor did not listen to why I was scared...."*

> *"..... midwives listen to you, the doctors don't...."*

> *"..... the doctor would not listen to me..... she had got it wrong but wouldn't accept it....."*

Of particular importance to a small number of women was the ability of midwives to discern what was needed by responding to non-verbal cues. Unfortunately one woman encountered a GP and another a community midwife who they felt lacked discernment and common sense and therefore these women said they:

> *"..... held things back, I didn't ask her anything....."*

> *"..... did not tell him how I felt....."*

Written communication

Making good records and reading the notes were significant omissions by a few doctors and midwives. Usually this caused irritation for the women and their partners or resulted in conflicting advice. In at least two instances failure to read notes caused unnecessary pain and delay in delivery.

(ii)   *Knowledge and ability to inspire confidence*

Twenty-six women were particularly impressed with midwives' knowledge of childbirth and felt they inspired confidence. They generally found midwives could answer all their questions, gave sound advice and really understood all about what it was like to be pregnant and have a baby. On occasions if the midwife could not answer the woman's questions, she said that she would find out and come back to her. For the most part they did so very quickly. Women encountered disappointments with three midwives at the booking interview when they seemed to lack knowledge of some of the screening tests. However, two of these midwives redeemed themselves by following the women up and providing more information.

(iii)   *Psycho-motor skills*

All carers were described by the majority of women as technically or highly competent. A few women were disappointed that although some midwives were *"excellent at their job"* they *"didn't have a relationship with you as a person"*. Women found that where staff were highly competent it instilled them with confidence. Where this was most appreciated was on labour ward and midwives were commended particularly for their gentleness and care when suturing.

(iv)   *Infant Feeding*

Women who opted to feed their babies with artificial milk were reasonably satisfied with the help and advice they received. However some went home without knowing how to

prepare the feeds and one women found her community midwives so unhelpful about the different types of artificial milk that she rang her doctor's receptionist for advice.

When it came to breast feeding, there is an unfavourable comparison with even poor national statistics. That is, nationally about 25% of those who start to breast feed give up. In this study, of the 22 women who started breast feeding 9 women had given up altogether and 2 others were only giving the occasional breast feed at the time of the interview, 2-3 weeks postnatally. The reasons given for their difficulties are identified as follows:

- Inadequate help in hospital (3 women)

- Inadequate help in hospital and community (2 women)

- Inadequate help/help not for long enough in community (2 women)

- Woman's own decision in spite of good help (4 women)

In hospital women who gave up feeding said it was because the ward was busy and they did not get help when they needed it. Some women said advice was conflicting but other women said the varied advice helped them decide for themselves. When at home women who lacked continuity of midwife found advice confusing and 4 women were particularly critical of the health visitor, some of whom contradicted the midwife. Two health visitors apparently advised the women to give bottles of milk as they did not have enough breast milk. Two of the women who said they had sufficient help, but still gave up breast feeding, said it was too painful to put their baby to the breast . Of the other two women, one found breast feeding embarrassing and the other decided that as she had breast fed her first child she would *"bottle feed this one so that others can help me"*.

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Those who experienced difficulty with breast feeding, but continued, found the hospital breast feeding expert invaluable and would have given up if she had not helped them. Those women who breast fed successfully were pleased with the help they received from both hospital and community midwives.

(v)   *Parent Education*

Women that attended parent education classes found those held in the community and in the hospital to be excellent. Aquanatal classes were generally appreciated except by one women who felt the midwife in charge of her class was not really interested in the women as individuals. Most disappointments in relation to education was on the postnatal wards. Although at times the wards were extremely busy and short staffed, this was not always the case. Whereas a few women said how much they liked the non-interventionist approach and felt they could ask for help if necessary, nine women said they were not even shown basic baby care skills like putting on a nappy. One woman was worried about how to clean her baby boy's genitalia but when she went home the community midwife demonstrated all the necessary skills.

6.2.7   Discussion of issues about competence

Emerging from this study were three broad aspects of care which were important to women using the local maternity services. The first of these related to the qualities and attributes of the midwife. This and other studies (Berg et al 1996. Wilkins 1993) found

that women wanted to feel special, to feel significant and not just someone to be processed. The high priority given to good communication skills confirms the findings of others (Cartwright 1979, Kirkham 1987, MacIntyre 1982, McIntosh 1988, Fraser et al 1996). However, unless there was a relaxed and trusting relationship with the carers, women tend to hold back, do not hear what is said or feel in some way dissatisfied with their care. A partnership relationship between midwives and doctors was expected and women were disturbed by inter-professional conflict, they tended to defend the midwife as she was viewed as the woman's friend or advocate. Women did not appear to see a conflict between the midwife as friend and the midwife as competent professional, with one exception. This one women did not want a known carer with her in labour because her midwife had become her friend.

It is only in recent years that men have been permitted to practise as midwives. None of the women in this study had come into contact with a male midwife but there was a view that they could not have the same relationship with a male midwife as with a female. If the special relationship is only possible *".... because we are women...."* it has implications for defining a model of competence in midwifery. However it is recognised that this study has limitations in being able to draw conclusions from comments about gender, but it is suggested that further study is needed in this field. What is important is for the course team to consider the problems that might arise for male students during their midwifery programme as they already do for black students subjected to racial discrimination in the workplace.

The second important aspect of care was how well the women received continuity of care

which respected their individual needs and preferences and involved them in decision making. Generally women were realistic about being able to receive care from the same midwife throughout all stages of labour. What was important was being given realistic choices and better explanations as to why some options were not available. Women expected midwives to let them know when someone else would be taking over their care and to demonstrate knowledge of their past experiences and future requests. When labour required the involvement of medical staff, the midwife was seen as a key person in providing continuity. The overall view was that women were treated much more as equal partners in care than had been the experience of five years ago. There was however a minority of women whose care failed to meet their individual needs.

The third category of importance to women was the knowledge and practical skills demonstrated by midwives. Where these were lacking women distrusted their carers. There was however greater trust and respect for those who admitted their lack of knowledge or expertise, but agreed to find out, rather than those who are not prepared to admit they do not know or could be wrong.

Perineal suturing by midwives was one example of improved client satisfaction and women were generally happy for midwives to take on other activities traditionally carried out by doctors. However there was less satisfaction with some of the skills traditionally part of the midwife's role, in particular infant feeding.

6.2.8 Summary

Many of the issues emerging from this study were of value for the local maternity services and a more detailed report was circulated to midwives, obstetricians and general practitioners (Fraser 1997). However the purpose of this study was to obtain women's views of competence in midwifery to inform the pre-registration course planning team. The recommendations that contributed to developing the model of competence included the following:

·   Personal qualities need developing and assessing

·   Inter-professional learning should be facilitated to develop better understanding and respect for each other's values, attitudes and roles.

·   Communication skills need to form an important part of the taught and assessed curriculum.

·   Students need to be able to have the confidence to cope with uncertainty/make decisions

·   Team work and recording and handing over care need to be improved.

·   Management skills need developing to improve prioritising and targeting care.

·   A list of skills needs to be identified which must be learned prior to the end of the course.

6.3   OTHER STAKEHOLDERS' PERSPECTIVES

Our work in developing a model of competence in midwifery involved canvassing the views of all interested parties and stakeholders. Figure 6.4 illustrates the views and opinions of those concerned about competence in midwifery.

Figure 6.4   Sources and opinions in building a model of competence

Changing Childbirth
Report

EC directives

ENB
Guidelines

Clinical
Experts

Friend

UKCC
Midwives
Rules

Professional

Counsellor

Managers

Assertive

?

?

Research

Students
Construct

Dexterity

Knowledge

Midwifery
Supervision

MIDWIFERY
COMPETENCE

Teacher

Midwife
Teachers

Understanding

Effective
Communicator

Sensitivity

Midwife
Researchers

Women's
Experiences

Advocate

?

Organisational skills

Team Skills

Families'
Experiences

Partners'
Experiences

?

Adapted from Figure 3.1 Building a model of competence: Sources used (Fraser et al 1997)

The different stakeholders quite understandably valued or stressed different aspects of the role of the midwife. In my own institution brain-storming sessions with students, midwives and teachers helped contribute to this tentative model. In these sessions knowledge and communication skills were some of the first aspects to be identified as essential for competent practice. The study of women's opinions, reported in the

previous section, had a slightly different emphasis. Whilst there was an expectation that

midwives would be knowledgable and skilful, personal attributes assumed greater

importance in contributing to the quality of childbearing experiences.

In order to be more systematic, than was possible by brain-storming ideas, in finding out

students and midwives views about competence, questions on competence were asked of

all those involved in the case study interviews. The responses from each of the three

groups is presented in table 6.4, the list having been ordered in relation to the majority

views of all groups.

Table 6.4   Views on competence at registration

	n =44 Total	n =20 Students	n = 19 Assessors	n = 5 Teachers
a) knowledgeable	32	14	13	5
b) communicates effectively	31	13	15	3
c) seeks advice appropriately	29	11	16	2
d) knows limitations	29	11	14	4
e) demonstrates competence but not over-confident	26	12	10	4
f) able to take responsibility/good decision making skills	25	8	16	1
g) diagnose abnormalities	18	8	8	2
h) personal qualities, adapts to individuals	18	6	10	2
I) works well in teams	17	6	9	2
j) predict would be safe in emergencies	15	4	9	2

Lack of response does not imply lack of agreement, but it was not specifically mentioned

when interviewees answered the question, "What do you believe are the most important

capabilities of a newly qualified midwife?" It can be seen that being knowledgable,

knowing the limits of one's knowledge and who to go to for advice were identified as a

high priority by all three groups. There was however a contrast in the views of respondents about responsibility and decision making skills. The midwife assessors appeared to see an important balance between new midwives' ability in being able to take responsibility and make decisions themselves alongside knowing when and from whom to seek advice, as the following extracts illustrate.

> " .... the main thing is decision making ... when you are on a ward or labour suite you have to make decisions very quickly, very often things happen very fast ...."
>
> *(Assessor)*

> ".... to know to seek help when they need it ... even now sometimes in my years of experience you are always asking your colleagues advice ...."
>
> *(Assessor)*

> ".... as long as they're competent to leave with a woman ... they know what they're doing and you feel safe to leave them to get on knowing that if they're not happy, if they meet something they've not come across, if there's ever a situation that arises that they are not happy to deal with. .... you know they will come to you ...."
>
> *(Assessor)*

The course leader was the only one of the teachers who expressed a similar view to the midwife assessors.

> "I mean the most important thing is that they recognise their limitations .... they've got to be able to recognise normal progress in pregnancy and labour and also to know where to go for help if the need arises. They won't have had experience of all emergencies .... but they do have to know that something isn't right and know what to do...."
>
> *(Midwife Teacher)*

Students appeared to believe that taking responsibility and making decisions on their own would be a gradual transition following registration which perhaps explains why it was

identified less frequently than knowing their limitations and seeking help.

> *".... its OK as long as you know you own limitations as you will work in a team and there are people around who have more experience ...."*
>
> *(Student)*

> *"I feel I'm a safe practitioner .... I'd be the first to admit if I wasn't happy and go and get someone .... I think I'm known for that...."*
>
> *(Student)*

There were a few students who put the ability to make decisions on their own as a high priority but realised that they needed the knowledge and skills to be able to do so.

"I think a competent midwife is someone who is up-to-date and knows the latest research .... someone who gives safe care and who isn't going to do anything which could put the woman or baby at risk .... a competent midwife needs a very sound basis in normal midwifery and not be scared to make decisions on her own ...."

(Student)

Given that so many of the assessors appeared to believe that decision making skills were so important, it seems surprising that a small number of students had a different perspective:

> *".... there's a slight tendency in midwifery for them to see being competent as being dextrous ... expecting you to set a drip up in 10 seconds or how quickly you can do some other technical procedure ...."*
>
> *(Student)*

It could be that this student was disempowered to take responsibility as a result of her experiences as she later went on to say:

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"…. I felt I was quite dependent on my mentors … even though I was visiting on my own I had to come back and detail every aspect of care and make sure I'd done that correctly … to be honest I don't think I can say I could take on a caseload straight away …."

<div align="right">

(Student)

</div>

Dexterity and speed, except in emergencies were only identified as important capabilities by a few interviewees. Apart from those listed in Table 6.4 the following capabilities were included by at least 25% of the total number of midwives and students interviewed:

- good listener

- able to prioritise

- manage normal labours on own

- competent in abdominal examinations

- safe in drug administration

- enthusiasm for midwifery

Towards the end of the case study interviews everyone was asked what their perceptions were of less competent midwives. If midwives are to be able to judge whether a student should be entered on the professional register it seemed important that they were clear about their criteria for failing students. The majority identified a lack of knowledge and a lack of skills in normal midwifery as indicating an incompetent midwife because they could put the women or baby at risk. An equally important aspect identifying incompetence was poor communication skills. This related to being able to communicate effectively with individual women from all socio-economic groups and also being an effective communicator within midwifery and multi-professional teams. Midwives were

described as incompetent if they ignored women's individual needs, if they denied women access to other carers and facilities because they saw themselves as the providers of all care rather than members of a team. Midwives were also considered to be incompetent if their record keeping was poor, if they were over confident or over cautious. Most of these examples of incompetence supported the interviewee beliefs about competence. The quality of record keeping was the only element that was specifically identified as a measure of incompetence but not of competence although it could be implied by effective communications and teamwork.

6.3.1 Summary

No new elements of competence to add to the data from the national study emerged following an analysis of interview transcripts from my own case study students, their assessors and teachers. However it was important to recognise where their emphases lay as they would be making judgements about competence of future students. It was evident that an effective assessment of students knowledge and skills was necessary but there was a suggestion that a few assessors might value speed and dexterity in carrying out tasks more highly than more complex skills. All sources of evidence identified communication skills as important capabilities for competent midwifery practice but personal qualities and adapting to individual needs was highlighted as important less frequently by students, midwives and teachers than by childbearing women. Having obtained data on competence in midwifery from a wide variety of sources it became necessary to synthesise the data into a coherent and useable model of competence in midwifery. Without such a model it is suggested that midwifery educators and practitioners are less likely to make reliable judgements about student competence for midwifery practice.

6.4   TOWARDS A MODEL OF COMPETENCE

The statutory requirements for midwives and the ENB (1995) midwifery education guidelines provided a broad framework to develop a fuller model of competence. As the study progressed a tentative model of competence was constructed and refined. Testing of this tentative model was possible through discussions with the Project Steering Group, at conferences and in the light of evaluation data and the perceptions of childbearing women. What seemed to be crucial was producing a model that described the complexity and unpredictability of professional practice, and as Hassard et al (1990) and Page (1993) suggest, the components of competence should be intuitively integrated.

Another important aspect of designing an appropriate model was the need to demonstrate flexibility over contexts showing that midwives draw upon an overarching set of abilities with differing emphases as the situation required. What could have emerged from this might have been a complex constellation of skills and loss of the holistic notion of the concept of competence. Instead what emerged were three closely interlinked dimensions described as:

(1)   the ability to be autonomous and professional but "with woman" - **the professional/friend approach**

(2)   the ability to provide individualised care - **the individualised approach**

(3)   a sound knowledge base and appropriate skills for the provision of midwifery care - **the clinical competence approach**

These dimensions have been presented diagrammatically as three dynamically overlapping circles (figures 6.5) which are not fixed but have different emphases according to context (e.g. figure 6.6 shows the more likely emphases during the first antenatal meeting).

Figure 6.5 - Diagram of a holistic, integrated model of a competent midwife
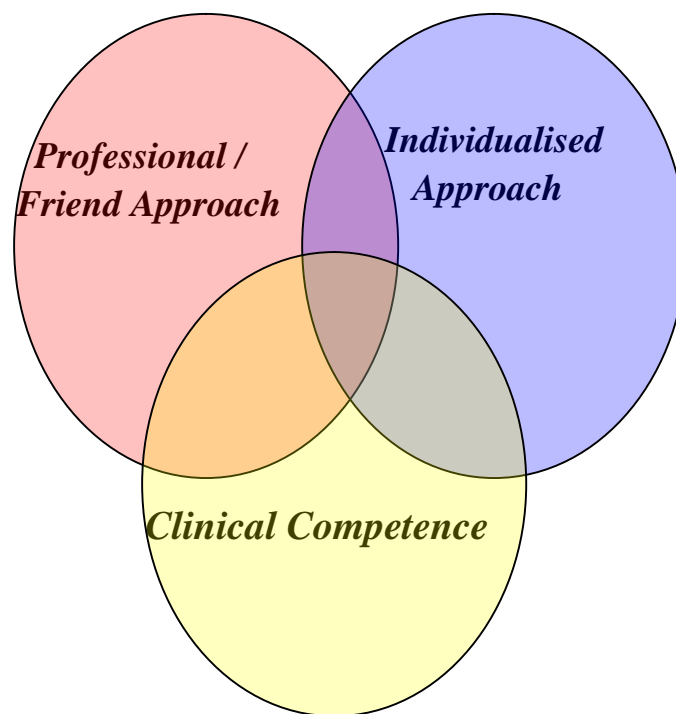
(Figure 3.2 in EME final report, Fraser et al 1997)

**Figure 6.6 -   Model where Professional/Friend and Individualised Approaches are
more dominant**
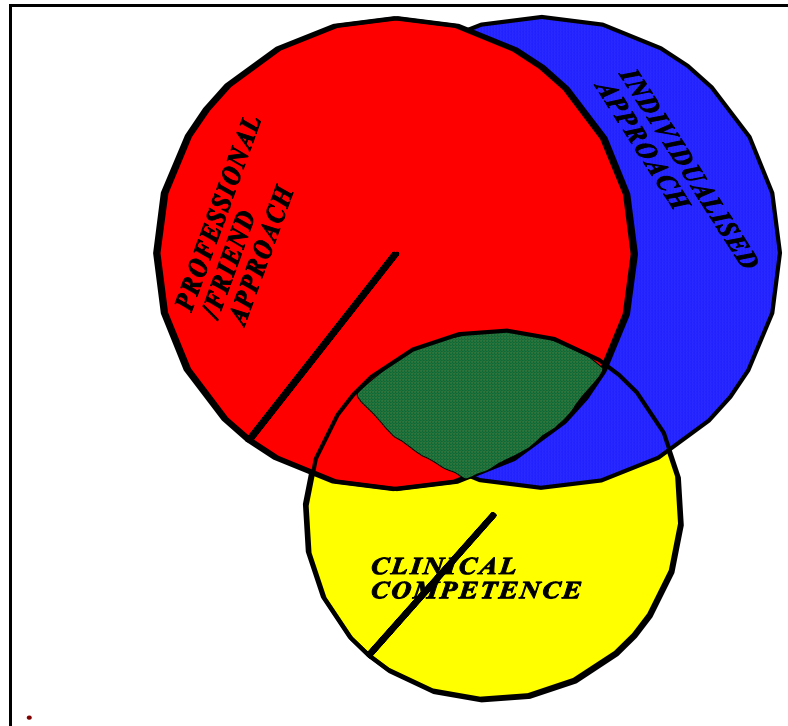
(Figure 3.3 in EME final report, Fraser et al 1997)

Most curriculum documents clearly identify the importance of students being able to
provide individualised care to women and from the case studies institutions would appear
to have been relatively effective in achieving this outcome. Similarly there was evidence
that students are expected to become clinically competent, that is develop the right blend
of knowledge, skills and understanding to provide safe care. There was variable evidence
as to the effectiveness of assessment of this dimension.   The professional/friend
dimension assessment of competence was less evident in case study evaluations. Personal
qualities and attitudes are important to childbearing women and their development was

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seen as essential for effective learning in my earlier study (Fraser 1994). Knowledge and understanding of statutory responsibilities were generally tested effectively, but there was very little evidence of programmes addressing student difficulties in holding in tension a 'special/friend' relationship with women whilst adopting a reflective and professional approach to work. It would seem from the evaluation data that this professional/friend balance proved difficult for some assessors too in their relationships with students, especially when it came to failing likeable students.

