Definitions of Midwifery Competence: Implications for Professional Learning

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Abstract

This study explores the nature of competence required to fulfil the role of the midwife, learning to become competent, and professional learning beyond registration. The research was undertaken through a qualitative, case study approach, exploring competence as a phenomenon, as experienced by thirty-nine student midwives as they went through the final stages of pre-registration midwifery education programmes, were assessed to be competent, and took on the role of the midwife. The views of the thirty-nine participants of competence and of their own capability, development and learning, were compared with the views of teachers, assessors, other midwives, and supervisors of midwives, working with participants. Also explored are the characteristics of the expert and the characteristics of good and bad midwives.

The case is made early on in the thesis that a definition of competence is required for midwifery to develop as a profession, to protect the public, and to facilitate midwife development pre and post registration. Towards achieving this, the research begins to construct a model of midwifery competence as an integrated, holistic concept. The research explores the relationship between the various components and dimensions in the integrated model and the factors involved in being competent across contexts and from situation to situation. Factors involved in the maintenance of competence over time and in learning beyond registration are identified by exploring the nature of learning beyond registration and the characteristics of good and bad midwives.

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Chapter One

Exploring competence and learning in midwifery: Introduction

1.1 Introduction

The midwife had an essential role in the provision of maternity care for women and their families in Britain long before the role became formally recognised at the turn of the twentieth century. It is also a role that has undergone considerable change in recent years reflecting wider reforms of the organisation of NHS and maternity care, public pressure for change, and government-led recommendations towards truly women-centred care.

Like all professional roles, numerous events over the last century have shaped modern midwifery practice and the role of the midwife. The status of midwifery is now considerably different to that of one hundred years ago. Midwifery is not unlike other disciplines in its efforts over that time to be recognised as a profession in its own right, ostensibly aimed at protecting women by ensuring that only competent midwives are allowed to practise and by developing the sphere of practice of a midwife as the lead professional in the provision of women-centred care. The route to professionalisation has featured constant debate with medicine and nursing around recognition of midwifery's unique sphere of practice, that midwives are autonomous practitioners and should carry their own caseloads, and that as a profession, midwives should maintain their own professional register.

Pregnancy and childbirth are also considerably different to a century ago. Today, at the beginning of the twenty-first century, women enjoy better maternity outcomes than ever in terms of maternal and neonatal mortality. In recent years, the focus in the provision of maternity care has shifted beyond ensuring a safe outcome for women and babies to include the quality of the experience that women and their partners have of pregnancy and childbirth.

The discussion so far would seem to suggest that agreement has been reached on the boundaries of practice of the midwife and on the knowledge, skills and attributes required to fulfil the role. Currently the scope and sphere of midwifery practice is outlined through frameworks enforced through national and international legislation, and in government policy initiatives. However, in a review of the literature there is little to be found in the way of an exploration of the nature of the competence required to fulfil the midwifery role. It is argued later in this thesis that such a model of competence is required to:

- protect women, their families and the profession from incompetent practitioners by outlining the standards that must be met and maintained in order to enter and remain within the profession
- outline for women, their families and other professionals what should be expected of a competent midwife
- make explicit to prospective and current practitioners the requirements for the role of the midwife, thus providing students and practitioners with a framework by which they can identify priorities for personal and professional development
- align programme outcomes to the requirements of the role by guiding curriculum development and assessment
- facilitate the development of midwifery as a profession by identifying an explicit body of professional knowledge, skills and personal conduct to be assigned to the role of the midwife and distinguished from that of other professionals.

This research explored three facets of the competence required of a midwife:

- the nature of competence required at the point of registration and how it might best be captured in assessment
- learning and the development of competence coming up to registration and beyond registration and how it relates to the competence of the expert
- the maintenance of competence over time and the attributes of good and bad midwives.

The opportunity to carry out this research came about while I was the main researcher on a three year national evaluation study of pre-registration midwifery programmes of education (Fraser, Murphy and Worth-Butler, 1997 – the EME study). Early on in the study, while developing an evaluation framework, it was noted that there was a particular gap in the literature on the concept of a competent midwife. Through a review of the literature, and group work and surveys with parents, midwives, students and midwife teachers, a tentative model of competence was developed, which continued to develop over the life of the project. This was sufficient for the purposes of the evaluation but was limited because of time and resource constraints and the fact that other issues needed to be explored in order to fulfil the terms of reference agreed with the EME study's commissioners – the English National Board for Nursing, Midwifery and Health Visiting (the ENB). The research presented in this thesis aims to build on and further develop that model through an in-depth exploration of what it means to be competent and the lived reality of becoming competent and developing and maintaining competence over time.

Although the design of the research had to fit in with the work carried out for the EME study, there were several advantages to carrying out the research on the back of the EME study. For example, involvement with the EME study provided the opportunity to access some very rich data from a national sample. Without such access and funding it would not have been possible to do such an in-depth, longitudinal and broad examination of midwifery competence. The study design aimed to complement the EME study. The research design and methods are outlined in detail in Chapter Four.