From an examination of my own institutions's assessment scheme it was evident that a few elements of this holistic model of competence were not assessed at all or were not assessed very effectively. It therefore became essential when re-designing the pre-registration midwifery curriculum to draw upon an assessment framework to judge the validity and reliability of our proposals for a revised assessment scheme.

CHAPTER SEVEN   THE ASSESSMENT OF COMPETENCE

7.1   DEVELOPING A FRAMEWORK FOR ASSESSMENT

The case study work revealed considerable variations in the comprehensiveness and emphases in assessment. Some appeared to be more effective than others in achieving curriculum intentions in assessment and there was a suggestion in my own institution of variations in reliability of assessment of individual students. What was lacking was an assessment matrix to provide a framework to judge the comprehensiveness of assessment schemes and a better system to monitor assessor reliability.

My own institution had failed in the past to use a systematic approach when designing assessment schemes. Instead intuitive judgements and experiences from previous courses were drawn upon. This study provided the opportunity to develop an evidence based assessment matrix for designing assessments in midwifery education.

7.1.1   Survey

The wide variety of assessment methods, differing emphases and areas actually assessed in midwifery education programmes indicated a need to survey the views of the midwifery profession to assist in the development of an assessment matrix. Although questionnaires are not without their problems (Chapter 3.4.3) they were considered to be probably the most effective way of consulting with a group of expert midwife advisors within the resources of the project. The expert group selected was the ENB's

Professional Midwifery Advisory Network (PMAN) members and the six ENB Midwifery Education Officers, a total of 60 potential participants. Although there was a 75% response rate to the questionnaires, it subsequently transpired that some of the responses were not valid or reliable (Worth-Butler, Fraser and Murphy 1996). As the questionnaire data was only the first part of a strategy to survey the views of this expert group of midwives, these weaknesses did not adversely affect the outcome. A two stage approach to the survey was chosen as we were aware of the limitations of using a questionnaire alone. Analysis of curricula, ENB and UKCC documents plus ideas from brainstorming sessions with midwives and students in my own institution generated a wealth of items that were considered necessary in determining competence to practice as a midwife. There were variations in opinion as to what was realistic to expect of a new midwife and also there were differences about the best context for assessment. These issues seemed important to include in the questionnaire survey. The items generated from documents, midwives and students were used to construct a pilot questionnaire which was tested in my own institution, modified and re-tested . Advice from the ENB Steering Group included suggestions about improving the layout of the questionnaire and the choice of yellow paper to improve response rates (whether anecdotal or supported by research has not been established).

The second stage of the survey involved group work with PMAN members at one of their regular meetings. The timing of our session was not ideal. As a member of PMAN, I was present at the morning meeting of the network. This session comprised a heated and, at times, angry exchange between PMAN members and ENB officers following an earlier project on staff:student ratios (Murray et al 1994). In spite of the initially hostile

atmosphere, the group work for this study, held after lunch, had a mixed but generally favourable response. The experts were pleased that they were being involved in contributing to a research study of direct relevance to their field of work, in contrast to the research report discussed in the morning. However they were less satisfied when presented with the data analysed from the questionnaires. Concerns were expressed about the validity of findings, especially if used in making policy decisions. It became apparent that some respondents had answered the questionnaire to reflect what happened in their institution rather than, as was asked, identifying what they believed was the most effective way to assess students. In spite of this, the majority of respondents included further details in the free response section at the end. As a team we had assumed that these experts would be reasonably familiar with educational terminology. This was a false assumption. Some of the most vocal members of the large group disliked the atomised nature of the questionnaire (example - Appendix 15) whereas others felt that some of the statements should have been broken down even further. In order to establish the most important issues arising for PMAN members in relation to assessment, the large group was divided into four smaller groups. They were asked to focus specifically on what was surprising about and what were the implications of the findings.

At the feedback session for the whole group the following issues achieved consensus:

·   why do some favour a "belt and braces" approach to assessment? Does it imply that teachers do not trust assessors' judgements in practice?

·   simulation is necessary if actual practice is lacking e.g. resuscitation of the newborn

- difficulties in assessing ability to provide holistic care if assessment is competency based alone

- assessing abilities in different situations is necessary

- surprise at the lack of 100% agreement about assessing some essential activities of a midwife (e.g. normal delivery)

- concerns about differing emphases of managers, clinicians and supervisors of midwives

- the emphasis on theory could detract from assessing students in practice

- teachers need to be involved in supporting and ensuring reliability of assessors.

A record was kept of areas of assessment where there was a consensus from the network members as well as feedback from the small groups. The network members were aware that data from them would contribute to an assessment matrix. As a framework for assessment this was welcomed, but the notion of a national assessment tool was totally opposed.

The survey of PMAN members provided the basis for constructing the first draft of an assessment matrix. In cognisance of the need to assess across contexts, and knowing that many assessment schemes divide assessment into pre-conception/antenatal care, care in labour and postnatal care, these three contexts were used for the next research phase.

7.1.2 Focus Groups

The expert group made a valuable contribution to constructing an assessment matrix.

However many of them had minimal involvement in actually assessing students during their midwifery programme. Complaints about assessment schemes were frequently about difficulties in interpreting ambiguous statements and the use of educational jargon. It therefore seemed that focus group work involving all those involved in assessment would assist the team to:

· decide what elements <u>must</u> be included in an assessment matrix for determining eligibility to practise as a midwife

· consider the best way to present the matrix

· identify how and in what context each element should be assessed

· critically review our thinking

The six national case study institutions were asked to host the focus groups as they could provide all those groups involved in assessment of student midwives. Locally a similar approach was adopted by the assessment scheme working group. Good attendance was considered to be more likely by using the case study sites as a positive rapport had developed between the institutions and the project team. On average there were eight people present for most of the focus groups. The participants represented midwife teachers, supervisors of midwives, midwife assessors, current three-year and shortened programme student midwives and our case study students in their first year in practice. Prior to the focus group day, the first draft assessment matrix was sent to them with a request for sections to be completed and brought with them. This strategy seemed most likely to ensure a clear focus from the outset and would give less confident members some material to contribute from early on.

Unlike many advocates of focus groups who suggest a two hour session is sufficient (e.g. Kreuger 1994) we decided upon a four hour session divided by a lunch break. This seemed necessary if there was to be a really critical forum in which all opinions were valued and everyone had an equal opportunity to contribute. The procedures for conducting focus group work outlined by Morgan (1988) were used to fulfil these aims. My role was that of facilitator and the research assistant acted as scribe. Two tape recorders were used for a dual purpose. Firstly in case there was a human or technical error in operation and secondly to ensure voices at the extremities of the group would be recorded.

Following the six focus group days, the tapes were transcribed and members of our research team independently reviewed the data to identify the most important issues that emerged. There was almost a total consensus. One of the most fundamental issues that emerged from the data was identifying the inappropriateness of the three contexts of pre-conception/antenatal care, care in labour and postnatal care as a framework for the matrix. A variety of alternative frameworks for structuring the matrix were explored and the only framework that did not conflict with earlier research data was the three dimensional model of a competent midwife described in the previous chapter (Figure 6.5). The areas identified from PMAN and focus group work as needing to be assessed, could all be categorised into this framework.

7.1.3 Testing the framework

Data from the study as a whole was drawn upon to break down the areas needing to be

assessed into assessment evidence. All through the study concerns had been expressed about the heavy written assessment load and the lack of credit given to assessment in the practice setting. In some way the importance of practice based assessment needed to be emphasised, especially when our research data indicated the more likely validity of practice based assessment in determining fitness for practice and for employment. An example of the final design is provided in appendix 16 . Essential and possible contexts for assessment were identified . The "essential"contexts were designed to reflect the evidence needed when determining fitness for registration as a midwife. "Possible" contexts were included to provide suggestions for additional evidence to meet local requirements or where an "essential" context could not be identified from our data.

Neither the PMAN members nor the focus group participants had sight of the draft matrix that emerged following work with them. This emerging matrix therefore needed to be tested critically before being finalised. This testing was carried out in three ways. The first two were carried out simultaneously and the third involved presentation of extracts of the matrix at the 1996 Research in Midwifery Conference at Aston University.

The project administrator had not been involved in field work and therefore undertook to cross-check the assessment matrix with midwifery curricula assessment schemes and case study students' competence in their first job. The second element of testing involved my own institution in two ways. Similarly to the project administrator's cross checking, data from work with my own case study students and students who completed the questionnaire were used. The purpose was to check whether their views on what evidence is necessary for determining competence at registration (table 6.4) was included in the

matrix. These case study students had also identified where there were gaps in our assessment schemes, and the matrix was also checked to ensure these had been included. As the UKCC Rule 33 (UKCC 1993) specifies learning outcomes, my own students were asked to identify where assessment of each had been most effective. These findings proved particularly helpful in determining the feasibility of essential contexts for assessment. At the same time as the cross-checking, the draft assessment matrix was subjected to critical review by the examinations and assessment sub-committee in my own institution. Minor changes only were suggested where there was the potential for ambiguity or a good source of evidence had been omitted.

The shape of the matrix was well received at conferences and no conflicting evidence has been received from any sources. This matrix, whilst not in the public domain at the time of re-designing my own institution's programmes and could not therefore be distributed to the course planning team, enabled me to check the comprehensiveness of strategies being proposed by my own course team.

7.2   DESIGNING THE PROCESS AND PROCEDURES

Whilst it was not possible to share with my institution's course team the findings as they emerged from the ENB commissioned part of the study, knowledge of these findings enabled me to ask potentially the 'right' questions when discussing the assessment strategy. Another advantage of being aware of the importance of practice based assessment, in either allowing or preventing borderline students from being given the 'benefit of the doubt', was the knowledge I had from the national and local data to

underpin my arguments for seeking specific credits for these assessments. My own university was particularly reluctant to award credits for practice based assessment for some quite understandable reasons. Although subject divisions have some flexibility in the format of assessments, and were expected to be innovative, they were expected to include assessments that were commensurate with the amount of work for each module. The examples given for a 10 credit module comprised a 2,000 word essay plus a two hour examination or two essays of approximately 2,000 words.

In contrast the ENB were concerned that the weight of written assessments would not be excessive and only required one unseen written examination alongside course work during the three year programme. This was in recognition of at least 50% of the programme being spent in practice placements and hence students had less time than for example language students, to read books and draft assignments. Added to this, hours spent physically working in practice placements meant that students were likely to be more tired during their study time in the university. Evidence from the case studies suggest that inappropriate or over assessment could detract from more important areas of learning.

These important areas of learning, that is learning to use theoretical knowledge in a variety of practice settings and learning how practice might generate theory, form a large part of the midwifery curriculum. The course planning team were agreed that a considerable proportion of the curriculum outcomes could only validly be assessed as a more continuous process in the context of midwifery practice. According to the findings of the ACE report (Bedford et al 1993, p.162) there is "often a considerable gap between

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the rhetoric of documentation and policy and the reality of what happens in practice".

The most difficult challenge for the course team appeared therefore to be to close this gap

and produce an assessment in practice scheme that met the requirements of the

curriculum, the ENB and the university.

7.2.1   Curriculum requirements

Within the new curriculum two modules had been developed to enable students to learn

about holistic individualised midwifery practice from the perspective of normality

(appendix 17) and holistic midwifery practice in any childbearing situation (appendix 18).

These modules were agreed as essential to enable students to move their focus from

discrete but important aspects of midwifery, such as applied reproductive biology, to

developing the skills of critical analysis and synthesis across the breadth of the

curriculum. The skills should enable them to make sound decisions for practice in a

variety of contexts. Modularisation has a tendency to fragment or compartmentalise the

curriculum. A key purpose for these modules was to integrate all elements into a more

holistic concept which could be applied in a range of midwifery situations. Each module

requires a separate assessment. The challenge in assessment for these more holistic

modules was to ensure that all learning outcomes were included in the assessment. The

project assessment matrix provided a framework to ensure that all the "essential" items

for practice based assessment were included in our assessment scheme. What was also

necessary was to ensure that assessment took place across context and time. Without

such as an assessment tool it could be theoretically possible for students to achieve in one

context and for there to be no re-visiting of that element in another similar but different

context. Although some authors suggest an OSCE (Objective Structured Clinical Examination) style assessment as one way of providing practice assessments, it was rejected as it was likely to only capture mastery of one element at a time at one point in time. Instead there needed to be some way to assess whether students had the capability to intuitively integrate the components of competence to provide appropriate care in all situations. This ability suggest, Hassard et al (1990) and Page (1993) is necessary for the complexity and unpredictability of professional practice.

It was agreed that the only way in which this assessment could be carried out is by midwives teaching and working with students over a period of time in the full range of midwifery contexts and assessment taking place throughout the period.

7.2.2 ENB requirements

The ENB requires pre-registration programmes to be assessed in theory and practice (ENB 1996 Section 5) and that students who complete the programme demonstrate evidence of having met the requirements of Rule 33 of the UKCC Midwives Rules (UKCC 1993). Many of the findings of the ACE report (Beford et al 1993) have also been incorporated into the ENB's regulations and guidelines for approved institutions. In particular these regulations and guidelines require:

· students to have a portfolio where all learning and outcomes of assessment will be recorded to provide cumulative information about a student's progress and achievement

· assessment criteria to discriminate between differing levels withing a programme

· use of reflective dialogue on experience supported by documentation

· assessors to facilitate learning, supervise practice and assess levels of attainment related to outcomes

The implications for the course team were two-fold. Firstly there was a need to review the current student portfolio in terms of effectiveness in meeting ENB requirements and usefulness in facilitating student learning and assessment.. Data from the case study evaluation was drawn upon to bring about these improvements (Table 7.3). The second implication was the way in which we interpreted the ENB assessment policy for "separate pass criteria for theory and practice" and to ensure "that equal value and accreditation is given to assessment of both theory and practice" (ENB 1996a, 5.7). The team agreed that these statements should be addressed in the context of a later statement in the regulations calling for integration and coherence in assessment. Our case study students had identified the value of written work as important for the development of their knowledge and ability to understand and critique research. However the written work of less value was that which was not related to midwifery. This was being addressed in all the new curriculum assignment guidelines. Examinations were already based on midwifery practice scenarios. What was lacking in the current assessment in practice documentation was recording of evidence that students had demonstrated appropriate use of theory in practice, although it was a pass requirement for the assessment (Appendix 19). These ENB statements were therefore interpreted firstly to mean that all summative assessments would draw upon theoretical knowledge, concepts and application to midwifery practice (equal value). This appears to correspond with the qualitative interpretation identified in

the Gerrish et al study (1997) although others in their study interpreted it quantitatively i.e. equal credits for theory and for practice. Secondly that the criteria used to asses work undertaken in the university would be different from, but of the same intellectual rigour for the stage in the programme as the criteria used to assess work undertaken in the practice placements. In this way the team's philosophy of holism in assessment would be preserved whilst also meeting the requirements of the ENB.

7.2.3   University requirements

Midwives on the course team were aware of the university's reluctance to award credits for assessments carried out in clinical practice. In spite of this knowledge, there was agreement that midwives practice in a variety of different contexts which require many different responses. Although there is a wealth of knowledge that has to be learned and understood by midwives, there are contexts which will be unexpected and unpredictable. The only way in which the students' responses and application of principles can be interpreted is in the context of practice. Effective responses it is suggested require a high level of intellectual abilities. Students need to have the capabilities to be able to rapidly recognise, interpret and act appropriately and quickly on some occasions but on others to act following a period of reflection or deliberative analysis. The team could not therefore understand why there was reluctance by the university to award academic credits for achievements which, to them, were clearly cognitive as well as skills-based. Without such credit rating neither students not midwives would believe they were equally valued as part of the diploma/degree award. The findings from the seven case study institutions enabled potential areas of difficulties to be identified and addressed.

7.2.3.1 The assessors and practice environments

One problem for universities generally seems to lie in the assessors in midwifery being employed by another organisation. Normally only internal examiners (university employees) and external examiners (university appointees) make assessment judgements. There are however exceptions to this practice in the appointment of NHS staff on honorary contracts as clinical tutors to teach and assess medical students. This is a clearly defined group of people who, it might be argued, are all familiar with the university system for granting awards. Midwifery is a new discipline in higher education and very few midwives have followed a university course. However midwives play a key role in teaching and assessing medical students in intrapartum care, so by implication universities have traditionally accepted the expertise of NHS employed midwives. Whilst this might help to support the case for midwives having a key role as assessors of student midwives I believed there was likely to be a counter argument. This could include the university having to defend an appeal that they failed to provide students with adequate learning opportunities and feedback to enable achievement of module outcomes.

This potential problem resulted in an appraisal of existing procedures. These included: the annual audit of practice placements, preparation and updating of assessors and monitoring the assessment process internally. The first of these was working well and the team agreed did not require further modification. The preparation and updating of assessors had improved but needed to be developed in the light of local and national findings in this study and the ACE report (Bedford et al 1993). The third, monitoring of

the assessment process in practice appeared to be more reactive than systematically pro-active and became an important aspect for the working group on assessment to tackle. Because of the importance attached to these two elements in relation to validity and reliability in assessment, they are discussed more fully later in the chapter.

7.2.3.2 The external examiner

A second potential objection of higher education to practice based assessment carrying credit lay in the role of the external examiner. External examiners are required to moderate a selection of all work which contributes to the final award. If practice based assessments are not included in the sample moderated by the external examiner, this is likely to give students grounds for appeal that assessment procedure are not fairly applied. The current course assessment document followed a process similar to that identified in documents from other institutions offering midwifery programmes. Whilst the external examiner could assess whether the assessment documents had been completed satisfactorily, there was very little consistency of evidence to demonstrate how assessment judgements had been reached. The external examiner would be invited to meet with student and assessor in the case of second attempt failure, but this gave no assistance in developing judgements about rigour for students who passed. In recognition of some of these difficulties a professional progress committee had been established for hearings in respect of failure to meet professional standards. The course team were of the opinion that although this was relevant in some instances, the award was a diploma/degree in midwifery and hence one of the most important assessment elements of the course, assessment in practice, must contribute to and be treated procedurally in the same way as other assessments.

7.2.3.3 Assessment at differing academic levels

Many debates have arisen about the nature of the assessment of professional practice and how this fits into the hierarchy of university awards (e.g. Stanton 1994, Crotty 1993, Pleasance and Sweeney 1994). A review of the literature in the field was commissioned by the ENB but the report concluded that there is a need for further work in defining the threshold characteristics of different levels of professional practice (Gerrish et al 1997). This curriculum assessment strategy could not wait for further work to be undertaken but had instead to convince the university that the assessment standards for all modules would meet university requirements.

Of value for the course team was knowledge that much debate was occurring about the nature of assessment standards in universities. A series of reports from HEQC in the last few years (HEQC 1995. 1996) have explored the question of comparability of awards from different degree courses, the notion of graduateness and the way in which mechanisms can be used to provide some guarantee of comparable standards within and between institutions. Discrepancies between judgements of assessors and assessor variability identified in this study and the ACE report (Bedford et al 1993) enabled me to challenge the course team to consider how assessment in practice could contribute to grades at diploma and degree levels.

The team had confidence that provided assessors were adequately prepared for the new curriculum, they would be able to provide students with a practice environment within which appropriate learning can occur and be assessed. Bines and Watson (1992) describe

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this as a supportive, structured learning environment where assessors are equipped to encourage students to reflect on practice and are able to challenge them without undermining their confidence. The full planning team modified very slightly the criteria for clearly demarking the requirements for acceptable performance for the diploma module and degree module but failed to reach agreement about how to translate this into grades for a degree classification. This was to form an important part of the task for the working group on the assessment in practice document.

7.2.4   The assessment in practice scheme

The comprehensiveness and appropriateness of the assessment in practice scheme was an important element in re-designing the documentation to be completed for the practice based modules. An important issue that emerged from the research data was the need for the assessment document to be clear, unambiguous, and user friendly for students and assessor alike. It became clear that it was necessary for assessment to be based on multiple performances across a variety of contexts, not one-off performance. In implementing the findings of the ACE report, the ENB now require written evidence to be included in student assessments in practice. Whilst no one disagreed with these principles they had to be considered alongside the evaluation research specific to our own institution.

The interview schedules drafted for the six national case study sites provided the basis for the semi-structured interviews for the case study work locally. In addition all of the three groups interviewed locally were asked for their opinions about: the assessment of practice

document currently in use (table 7.1), the overall fairness of the assessment scheme (table 7.2); and the value of a portfolio such as that described by the ENB (table 7.3).

Table 7.1   Evaluation of assessment of practice document

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Comments pages necessary, but not always filled in well, mid-point interview not always done	38	18	17	3
b)	Specifying levels was clear, but some lack of understanding, some unreal expectations	25	9	11	5
c)	More space for comments is necessary:	25	10	14	1
d)	Need to subdivide some of the statements:	20	12	8	-
e)	Overall document very clear:	18	5	9	3
f)	Need somewhere to record skills:	14	6	6	2

Table 7.2   Overall fairness of assessment scheme

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Discussion with other midwives who work with the student contribute to judgements	42	20	17	5
b)	Accurate reflection of student abilities	27	18	7	3
c)	A variety of methods are used to make judgements eg. observation, discussion, questioning	27	14	13	-
d)	Dialogue between student and assessor is vital in making judgements	27	10	15	2
e)	Good assessment of knowledge	17	5	10	2
f)	The womens' views of students contribute to decision making:	7	7	6	-

Table 7.3   Value of a Portfolio (ENB Regulations)

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Would provide cumulative evidence	23	12	8	3
b)	Assessors would see what has been done before, including written work	21	9	9	3
c)	It would provide evidence of reflection	19	9	8	2
d)	A record of skills achieved should be included	14	6	5	3
e)	Current portfolio is adequate	11	-	-	-
f)	A good idea but finding time would be difficult	8	-	-	-

It can be seen from table 7.1 that "room for comments" was considered necessary by the majority yet some students and assessors failed to complete the comments pages provided at present. Although it might appear that less than 50% found the documents clear overall, those that had difficulties went on to add,

>   *"It was really complicated at first, but in this last year its been fine"*
>
>   *(Student)*

Assessors found that as they got used to the document they had no difficulties completing it apart from lack of time. Quite a few were anxious that it was not going to be totally changed.

>   *"Its OK .... we can all follow it now .... you're not going to change it are you?"*
>
>   (*Assessor*)

Although only mentioned by a third of interviewees, there was support for including a section for skills to be recorded as well as the attainment levels and a record of the

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process of achievement.

Students found working with a variety of midwives gave them different and valuable learning opportunities (table 7.2.). All of them welcomed the inclusion of these other midwives perspectives in reaching a judgement about them and the majority seemed satisfied that the assessment document accurately reflected their abilities. In the light of 100% of students identifying discussion with other midwives as important to the assessment process, it is suggested that because only 50% said dialogue between student and assessor is vital, it is more likely that the remainder did not think about it rather than possibly disagreed. To test out this theory, the cohort of students asked to complete the questionnaire were asked how assessors reached their assessment judgement. Of these 25 students, 88% identified dialogue in the form of discussion and questioning. From these findings it seemed reasonable to assume that dialogue in making assessment judgements did take place. What was lacking however was the recording of evidence that led up to that decision.

The questionnaire data also supported the case study findings where participants did not want the assessment document to change very much. Of the 14 of 25 students who would like some changes to be made, only five made comments about the wording, for example:

> *"Clear objectives ... some assessors misunderstood"*
>
> *"Improve wordage on specific practice skills"*
>
> *"Clearer explanation of skills as the present activities are open to personal interpretation"*

The remainder of the comments related to the assessors which is discussed more fully in the next section.

All of these findings led to the redesign of the assessment document to:

·   produce a simpler document for the first teaching period (level one) of the course

·   provide separate documents for the two credit-rated modules (level 2 and level 3)

·   review each statement to ensure each was clear and unambiguous

·   provide space for students to record evidence

·   provide more space for assessor comments

·   provide a section for the teacher to record the dialogue between assessor and student

·   include clear instructions in each assessment pack

·   insert the assessment criteria at the bottom of each page of assessment activities

·   include a section for the names of all midwives who participate in the assessment decision

·   devise a sheet for the cumulative record of practical skills

7.2.4.1 Grading the assessment in practice

Midwife teachers, like many nurse teachers, had initially lacked confidence in marking diploma and degree level work. From evaluations in the early days of Project 2000, studies such as those by Jowet et al (1994), Crotty (1993) and Elkan and Robinson (1995) found much uncertainty about what constituted 'diploma' and 'degree' level academic

work. Many of the teachers in these studies had themselves had experience of higher education, but still found difficulties.

Given these difficulties for nurse and midwife teachers the course planning team working group were agreed that asking the large number of midwife assessors to discriminate between the four degree classification bands (Class I, Upper and Lower Second and Third) was unreasonable and unlikely to be to be reliable. There was already evidence in our data that even the 'achieved'/'not achieved' categories were very occasionally subject to inter-assessor disputes.

A potential solution to this problem involved looking at assessment schemes elsewhere. The few that were available to the group involved assessors determining the grade from quantitative measures. The notion of a quantitative strategy did not sit comfortably with our more holistic concept of capability. A theoretical solution to the grading problem came following discussion around the module aims and objectives. The level two module includes the objectives:

> *"Record their reflections on the effectiveness of midwifery care...."*
>
> *".... record, collate and interpret information"*
>
> *(Appendix 17)*

It was agreed that over the period of the module the students would be expected to record evidence of their performance and development in relation to the core and essential activities of a midwife. This evidence would be verified, or not, by the midwife assessor and other midwives who contributed to student learning. The original intention had been

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for this evidence to contribute to the student/assessor dialogue and the summative assessment decision of pass/fail. However following team discussion, it was felt that the assessment document should be used for making grading judgements. The working group agreed that developing self-awareness, skills of reflection, evaluative skills and record keeping were vital to competent midwifery practice. Deficits in these areas, according to texts on the law and the midwife and risk assessment (e.g. Chamberlain 1992, Dimond 1994, Jenkins 1995, Symon 1994) often contributed to litigation claims. To grade the student's assessment document using criteria which draw upon these principles seemed the obvious solution to the group to meet both course and university requirements. This document would be marked, moderated and sampled by the external examiner.

A similar exercise was adopted for the level three module. Again reflection was included in the module outcomes as was another objective which was not obviously assessed anywhere in other assessment elements.

> *".... demonstrate the ability to reflect on .... recognise ..... know what actions are appropriate"*

> *"Evaluate their experiences and take responsibility for identifying and continuing with their personal and professional development"*
>
> *(Appendix 18)*

This study found very little evidence of students being assessed in relation to being able to identify and continue with their development, although an outcome requirement of the UKCC (1993). The students described as borderline were those who appeared to have particular problems in identifying their needs for development. Although this information could not be shared with the curriculum working group during the planning stage of our

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strategy, it had enabled me to ask probing questions when carrying out case study interviews. The working group was provided with the data from the case study work locally which identified priorities for development once qualified (Table 4.4 in Chapter 4)

The majority of interviewees considered it important to continue developing the skills acquired during the programme so that new midwives would become more confident, especially when taking responsibility for normal intrapartum care.

The main differences in priorities were how much and how soon new midwives should become involved in caring for women with complicated pregnancies. A small number of students thought they should concentrate on learning about more complications immediately following registration but this was not the majority view. More students, midwives and teachers saw taking on a bigger workload as a more immediate priority:

> *".... improving suturing is a priority but really I think just building up confidence in general and taking responsibility ...."*
>
> *(Student)*

> *"... practical things like suturing, and it would just be em ... sort of organising your own workload and taking in a little bit more of the workload and responsibility .... as a student you have the one lady, but that's not reality really is it?"*
>
> *(Assessor)*

Very similar responses were given by students when asked how important it was to continue with their learning once qualified:

> *".... you've got to keep refreshing .... its like ongoing education, there's always something new to be learned, new developments and research ...*

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I'll try to get as much experience too in every area ...."

<div align="right">(Student)</div>

"... with midwifery obviously you've got to continually develop and you've got to keep your practice up to date, research is changing .... you're forever reading and learning new ideas ...."

<div align="right">(Student)</div>

"... it definitely motivated me in terms of research and finding out things more for myself and not just accepting what people say as gospel truth ... midwifery is like that ... like ongoing process .... all the time it changes and its making yourself aware that changes are going to occur and that you've got to keep up with current thinking, so I think the course has done that .... its made me open my eyes ...."

<div align="right">(Student)</div>

The working group discussed the data from the case study interviews and agreed that we should require students to provide evidence of being able to reflect upon, critically analyse and evaluate their learning and also identify their priorities once qualified. A short summary of their reflections would then be included in the assessment of the level three module and would form an important part of the grading criteria to be developed. Evidence from the whole assessment in practice document would enable the markers to assess how well students demonstrated insight into their capabilities and personal needs for immediate development post-registration. The importance attached to students being able to recognise their own limitations and use initiative to secure relevant learning opportunities has been discussed in earlier chapters and supports the need to develop an assessment such as this.

The new assessment in practice document included detailed procedures for its completion. However concerns had been raised in many studies (e.g. Bedford et al 1993, Ilott 1993), as well as in the evaluation phase of this study, that assessors did not always make accurate records of students in the assessment document. In order for effective

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assessment to take place, assessment frameworks and assessment schemes need to be used skilfully. Assessor preparation forms an important part of achieving effectiveness in assessment.

7.3 PREPARING AND SUPPORTING THE ASSESSORS

The ENB has recognised the vital role of the assessor in contributing to decisions about student competence by listing 12 items in relation to the role, preparation and appointment of assessors (ENB 1996a, 5.16 - 5.17). Although these items include a statement that, ".... the assessor must be adequately prepared for the role" and "institutions must demonstrate that an educational programme to support assessors is undertaken annually", this study found evidence that assessors sometimes received no preparation for their role or were unfamiliar with assessment schemes. There were considerable variations between the six national case study institutions in relation to selection of assessors and the preparation received. Even when institutions organised regular preparation and updating workshops, many assessors did not attend. This situation was mirrored within and between the seven NHS Trusts providing assessors for my own institution. However, the majority of comments were about good assessors who carried out assessment well and drew upon the views of their colleagues in making assessment judgements.

> *"... my midwife who was assessing me discussed it with me and she discussed it with some of the other midwives...."*
>
> *(Student)*

> *"... If I felt she hadn't achieved that then I would have to discuss it with the student obviously ... I probably would approach my colleague .. yes ... but I would always go back to the school ...."*

As there was evidence from the national case study sites suggesting poor preparation of assessors, although many carried out good assessment in spite of this, I asked the interviewees locally how well assessors were prepared for their role. A summary of the main issues that emerged has been identified in chapter five (Table 5.9).

Failing students was, as in Ilott's study (Ilott 1993), the most difficult aspect of an assessor's role, according to assessors and teachers. From the case study data very few students appeared to find any major deficiencies, although those who had lack of continuity of assessor made comment about the need for better preparation and noted differences between assessors. The third cohort of students in my own institution was also asked how well the assessors had been prepared and again the majority (88%, n=22) of respondents were satisfied. Those students who felt assessors lacked preparation generally identified assessor unfamiliarity with the assessment document as the major problem.

The majority of assessors said they had been adequately prepared for their role but about a third had found it inadequate or they had forgotten how to complete the assessment document by the time they had a student.

> *"I was very well prepared, I understood the assessment forms and this wasn't a problem for me"*

> *"I wasn't really instructed very well on how to fill them in"*

Where they regularly met with the teacher they found most uncertainties could be resolved.

> *"the 997 doesn't give you enough in critical assessment ... meeting with teachers helped though..."*
>
> *"... you need to have regular meetings with the tutor ...."*

The preparation of assessors seems to be particularly important in the case of borderline students. Even when students were identified as unsatisfactory from very early on in their programme, if they had different assessors, or the assessors were poorly prepared, they managed to get to the end of the course. Discontinuation at the end of the course proved particularly problematic for assessors across professional groups (Ilott and Murphy 1997).

The pocket book for assessors introduced as an interim strategy, was evaluated well by assessors who were given a copy. It was decided to modify this pocket book for the new programme. It was agreed that the revised pocket book should give examples of recording and verifying evidence as this was a significant change in the process. Another important strategy was to consider one-to-one preparation of assessors by midwife teachers. This is being implemented at the time of writing. Subsequent evaluations should demonstrate whether the following areas, identified in this study as weaknesses in assessor preparation, have been addressed satisfactorily :

· 	clarification of the skills students need to acquire and develop

· 	programme expectations in terms of knowledge, competencies and attitudes

· 	emphasis on problem-based learning not apprenticeship model

·   involvement of students in the decision making process

·   providing students with more responsibility during the final few months

·   clearer written guidelines for assessment

·   the dilemmas of failing students

It was recognised locally that after the initial preparation session, assessors rarely attended the follow up or assessor drop-in sessions for support. The response of the curriculum team was to agree the need for a rolling programme of assessor updates. Where assessors fail to attend, it was decided that the link teachers would need to do the updating in the practice setting. It is too soon to identify whether this strategy has proved effective. However the institution has commissioned an evaluation study into the effectiveness of the ENB 997/998 course in preparing midwives/nurses for their role. The findings from this, it is hoped, should provide important evidence for improving our preparation courses for midwives.

7.4.   MONITORING THE PROCESS

Perhaps one of the most important emerging issues from this study was the lack of monitoring of assessor reliability. It would appear that an essential role of the midwife teacher must be to try to ensure validity and reliability in assessment in practice judgements. A partnership approach between student, assessor and teacher is suggested as a way of enhancing effectiveness (figure 7.1).

Figure 7.1   Partnerships in Assessment
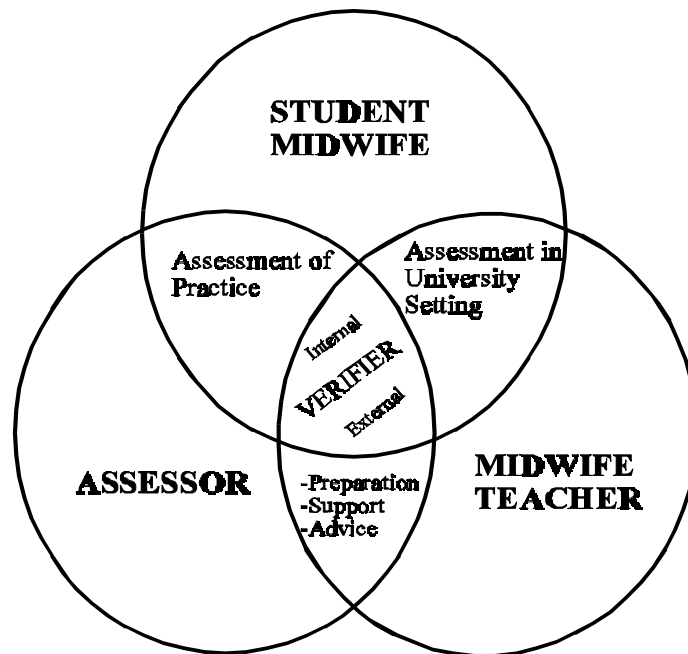
From: EME Report, Fraser et al 1997, Figure 11.1 p.234

Although specific questions about the teacher's role in clinical practice were not part of the structured element of local case study interview schedules some important issues emerged. It can be seen from table 5.10 in Chapter five that although teachers appeared always to be involved when there is a problem in relation to assessment, there was a majority view from assessors and teachers that they should be more actively involved throughout. When analysing the case study data it was noted that students had made very little contribution in relation to the teacher's role in monitoring the assessment process in the practice setting. This lack of evidence suggested the need to ask a more direct question to the next cohort of students just prior to course completion. Of the 25 students who returned the questionnaire, 80% believed the teacher should monitor the process, and

only one student (4%)believed it was unnecessary. The remaining four students were uncertain. Concerns about the effectiveness of the teacher in practice acted as a catalyst for my involvement in a three profession (midwifery, nursing, teaching) bid for an ENB project to explore the effectiveness of this role. This project (the ROLE Project) is due to report in 1998, but preliminary findings would suggest that the teachers' role in monitoring assessment in practice schemes systematically is either minimal or non-existent.

Given my accountability for pre-registration midwifery programmes and knowledge of the gaps and weaknesses in the assessment in practice schemes locally and nationally meant that for me, systematic monitoring seemed essential. The extent of this monitoring would however need to be implemented within existing resources and variations in midwifery practice across the placement Trusts for my institution.

Systems were clearly already in place to keep a "live register" of assessors as required by the ENB (ENB 1996a 5.17). What was not in place was any mechanism to check whether assessors were able to assess effectively since completing the assessors course. The evaluation part of this study suggested that the majority of assessors engaged in continuing dialogue with the student throughout the allocation, as seen in these extracts from students interviews:

> *"... we discussed the ethics of what's happening ...."*

> *"... once you pin them down and regularly discuss it, it worked for both sides ..."*

> *"... we used to talk about ... talk through everything, she just didn't say yes ... she would ask me everything and say now what do you think this involved and why do you think you have done that? ..."*

However it was not possible from scrutinising the current assessment documents to know whether the assessors had engaged in dialogue and questioning at the appropriate level for the stage in the course. Students suggested that some midwives are more academically able than others:

> *"... literature and recent research findings have been drummed into us ...but depending on which clinical area you are in and who you work with I think depends on whether that comes over... as well obviously there are more midwives that are maybe more tuned in to recent research than others"*

Until the design of this new curriculum the Supervisor of Midwives had been the key person to verify the competence of midwives to act as assessors. The working group agreed that this system should continue but the Supervisor was less likely to be aware of midwives ability to assess student learning and achievement at various academic levels. It seemed apparent from the reality of practice locally that the teachers could not abdicate their responsibility for monitoring the assessment process no matter whether in the university or practice setting. How to systemise this monitoring process proved more difficult to resolve.