1.2 Structure of the thesis

In Chapters Two and Three the literature on midwifery, education, nursing, medicine, industry and other areas is reviewed to identify a number of the key issues relating to the role of the midwife and understandings of competence. This review of the literature helped to inform the design of the research and the methodology used, which is outlined in Chapter Four. The circumstances in which the research took place and the aims of the research are also outlined in

Chapter Four. In Chapters Five to Nine, the analysis of the data on competence at the point of registration and the development and maintenance of competence before and after registration is presented. Drawing on the themes raised in the analysis presented in these chapters, the focus in Chapter Ten is on the development of a model of competence and the implications for the assessment of midwifery competence at the point of registration. Finally, the thesis is concluded in Chapter Eleven by pulling together the key conclusions and discussing their implications for midwifery competence.

1.2.1 Setting the scene for a study of competence in midwifery

The aim of Chapter Two is to position the competence debate within the context of the evolving role of the midwife and the development of midwifery as a profession. The review traces the development of the role over the last century focusing on the regulation of midwifery practice and education and the influences that other professions, the state, and legislation have had on the midwife's scope and sphere of practice. In addition, the concept of pregnancy and childbirth as normal is highlighted as a major theme in developments in the organisation of maternity care and the roles of the midwife and other professionals. One particular issue raised is the impact that the increasing medicalisation of pregnancy and childbirth has had on the care that women receive and on the midwifery profession. The review notes that over recent years there is increasing support for a move away from the medical model of care towards patterns of care that reflect the normality of pregnancy and childbirth and that are more focused on meeting the needs and preferences of women. It is argued that the midwife has a unique role in such patterns of care as the only 'expert' in the provision of care for women with normal pregnancy and childbirth. Further it is argued that most women stand to benefit from moving towards such patterns of care, particularly in terms of continuity of care, improved choice, improved control over the care that they receive, and emotional and psychological support. Given the specific points made about the role of the midwife in the provision of care for normal pregnancy and childbirth, the lack of clarity about the role of the midwife in the provision of care for women who develop complications or are ill is identified.

Accepting that there is support for midwife-led care, the debate nevertheless considers whether the pursuit by midwifery of recognition as a profession is appropriate or in the best interest of women. The question of who benefits most – the public or the professional – is examined. There are certain obligations on members of a profession that serve to control how members behave and the quality of practice. While it is noted that the ostensible aim of professionalisation and of identifying a profession is to protect the public from incompetence, it is also noted that professionalisation also serves to benefit members of a profession by protecting the profession against unfair competition, creating a monopoly, and perhaps ensuring prestige and capital gain. In terms of midwifery's pursuit of professionalisation it is suggested, on the basis of the literature reviewed, that a profession would usually be expected to take responsibility for a prescribed body of specialist knowledge and skills and practices, and to establish clarity about the boundaries of the professional role and how it relates to other professions. In addition, it is argued that a profession would usually be expected to be responsible for regulating membership and education, whereas currently it is the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC) and the ENB who regulate nursing, midwifery and health visiting practice and education, a much wider area than midwifery. The review also suggests that the concept of the midwife as an autonomous practitioner would need to be clarified if midwifery is to continue its pursuit of professionalisation.

Following on from the discussion about the role of the midwife in Chapter Two, the focus in Chapter Three is on issues related to definitions of competence. The review explores the range of understandings found in the literature on the nature of competence and how it can be applied to midwifery. Key issues explored include: capturing competence as an integrated phenomenon; the involvement of knowledge, thinking and action in being competent; the influences of context and time on competence; and the roles of reflection and tacit knowledge. The tentative model of competence developed in the EME study is introduced as an example of a holistic and integrated competence framework. The Chapter

concludes by identifying a number of key issues to be included in the development of a model of competence.

The key issues considered in the design of the research are explored in Chapter Four. It is argued that the interpretivist, case study approach is the most appropriate approach for a study of competence, given the complex and elusive nature of competence, and the circumstances in which the research took place. The emphases in choosing the case study approach were on: the *thick description* that can be provided and the ability to explore competence in the context in which it exists; the use of complementary methods of interviews, documentary analysis and critical incident interviews; and discovery and building faithful representations of the phenomenon in the natural language of those involved. The approach sought to examine the lived reality of competence of those closest to the phenomenon by the researcher interacting with them and exploring their understandings and interpretations of that competence. It is argued that the approach used acknowledges the concept of multiple realities and how they might be managed during analysis by using the constant comparative method of analysis. The longitudinal nature of the data collection also enabled competence across time to be explored and this is reflected in the structure of the thesis.

1.2.2 Competence at the point of registration

In Chapter Five, the nature of competence at the point of registration is explored. It is argued that registration is the key landmark on the competence landscape and the vital stage at which it is judged whether or not an individual should be admitted to a profession. The key themes identified in the analysis presented in Chapter Five are that competence is limited at the point of registration but that it is also 'conditional'. The nature of the limitations and the reasons behind them are explored and whether such limitations are acceptable. Fitness for practice is also distinguished from fitness for award and fitness for purpose.