Two principles emerged from the research which were of assistance in developing a systematic monitoring process. The first of these was the assessor and student relationship. From the case study evidence it appeared that most assessors and students enjoyed a good relationship in which there was honesty and mutual respect. There was

only one interview transcript that included some comments that suggested a less positive assessor/student relationship:

> "... it wasn't a direct conflict, it wasn't a problem of personality it was hard to pin her down..."
>
> *(Assessor)*

However the student did not suggest that the relationship was anything other than supportive. A rather different suggestion about the relationship could be inferred from the following extract:

> ".... I didn't actually have a mentor... I just went to one particular member of staff at the beginning, middle and end of the placement ... she wasn't actually assigned as my mentor but I was fairly confident in my mind ... I knew what I was doing"
>
> *(Student)*

On the one hand this extract could imply that the student showed initiative to seek out a competent midwife to act as her practice based teacher and assessor and hence acquire the necessary learning opportunities to achieve her learning outcomes. On the other hand she could have been behaving like student C, from one of the national case study sites, where this student "resolved it (passing her assessment) by getting another assessor to repeat the assessment so that the outcome was satisfactory" (Fraser et al 1997, p.183). Triangulation of data in relation to student C left us with question marks about her competence to register as a midwife at the end of three years. I was reassured that when scrutinising data from all sources for my own student cited above, there were no question marks about her capabilities. Although there was no evidence from my own research data to suggest assessor/student relationships could have adversely affected assessment

outcomes, the national findings and a recent allegation by a student at an appeal hearing locally suggested to us that there needed to be documented evidence that neither student nor assessor had problems working together.

The second principle of importance in developing a monitoring system was the need to confirm each assessor's ability to make judgements about the student's capabilities as a whole, rather than merely observed behaviour and student ability to describe and analyse what they were doing. There were numerous examples of students being able to carry out individual activities but a lack of evidence which demonstrated whether students could integrate the elements and dimensions of competence into holistic midwifery practice. This is not to say that they did not reach the intellectual level required by the end of the course, but evidence was lacking that assessors had the information to make these decisions. If, as a few students suggested, *some assessors were not up to date* then it is possible that their assessment judgements were not valid. It could be argued that the "live" register of assessors would overcome this potential problem, but students gave examples of changes of assessors because of unavoidable situations such as sickness and maternity leave. From the evidence presented the university could not guarantee that the assessor initially allocated to a student would be the person who actually worked with and assessed the student. These findings were similar in all seven case study institutions. The system of having Supervisors of Midwives in midwifery helped to ensure that assessors were up to date practically, but the working group agreed that it was inadequate in monitoring the effectiveness of midwives as assessors.

These two important principles of monitoring the mutual acceptability of student/assessor

pairings and the ability of assessors to carry out a valid and reliable assessment formed the basis of determining the teachers' role in the assessment in practice. This role included designating intervals in the course when the student's personal teacher would meet with student and assessor in the practice placement. The teacher, it was agreed, would not make the summative assessment decision as evidence supported the assessors making these decision. Instead the teacher would be expected at these meetings to:

- ensure understanding of expectations in relation to student achievement
- ensure that dialogue between student and assessor takes place to identify appropriate academic learning
- establish progress towards achieving the outcomes for the module and assist in formulating an action plan if necessary
- record the dialogue observed and make comments in the assessment document
- ensure teacher, student and assessor sign the assessment document at the end of the tripartite meeting, including any disagreements and action for resolution

For teachers to undertake these visits for all students, not just those where there were problems, inevitably increases work loads. However the Delphi exercise with teachers, discussed in chapter 5, indicated priorities for change in the management of the Division of Midwifery which it was hoped would enable time to be managed more effectively. A recent appeal hearing had also provided the opportunity for a review of procedures and agreement that teachers needed to be more involved in the process of practice based assessments. Although some teachers expressed concern about the additional workload, there was a commitment to implement the new assessment strategy.

7.5 SUMMARY

Earlier chapters drew upon research data to re-design our pre-registration midwifery curriculum to provide more effective teaching and learning opportunities as well as improved recruitment and selection strategies. This chapter has concentrated on how research findings assisted in the development of a more comprehensive and robust assessment strategy to provide confidence to the stakeholders that students completing the programme would be competent to practice as midwives and eligible for their academic award.

Inadequacies in assessment strategies were identified nationally as well as locally. Difficulties were experienced in securing agreement about what was realistic to have assessed by the end of three years and what context and mode of assessment made for the most valid scheme. Assessment in midwifery practice was identified as the most important but most difficult aspect of assessment. Constraints were imposed by both the professional body and the university and there were potentially different ways in which their regulations could be interpreted.

As assessment matrix provided the framework for ensuring no gaps in the various assessment methods and enabled us to use this and evaluation data to include areas that had previously been neglected or under-assessed. As the assessment in practice contributed to an honours degree classification ways were explored of providing a reliable way in which student capability could be graded and the external examiner could

sample the assessments. Student ability to reflect upon, critically analyse their performance, identify needs for development and make accurate records formed part of the final design of the grading process.

Of equal importance to designing a comprehensive assessment document was the evidence which emphasised the importance of adequately preparing the assessors and monitoring whether the assessment decisions were valid and reliable. Systems were therefore designed to provide better preparation and updating of assessors and involvement of the midwife teacher in the process of practice-based assessment.

This dual strategy, arising from systematic evaluations and other research evidence, of improved assessment documentation and detailed guidelines for its use, together with a tripartite assessor/student/teacher assessment process including internal (Supervisor of Midwives and moderation panels) and external (external examiner) verification of standards, I believe should give more confidence that an incompetent student would be unable to qualify. Although fitness for a particular university award and fairness in allocation of grades is vital for each student, it seems to me that those of us involved in professional education have a professional and ethical responsibility to value protecting the public more highly than success ratings measured by degree classifications.

CHAPTER EIGHT   THE END OF THE BEGINNING

8.1   INTRODUCTION

This study has sought to demonstrate the need for a systematic enquiry when re-designing and seeking re-approval of the pre-registration midwifery curriculum in one large university in England. Action research was the methodological approach adopted for this important area of educational research. This approach enabled me to retain the central focus of bringing about course improvement whilst exploring other areas of relevance as they arose during the course of the study. Each stage of the enquiry raised more questions, most of which required further cycles of action. All data were synthesised into the whole at appropriate stages rather than the more sequential, spiral of steps described by many action researchers (Lewin, cited McNiff 1988; Kemmis & McTaggart 1982). This facility of "switching focus while maintaining a systematic, disciplined enquiry" is, according to McNiff (1988, p45), often a more realistic picture of the way in which action research takes place in practice. Whether I have succeeded in doing this action research well will be judged by not only the reader of this study but also by reflexive critique once the revised curriculum has been implemented.

McIntyre (1997) believes that it is:

> *"very difficult to do educational research well. It requires rigorous thinking, perceptiveness, imagination, self-awareness, social skills and self-discipline in such demanding combinations that I am usually disappointed with the quality of my own work"*
>
> *(McIntyre 1997, p.129)*

I am not disappointed with the recommendations made to the national audience nor the local curriculum now written and the processes adopted to reach the point of validation. What may be of disappointment is an inadequacy in describing on paper the dynamic processes that went into the observations, acts, reflections, discussions and decisions of the last three years. Hitchcock and Hughes (1989) believe it essential to provide the reader with enough data to be able to judge whether depth of detail and reflexive analysis have been sufficient. This final chapter seeks to provide an overview of the whole study and demonstrate my awareness of the strengths and limitations to enable an assessment of the quality of the claims being made given the context in which the research was conducted. That context was one that required all threads of enquiry to be woven together to produce a written curriculum and prepare for its implementation as well as providing recommendations for the pre-registration midwifery curriculum nationally. A final chapter in a thesis attempts to bring together all research findings and on-going argument to a final conclusion. Given the complexity of constructing a curriculum in contexts of continual change, a final chapter can only be the end of the beginning. In the sections that follow the reader is provided with a synopsis of the main findings and actions which informed that new beginning.

8.2   CONTEXT IN WHICH THE STUDY WAS CONDUCTED

The introduction of pre-registration midwifery programmes followed soon after strong protests about the increasing medicalised, depersonalised approaches to childbirth (Cartwright 1979, Inch 1982, Oakley 1984, Kitzinger 1987). The first wave of

programmes were being implemented at a time when government policy had just responded to these concerns and had put women at the centre of the maternity services (DoH 1993, 1994). Legislation allows midwives to practice independently and there were at the time fears from obstetricians and General Practitioners that there would be a massive swing to home births. This fear was unfounded but with government policy recommending the midwife as lead carer, if that was the woman's choice and a normal outcome was expected, it became imperative that students were prepared to:

"be peripatetic and competent to practise within the community or hospital environment with equal ease"
(Royal College of Midwives, 1987 p.7).

Within the National Health Service there is pressure for providers of care to look at ways they can ensure, "equity, efficiency and responsiveness" (DoH 1996 p.44). Objectives to achieve this include developing a more primary care focus and a seamless service. Staff are expected to collaborate more effectively to provide a highly trained and skilled workforce to be responsive to public needs. This white paper comes at a time when there is also a requirement to reduce junior doctors' hours, a national shortfall of midwives and an increase in risk management initiatives to cope with the rising tide of litigation as public expectation rises. Given these factors the effective education of the new generation of midwives has rarely been more important. The first five years of the pre-registration midwifery curriculum has not only had to cope with these complex practice based scenarios but has also had to adapt to integration of small midwifery schools with schools of nursing and other schools of midwifery to form large colleges. More recently this has been followed by mergers into universities. Conjoint validation of curricula by

the university and the ENB is intended to protect academic standards and protect the public from incompetent practitioners. From evidence obtained in this study, absolute outcome effectiveness is difficult to guarantee.

8.3   STRENGTHS AND LIMITATIONS OF THE STUDY

This study provided the opportunity to make judgements about the effectiveness of pre-registration midwifery programmes and to propose and implement changes to improve effectiveness. A particular strength of the study has been the wealth of data drawn upon to inform decision making. The study has been largely qualitative and hence data analysis has been complex and time consuming. A full-time research assistant was able to use a computer software package to handle much of the national data and I used the same package for some of the local data sets. Data not sorted by computer was sorted manually. Although it might be suggested that manual sorting of data is a limitation, like Murphy et al (1997a), I believe it was a strength. The whole transcripts had to be re-visited a number of times to re-check margin codes and consistency of categories and themes. This meant that I had a greater appreciation of the whole than would be gained from reviewing all extracts on a theme from a computer print out. An added strength was being able to cross-check my theories with those emerging from the national case study data and then identify and re-explore any similarities and differences.

A second strength of the study lies in my movement between roles as actor and director. As director, access to data and people was facilitated. I might argue that this access was enabled because I was known to colleagues and shared a passion for curriculum

improvement to benefit our clients. However it is possible that those contributing evidence might have seen the role of director as a power position and hence felt coerced to participate. If coercion was felt, then the accuracy of data is more questionable. This was more likely when I took on the role of actor who is also the known director. However there is no evidence to suggest that responses were less honest because of my roles and data gathered by me had similarities to that obtained by the 'unknown' research assistant.

A further strength arising from my different roles is that of 'quasi' insider and outsider. Professional ethics meant that I could not act without first taking account of the potential consequences of different courses of action. Whilst this might have meant that certain lines of enquiry were not pursued, this ethical stance could have increased willingness of others to participate and hence uncover issues that might otherwise have remained hidden. Any deficiencies of evidence should therefore be judged within the ethical framework of practitioner research.

A potential weakness in this study could lie in the limits of collaboration. Collaboration took place amongst members of the EME research team and my own course planning team at a reflective and discursive level as well as data gathering level. The EME team collaborated as equals at each stage in the project. This equality in collaboration was less of a feature in my own institution. I initiated most of the actions, collected the data, analysed the data and presented the reports. The Delphi technique and curriculum working groups provided the only opportunities for colleagues to be more instrumental in the process. For the purposes of this study I believe this strategy was acceptable. Firstly I

was not involved in day-to-day curriculum operations and might therefore be perceived more neutrally than teacher colleagues. Secondly I was aware that teachers already felt workloads were heavy and might not readily have participated in data gathering. Thirdly the knowledge that the study would be used for my personal development and thesis made it somewhat unethical to involve others in time consuming data collection. Teachers were already playing a vital role at course planning and working group meetings and the re-designed curriculum arose from collaborative interpretations of the data. This collaboration of teachers "with the conceptualisation process" is, according to Eisner (1997 p.265), more important than "at the data gathering process" and hence lends support to the decisions about the extent of collaboration locally.

A strength of this strategy to undertake most of the data collection and analysis myself has been my own development and understanding of the work involved for co-researchers who also have full-time jobs. This has enabled me to nominate and support one of the midwife teachers to become a member of a collaborative research group in a current ENB commissioned project. It has made me vigilant in trying to monitor her workload to ensure demands I make on her time have not been excessive during the periods of intensive data collection, analysis and report writing.

8.4   METHODOLOGY

This action research study drew upon a wide range of research methods. These included interviews, observation, questionnaire survey, focus groups, Delphi technique and a conference workshop. In all they brought together well over 400 subjective perspectives

of stakeholders about midwifery education. Alongside these perspectives were added a review of the literature on competence, an analysis of midwifery curricula and a review of policy documents on midwifery and the maternity services.

The study comprised the national project, which drew upon six case study sites for most of its data collection, and a local project which investigated our curriculum as validated by one multi-sited university. Whilst each site constituted a single case, within each site the case study students were each considered as an individual case. This enabled issues to be explored from multiple perspectives for each case study student and avoided the potential for anomalies being missed which might have significance. To protect confidentiality, the amount of description had to be limited when discussing sensitive scenarios.

The complexity and unfolding of issues needing further investigation have made coherent reporting difficult. Themes emerging from different cycles of this action research study have been threaded into the central plan as and when relevant. The intention being to gradually build up an overall picture rather than constructing separate stories of the various action phases. The overall findings are now developed into a summary of the issues that emerged and were used to construct what it is hoped will be a more effective pre-registration midwifery programme of education.

8.5   CURRICULUM PROBLEMS

The systematic evaluation of curricula nationally and locally, alongside complementary areas of enquiry, helped to identify six areas in particular which affected the effectiveness of pre-registration midwifery programmes.

8.5.1   Wide ranging student profiles on course entry

Universities selecting students for midwifery programmes at diploma and degree levels are faced with two major decisions. Firstly determining whether applicants meet the university's entry criteria for academic programmes and secondly whether they have the personal qualities and motivation necessary for a holistic midwife practitioner. Balancing academic potential and personal qualities when short listing and selecting candidates has resulted in cohorts of students with wide ranging profiles (Chapter 5.2). Whilst the richness of life and academic experiences as well as a broad range of ages can enhance group learning, it can also create difficulties for structuring learning. It could also account for the relatively high rate of attrition (Chapter 4.3.2).

Attrition from failure in academic work has the potential to encourage institutions to set their academic criteria higher. This study has demonstrated that this is not the solution. Personal qualities were considered to play an important role in determining competence for midwifery practice and highly motivated mature applicants were seen to excel in both written and practice assessments. High academic achievers on entry to the course do not necessarily achieve as well. The recent report on key skills deficits amongst new

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undergraduates supports this finding (Murphy 1997, Murphy et al 1997b). Instead the structure of the course, individual experiences of the realities of midwifery practice and the support provided, alongside the dynamic within the cohort and students' personal lives all made an impact on achievement and attrition. All of these factors led to the need not only to review the design and implementation of the course but also to provide prospective students with a better insight into the realities and challenges of life as a student midwife.

Evidence from this study led the course planning team to go against the current educational philosophy of rejecting mixed ability groupings. Instead we looked at ways of structuring learning more effectively and capitalising on the wide range of student profiles to enrich the learning experiences for the cohort as a whole.

8.5.2   Curriculum structure

The title of the government report *Changing Childbirth* (DoH 1993) implies that the context for midwifery practice is one of constant change. It might therefore be assumed that the midwifery curriculum is designed to reflect flexibility and adaptability in response to the changes in health care practices. Instead, curricula were found to adopt a fairly structured design encompassing a double-wedge approach of theory first and practice later. Students' theory sessions were taught from the simple to the more complex, health before illness and normal before abnormal (Chapter 2). This organisation of the curriculum, including that in my own institution, contrasts with the realities of midwifery practice. Midwife practitioners are often faced with puzzling

situations and move from the normal to the abnormal within short periods of time. This requires the development of complex cognitive as well as psycho-motor abilities.

This tendency of curricula to demonstrate a more traditional model of professional knowledge based on a somewhat positivist epistemology was possibly attributable to the desire for academic credibility. However evidence suggests that these curricula failed to equip some students to be able to use theory effectively in practice. The compartmentalised nature of curricula may also have contributed to the transition problems encountered by many new qualifiers when moving from student to the world of autonomous midwife practitioner.

8.5.3   Curriculum constraints

In spite of potential weaknesses in curriculum structures, all midwifery curricula demonstrated high ideals. The national case study data found that whilst students were well prepared to provide holistic midwifery care to women with normal pregnancies and on a one-to-one basis, there were variations in the ability of students to cope in busy, often short-staffed maternity units. Similar issues were identified by students in my own institution (Chapter 4.2). A particular difficulty was preparing all students to have the confidence to take consequential decisions appropriate for a newly qualified midwife. A previous study (Fraser 1994) demonstrated the importance of developing students' personal and professional characteristics for effective performance as a midwife practitioner. This study has supported those findings. However the process of achieving these curricular ideals requires significant resources in terms of time and structuring

learning dialogue.

There was little evidence that there was a systematic approach to structuring dialogue between students, teachers and practitioners. There were variations in the ways in which students were required to be actively involved in synthesising theoretical and practical knowledge within different contexts to produce their own original perspectives. Much of this type of activity appeared opportunistic and was experienced by students to different degrees. Ensuring opportunities exist for this sort of learning experience to take place regularly for all students, as well as facilitating subsequent reflection and evaluation of actions, requires considerable resourcing. Economic and practical constraints were evident. Shared learning with other student groups appeared to be planned more to reduce course costs than to necessarily enhance inter-professional learning. Whilst shared content of subjects in common might appear a pragmatic solution when costing curriculum implementation, it is unlikely to provide opportunities for students to synthesise knowledge within their particular contexts of practice. This was a particular problem locally. Students quickly forgot much of the knowledge initially acquired during shared learning sessions if not perceived by them to be of immediate relevance. A finding also uncovered in another ENB commissioned project (Eraut et al 1995).

Providing tutorials or small group sessions for student midwives to facilitate application of knowledge, alongside shared learning sessions, was limited locally by teacher availability. Bringing students together from all base sites on a regular basis was constrained by shared learning being timetabled in a different order on different sites as well as the cost and time involved for travel. Potentially placements in midwifery

practice areas should have enabled structures to be created for dialogic and practical linkage of theory and practice. Curricula emphasised the importance of practice based dialogue. Evidence of the quality and quantity of dialogue was variable within and between institutions. Problems were cited of assessors who lacked familiarity with the course, insufficient staff to teach and supervise the large numbers of learners on different courses and at different stages in their programme and the peaks and troughs of clients in the practice placements. On sites where there was effective dialogue between midwife teachers and midwife practitioners, problems were less acute. Whilst every eventuality cannot be anticipated in practice placements, the wide variations identified demonstrated the need for a systematic approach to structuring opportunities for educational dialogue.

8.5.4   Learning opportunities

Students demonstrated concern about the differences in learning opportunities. Differences were in part inevitable and acceptable given the variations in location of practice and the unpredictable nature of pregnancy and childbirth. Some differences were due to inadequacies of curriculum structure and implementation on different sites. If structures had been in place to support dialogic processes then students might have been more able to generate a gestalt from their different learning experiences and propose principles for practice of relevance to each other. Other differences could be attributed to students failing to take the initiative to seek out relevant experiences until far too late in the course. Concentrating on developing student qualities and constructing knowledge as arguable could help the less confident students to become assertive from early on.

From the data it became clear that students who were given more responsibilities towards the end of the programme were better equipped for the role of practising midwife. Some students had been over-protected throughout their course and therefore found the responsibilities of practice excessively stressful. The notion of allowing students "to be a midwife" prior to course completion varied according to the students achievements and according to the midwives responsible for their supervision. From a review of the literature on professional education it was evident that many writers view competence as a continuum with the accompanying expectation that students will not reach the same point at the same time (Worth-Butler et al 1994, Eraut 1994a). This view is only acceptable in part where student midwives are concerned. Midwives, unlike many other professionals, have a licence to practice independently at the point of registration. Hence there is a responsibility for the education providers to structure a curriculum that provides learning opportunities for all students to be able to demonstrate whether they have the capabilities to be a competent midwife. This evaluation has helped to demonstrate the need for more practice based problem framing and re-framing situations much earlier in the course alongside enabling and monitoring the achievement of key skills from the outset. Once all statutory elements of the course have been achieved (EC 1980, 1989) a structured period of time could be designated towards the end of the programme for students 'to be a midwife' in 'pressured' practice environments.

Providing the learning opportunity to experience being a midwife, whilst supported by the designated assessor, should enable more effective dialogic reflection in which evidence from a range of sources can be drawn upon by the student to help consider alternative courses of action in familiar and unfamiliar situations. Whilst some might

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suggest that this could be difficult to achieve and therefore classroom simulation is an acceptable alterative, evidence in this study points to it being a far less effective strategy in facilitating the transition from student to midwife practitioner.

8.5.5 Different perspectives of competence

Chapter six demonstrated some of the complexities in attempting to define what is meant by competence at the point of registration as a practising midwife. Without a model of competence it becomes impossible to judge whether each student is fit for practice in a changing childbirth context. The lack of a clear definition or model meant that students experienced different attitudes towards their course and their abilities. The three dimensional model (fig. 6.5) that emerged during this study enabled all stakeholders views to be reconciled and demonstrated the need for differences in emphasis according to differing situations (e.g. figure 6.6). What was more difficult was to find some way of influencing differing emphases in assessment judgements.

From an analysis of the data it became evident that a few assessors might value speed and dexterity in carrying out tasks more highly than the acquisition of more complex skills. All sources of evidence identified the crucial importance of communication and inter-personal skills for competent practice but assessment evidence of achievement was often lacking. As personal qualities and attitudes have been identified as very important for childbearing women it remains vital for curricula to place as much emphasis on obtaining assessment evidence in this area as in the area of theoretical knowledge.

Learning to be professional alongside developing a special or special-friend type of relationship with women is a much neglected concept in the midwifery curriculum. Being professional means not only functioning within the professions statutory framework, but also about being able to make judgements in situations that are unfamiliar or complicated. Evidence based practice has become a key phrase in clinical medicine (Evidence-based Medicine Working Group 1992, Sackett 1996) and is becoming more evident in midwifery (Oliver & Needham 1997, Oliver et al 1997, Renfrew M J 1997, Renfrew M 1997). This emphasises the importance of incorporating critical appraisal skills in the curriculum to enable judgements to be made and practices to be challenged in the light of all available evidence. However, like Walsh (1996), I believe that if evidence is drawn mainly from experimental research studies and reviews of the literature and neglects patient/client evidence or contextual evidence, inappropriate decisions might be made. This emphasis is more likely if the professional element of the professional/friend dynamic takes precedence. Conversely if the friend element takes priority the evidence from the woman or her situation might influence decisions out of proportion to the evidence available from research. Women are likely to put different values on the outcomes arising from variations in decision making. These consequential decisions require reflexive dialogue between the student and members of the maternity service team to be facilitated to improve achievement of the professional/friend dimension of competence.

In a similar way to the difficulties of students in achieving the professional/friend balance, some assessors had similar difficulties when teaching and assessing learners. The need to ensure understanding of this dimension of the model of competence and to

obtain reliable assessment evidence emerged as a key issue in this study.

8.5.6   Assessment judgements

Evidence throughout different phases of the study pointed to the practice environment as the only valid context for making judgements about key capabilities needed for competent midwifery practice. Practice was believed to be the necessary context for assessing whether students could synthesise subject disciplines, applied sciences and practical knowledge to deliver holistic midwifery care for a range of client groups. Assessing complex capabilities in practice situations created problems of reliability as well as validity given the number of assessors and apparent deficiencies in understanding the curriculum. A problem for education providers lay in trying to operate the same rigour in assessment in practice decisions as when assessing written assignments and examinations. Numbers of examiners for university based assessments were small in comparison to the number of practitioners involved in assessing students in practice. The need to assess students across contexts and over time requires a system of continuous assessment which cannot be replicated for an external examiner to sample.

Students were also more likely to appeal against the assessment process if the outcome was unfavourable or perceived to be unfair. For example students complained that different assessors made them *"jump through more or less hoops"*, or were uncertain what level of attainment to expect or *"did not know how to complete the assessment documents"*. Assessors complained that they are sometimes too busy to attend assessors course, have difficulty working with their student regularly or do not have time for

progress discussions and completion of assessment documents. Teachers generally believed that they are kept informed of problems and participate in difficult assessment decisions. They were satisfied, on the whole, that only competent students would appear on the end of course pass list.

This study casts doubts on this belief. A category of 'borderline' students emerged where a few students were given the benefit of the doubt and were 'passed'. If students and assessors identify variations in the assessment process within the same institution, it is equally possible that some potentially capable students were failed. Although anecdotal comments were made to this effect, no evidence emerged to support this suggestion. What seems of relevance when trying to improve assessment strategies is that in spite of flaws in the assessment process, intuitive assessment judgements (as well as formal ones) appeared to accurately predict capabilities in subsequent employment as midwives (Chapter 4.2.4). It became evident that if pre-registration midwifery programmes were to have improved effectiveness, improvements in course design had to be matched by improvements in the assessment process and the articulation of intuitive judgements.

8.6   CURRICULUM RE-STRUCTURING

According to Phillips (1995) the,

> "... education of many students is accidental, serendipitous and ad hoc.
> It depends on meeting the 'right' practitioner in the 'right' clinical
> environment, or the 'right' lecturer in the 'right' classroom".

(Phillips 1995 p.210)

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Evidence from this study supports Phillips' findings. If important learning is left to chance it is likely to be the less able or the less confident students who miss vital learning opportunities. Instead of relying on chance, the curriculum must be structured in such a way to enable students to capitalise upon learning opportunities and explore contradictions and differences in the maternity services. Such structures should enhance student confidence to make informed, ethical decisions in uncertain as well as familiar situations.

Although it is essential for students to understand and promote pregnancy and childbirth as normal physiological processes, they need to appreciate the complexity of factors that impinge upon those stages in a woman's life. In addition, the reality of practice placement experience means that students will meet women with pathological problems and complications during the early months of the course. In order to enable the integration of theory and practice, the inculcation in students that childbirth is a normal, straightforward process needs to be balanced with introducing complexity, the abnormal and allowing them to experience theory and practice from early on. This move from a compartmentalised 'ologies' orientated curriculum in year one, to a more integrated midwifery focused educational cycle of student critical reflection and action, required fundamental changes to the first year of the pre-registration midwifery programme locally.

Economic constraints required the continuation of selected shared learning with student nurses. However it was evident that structures were necessary to enable students to move

from merely soaking up vast quantities of new information to develop skills in problem design, analytical dialogue and decision making. It is suggested that structuring the curriculum in such a way will help to influence attitudes towards maternity care and promote in students the capability to be responsive and adaptable to the demands of changing childbirth.

In order to integrate theory and practice more effectively, facilitate curriculum coherence of shared learning sessions taught by a wide variety of teachers and enable students develop skills of critical reflection and judgement, as well as practical skills, the following structures were put in place:

- course leader to meet with the intake leaders from the two circuits prior to course commencement to agree essential key sessions to be shared with student nurses. (The student nurses' programme being timetabled in a different order on each of the 5 sites made timetabling midwifery theory problematic and in need of revision.)

- student midwives to commence the midwifery programme a week before the start of the nurses' programme to give coherence to shared and midwifery sessions and provide a midwifery frame for the whole programme.

- reduce the number of whole circuit midwifery theory days in year one to enable better coherence in timetabling and student attendance at all designated shared learning sessions.

- timetable one day per week, avoiding overlap with shared learning sessions, for personal teacher facilitated midwifery praxis sessions on base sites (7 sites). These days to be used for example: to teach new skills; use real scenarios to facilitate integration of subject knowledge, problem design skills, critique of practices and use of relevant theory, evaluation of actions, explanation of different perceptions, beliefs, values; individual and group tutorials and exercises.

The intention of these changes is firstly to reduce the piecemeal way in which knowledge was acquired in previous courses through facilitating horizontal and vertical integration

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and relevance of theory and practice. Secondly, recognising the pressures for health service practitioners and the time needed to teach basic practical skills and hence personal teachers facilitating some of these skills in simulation or the clinical environment. Learning these skills earlier, it is hoped, will help to avoid the rush to meet the statutory requirements at the end of the course and release time for consolidation and learning 'to be a midwife'.

Finally, and of most importance, to move to a more problem based curriculum to enable students to explore the evidence on which choices are made and debate the emerging issues in a 'safe' teacher led environment. These structures should enable students to have the "right level of confidence" (Chapter 4.2.1) to be competent midwives in a changing maternity service where they will be faced with situations of ambiguity and uncertainty.

8.7   IMPROVING THE ASSESSMENT PROCESS

The emergence of a category of 'borderline students', locally as well as nationally, meant there was a need to make our assessment strategy more robust. The study outcomes of a model of competence and an assessment matrix provided the framework within which we developed our assessment scheme. Evidence from my case study students demonstrated the value of written assessments in helping them develop their breadth of knowledge, understanding and research (Chapter 5.5). However there were concerns from some of the case study institutions that a heavy assessment load detracted from learning in the practice environment. It was therefore necessary to ensure a reasonable balance between

university and practice based evidence of learning and achievement.

University and ENB regulations inevitably had an impact. The former was reluctant to credit rate assessment in practice without accompanying written evidence and the latter expected equal credit to be given to theory and practice. The university also had guidelines for modules which provided examples of the weight of assessment wordage expected for each 10 credit module. These constraints and evidence as it emerged from this study were debated by our course team and informed the development of the new assessment strategy. It included the following principles:

- assessments which evaluated well to be retained if appropriate

- all assessments, to be designed by midwife teachers, to draw upon theory and practice

- subjects to be grouped where appropriate to create 20 credit modules. Hence a smaller number of assessments but which require exploration from more than one perspective

- the last unseen written examination to take place before the final six months of the programme

- assessments to promote critical appraisal skills and skills of reflection wherever possible

- re-structuring of student portfolios for greater clarity and to enhance learning in university and practice contexts

- assessment to avoid a 'belt and braces' approach and to take place in the most appropriate context

- assessment in practice document to be revised in three sections to relate to the three teaching periods in the programme (teaching periods are used instead of the inappropriate divides caused by semesterisation)

- assessment in practice instrument to incorporate more detailed explanations of

responsibilities and completion requirements and remove jargon-type language

- assessment in practice instrument to include sections for students to record and sign evidence to support capability claims, learning needs and action plans

- assessment in practice instrument to include sections for midwife assessors to record and sign perceptions of student progress, record of dialogue and verification of evidence

- assessment in practice scheme to identify two specific weeks in each teaching period when student's personal tutor will engage in tripartite dialogue with student and assessor

- assessment in practice instrument to include sections for personal tutor to record her contribution to dialogue and judgements on the assessment process

- practice based midwife assessors required to make pass/fail judgement not classification judgements

- assessment in practice document to be graded by personal tutor according to criteria which will include: quality of evidence and accuracy of record keeping, evidence of reflection and learning from experience, evidence of sound knowledge and research, evidence of initiative and self-awareness

- all work attracting credits to be subject to internal moderation and sampling by the external examiner

- compensation for specified modules to only be permitted in teaching period one

Constructing the assessment in clinical practice scheme proved the most difficult as this was the area where loopholes in assessment were most evident. The tripartite discussions between student, assessor and teacher appeared key in enabling discussions about potential differences in midwives' perceptions of competence and ensuring that student/assessor dialogue was taking place as intended. It seemed the only way to ensure all students had a fair and reliable assessment and where assessors could be monitored as to their ability to judge intellectual as well as practical skills and capabilities,

8.8   STRATEGIES TO SUPPORT TEACHERS

In evaluating and re-designing the pre-registration midwifery curriculum it became clear that there were differences in interpretation of student-centred learning. On the one hand there were a few who assumed if students were given the programme outline, module content and assessment guidelines they would attend timetabled sessions and negotiate all necessary learning experiences with minimal reliance on teachers. At the other extreme there were those who persisted in a maternalistic mode, seeking to meet all student needs, organising everything for them and expecting to be consulted over every detail. The new curriculum recognised that early on students would need help in learning to take responsibility for their learning and to develop different learning styles according to context or goal (Chapter 5.4). Initially it was agreed that students needed to be supported and challenged in a 'safe' environment. The personal teachers were designated as the facilitators for this process during the first year of the programme. It required them all to have an understanding of the new curriculum and have a shared philosophy about student-centred learning in the context of the complex world of midwifery practice,

The Delphi technique provided the data from which teacher needs emerged and support systems could be actioned. A strategy for providing better support for teachers in the continually changing education and practice environments is just beginning and will require subsequent actions following initial evaluation. Strategies that have been put in place so far to facilitate and monitor change include:

- briefing of each pair of intake leaders 6 weeks prior to every intake to ensure they

understand the curriculum and have been informed of changes following evaluation

- providing a guidelines folder on each of the 7 practice sites to facilitate ease of reference if a computer is not easily accessible

- opening management meetings to all teachers and providing minutes for everyone not just a copy per centre

- staff development sessions to address team building and skills for new programmes

- a review of administrative responsibilities and teaching workloads and a regular date for agreeing the master timetable

- seminar programmes to provide opportunities for critical debate and peer support for staff doing part-time research degrees

- course leader seconded one day a week to collect and analyse data for the ENB commissioned project on the role of teacher in practice (Day et al in progress)

- meetings scheduled to agree a strategy for midwifery education over the next 5 years

Valuing teachers is an important part of a strategy to support them through times of heavy workloads and rapid change. It is possible that the team building exercises will be the most instrumental in ensuring curriculum effectiveness. Teachers need to feel they can engage in open dialogue with their peers in a trusting relationship before they can facilitate 'safe' situations for students. This feeling of trust and openness has been difficult since the merger with higher education as structures have changed, posts have disappeared and new ones have emerged. Many midwife teachers have yet to develop a clear and relatively stable view of their role. While research is valued more highly than teaching on the promotion ladder in the university, the rhetoric of teaching being of equal importance tends to fall on deaf ears. This has the consequence of teachers wanting to

keep all their options open and makes strategic management one of the biggest challenges in ensuring curriculum effectiveness.

8.9 STRUCTURES TO SUPPORT THE ASSESSORS

This study revealed considerable variations between and within the case study sites in relation to the preparation and support of assessors. Locally the preparation and support was described as satisfactory for the majority, but sites reported difficulties in releasing assessors from practice to attend up-date sessions (Chapter 7.3). Students, when making comparisons with colleagues and when changing placements, found variations between assessors but were in the main satisfied. This provides little re-assurance that assessors might not be manipulated by students, especially as there is considerable evidence that failing students is one of the most difficult aspects of an assessor's role (Ilott 1993, Ilott and Murphy 1997).

In order to facilitate the role of the assessor, the issues raised by them as important have been incorporated into the revised curriculum. The assessment documentation has been made more user friendly and divided up into three separate sections, one for each teaching period. Programme expectations and guidelines have been incorporated into a pocket book for assessors which includes examples of how to complete different sections of the continuous assessment scheme.

We have acknowledged the time it takes for assessors to teach and check which skills students have learned by incorporating skills teaching into personal teacher facilitated

sessions. A cumulative record of skills practised and accomplished has been included in the student's portfolio. Assessors have the right to see any part of this portfolio to assist in the structuring and assessment of learning. Whilst there are critics of this strategy, believing it could encourage the 'halo' effect in assessment, this criticism is an inappropriate diversion from trying to make assessment more effective. Discussion of student capabilities within teams of midwife practitioners was believed to be essential when verifying evidence of achievement. Students cannot work with the same midwife throughout the course as they need to move where experience is most relevant. It is therefore essential for the named assessor, for a particular period of time, to read assessment judgements made by colleagues and to enter into dialogue about those judgements. This dialogue is also a vital source of support especially when needing to critically analyse rationales for passing or failing borderline students.

Assessors and midwife teachers have different employers. Hence the education providers have little control over assessor attendance at preparation and up-date workshops for assessors. Although there is a University/NHS(E) Education Consortium contract specifying standards for courses, the demands of clinical practice will always take precedence over education briefings. Whilst the assessors' pocket book has gone some way to addressing the problem, it does not solve all eventualities. Like most other institutions we have a designated named teacher to link with each practice placement area. This is variable in its effectiveness (Day et al in progress). In order to try to make the link teacher role more effective we have, unlike many other institutions, retained teacher bases in NHS Trust locations. This facilitates access to practice for teachers and to teachers for practitioners. A second important strategy has been to encourage a culture

that equally values learning in practice with learning in the classroom. Teacher time spent in practice (normally 20%) is seen as much of a priority as teaching in the university. This regular involvement in the practice culture not only enhances teaching content and teacher credibility but enables practitioner uncertainties to be highlighted and addressed much earlier.

The tripartite assessment in practice dialogues have not yet been experienced but assessors are optimistic that this will provide the most valuable form of assessment support.

8.10   NEW BEGINNINGS

The new beginning for a re-designed midwifery curriculum locally is one of three key issues arising from this study. The second relates to the lessons learned that go beyond those for an individual case study and are issues of national significance. The third concerns recommendations for further study and dialogue.

8.10.1 Midwifery education locally

As validation of the new pre-registration midwifery curriculum exceeded all expectations, in that approval was granted without conditions or recommendations, the course team expressed feelings that now we might enter a phase of curriculum stability. Whilst having some empathy with this sentiment, it is not one to which I subscribe. The curriculum as written can only be the first step towards curriculum improvement and

outcome effectiveness. That is, low attrition alongside producing competent, confident midwives committed to career long learning and development to equip them for the uncertain world of professional practice.

This new beginning, of implementing a re-structured curriculum, it is hoped will provide sufficient and appropriate learning opportunities to enable students to develop the qualities and capabilities that match the model of a competent midwife (figure 6.5). An even more important ideal and reality is that it will provide the structures and processes in which valid and reliable judgements are made about fitness for practice, purpose and award. What is not hoped for is that it will be a static curriculum. This new curriculum must be reflexive, improving as stakeholders' views are incorporated, provided that they have been subject to critical analysis and collaborative, systematic discussion. A recent merger locally of midwifery with the academic department of obstetrics and gynaecology should provide a unique opportunity for improved teaching, learning, research and dialogue between the lead professionals in maternity care. Lessons learned from this study it is hoped will therefore impact on the medical curriculum locally.