The conditional aspect suggests that midwives are fit for practice at the point of registration provided that they are safe, have the right attitude and are effective communicators. Being safe was identified by most interviewees as the most

important requirement at registration and the research also explored understandings of what it means to be safe. A model of competence at the point of registration is outlined, focusing on the limited, conditional and developing aspects of competence identified by interviewees. Based on themes identified in the analysis, the research goes on to explore views in the literature about whether it is appropriate that competence at registration should be seen as a minimum standard. Two other key themes are also explored by comparing the views of those involved in the research with those in the literature: the role of the midwife in the provision of care for women who are ill or have complications; and the midwife as an autonomous practitioner at the point of registration.

1.2.3 The development and maintenance of competence

In Chapter Six, the research focuses on the development of competence in the final stage of education programmes. The first theme identified in the analysis is the differences between students in the pace of learning over this period. The research then goes on to explore these differences in further detail. The second theme explored is that of transition from student to midwife, which it is suggested is a significant event for qualifiers which leaves many students feeling vulnerable. This is reflected in a drop in confidence at the point of registration, which many students, their assessors and experienced midwives identified as significant. A third theme explored is the need to consolidate practice in the final months of the programme so that newly qualified midwives will feel ready to step into the role of the midwife. Interviewees referred to consolidation as a process through which students focus specifically on putting all of the elements of practice together and using knowledge in practice. Interviewees also suggested that consolidation involves taking on increasing responsibility and making decisions for oneself. One other issue identified in the data is that sometimes there can be a mismatch between the views of students and those of other, more experienced midwives about what should be expected at the point of registration, and that this mismatch can be troublesome for students.

In Chapter Seven, the research explores the development of competence beyond registration and over the first year in practice. Several interviewees suggested

that learning over that period is different to that as a student. It is suggested that learning is accelerated and focuses initially on *being* a midwife and then becoming fit for purpose. The areas where it is suggested that midwives developed most were becoming confident, taking on responsibility, coping, and judgement. Also identified is the need for midwives to fit in and to develop as team members. It is also suggested that knowledge development becomes more focused on the area where midwives practise, which may result in the loss of knowledge that is not used. The research then goes on to analyse differences in development over the year and to identify some of the factors involved.

Building on the findings of competence at registration and its development over the first year in practice, the research in Chapter Eight attempts to differentiate between competence at the point of registration and the competence of experts on the basis of the views presented in the literature. Key themes identified are differences in knowledge, the use of knowledge in thinking and action, the use of tacit knowledge and intuition, and how experts deal with uncertainty. Experience is identified as a key factor in becoming an expert, through which experts refine and further develop their knowledge and thinking.

This review of views on experts and expertise is followed in Chapter Nine with an exploration of the attributes of good and bad midwives. This exploration involved critical incident interviews with twenty additional midwives to identify particular attributes that made some midwives stand out as being particularly good or bad. The particular attributes of good midwives identified relate to knowledge and capability, commitment, judgement, coping, and being able to work with women and within a team. Overall, the findings suggest that motivation, attitudes and personal disposition are the key factors involved in being good or bad.

Building on the findings in Chapter Five to Nine, the development of a model of competence is discussed in Chapter Ten. The Chapter begins by outlining the key themes arising from the analysis of the nature of competence and learning before and after registration. Next these themes are included in the development of an

integrated model of midwifery competence, building further on the model of competence developed during the EME study. This is followed with a review of current thinking on assessment and in the development of the competence-based approach to assessment, aimed at addressing perceived inadequacies in traditional approaches to assessment. It is suggested that the development of competence-based approaches shifts the focus in assessment to performance, thereby giving knowledge a fairly subordinate role in assessment. In addition, it is suggested that there is a danger that insufficient attention could be given to other less tangible but vital aspects of competence such as attitudes, values, coping and judgement. The other major concern identified about the competence-based approach is its tendency towards reductionism. The chapter also explores the theory/practice divide in assessment and examines some ways which it is suggested could better integrate theory and practice in assessment. On the basis of the issues raised and those relating to some of the limitations of the competence-based approach, the integrated approach to assessment currently being developed in Australia in medicine and teaching is explored as a possible third way. The review also examines some of the criticisms made about the integrated approach and whether such an approach is appropriate for the assessment of midwifery competence.

Chapter Eleven concludes the thesis by outlining the key themes that emerged during the study on definitions of competence and the implications for midwifery and professional learning.

Chapter Two

The evolving role of the midwife as a professional

2.1 Introduction

The purpose of this chapter is to set the study of competence within the context of the development of midwifery as a profession. This review seeks to establish the role of the midwife in the provision of maternity care and as a professional. This debate is highly relevant in advance of an exploration of midwifery competence. For example, as a professional, a midwife would be required to function in an autonomous capacity. In addition, it is argued that there are several implications for professional status in terms of the regulation of practice and education. The review begins by exploring the role of the midwife and how it relates to that of other professional roles in the provision of maternity care. Key issues here are the concept of pregnancy as a normal event and the role of the midwife in the provision of care for women with complications or who are ill. The review also considers if midwifery is justified in its pursuit of professionalisation and if the concept of midwifery as a profession is in the best interest of women and their families.