8.10.2 Issues of national significance

This study has provided the starting point for a national review, by the professional validating body, of the regulations and guidelines for pre-registration midwifery programmes of education. In spite of prejudices held by some midwives and doctors about this new way of preparation of midwives, the overall finding is that the three-year route is an effective preparation for contemporary midwifery practice. Three key

outcomes of the study and the implications of these for curriculum design and development have been widely disseminated through the production of a substantial report, a summary paper (ENB Research Highlight 24), and national conferences and workshops. The model of competence has provided a framework for institutions to re-think their priorities when re-designing and implementing curricula and to consider more carefully the continuum from student to lifelong learner. The assessment matrix should be of value not only to those involved in pre-registration midwifery but also to Supervisors of Midwives for use as the basis for assessing the needs of those returning to midwifery practice. It should also be of interest to the profession as a whole as midwifery seeks to respond more effectively to the challenges set out in Changing Childbirth (DoH 1993). The third key outcome provides examples of good practice in assessment. As institutions struggle to develop robust assessment strategies in situations of diminishing resources it is hoped that these examples will provide new ideas and stimulate dialogue for greater effectiveness. New Labour and the Dearing Review of Higher Education (1997) are just beginning to make an impact on health and education. They have the potential to bring about curriculum change and constraints as well as exerting an influence on the way in which the maternity services will be managed in the future. This research has therefore been particularly timely in providing a source of evidence to contribute to future debates and decision making.

8.10.3 Recommendations for further study and dialogue

All studies are limited by external and self-imposed parameters and this is no exception. Whilst the research intentions locally and nationally have been fulfilled, the value of an

action research approach goes beyond the original research aims. This study has provided me with invaluable opportunities for personal development and has enabled me to influence midwifery education locally and nationally. It has succeeded in increasing my passion to participate in improving the maternity services through seeking opportunities for further collaborative work. In addition it has raised awareness of issues that impact upon vocational education more broadly, in particular, the dilemmas in assessing borderline students.

Two areas have emerged from this study which appear to merit further investigation and dialogue. The first of these concerns effective learning and the second encompasses policies and procedures in higher education.

8.10.3.1 *Learning*

Whilst there is a wealth of literature about learning, this study has highlighted a lack of discourse about effective learning for particular purposes. Chan's (1997) study about newly qualified teachers in schools demonstrated the interplay of two key factors, survival and growth. This has similarities with the experiences of student midwives when faced with the realities of professional practice. Of concern to Chan is the effect of survival strategies on the growth and development of new teachers. This study has similarly identified the effect that concentrating on survival strategies has on the effectiveness of more complex learning. Where lack of attention is paid to enabling students to cope with complexity and uncertainty then there is more likely to be resort to survival strategies and new learning opportunities are missed or avoided.

Midwife teachers, it is suggested, have tended to develop the norms of firstly nurse education through shared "learning" initiatives and reliance on clinical practitioners for practice based learning. Secondly they have tended to adopt the norms in higher education of valuing intellectual skills more highly than psycho-motor skills. This study has demonstrated a lack of confidence of some midwife teachers by allowing former good practices to be thrown out in favour of practices, not necessarily well thought through, in higher education. Shared learning should perhaps be re-named shared content as it emerged as the least effective aspect of learning for most students in this study. It could benefit from more comprehensive evaluation. Inter-professional learning on the other hand was less evident and could go someway to improving collaboration amongst members of health care teams and enhancing practice through asking different sorts of questions. The lack of debate about learning also appears evident in a joint statement on midwifery education by the English National Board and the Royal College of Midwives (ENB/RCM 1997). In this statement they cite examples of good practice emerging from higher education institutions. One such example includes, "curricula which are built on problem solving approaches.... ." Evidence from this study suggests that problem solving is not enough. Instead students need to be equipped with the ability to 'frame' and 're-frame' questions and not merely solve problems.

This study has raised for me two new challenges in relation to learning. The first is, like Chan (1997), the need to seek a model to promote lifelong learning in teaching. This model will need to encompass and balance the demands of university based teaching and research alongside teaching and research in practice situations. The second challenge is to investigate ways in which inter-professional learning might improve inter-professional

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collaboration and dialogue and hence impact upon the effectiveness of professional practice.

8.10.3.2 Policies and procedures in higher education

Some of the problems which emerged from this study arose in part from the differences in culture between higher education and the national health service. Two issues stand out in this respect. The first is the value placed on teaching and assessment by academic staff in the university settings compared to that by health service employees in practice settings. The second issue concerns the balance of doubt when dealing with failing or borderline students.

From this study it has emerged that there are problems of reliability in relation to practice based assessment schemes. This can partly be attributed to the large numbers of assessors involved and inadequacies in preparation and monitoring of assessors. These problems might help to explain why some universities only allow academic credits to be awarded for more traditional university based assessments which can be marked and externally moderated by university academics. However this emphasis in assessment by examinations/essays/written materials etc, neglects issues of validity for professionally validated courses. Midwifery, and other professions such as teaching, the therapies and nursing, need to assess student capabilities in prolonged contacts with client groups, in complex situations and across contexts and over time. The assessment matrix outcome from this study demonstrates the need for a wide variety of assessment evidence where theory and practice are integrated and assessments are appropriate to context. What

appears to be needed is collaborative dialogue by those concerned about professional education to look at how the practice based component of courses might be accepted as academically credible by those holding the power in higher education. Given the difficulties of HEQC (1995,1996) in determining standards for academic awards within and between universities, the task should not be insurmountable.

Determining whether a borderline student should be assessed as passing/failing is rarely "done lightly" suggest Ilott and Murphy (1997). Data from this study identified students who had been failed and then left the course but what was of particular concern was why some students, described as borderline, were given a licence to practice. There was some evidence to suggest that universities gave the benefit of doubt to the students. Ilott's (1993) work, which investigated the feelings of assessors assigning a fail grade in occupational therapy, demonstrated the distress this caused to assessors. It is possible that if Boards of Examiners or appeals committees overturn these decisions because of discrepancies in evidence then assessors might tend towards a "failure to fail". The need to protect the public from incompetent or unsafe practitioners was made particularly evident in the case of Beverly Allitt (Clothier et al 1994). It is my contention that the benefit of the doubt, when considering the boundary between competence and incompetence for recommending a licence to practice, cannot be given in favour of the student.

If practice based learning and assessment are less valued by universities than more traditional lectures, seminars, experiments, essays and examinations then assessors might be less likely to confront the dilemmas of making judgements about borderline students.

The dilemmas identified by Ilott (1993) and by this thesis in relation to practice based assessment merit further study. A multi-professional approach might be a more powerful way of investigating issues which are applicable across vocational programmes. Without such an investigation to provide evidence to improve practices and influence university regulations there remains the potential for unsafe or incompetent practitioners to be given a licence to practice or failed students claiming that assessment is invalid or unfair.

8.11   CONCLUSIONS

Inevitably when evaluating curricula to assess outcome effectiveness, weaknesses will be highlighted so that improvements can be made. In spite of the weaknesses that were revealed, the overall finding has been that the three-year pre-registration route is an effective preparation for competent midwifery practice.

Recommendations have been made to improve:

·   recruitment and selection

·   curriculum design and development

·   assessment schemes

·   the preparation and support of assessors

What has also emerged is the need for dialogue to be a meaningful learning experience not only for students but also for teachers and practitioners. Structures need to be in place for staff to have opportunities to look critically at accepted practices and values and

explore contradictions and differences as well as similarities. Developing the individual and building collaborative teams through reflection, dialogue, argument and research are key factors when seeking to improve the quality of teaching, learning and professional practice in the maternity service.

This evaluation of pre-registration midwifery programmes has identified both the positive and problematic or challenging features of developing a new preparation for midwifery practice. Some of these problems and challenges are already being addressed at national level by the ENB. However it is hoped that this study will help to stimulate local and inter-professional discourse and actions. It is my belief that the issues raised are not only important for providing a safe, satisfying and effective maternity service for childbearing women, but also provide interesting intellectual and practical challenges for all of us involved in professional education.

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APPENDICES

RICHARD WINTER'S SIX PRINCIPLES FOR THE CONDUCT OF ACTION RESEARCH

(From Winter, 1989. Learning from Experience: Principles and Practice in Action Research, London, The Falmer Press)

Chapter 4

Principle 1:   Reflexive Critique (opens up lines of argument and discussion)

Principle 2:   Dialectical Critique (subject observed phenomena to a critique)

Principle 3:   Collaborative Resource (treat all viewpoints as potentially of equal significance)

Principle 4:   Risk (managing the sense of threat that we may pose)

Principle 5:   Plural Structures (multiplicity of viewpoints relevant in various ways for different readers)

Principle 6:   Theory, Practice, Transformation (the mutual questioning between theory and practice which is unending, whatever may seem impractical now may well seem feasible later when circumstance will have changed .... theory and practice need each other and thus comprise mutually indispensable phases of a unified changed process)

PAMELA LOMAX'S SIX GOVERNING PRINCIPLES OF ACTION RESEARCH

(From Lomax, 1994. Action Research for Professional Practice, Invited Paper BERA 1994)

1.   Action research is about seeking improvement by intervention.

2.   Action research involves the researcher as the main focus of the research.

3.   Action research is participatory and involves others as co-researchers rather than informants.

4.   Action research is a rigorous form of enquiry that leads to the generation of theory from practice.

5.   Action research needs continuous validation by "educated" witnesses from the context it serves.

6.   Action research is a public form of enquiry.

JEAN MCNIFF'S THREE DIMENSIONAL SPIRAL OF SPIRALS MODEL FOR ACTION RESEARCH

(From Fig 3.9 p.45 McNiff 1988, Action Research Principles and Practice, London, Macmillan Education Ltd)
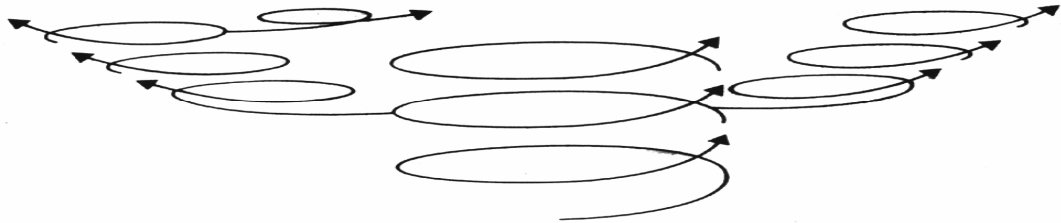
SAMPLES OF RESPONSES FROM OWN INSTITUTION'S STUDENTS IN FIRST YEAR AS A MIDWIFE

Sample One - dated 16th June 1996

Dear Diane

Thank you for the evaluation of the 3 year pre-registration programme. In answer to your questions:

1.   *Midwife rotational throughout areas at Hospital A. E Grade.*

2.   *Promotion. F grade. Hospital A rotational throughout areas (to commence Aug 96).*

3.   *Felt confident and competent. Managed post natal ward with few staff (28 beds). Delivery suite more confident than staff in allowing mobility to women not monitoring throughout labour. Allowing delivery in different positions.*

4.   *More information on pre-term labouring - management and caring for women who are in pre-term labour.*
   Pre-eclampsia - more experience with caring for women.
   Dopplers - information.
   Site B doesn't allow experience in these areas.

   The CTG lecture given by a float lecturer was excellent and has helped in my experience of CTG interpretation.

5.   *Swapping sites e.g. site B - site C. If students willing to allow more experience in abnormal/normal midwifery.*

I would like to thank Mid Trent tutors for giving such a good training and the midwives at site B for their help and support during my three year programme.

Yours sincerely

Sample Two - dated 4th June 1996

Dear Diane

These are just some brief points in response to your letter and formats. Sorry not to write at greater length but am very busy.

1.   Staff midwife E Grade at consultant unit - 10 months (nearly)

2.   Current post E Grade

3.   Very nervous in first few months post qualifying, well first 6 months really. Still nervous now on and off. Especially nervous of labour suite as opposed to ward and clinic. Now feel slightly more confident, but not necessarily more competent. Have very little experience of certain situations e.g. emergencies, perinatal death, multiple birth, recus of newborn. Have more experience of these situations than 10 months ago, but not much compared to senior colleagues.

Feel more competent and confident about certain aspects of care e.g. breastfeeding (due to 2 weeks induction experience with breastfeeding counsellor) and child protection (due to on the job learning).

Feel that with experience, support of colleagues and further learning can become more competent and give more to women and their families, but to guard against over-confidence as there's always more to learn in midwifery.

4.   Feel midwifery-oriented theory and midwifery practice placements were most important preparation for practice. As we commented on in evaluations during course, feel the early general theory and placement could have taken up less time and the midwifery placements later in the programme expanded.

Some of shared learning e.g. nursing models were not relevant to midwifery practice. Wish we'd spent longer in training covering suturing, IV cannulation and drug administration.

5.   As 4.

from

Sample 3 - dated 19th June 1996

Dear Diane

Thank you for your feedback from the pre-registration evaluation interviews.

Here is the further information you asked for:

1 & 2   On qualifying I applied for three posts in London and was offered all three.

I chose to take up the post of "E" Grade full-time permanent midwife at the Hospital D (having read so many good things about the place in all the Journals).

I commenced on August 28th 1995 and worked as a "core" midwife on the ante and post natal ward for 5½ months.   In February 1996 I moved into a team (or "group practice" as they call them here) of 6 midwives - hospital based.   I now work in ante natal clinic, labour ward, ante and post natal wards and hold parent education classes weekly.

The idea of working as a core midwife when newly qualified is to "break you in gently" before becoming a fully-fledged team midwife, incorporated into my time on core was meant to be 4-6 weeks labour ward experience.   However, due to the chronic under-staffing which appears to plague the whole of London it was not a general introduction - I was frequently left as the only qualified member of staff on a 27 bedded ward and was only actually given 2 weeks labour ward experience.   So it was a great relief to get on a team.

3.   My experience of being thrown into a very deep end during my first few months as a qualified midwife did make me feel actually under confident and competent.   I don't think that was inadequate training but rather inadequate staffing and support of newly qualified staff here.   I have seen 6 or 7 newly qualified "post registration" midwives go through the same process since me and they seem to have all felt at least as if not more under confident than myself.

Also I think you need quite a bit of labour ward experience when you're newly qualified to boost your confident and competence - which I didn't get . After the first 8 weeks I did begin to feel a bit more confident but I really felt its only now after about 10 months that its really "coming together" a lot more.

4.   Better preparation would have included:

- management experience of running a ward
- more theoretical input on substance misuse in pregnancy; HIV and pregnancy (including issues re: antenatal testing, pre-test counselling, antenatal treatment of mother and treatment of child of HIV +ve mother); child protection procedures; taking cervical smears; use of speculums; scrubbing for theatre.

5.   I think I went on at some length throughout the course about ways to improve it - so I won't bore you with more of the same now! Overall I feel I was well prepared for the role. I think maybe London does present one with particular difficulties/opportunities which were bound to be a bit of a shock after Nottingham. But now I really am enjoying it.

Hope this is of some use

Yours

DIVISION OF MIDWIFERY

PRE-REGISTRATION MIDWIFERY PROGRAMME

INTRODUCTION

The Diploma in Midwifery Programme is currently being re-designed in readiness for 1997. During 1995 a systematic evaluation of the course was undertaken in relation to the September 1992 cohort. The themes and categories listed below emerged from that evaluation. It would be helpful if you would now add to the evaluation, to inform the assessment strategy for the revised course, by completing the following questionnaire.

Q U E S T I O N N A I R E

Please tick (✓), comment or rank order as indicated

1. The course has prepared me for the role of a newly qualified midwife

   Very well ☐
   Satisfactorily ☐

   Please comment on any lack of preparation

2. The following list represents some of the possible capabilities of a newly registered midwife. Please circle, on a scale of 1 - 5 how important it is that these capabilities should be formally <u>assessed</u> during the midwifery course.

   1 = not important to 5 = very important

a)	Depth and breadth of knowledge	1 2 3 4 5
b)	Effective communication skills	1 2 3 4 5
c)	Seeks advice appropriately	1 2 3 4 5
d)	Knows own limitations	1 2 3 4 5
e)	Demonstrates confidence	1 2 3 4 5
f)	Capable of assuming responsibility	1 2 3 4 5
g)	Decision making skills	1 2 3 4 5
h)	Personal qualities	1 2 3 4 5
i)	Team work	1 2 3 4 5
j)	Interpersonal relationships	1 2 3 4 5
k)	Response to emergencies	1 2 3 4 5
l)	Listening skills	1 2 3 4 5
m)	Able to prioritise	1 2 3 4 5

n)   Speed in carrying out activities   1 2 3 4 5

Others - please add any others you think it important to be assessed

3.   Please list below any of the Activities of a Midwife (EC Midwives Directive) that you have not achieved

4.   Please list below any of the UKCC Learning Outcomes (Rule 33) you do not think you have achieved

<u>Comments</u>

If there are any gaps, why do you think this is?

5.   Has the course prepared you for:

a)   Taking responsibility/accountabilityYes ☐

No ☐

b)   A career of continuing learning and developmentYes ☐

No ☐

Please comment if No to either:

6.   What changes would you like to see to the assessment of practice ?

7. How do the midwife assessors reach a judgement that you have achieved level "D" in the assessment of core and essential activities?

8. How well prepared were the assessors? Very well ☐

    CommentsNot well ☐

9. How much did a midwife teacher work withQuite often ☐
   you in clinical practice?Occasionally ☐

    Does it matter? Please comment

10. Should teachers work for some of the time in theYes ☐
    practice placements?No ☐

    If yes, in what ways might it make a difference to the course?

11. Teachers should monitor the assessment process in the practice placement areas

Yes ☐
No ☐

12. Do you think an incompetent student could pass Yes ☐
all elements of our assessment schemeNo ☐

Please give details

---

13. Please describe the sort of person that would, in your view, be an incompetent midwife

---

Thank you for your assistance. I will provide you with a summary of data from the whole group once it has been analysed.

Diane M Fraser
Assistant Director
Head of Division of Midwifery

EXTRACT FROM U.K.C.C. MIDWIVES RULES (U.K.C.C. 1993)

Outcomes of programmes of education leading to admission to Part 10 of the register. Such programmes of education shall:-

a) meet the requirements of the Midwives Directive; and

b) be provided at an approved educational institution; and

c) enable the student midwife to accept responsibility for her personal and professional development, and to apply her knowledge and skills in meeting the needs of individuals and of groups throughout the antenatal, intranatal and postnatal periods, and shall include enabling the student to achieve the following outcomes:-

    (i) the appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health;

    (ii) the recognition of common factors which contribute to, and those which adversely affect, the physical, emotional and social well-being of the mother and baby, and the taking of appropriate action.

    (iii) the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family;

    (iv) the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and seek assistance when required;

    (v) the ability to interpret and undertake care prescribed by a registered medical practitioner;

    (vi) the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines;

    (vii) the use of relevant literature and research to inform the practice of midwifery;

    (viii) the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team;

    (ix) an understanding of the requirements of legislation relevant to the practice of midwifery;

    (x) an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice;

    (xi) the assignment by the midwife of appropriate duties to others and the supervision and monitoring of such assigned duties.