Midwifery education is regulated and midwifery education programmes and assessment schemes are validated by the English National Board for Nursing, Midwifery and Health Visiting (ENB). Midwives are deemed eligible for registration by individual education institutions that devise their own assessment strategies under guidance from the ENB. Once deemed eligible for registration and of good character, a midwife applies to the UKCC for registration. Midwives are also required to re-register every three years and are required to fulfil certain obligations in order to be maintained on the register, including complying with the UKCC's code of professional practice and providing evidence of continuous learning. The UKCC (1998, 2000a) suggests that it and the Government are in favour of looking at ways in which the role of the midwife can be developed further and that an exploration of the implications for the

preparation of midwives and post-registration education would be completed in June 2001.

Three key themes can be identified in the literature on the evolution of the midwifery role. Firstly, midwifery was not as successful as other occupations in its pursuit of professionalisation and continued as an amateur role at a time when other similar occupations, such as physicians, surgeons, and apothecaries were organising themselves into specific professions through licensing and Parliament charters (Aveling, 1872). Throughout the last century, midwifery competed with medicine and nursing, to be recognised as a separate entity, with a distinct role in the provision of maternity care.

Secondly, new models of maternity care have developed, each of which has impacted on the role of the midwife in different ways. The development of the medical model of care can be linked to an increasing paternalism within society and the increasing role of the state in health and welfare issues over the last century. It also coincided with increasing concern with high mortality and morbidity rates.

Thirdly, in recent years women have become more empowered as members of society, in occupations, and as mothers, and increasingly expect to be involved in decisions about their care. This has resulted in alternative models of maternity care to the medical model being developed. The empowerment of women is also reflected in increasing calls within the ranks of midwifery itself to advance the status of and to develop the midwifery role.

2.2 The role of the midwife and that of the medical practitioner

Up to 1900, midwives were usually local women whose only training was that they had had children themselves. By contrast, the concept of midwifery today is as a profession, with midwives as highly trained and skilled autonomous practitioners. Moreover, it is suggested the midwife is the '**only** expert' in the provision of care for women with normal pregnancy and childbirth and that this role needs to be developed to 'ensure that midwives have all the skill,

knowledge, attitudes and experience to enhance physiological processes' (Page, 1993). Since the early 1900s, midwifery has sought an independent role for itself, which is distinct from the role of obstetricians and from that of nurses. The role of the midwife in normal pregnancy and childbirth is supported by the definition of a midwife[1] adopted by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, 1998) in its code of practice which emphasises *supervision, care* and *advice*. The reference to *supervision* implies a supportive role, but in a capacity to oversee (the normality and progress of) pregnancy. The definition outlines the scope of *care* in terms of promoting preventative measures, conducting deliveries on a midwife's own responsibility, detecting abnormality and the procurement of medical assistance for such cases. This reference to the procurement of medical assistance when abnormalities are detected defines the split between the roles of the midwife and the doctor. This is further emphasised by the requirement that a midwife should be able to execute emergency procedures in the *absence* of a doctor - suggesting that emergency situations are the realm of the doctor. The reference to *advice* emphasises the midwife's role in education and in informing choice. Finally, prefixing the three aspects of the role of the midwife by the term *necessary* emphasises the needs-meeting dimension underpinning the role of the midwife.

2.3 The medicalisation of pregnancy and childbirth

Central to the debate about where the role of the midwife and that of the medical practitioner are positioned in the provision of maternity care is the question of whether or not pregnancy is normal and how the best outcomes can be ensured for women and their babies. On the one hand it is argued that childbirth is a normal physiological process intimately dependent on the psychological state (Tew, 1995), and that pregnancy and childbirth are a normal 'physiological process to be watched rather than interfered with' (Aveling 1872).

On the other hand, the medical view is that pregnancy is only ever normal in retrospect. The medical (obstetric) model of maternity care became popular at a

[1] The UKCC adopts the definition of a midwife recognised by the World Health Organisation and the International Federation of Gynaecology and Obstetricians and first adopted by the International Confederation of Midwives. The UKCC has statutory responsibility for maintaining the professional register for nurses, midwives and health visitors in the UK.

time when there was widespread concern about high maternal and neonatal mortality rates, at the early part of the last century, and coincided with consistent reductions in pregnancy-related mortality rates. Of historical significance in terms of the organisation of maternity care at the time is the introduction of forceps into childbirth by obstetricians, one view of which is that this marked the end of childbirth as a natural event (Towler and Bramall, 1992).

However, it is also argued that there is no proven causal link between increased medicalisation and improved outcomes. Tew (1995) suggests that claims that hospital birth is safer are based on a 'successful denial and concealment of extensive and unanimous evidence that obstetric intervention only rarely improves the natural process' (preface, p.1). Tew argues that on the basis of an 'impartial statistical analysis' of results of care, it is evident that birth is safer 'the less it is interfered with' (p.11). Sandall (1995) highlights a report by the World Health Organisation (1986) describing the adverse impact of increasing medicalisation and a systematic meta-analysis of maternity care by Chalmers et al (1989) which suggests that there is no proven benefit of many interventions and that others cause harm.

It is also suggested that the obstetric model of care adversely affects other outcomes such as the quality of care women receive and the care experience itself. Further, the 'redefinition of childbirth as being normal only in retrospect' (p.2) and the resulting move from home to hospital and to task-oriented as opposed to women-centred care, has undermined the normal nature of childbirth itself and is the cause of much dissatisfaction with maternity services, evidenced in the number of pressure groups concerned with those services (Flint and McAnulty, 1992). Other practices associated with hospital-based care can also be seen to have undermined the concept of pregnancy and childbirth as normal events, such as the location of care in an environment normally associated with illness, the active management of labour, bottle feeding, four-hourly feeding and leaving the baby in the nursery. It is also suggested that intervention is further endorsed through trends in litigation, and that fear of litigation results in higher

intervention rates as the legal system favours those who intervene over those who do not (Flint and McAnulty, 1992).

Consistent with Illich's (1977) 'disabling professions', it is argued that the medical model forced women into a submissive and passive role, which conflicts with the fact that childbirth involves a 'transition to … a status of social seniority and responsibility' (Pratten, 1990, quoted in Flint and McAnulty, 1992, p.38), and where science and technology dominate over the 'female characteristics (of) … intuition, emotion and instinct' (Towler and Bramall, 1992, p.280). Tew (1995) suggests that the medicalisation of maternity care and the focus on detecting deviations emphasise the negative aspects of pregnancy and undermine women's trust in the adequacy of their own physiology to achieve a safe outcome. It is suggested that the shift in the organisation of maternity services to the medical model 'demoralised' many midwives (Flint and McAnulty, 1992) and resulted in the under-utilisation and possible loss of midwifery skills (Downe et al, 1991). Further, Tew (1995) argues that the influence of obstetricians on midwifery education programmes has eroded the midwife's traditional role to support and encourage and has compromised the philosophy of midwifery.

It is suggested that the shift to hospital-based maternity care and the acceptance of the 'safety of hospital as an undisputed fact' came about as a result of the flourishing of lying-in hospitals in the eighteenth and nineteenth century and was further endorsed in the Cranbrook (1959), Peel (1970) and Short (1980) reports (Tew, 1995). However, Tew suggests that these developments happened without any evidence that hospital births were safer. The increased shift to hospital-based care fragmented the delivery of care and significantly eroded the role of the midwife in the provision of care for women with normal pregnancy (Ho, 1986). This erosion of the role of the midwife was further compounded by other changes in the organisation of maternity care. For example, the Maternal and Child Welfare Act in 1918 increased the emphasis on antenatal care and gave responsibility for it to the local medical officer. With the inception of the NHS in 1948 the GP became the first point of contact for women accessing NHS maternity services. Previously the midwife would have been the first point of

contact. Drawing on the work of Rhodes (1995), Flint and McAnulty (1992), and Towler and Bramall (1992), the range of key events since the late nineteenth century that directly influenced the role of the midwife in England, midwifery's status as a profession and the notion of the midwife as an autonomous practitioner, are summarised in Figure 2.1.

2.4 The shift towards woman-centred care

Thinking has shifted dramatically over the last decade or so, and the quality of care that women and their families receive and the experience of care are now perceived to be highly important. This view has gained wider acceptance in the light of research findings that highlight the importance of the emotional and psychological dimensions of care (Kitzinger, 1992). This change in thinking has also been supported by women themselves who have openly questioned the need for so much intervention in childbirth. Consumer groups such as the Maternity Alliance, the Association for Improvements in Maternity Services (AIMS), the National Childbirth Trust (NCT), and midwifery groups such as the Association of Radical Midwives (ARM), have campaigned for more control for women and for them to have real choices and options for care. Bradshaw and Bradshaw (1997) suggest that midwives are the natural allies of consumer pressure groups in their pursuit of 'continuity of care, improved choice, and the right of women to have control over their bodies in all stages of pregnancy and birth'. The notion of consumer choice in health care was first introduced into health policy by the government in its white paper *Working for Patients* (Department of Health, 1979*). Changing Childbirth* (Department of Health, 1993) further endorsed the importance of choice and of giving women information on the options available to them so that they can make informed choices.