(Statutory Instrument 1990 No 1624)

Nine student midwives (1995 completers) who emerged as demonstrating significant capabilities as future midwives

STUDENT QUALITY/ CAPABILITY OF MOST EFFECTIVE STUDENTS		STUDENT REFERENCE NUMBER AND SITE CODE (A-F)								
		05A	08A	02B	09B	12B	01C	03C	04C	18D
1	Confidence is evident, not over-confident	R P S	RS	RPAS	PAS	AS (T)	PAS	RPAST	P A S	R P
2	Initiative demonstrated	RPAS	PA	RPA	RPAS	T	RPA	RPAST		PAT
3	Excellent potential as midwife **and/or**	T	PA	PA	-	TA				
4	Exceptional student	-	-	-	PAT			RPAT	PA	RPAT
5	Calm, demonstrates confidence to women	PAS	PS	PA	AS	S	AS	PA	PA	
6	Predict would cope well/ safely with emergencies	PAST	PA(S)T	PAT	AST	AT	AT	PAST	AT	AST
7a	Very capable, achieved a high academic standard **OR**	✓	✓	✓	✓			✓		✓
7b	Capable, achieved an above average academic standard					✓	✓		✓	
8	Good decision making abilities	PAST	PAST	RPST	AST		ST	PAST	AT	ST
9	High level of motivation demonstrated	RPAST	RPAST	RPAST	RAST	average	ST	RPAST	RPAT	AST
10	Assertive and articulate	✓	✓	✓	✓			✓		✓
11 Personality descriptions (Lack of ✓ does not necessarily mean it is not present, but it was not identified as an attribute)	Likeable	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Popular/ leader			✓				✓		✓
	Friendly	✓		✓				✓		
	Caring / compassionate	✓	✓	✓		✓		✓	✓	
	Mature	✓	✓	✓				✓	✓	
	Sense of humour							✓		✓
	Quiet						✓		✓	

KEY: Evidence obtained from: R = Reference at outset   P = Profile   S = Student Interview
T = Teacher interview   A = Assessor Interview   ( ) = Some anxieties but agrees overall

SUMMARY OF LOCAL CASE STUDY INTERVIEW DATA (1995 COMPLETERS)

DIVISION OF MIDWIFERY

PRE-REGISTRATION MIDWIFERY PROGRAMME

THEMES AND CATEGORIES FROM END OF COURSE INTERVIEWS WITH STUDENTS
TEACHERS AND ASSESSORS - SEPTEMBER 1992 INTAKE

(20 students, 19 midwife assessors and 5 teachers, total = 44 interview transcripts)

1. EFFECTIVENESS OF PREPARATION

- 18 out of 20 students felt well prepared
- 16 out of 20 felt relatively confident but a little nervous about the responsibility
- 8 felt particularly anxious about emergencies as they had not had the opportunity to put themselves to the test
- 12 would have liked more practice earlier and less crammed at the end
- the majority appreciated being given a case load towards the end of the course

2 VIEWS ON COMPETENCE AT REGISTRATION - must assess for evidence
Lack of response does not imply lack of agreement, but it was not specifically mentioned when answering the open response question.

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	knowledgeable	32	14	13	5
b)	communicates effectively	31	13	15	3
c)	seeks advice appropriately	29	11	16	2
d)	knows limitations	29	11	14	4
e)	demonstrates competence but not over-confident	26	12	10	4
f)	able to take responsibility/good decision making skills	25	8	16	1
g)	diagnose abnormalities	18	8	8	2
h)	personal qualities, adapts to individuals	18	6	10	2
i)	works well in teams	17	6	9	2
j)	predict would be safe in emergencies	15	4	9	2

others =   good listener, high standards, able to prioritise, manage labours (normal on own), abdominal examinations, drug administration, enthusiasm for midwifery.

3 QUALITIES IDENTIFIED MOST IN THESE STUDENTS

		n = 19 Assessors	n = 5 Teachers	Lacking
a)	knowledgeable	17	-	1
b)	enthusiastic	13	-	1
c)	initiative	16	-	1
d)	good communicator	17	-	-
e)	high standard of care but do not always see need to balance priorities when busy	9	-	-
f)	unreal expectations at times - measures self against experienced midwives	12	-	1
g)	learned quickly in last 6 months	10	4	-

4. ACHIEVEMENT IN RELATION TO ACTIVITIES OF A MIDWIFE (EC Midwives Directive)

Majority achieved but some uncertainties in relation to:

• family planning
• breech
• episiotomy
• emergencies

Simulation, role play and written work to compensate

5. ASSESSMENT IN RELATION TO UKCC RULE 33

Outcome	Assessed in school and practice	Practice	School
1	15	9	6
2	12	12	0
3	5	17	1
4	2	19	0
5	5	17	0
6	11	11	1
7	24	1	6
8	6	16	0
9	12	3	7
10	12	4	4
11	4	12	1
Resp/account			24

Cont. Educ. All agreed evidence for this

6. VALUE OF WRITTEN WORK TO STUDENTS

a)	Increased knowledge:	19
b)	Majority of assignments of value:	18
c)	Developed research knowledge:	11
d)	Good feedback enhanced learning:	11
e)	Timing of examination is wrong:	3
f)	Some work of less value:	- formative assignments
		- timing of concepts of health
		- if not related to practice
		- if work not graded
		- enquiry into community placement.

7. EVALUATION OF ASSESSMENT OF PRACTICE DOCUMENT

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Comments pages necessary, but not always filled in well, mid-point interview not always done	38	18	17	3
b)	Specifying levels was clear, but some lack of understanding, some unreal expectations	25	9	11	5
c)	More space for comments is necessary:	25	10	14	1
d)	Need to subdivide some of the statements:	20	12	8	-
e)	Overall document very clear:	18	5	9	3
f)	Need somewhere to record skills:	14	6	6	2

8 OVERALL FAIRNESS OF ASSESSMENT SCHEME

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Discussion with other midwives who work with the student contribute to judgements	42	20	17	5
b)	Accurate reflection of student abilities	27	18	7	3
c)	A variety of methods are used to make judgements eg. observation, discussion, questioning	27	14	13	-
d)	Dialogue between student and assessor is vital in making judgements	27	10	15	2
e)	Good assessment of knowledge	17	5	10	2
f)	The womens' views of students contribute to decision making:	7	7	6	-

9. VALUE OF A PORTFOLIO (ENB Regulations)

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Would provide cumulative evidence	23	12	8	3
b)	Assessors would see what has been done before, including written work	21	9	9	3
c)	It would provide evidence of reflection	19	9	8	2
d)	A record of skills achieved should be included	14	6	5	3
e)	Current portfolio is adequate	11	-	-	-
f)	A good idea but finding time would be difficult	8	-	-	-

10. PREPARATION OF AND FUNCTION OF ASSESSORS

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Failing students is difficult: - helped by talking to each other - contact teachers if a problem - with diploma courses realize it is their responsibility too	19	2	12	5
b)	Better preparation needed	13	3	7	3
c)	Most assessors very rigorous but others are less effective	11	6	5	-
d)	Documentation difficult at first but understood at end:	8	4	2	2
e)	Lack of continuity of assessors caused problems	7	3	4	-

11. TEACHERS IN CLINICAL PRACTICE

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Teachers always involved when there is a problem	25	1	19	5
b)	Teacher should be involved with all students	22	2	15	5
c)	Teachers should monitor assessment process and support assessors	20	1	14	5
d)	Teachers should work in clinical practice	14	-	12	2
e)	Assessors, not teachers, should make assessment decisions	9	-	9	-
f)	Teachers should work with students if a problem	7	-	6	1

12. SUGGESTIONS FOR COURSE IMPROVEMENT

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Learn basic skills earlier in course	29	14	10	5
b)	Reduce theory/shared learning in year one	18	14	-	4
c)	Increase contact with midwife teacher in year one	17	10	4	3
d)	Give greater responsibility towards end of course	17	5	12	-
e)	Reduce gaps between allocations, especially labour ward	9	4	5	-
f)	Improve continuity of assessors	8	4	4	-
g)	Teachers to be more in contact with assessors	7	1	6	-

13. GENERAL IMPRESSIONS OF THREE YEAR PROGRAMME

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Equally competent as shortened programme qualifiers	15	-	13	2
b)	Amazing change towards end of course	14	-	10	4
c)	Equally confident as shortened programme qualifiers (Some reservations in area of management and emergencies)	13	-	11	2
d)	Initial prejudices, now in favour of this route	10	-	9	1

Other Comments: work very hard
                            Learn quickly
                            Refreshing to work with
                            Their life experiences are of value

14. PRIORITIES ONCE QUALIFIED

		n = 44 Total	n = 20 Students	n = 19 Assessors	n = 5 Teachers
a)	Develop skills, consolidate learning	25	14	9	2
b)	Concentrate on normal midwifery initially	18	5	12	1
c)	Take on larger workload and develop management and prioritising skills	13	3	9	1
d)	Work as a member of a midwifery team	13	11	1	1
e)	Gradual development of caring for complicated pregnancies	9	2	7	-
f)	Work in a hospital initially	7	4	3	-
g)	Worried about job opportunities	5	5	-	-

PERCEPTIONS OF LESS COMPETENT MIDWIVES

a) Lacks knowledge
b) Lacks skills in normal midwifery
c) Poor communicator
d) Ignores woman's individual needs
e) Poor records
f) Not a team worker
g) Over confident
h) Over cautious

ISSUES TO CONSIDER IN RELATION TO ASSESSMENT

1.   There are no loopholes in our strategy because:

- there is good teacher/assessor liaison
- we do not use poor midwife assessors
- the supervisors of midwives know the assessors
- we all know each other and poor students do not go unnoticed
- documentation provides a progressive record
- assessors accept responsibility for students entering the profession

BUT

2.   There are potential gaps in our strategy because:

- we don't assess attitudes
- there is sometimes lack of continuity of assessors
- some assessors give the benefit of the doubt
- assessors have not all got critical assessment skills and find it difficulty to fail students
- we don't know what they'd be like in emergencies

PROCEDURES IN RELATION TO ASSESSMENT IN PRACTICE
PRE 1997 CURRICULUM

UNIVERSITY OF NOTTINGHAM
SCHOOL OF NURSING AND MIDWIFERY

DIVISION OF MIDWIFERY

DIPLOMA IN MIDWIFERY PROGRAMME

PROCEDURES FOR SUMMATIVE ASSESSMENT OF PRACTICE

1.	At the start of, or return to, each new practice placement (or attachment to a midwifery team) the student and the designated assessor/supervisor midwife review and record the student's learning needs in the Continuous Assessment of Practice Document. Priorities must be identified and activities specified which should enable the student to make satisfactory progress and achieve the required level of competence.

2.	At a midway point, or sooner if necessary, progress is assessed and an action plan is formulated to try to ensure the student achieves the required learning outcomes for the placement at this stage in the course. Any actual or anticipated difficulties should be referred to the link midwife teacher at this stage.

3.	When the student self-assesses as having achieved the required level of competence for an activity this is recorded in the continuous assessment of practice document. e.g.

> Level A 15.1.93
> Level B 27.2.93   etc

4.	Throughout the allocation the students should take time to reflect upon and evaluate their learning and, in discussion with their midwife assessor/ supervisor, identify situations/activities which provide evidence that they have achieved the required competence. A summary of the evidence should be documented prior to the end of the placement and the midwife/assessor/ supervisor must record the level achieved, date and sign their name legibly in the "Assessor" box for each activity. Any unresolved differences between student and assessor to be referred to the student's personal tutor.

5.	Action to be taken when student has been unable to achieve the required level of competence by the specified week due to extenuating circumstances e.g. sickness
	a)	provide further learning opportunities to compensate for those that

have been missed and identify a new date for the student's summative assessment of practice

b)   intake leader to inform the Registry of revised date for the student to achieve the required level of competence

6.   Action to be taken when student is deemed to have failed to achieve the pass requirement by the specified week in the course.

a)   personal tutor meets with the assessor/supervisor to discuss and document the reasons why the student has failed to achieve the requirements

b)   personal tutor informs the intake leader of the outcome of the dialogue

c)   intake leader informs the Registry, in writing, that the student has been referred in the summative assessment of practice

7.   Action to be taken for referred candidates:

i)   Personal tutor, student and midwife assessor/supervisor discuss the most appropriate placement to enable the student to have the best opportunity of achieving the outstanding learning outcomes.

ii)   Intake leader arranges for student to have a further three weeks practice in the designated midwifery placement/with specific team of midwives.

iii)   Supervisor of midwives consulted by the intake leader to advise regarding support for the midwife assessor/supervisor.

iv)   Intake leader informs the link teacher that the student and assessor/supervisor midwife will need additional support.

v)   Intake leader informs Course Co-ordinator and Head of Faculty who alerts the External Examiner of the situation.

vi)   At the end of the further three weeks experience the student, midwife assessor/supervisor and personal tutor meet to discuss the evidence which has informed the midwife's judgement as to whether the student has achieved the pass requirement.

vii)   Intake leader to be informed, by the personal tutor of the decision and if:

a)   PASS - informs Registry in writing
b)   FAIL - informs Registry, Course Co-ordinator and Head of

Faculty immediately (telephone or Fax).

8. Action to be taken following failure to achieve the pass requirement on re-assessment.

    a) Intake leader arranges for a copy of the continuous assessment of practice document to be sent to the External Examiner with a report from the personal tutor citing the evidence which formed the basis for the judgement of non-competence.

    b) External Examiner arranges to see the student, midwife assessor or personal tutor if considered necessary.

    c) Supervisor of Midwives consulted by the intake leader to determine whether the student can continue in a midwifery practice area pending the decision of the Board of Examiners. A report from the Supervisor of Midwives to be included in the report on the student that will be presented at the Board of Examiners.

    d) Student to be allocated to wherever the intake leader and Supervisor of Midwives deem most appropriate, pending the outcome of the Board of Examiners.

    e) Board of Examiners will normally recommend that:

        - Student withdraws from the course

                or

        - Student is provided with a further fixed period of midwifery practice and is re-assessed for third and final time.

    f) Registry informs the student of the recommendation of the Board of Examiners

LIST OF RELEVANT STUDIES DRAWN UPON BY COURSE PLANNING TEAM
WHEN RE-DESIGNING THE CURRICULUM

a) 1993 Assessment of Competencies in Nursing and Midwifery Education and Training (the ACE Project). Bedford H, Phillips T, Robinson J and Schostak T. ENB. London.

b) 1993 Experiences of Shared Learning within a Pre-Registration Diploma in Midwifery Education Programme. An Evaluative Study. Marshall J, University of Loughborough, Unpublished MA Dissertation.

c) 1994 Direct but Different. An Evaluation of the Implementation of Pre-Registration Midwifery Education in England: A Research Project for the Department of Health. Kent J, MacKeith N, and Maggs C. MRA. Bath.

d) 1994 An Evaluation of the non-midwifery Placements in a Three Year Diploma in Midwifery Programme. Fraser D M, University of Nottingham. Unpublished MPhil. Thesis.

e) 1995 An Investigation into the Changing Educational Needs of Community Nurses, Midwives and Health Visitors in Relation to the Teaching, Supervising and Assessing of Pre and Post Registration Students. Davies S, Shepherd B, Thomson A and Whittaker K. ENB. London.

f) 1995 Learning to use specific knowledge in nursing and midwifery education. Alderton J, Boylan A, Eraut M and Wraight A. ENB. London.

g) 1995 Getting a Job and Growing in Confidence. Report to the DoH. Maggs C. MRA. Bath.

h) 1995 Outcome Evaluation of the Effectiveness of the Pre-Registration Midwifery Programme for the second cohort at University of Nottingham. Fraser D M, Part of PhD Study in Progress.

i) 1993 -96 An Outcome Evaluation of the Effectiveness of Pre-Registration Midwifery Programmes of Education (the EME Project). Fraser D M, Murphy R J L, Worth-Butler M. Conference Papers and Reports in the Public Domain. ENB Project in Progress.

j) 1996 Women's Views of Midwives' Competence. Fraser D M, Part of PhD Study in Progress.

DELPHI TECHNIQUE: QUESTIONNAIRE ONE

UNIVERSITY OF NOTTINGHAM
SCHOOL OF NURSING AND MIDWIFERY
DIVISION OF MIDWIFERY

The following list of problem areas and suggestions for improvement in the Division has been generated following my meetings with all teachers. Would you please "tick ✓" to indicate your response to each statement and the additional points where appropriate. Add any suggestions you might have and fill in, where possible, where there is a "?" or "e.g.".

		Agree	Disagree	Unsure
9.	**Communications remain problematic**			
	a) All teachers to receive a copy of Division minutes			
	b) Other?			
10.	**Do not always feel party to decision making**			
	a) Teacher meetings to be a priority for attendance			
	b) Use colleague representing Centre more effectively			
	c) "Pair" with a colleague to represent views when cannot attend			
11	**Need updating prior to new intakes**			
	a) Maggie Cooper to meet with intake leaders 4-6 weeks in advance			
	b) Intake Leader to convene regular meetings with personal teachers			
12	**Not enough time for corporate planning across Division**			
	a) Consider semesterisation of programmes			
	b) Stop annual leave for specific weeks			
13	**Teachers are involved in too many different activities**			
	a) Consider more specialisation			
14	**Teachers should be involved in a range of different activities**			
	a) Share resources to avoid duplication			
	b) Be disciplined with diary management			
15	**Intake leader should have more personal students from the intake than those on the teachers base site only**			
16.	**Intake leader should always have some personal students on base site**			
17.	**Personal students should normally be those on teacher's base site**			
18.	**It is difficult to remember administrative procedures etc**			
	a) Review Division guidelines and procedures annually			
	b) Everyone has a responsibility to recommend additions/ amendments to procedures and guidelines			
	c) Copies of guidelines should be at each site			
19.	**Teachers should be based where the students are based for practice**			

		Agree	Disagree	Unsure
20.	**Teachers should be based where major classroom education takes places**			
21.	**Teachers do not always cover for others**			
	a) Ansaphone should be listened to by first person in			
	b) Ansaphone should be listened to if secretary is not in or late (by whom?..)			
	c) Secretary should prepare classrooms and directions board as soon as she arrives			
	d) First teacher in should prepare classrooms and boards			
	e) A contingency plan should be made for each Centre			
22.	**Workloads not always evenly balanced**			
	a) ?			
23.	**Roles and responsibilities need writing down and retaining in guidelines folder**			
24.	**Travel is a problem, especially if not based where students are for practice**			
	a) Solution?			
25	**Double blind marking preferable to marking followed by moderation**			
26.	**Feedback to markers when grades are changed is inadequate**			
27.	**We need to compare our marking standards with each other**			
28	**Teachers should attend Division meetings for longer than 3 months**			
	a) 6 months			
	b) 12 months			
	c) Other?			
29	**Secretarial staff should be delegated for specific functions**			
	a) Specifically?			
30	**Secretarial staff should become more involved in midwifery practice placement administration**			
31.	**More teachers should share 901 course clinic audits and visits**			
32.	**System needs to be in place to deal with a teacher's work when she is away**			
	a) Correspondence should be opened and dealt with by? ? Secretary ? Named colleague			
	b) Circulars should not be put in the file of a teacher who is away unless seen by everyone else first			

PLEASE ADD ANY YOU HAVE THOUGHT OF SUBSEQUENTLY

PLEASE RETURN TO ME BY 7TH MAY AND I WILL RE-CIRCULATE AS PER DELPHI TECHNIQUE. THE FINAL VERSION WILL BE DISCUSSED AT THE INSET DAY ON 21 JUNE 1996

UNIVERSITY OF NOTTINGHAM
SCHOOL OF NURSING AND MIDWIFERY
DIVISION OF MIDWIFERY

PROBLEM AREAS AND POSSIBLE SOLUTIONS

The following represents the views of 11 out of 18 midwife teachers. Please now indicate on a 1-5 scale which ones you feel strongly about. 1 = not important to 5 = very important.