Figure 2.1 Key events in the evolution of the role of the midwife

	Event	Implications for midwifery	Implications for women
1890-1900	Midwives Institute founded	Aim: to improve the status of midwives and to provide education for midwives	Improved quality of care
	8 bills to parliament for registration and regulation of midwifery practice opposed - by medical profession – concerned about loss of income - by campaigners for nursing registration - wanted midwifery to become a specialty of nursing	Failure to be recognised as a distinct profession and the midwifery role weakened	Lack of clarity about role of the midwife in the provision of care Loss of direct relationship with midwife as an autonomous practitioner in their care
	- British Medical Association - Obstetric Registration Bill - Setting up of 'Lying-in' hospitals	Midwifery nurses practising under direct supervision of a medical practitioner.	Shift to obstetric model of care Shift to hospital-based care
1902-1936	Midwives Act - set up the Central Midwives Board to regulate midwifery practice and post of Supervisor or Midwives	Role of the midwife shaped externally	By 1947 all midwives trained and deemed competent to provide care - protection from incompetent practitioners
	To appease medical profession - majority of members of the CMB were doctors, remaining members had to be a member of one of two nursing bodies	Lack of involvement of midwives in decisions affecting the role of the midwife and midwifery practice – thereby countering professionalisation	Reinforcement of medical model and reduced choice and control for women over care
	Maternal and Child Welfare Act	Increased emphasis on antenatal care and responsibility for it given to local medical officer – undermined the role of the midwife in monitoring normal progress	Explicit effort to tackle the unacceptable level of perinatal and maternal mortality through medicalisation of childbirth
1948	NHS established	GP is the first point of contact – shifting role in care and advice on options for care from the midwife Domiciliary midwife gave up responsibility for care once woman admitted to hospital Hospital-based medical model favoured	Medical care provided for those who could not pay Reduced choice regarding patterns of care
1950	Midwives Rules revised to allow midwives to administer pethidine without the instruction of a doctor	Role of midwife as an independent practitioner reinforced	Improved control of pain in labour
1959-1970	- Cranbrook Committee - recommendations - Peel Report - recommendations	70% of deliveries should take place in the hospital, length of stay of 10 days 100% hospital births - Reinforcing medical model and hospital-based care	Separated from families for 10 days Fragmented care, loss of continuity of carer, loss of control – normality of childbirth undermined and women disempowered
1970s	- Growth in number of hospitals - Increased specialisation of obstetricians - Active management of labour and shorter length of stay, increased use of technology	Continued shift from community based care to hospital-based care. Medical model became the dominant model of maternity care	Increased use of induction and acceleration, scalp electrodes – reduced control, increased fear and increased pain. Epidurals -further intervention and limited positions in labour
1979	Nurses, Midwives and Health Visitors Act	Loss of separate identities for nursing and midwifery – weakening professionalisation	Not clear
1990	Education Officers not required to be midwives	Loss of midwives' control over own education – weakening professionalisation	Not clear
1993	'Changing Childbirth', public opinion	Shift back towards midwife-led care in low-tech settings for most women	The importance of women-centred care and informed choice promoted

Based on the work of Rhodes (1995), Flint and McAnulty (1992), Towler and Bramall (1992).

It is also suggested that these changes in thinking were consistent with the principles of 'managerialism' and its pursuit of more cost-effective care. The principles of managerialism dominated in health policy in several countries, including England, in the 1980s where there was increasing concern over the spiralling costs of medical care in general, and increasing interest in examining the cost-effectiveness of different patterns of care. Research carried out at that time in the UK, Canada and the USA suggested midwife-led units could be more cost-effective than centralised units and could provide outcomes of care that were at least as good in terms of satisfaction and infant and maternal morbidity (Sandall, 1995). In addition, Sandall reports on the work of Campbell and MacFarlane (1987) and Tew (1985, 1990) to suggest that 'low obstetric risk' women could have similar or better outcomes from planned home birth than delivering in an obstetric unit. Responding to political and consumer pressure, the House of Commons Health Committee on Maternity services was established in 1992 (Bradshaw and Bradshaw, 1997). The Committee (The Winterton Committee) sought evidence extensively from women and professionals. Bradshaw and Bradshaw suggest that key themes in the submissions from consumer groups and the Royal College of Midwives to the Committee were:

- the normal nature of the majority of births and that midwives are expert in the provision of care for normal pregnancy and childbirth
- that midwife-led care is consistent with improved continuity of care, would be safer and more rewarding for staff and women, and probably more cost-effective
- that women have the right to be full partners in care, with fully informed choice
- that midwives have a right to practise their profession in a system that makes full use of their skills.

Following on from the work of the Committee, the Expert Maternity Group was set up to translate the Committee's recommendations into action. The Expert Maternity Group's report - *Changing Childbirth,* launched by the Department of Health in 1993, was welcomed by the National Association of Health Authorities and Trusts and the National Health Service Management Executive, which

instructed all regions, districts and trusts in England to review maternity services and develop strategies to implement the ten key *indicators of success* within five years (Sandall, 1995). Some of the ten indicators of success are of particular relevance to this debate, including: that at least 30% of women should have the midwife as the lead professional; that midwives should have direct access to some beds in all maternity units; that at least 30% of women delivering in a maternity unit should be admitted under the management of the midwife; and that all front-line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency. Thus the latest philosophies for care in pregnancy and childbirth emphasise the need for women-centred and needs-meeting approaches to care. The developing model of care for women with normal pregnancy, which accounts for the majority of women, is based around the midwife as the lead professional and the provision of care in low-tech community settings. This approach to care emphasises the importance of continuity of care and reserves hospital-based, high tech care for women with complications or special needs.

Midwifery education institutions have already reflected changes in thinking in their philosophies for care and in their proposed outcomes to programmes (Mountford et al, 1995). Moves towards midwife-led care with the midwife providing the majority of care for women with normal pregnancy have specific implications for competence to undertake such a role, which will be considered during the course of this study. In addition, the nature of the role that midwives undertake upon registration will be examined. If it is accepted that the role of the midwife is based around providing care for women with normal pregnancy and childbirth, then the involvement of the midwife in care for women with complications also needs to be examined. This is among the issues explored in Chapter Five.

2.5 Midwifery as a profession?

Sandall (1995) suggests that the launch of *Changing Childbirth* represented a radical shift in policy and supported the process of professionalisation within midwifery. She suggests that central to this new found enthusiasm is the notion

that midwives would regain the professional autonomy lost in the past through medical domination and also that greater autonomy over practice and the organisation of work would enable midwives to provide greater choice and control for women. Sandall also identifies several challenges to existing occupational boundaries contained in the new proposals for maternity care and notes that 'midwives are claiming a discrete sphere of knowledge and expertise, legitimated by a desire for a more equal partnership with women in an area where medical care has been criticised' (p.206). However, for the purposes of this thesis it is important to consider if midwifery is justified in its pursuit of professionalisation, who is likely to benefit, and what the implications might be. The literature suggests that both women and midwives stand to benefit from professionalisation but that there are also some inherent dangers that those pursuing professionalisation should be mindful of.

Hassall et al (1996) provide a useful distinction between *professionalism* as an ideology, and *professionalisation* as a process by which an occupation seeks to advance its status and progress in a manner consistent with that ideology (citing Johnson, 1972, 1984). Midwifery's pursuit of professionalisation can be said to be both enabling and controlling, enabling in terms of developing the role of the midwife as an autonomous practitioner with a specific remit, and controlling in terms of protecting the public from substandard practice. However, there are several critiques of professionalisation in the literature that question who benefits most – members of a profession or the public?

The ostensible aim of a profession is to protect the public from incompetent practitioners and impostors. This is based on the assumption that the client is in no position to judge competence except in extreme cases (Moore, 1970). However, it is suggested that this function, whether by coincidence or design, also serves to protect the qualified practitioner from competition from outside the profession. It is suggested that because the self-regulatory function of a profession limits the supply of labour and expertise, it also results in monopoly and a certain prestige for members of the profession. Hodkinson (1995, p.62) suggests that key features of professionalism are 'status preservation and

boundary management through rites of passage'. In certain market conditions, this limiting of labour and expertise may also provide the profession with bargaining power for terms, conditions and remuneration. It is suggested that professionalism is a means of maximising capital, including symbolic and cultural capital (Hodkinson, 1995, citing Bourdieu, 1984) and that prestige and control also emanate from access to influence (Moore, 1970).

However, in exchange for access to the benefits of membership of a profession, certain obligations must be met, which serve to protect the interests of the public. In this sense, professionalism has a certain appeal as a disciplinary mechanism:

> … professionalism acts as a mode of government of autonomous labour; the autonomy of professional practice is predicated upon its government 'at a distance' … through the articulation of 'professional competence' (Fournier 1999, p.281).

This also benefits the profession itself by protecting its credibility from the repercussions of bad practice. Buchan (1998) highlights the increasing number of references in the healthcare literature to unacceptable variations in standards of practice, and emphasises the important role that professionals have in setting and monitoring their own standards. In terms of public credibility, the ability of professions to police themselves is increasingly being questioned, especially in the wake of recent high profile cases such as the Bristol cardiac surgery and Harold Shipman cases. Buchan suggests that in healthcare, safety tends to be the baseline both for patients and their relatives.

> They hope for excellent treatment and a good outcome. But they expect that when they are cared for, they will be safe … Judgements about levels of quality will vary depending on assessments of technical capacity and proficiency but ability to practise safely, both as an individual clinician and within the system, is seen as a minimum requirement (Buchan, 1998, p.63).

In this sense, a definition of competence is required in a profession such as midwifery, to be sure of a certain standard of practice and to establish the credibility of its members (Bashook, 1985, Scott, 1984). Fournier suggests that for professions today, public dependency and trust need to be continuously negotiated:

> Furthermore, in order to build their legitimacy, the professions need to engage with the other cultural forces and discourse with which they are implicated. They need to forge connections, operate translations, between their own systems of knowledge and the discursive formations of other agents in the name of whom they claim to profess (Fournier, 1999, p.286).

A profession needs to define its role and how it relates to that of other professions, and accordingly the scope, range and nature of the competence required to fulfil the professional role. One of the key features of a profession is that it takes responsibility for a prescribed body of knowledge which is identified by the profession itself and that relates to a substantive field of specialist knowledge which professionals command and apply (Hassall et al, 1996). In addition it is suggested that a profession must own this knowledge - the professional knowledge that creates and explains 'the official accepted 'facts' about the social and physical world that form our consciousness (Freidson, 1994, p.44)'.