	Agree	Disagree	Unsure	Importance
1.　　There needs to be more forward planning of programmes	5	1		
Two months in advance is usually satisfactory	5		1	
Six months in advance is necessary	5	1		
★ 3-4 months in advance	1			
★ Some programmes need longer than others	1			
2.　　Preparation of programmes and timetables takes up a lot of time	6			
More secretarial support is necessary to do them	7		1	
A master layout on network for teachers	8			
3.　　Typing is not done quickly enough	2	3		
Secretarial service is needed to complete work in 5 days	7			
Better access to computers to allow teachers to do it	2	6	1	
4.　　There is sometimes duplication of materials (teaching)	4	1	1	
More standard packs are needed e.g biological sciences, teaching and assessment	2	1	1	
★ Teacher guides need to be more detailed	2			
Central bank of resources is needed in each Centre	4		1	
5.　　Teacher guides, modules and reading lists not always updated	6			
Teachers to update each summer	8		1	
Teacher guides for new programmes to be completed two months in advance of module launch	8			
6.　　More collaboration is needed for continuing education activities	7			
Quarterly meetings necessary for co-ordination	5		1	
Written/telephone communications are sufficient	2	3	1	
7.　　Student nurse allocations are time consuming	6		1	
Written guidelines would be helpful	3	1	5	
★ Allocations Officer is necessary	1			
8.　　I.P.R. system is not as helpful for development as hoped	5	1		
Wait for University system before changing	8			
Modify current system	2	2		

			Agree	Disagree	Unsure	Importance*
9.	**Communications remain problematic**		6			
	a)	All teachers to receive a copy of Division minutes	7		1	
	b)	★ Head of Division to meet each teacher 6-8 weekly	1			
		★ More opportunities to meet together	1			
		★ Need to guarantee a telephone response	1			
10.	**Do not always feel party to decision making**		6			
	a)	Teacher meetings to be a priority for attendance	4	1	2	
	b)	Use colleague representing Centre more effectively	9	1		
	c)	"Pair" with a colleague to represent views when cannot attend				
11	**Need updating prior to new intakes**		6			
	a)	Maggie Cooper to meet with intake leaders 4-6 weeks in advance	9	1		
	b)	Intake Leader to convene regular meetings with personal teachers	8	2		
12	**Not enough time for corporate planning across Division**		3		2	
	a)	Consider semesterisation of programmes	5		3	
	b)	Stop annual leave for specific weeks	1	4	2	
13	**Teachers are involved in too many different activities**		2	2	1	
	a)	Consider more specialisation	3	3	4	
14	**Teachers should be involved in a range of different activities**		5	1		
	a)	Share resources to avoid duplication	8		1	
	b)	Be disciplined with diary management	7	1		
15	**Intake leader should have more personal students from the intake than those on the teachers base site only**		1	6	2	
16.	**Intake leader should always have some personal students on base site**		8		2	
17.	**Personal students should normally be those on teacher's base site**		10			
18.	**It is difficult to remember administrative procedures etc**		7			
	a)	Review Division guidelines and procedures annually	9			
	b)	Everyone has a responsibility to recommend additions/ amendments to procedures and guidelines	10			
	c)	Copies of guidelines should be at each site	10			
19.	**Teachers should be based where their personal students are based for practice**		8		2	
20.	**Teachers should be based where major classroom education takes places**		1	6	3	

* 1 = not important, to, 5 = very important

300

		Agree	Disagree	Unsure	Importance*
21.	**Teachers do not always cover for others**	3	2	2	
a)	Ansaphone should be listened to by first person in	3	4	1	
b)	Ansaphone should be listened to if secretary is not in or late (by whom?...)	7			
c)	Secretary should prepare classrooms and directions board as soon as she arrives. B = Board C = Classroom	2 + 2B	3 + 3C	1	
d)	First teacher in should prepare classrooms and boards		9		
e)	A contingency plan should be made for each Centre	9			
22.	**Workloads not always evenly balanced**	4		3	
a)	★ Co-ordinator to review workloads frequently	1			
	★ Account to be taken of intake leader role	1			
	★ Account to be taken of specialism role	1			
23.	**Roles and responsibilities need writing down and retaining in guidelines folder (i.e. Intake Leader, Personal and Link Teacher)**	5	1	1	
24.	**Travel is a problem, especially if not based where students are for practice**	7	2	1	
a)	★ Need better forward planning	1			
	★ Peripatetic teachers identify when available	1			
25	**Double blind marking preferable to marking followed by moderation**	5	3	3	
26.	**Feedback to markers when grades are changed is inadequate**	9		1	
27.	**We need to compare our marking standards with each other**	8		1	
28	**Teachers should attend Division meetings for longer than 3 months**	2	7		
a)	6 months	2			
b)	12 months		1		
	★ Not at all	1			
29	**Secretarial staff should be delegated for specific functions**	5	1	2	
a)	★ To individual teachers	2			
b)	★ For all midwifery administration	2			
c)	★ For specific courses	2			
30	**Secretarial staff should become more involved in midwifery practice placement administration**	3	2	4	
31.	**More teachers should share 901 course clinic audits and visits**	4	1	4	
32.	**System needs to be in place to deal with a teacher's work when she is away**	10			
a)	Correspondence should be opened and dealt with by? ? Secretary (4) ? Named colleague (3)	11			
b)	Circulars should not be put in the file of a teacher who is away unless seen by everyone else first	9			

```
┌─────────────────────────────────────────────────────────────────┐
│                                                                   │
│  SUMMARY OF ITEMS THOUGHT OF SUBSEQUENTLY                          │
│                                                                   │
├─────────────────────────────────────────────────────────────────┤
│                                                                   │
│  •       Post is lost between centres - fax is vital in each      │
│          centre                                                   │
│                                                                   │
│  •       There should be a course planning team for each course   │
│                                                                   │
│  •       There is a lot of goodwill to compensate for             │
│          insufficient teachers                                    │
│                                                                   │
│  •       Teachers should "pair up" regarding annual leave/absence │
│          cover and continuity with students                       │
│                                                                   │
│  •       Reduce number of teachers involved in each cohort        │
│                                                                   │
│  •       Intake leader plus "support" from one other teacher      │
│                                                                   │
│  •       Difficult to be personal teacher and not intake leader   │
│          as don't get to know students well                       │
│                                                                   │
│  Comments on specific questions                                   │
│                                                                   │
│  3b)     This is not what we are paid to do                       │
│  4b)     Depends on the resource - already being done in Derby    │
│  7)      Alright if a good system is in place                     │
│  9a)     Centre copy plus copy to teacher who needs to action an  │
│          item                                                     │
│  10a)    Ensure majority of teachers can attend when planning     │
│  11a)    Meet 8 weeks in advance.  Meet 3-4 months in advance     │
│  11b)    Difficult to find time                                   │
│  14)     Depends on needs of the individual                       │
│  14b)    Diary management must be respected by others             │
│  15)     Not practical                                            │
│  18a)    Must be effective communication of the outcome of review │
│  18c)    Every teacher requires a copy                            │
│  21)     Good support already exists.  Own workload can prevent   │
│          "cover"                                                  │
│  21a)    Not all centres have an ansaphone or want one            │
│  21b)    First person in should listen to ansaphone               │
│  21d)    Teacher who is to use classroom to prepare it            │
│  21d)    First teacher in could end up preparing 3 classrooms     │
│                                                                   │
└─────────────────────────────────────────────────────────────────┘
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Appendix 13

DELPHI TECHNIQUE: QUESTIONNAIRE TWO

UNIVERSITY OF NOTTINGHAM
SCHOOL OF NURSING AND MIDWIFERY

DIVISION OF MIDWIFERY

PROBLEM AREAS AND POSSIBLE SOLUTIONS
FOR IMPROVEMENT QUESTIONNAIRES

Stage One

The ELEVEN questionnaires that were returned (18 sent out) have been analysed and the results are detailed. Additional suggestions have been incorporated where appropriate and are indicated by ★. Comments that were made but which could not be incorporated easily are set out on page 4.

Stage Two

Will you please now rank on a 1 to 5 scale each item on the questionnaire in terms of importance for you.

    1 = not important
    5 = very important

Keep a copy for yourself and send a copy back to me by 18th June.

Stage Three

At the INSET day on 21st June in Grantham, we will discuss the areas of most concern and look at ways in which we can bring about improvements.

Thank you for all those who participated in Stage One, it would be good to have 100% response to Stage Two.

Diane M Fraser
20.5.96

DELPHI TECHNIQUE: RANK ORDERING OF RESPONSES TO QUESTIONNAIRE TWO
(TOP 30 STATEMENTS)

Rank Order	Item No	Statement
1	19	**Teachers should be based where their personal students are based for practice**
2	26	**Feedback to markers when grades are changed is inadequate**
3	27	**We need to compare our marking standards with each other**
3	2	**Preparation of programmes and timetables takes up a lot of time**
5	17	**Personal students should normally be those on teacher's base site**
6	11a	**Need updating prior to new intakes** Maggie Cooper to meet with intake leaders 4-6 weeks in advance
6	18c	**It is difficult to remember administrative procedures etc** Copies of guidelines should be at each site
8	16	**Intake leader should always have some personal students on base site**
9	1	**There needs to be more forward planning of programmes**
9	3a	**Typing is not done quickly enough** **Secretarial service is needed to complete work in 5 days**
9	5b	**Teacher guides, modules and reading lists not always updated** Teacher guides for new programmes to be completed two months in advance of module launch
9	9	**Communications remain problematic**
9	9a	**Communications remain problematic** All teachers to receive a copy of Division minutes
9	10	**Do not always feel party to decision making**
9	18a	**It is difficult to remember administrative procedures etc** Review Division guidelines and procedures annually
9	32	**System needs to be in place to deal with a teacher's work when she is away**
17	7	**Student nurse allocations are time consuming**
17	8a	**I.P.R. system is not as helpful for development as hoped** Wait for University system before changing
17	18b	**It is difficult to remember administrative procedures etc** Everyone has a responsibility to recommend additions/ amendments to procedures and guidelines
20	2b	**Preparation of programmes and timetables takes up a lot of time**

		A master layout on network for teachers
20	8	**I.P.R. system is not as helpful for development as hoped**
20	18	**It is difficult to remember administrative procedures etc**
23	6	**More collaboration is needed for continuing education activities**
23	10b	**Do not always feel party to decision making** Use colleague representing Centre more effectively
23	11	**Need updating prior to new intakes**
26	6a	**More collaboration is needed for continuing education activities** Quarterly meetings necessary for co-ordination
26	21e	**Teachers do not always cover for others** A contingency plan should be made for each Centre
26	22	**Workloads not always evenly balanced**
29	1a	**There needs to be more forward planning of programmes** Two months in advance is usually satisfactory
30	5a	**Teacher guides, modules and reading lists not always updated** Teachers to update each summer

S = Summative
F = Formative
N = No need to assess
U = Unlikely
? = Unsure

Pract	Simul	Theory	CLINICAL SKILLS	Comments
			temperature, pulse	
			blood pressure	
			urine testing	
			abdominal examination	
			breast examination	
			use of pinard stethoscope	
			use of sonicaid	
			use of CTG monitoring	
			drug calculation, administration and recording	
			injection technique	
			checking emergency equipment	
			use of TENS	
			vaginal examination	
			ability to carry out normal deliveries **- sitting**	

Pract	Simul	Theory		Comments
			caring for women who are ill	
			caring for the sick or small neonate	
			ability to recognise deviations from the norm	
			ability to respond appropriately to deviations from the norm	

COMMUNICATION SKILLS

			active listening	
			observation skills	
			information technology skills	
			ability to clarify and summarise	
			assertiveness skills	
			counselling skills	
			ability to communicate with different client groups	
			interpersonal skills	
			caring in loss or disability	
			report writing skills	
			verbal reporting skills	
			obtains necessary information	

EXTRACT FROM EME PROJECT ASSESSMENT MATRIX

Cross-references	COMPETENCE DIMENSION: Professional/Friend				
	Area of competence expected at point of registration	Evidence to demonstrate capability	Most likely context for assessment		
			Practice setting	Education Environment	Simulation
CC	1) Has a friendly, caring approach to women and can make them feel comfortable in any context	1.1 personal qualities	Essential	Possible	Possible
		1.2 attitudes	Essential	Possible	Possible
(vi) (viii)	2) Communicates with women and their partners as a professional &/or friend according to context	2.1 supportive/reassuring	Essential		Possible
		2.2 giving advice/guidance	Essential		Possible
		2.3 involves other team members	Essential	Possible	
		2.4 use of records	Essential		
CC Code (13) (vii)	3) Respects the woman's right to choose/empowers women to be in control and involved in their care	3.1 uses literature and research	Possible	Possible	
		3.2 explores woman's preferences	Essential		
		3.3 explains protocols	Possible	Possible	
		3.4 seeks permission from woman before acting	Essential		
EC (ix) Code (42) (vii)	4) Understands and practices within the legislation governing midwifery practice, including keeping thorough and contemporaneous records.	4.1 keeps accurate and detailed records	Essential	Possible	
		4.2 knowledge and understanding of Midwives Rules and other relevant legislation	Possible	Possible	
		4.3 knowledge and understanding of local requirements arising from legislation	Possible	Possible	

NEW CURRICULUM MODULE DM207

DM207   The Midwife and Woman in Partnership 10 credits

Level

Two

Semester module is taught in

Teaching Period II - Weeks 68 - 103

Pre-requisites to the module (if any)

All modules are compulsory for the award

Availability

Restricted to student midwives/return to practice midwives

Content description

This module analyses the role of the midwife in the provision of individualised midwifery care for women and their families when pregnancy and childbirth are normal. Opportunities will be given to develop further observation and communication skills and apply the knowledge, skills and attitudes needed in midwifery practice in order to plan and adapt care to meet the mothers' physical, psychological, social, cultural and educational needs and needs of the baby.

Method and frequency of class

Student centred learning to achieve required learning outcomes.

Methods of assessment including weighting of the various elements

Completion of student portfolio of learning.

Breakdown of how many hours students are expected to spend on each part of the module

Seminars and tutorials   20 hours
Reflection on practice,
completion of portfolio
and continuous assessment document 55 hours

Module convenors

Personal tutor in collaboration with link teachers.

Department(s) offering the module

Division of Midwifery

Module aims

To enable students to provide and critically analyse midwifery care when pregnancy and childbirth are normal..

Module objectives

This module will enable students to:

- demonstrate appropriate inter-personal skills to communicate effectively with mothers/clients and members of the multi-professional team providing maternity services.

- use a variety of systems to accurately record, collate and interpret information.

- critique health education/promotion activities for individuals.

- discuss the importance of assessing the individual needs of mother and baby taking account of physical, emotional, social, spiritual, cultural and educational factors.

- discuss options for planning and providing midwifery care in partnership with the mother/family to meet individual needs during the normal process of childbearing.

- record their reflections on the effectiveness of midwifery care in providing women with choice, control and continuity based upon appropriate evidence and research.

- administer drugs used in midwifery practice and apply knowledge of statutory and local policies in relation to the storage of drugs and record keeping.

- discuss the effectiveness of drugs and other techniques to minimise/control pain and minor disorders during pregnancy and childbirth.

Transferable skills

-         Communication and interpersonal skills
-         Assessment, planning and implementation skills
-         Analytical, reflective, diagnostic and evaluative skills

Resources

There is no additional demand on resources.
Adequate consultation over resources has taken place with the library and any other resource provider:
signed ....Head of Division

Departments and faculties who have been consulted
Supervisors of Midwives and Managers of Maternity Units.

DM303   Contemporary Midwifery Practice   20 credits

Level

3

Semester module is taught in

Teaching Period III - Weeks 108 - 135

Pre-requisites to the module (if any)

All modules are compulsory for the award

Availability

Restricted to student midwives/return to practice midwives.

Content description

In this module all course components will be integrated and developed to demonstrate the holistic role of the midwife in contemporary midwifery practice. This module focuses on the autonomy of practising midwives who are qualified and accountable for their sphere of practice and must ensure that care meets the standards of safety required for childbearing women and their families. Practice placements will be in a variety of settings to develop more precisely the knowledge, skills and attitudes needed in midwifery practice and to consolidate prior learning experience. The ability to recognise the signs of potentially abnormal conditions will be developed, to make competent judgements and diagnoses and to participate in the delivery of care with appropriate members of the healthcare team and other agencies. Reflection, critical analysis and evaluation of midwifery practice are integral parts of this module.

Method and frequency of class

Student centred learning to ensure the provision of appropriate learning opportunities. Fixed and negotiable attachments will be agreed with student, teacher and practice placement assessors.

Methods of assessment including weighting of the various elements

Completion and critique of student portfolio of learning.

Breakdown of how many hours students are expected to spend on each part of the module

Seminars and tutorials	25 hours
Reflection and dialogue on practice and continuous assessment document	50 hours
Self-directed/record of evidence	75 hours

Module convenors

Personal tutor in collaboration with link teachers.

Department(s) offering the module

Division of Midwifery

Module aims

To develop competence in the provision of holistic midwifery care for mothers and babies in a range of practice settings.

To develop skills of diagnosing and participating in care of women with complications associated with childbearing.

Module objectives

This module will enable students to:

-        justify their decisions when assessing, planning, implementing and evaluating the care of individual mothers and babies.

-        identify priorities of care, assigning duties to others and monitoring such assigned duties.

-        select, critically evaluate and apply the appropriate knowledge, skills and experiences to make diagnoses.

-        evaluate their experiences and take responsibility for identifying and continuing with their personal and professional development.

-        discuss accountability for their own midwifery practice and demonstrate the ability to reflect on and recognise legal, ethical and moral dimensions and emergency situations and know what actions are appropriate.

-        critically identify the achievements and limitations of contemporary midwifery

practice and draw upon research when proposing alternative strategies.

Transferable skills

- Knowledge, skills and attitudes relating to assessing, planning, implementing and evaluating the needs, related to childbirth, of women and babies.
- Interpersonal skills
- Diagnostic skills
- Advocacy
- Obtain, transmit, accurately record and store information relating to the delivery of a care service
- Enabling skills
- Leadership and management skills, Teaching and supervising skills

Resources

No additional resources are required.
Adequate consultation over resources has taken place with the library and any other resource provider:
signed ....Head of Division

Departments and faculties who have been consulted

Supervisors of Midwives in Maternity Services

Appendix 19

LEVELS FOR ASSESSMENT IN PRACTICE (1991 CURRICULUM)

Minimum levels of achievement have been set out for each part of the Programme. Students and their assessors/supervisors are required to identify the level of achievement for each activity by the end of each part of the Programme.

Criteria to be fulfilled for each level are as follows:

LEVEL A   =   Has observed the activity and is able to explain the basic concepts involved.

           (Level A = Minimum level to be achieved at end of Part One)

LEVEL B   =   Participate safely under direct supervision and is able to discuss the application of theory to practice.

           (Level B = Minimum level to be achieved at end of Part Two)

LEVEL C   =   Is able to perform accurately and safely with minimal supervision from a skilled practitioner. Critically analyses care and selects appropriate strategies to meet individual needs in a range of practice settings.

           (Level C = Minimum level to be achieved at end of Part Three)

LEVEL D   =   Competent to carry out the activity accurately, safely and reliably under indirect supervision. Demonstrate the ability to critique research and apply appropriate research findings to practice. Evaluates the quality of midwifery care delivered, reflects upon practice and initiates appropriate changes.

           (Level D = Minimum level to be achieved at end of the course)

LEVEL E   =   Confident in level of knowledge and ability to teach colleagues. Demonstrate the ability to respond flexibly to the needs of learners, is able to delegate appropriately and monitor and supervise others.

           (Level E = should be achieved for some of the activities but is not an end of course requirement for the award of a Diploma in Midwifery/ recommendation for registration as a midwife).