Also central to the theory of professions is the control of knowledge. Freidson suggests that the only *intrinsic* resource that a profession has is command over a body of knowledge and skill:

> The sole generic resource of professions is, like all labor (*sic)*, their capacity to perform particular kinds of work. They distinguish themselves from other occupations by the particular tasks they claim, and by special character of the knowledge and skill required to perform them. The authority of knowledge is central to professionalism, and is expressed and

> conveyed by a variety of agents and institutions; it is not solely contingent on practitioner-client relationships or on the official activities of associations (Freidson 1994, p.36).

Hassall et al (1996) suggest that the profession enters into a contract with society that allows exclusive use of the professional body of knowledge. The basis of this contract is that in order to practise, some guarantee must be given that knowledge will be used in a 'societally responsible way', often involving explicit control of members by a code of ethics.

It can be argued that midwifery has several of the features of a profession identified thus far. However, there would appear to be one fundamental flaw in midwifery's argument – that it is not midwifery itself as a profession that is responsible for these activities but the UKCC, the ENB, and the NHS Executive. This review suggests that this is a fundamental issue to be addressed for midwifery to advance its pursuit of professionalisation. As previously outlined, changes in the organisation and regulation of midwifery registration and education over recent years have further removed some of the distinctions between midwifery and nursing as separate professional entities.

The Winterton Committee (1992) support the distinction between nursing and midwifery in their recommendations that midwives should retain control over their training because midwifery has philosophies which are distinct from nursing. However, JM Consulting (1998) propose that midwifery and nursing should not be seen as separate entities in terms of regulation. They state that while the two professions differ in their practice and education, they share common values and principles that mean they can effectively come together in the public interest for the purpose of statutory regulation. The report recommends that the two professions should work together in regulating education, practice and conduct, and develop common frameworks for professional conduct and ethics. Almost in contradiction, JM Consulting later in their report go on to outline the differences between midwifery and nursing, including the midwife's unique sphere of practice, that the emphasis is on

normality, unlike nursing, and that midwives practise autonomously after initial registration, including diagnosis, the supply of drugs, and referral. Ryan and Rogers (2000) disagree with JM Consulting's conclusion and argue that:

> The fundamental differences between these professions are related to the entry, education and sphere of practice. While we share general principles with respect to codes of professional conduct, our uniqueness in relation to our education and scope of practice needs to be reflected in any legislative framework (p.600).

The UKCC promotes the benefits of statutory self-regulation and the importance of ownership of the regulatory system, even though it fails to acknowledge nursing and midwifery as separate professional entities. The UKCC issued a document in 1997 outlining its position on the regulation of nursing, midwifery and health visiting in the future. It states that the public have a fundamental right to be protected from those who are unfit to practise as members of the nursing, midwifery and health visiting professions, and that protection is best assured through a system of statutory regulation. Secondly, it states that:

> Self-regulation encourages individuals to adopt and express attitudes and behaviours that are conducive to public protection, namely: an authority to act in the public interest, a high degree of self-control and self-discipline, behaviour related to a code of conduct and ethics, and competence that is tested, certified and accredited by the professions (UKCC, 1997, p.2).

Further, the UKCC (1997) outlines criteria for the regulatory system to be successful. Along with several criteria relating to the protection of the public, it emphasises the importance of ownership and active participation of regulated professionals in the professional regulatory system. Outlining the benefits of professional self-regulation in a later statement, the UKCC (2000b) suggests that professional self regulation enhances the quality of practice by requiring practitioners 'as individuals, to go beyond 'policing' activities and be proactive

in delivering good quality services … A profession holds its practitioners accountable. Personal professional accountability flows out of professional self-regulation' (p.2). However, there is nothing to suggest that any changes are planned in the current system where regulation is not owned by the midwifery profession, and which by grouping midwifery with nursing and health visiting, ignores the fundamental differences in philosophies, roles and professional knowledge between the three.

The case for recognition of midwifery as a separate profession was a key theme in the Royal College of Midwives' annual conference in 1999. Among the arguments made was that midwifery's association with nursing is in fact damaging to midwifery as a profession. The decline in the numbers of midwives over recent years was highlighted and linked to the lack of a career structure for midwives. It was also suggested that the introduction of the new consultant nurse position fails to recognise the fact that midwives are already acting in a role that meets the criteria set out for consultant positions (Purton, 1999, Silverton, 1999), and that it will not open up management opportunities for midwives because the suggested criteria are difficult to apply to midwives (Purton, 1999). It is suggested that because more midwives are being managed by nurses, there are fewer role models and mentors for midwives. Purton suggests that the introduction of the consultant nurse is another example of a 'nursing model with midwives as an appendage'.

2.6 The midwife as an autonomous practitioner

Fournier (1999) suggests that autonomy is a key feature of professionalism and that individuals are governed through 'systems of 'truth' … the proliferation of expert practical knowledge that serves to constitute human beings as autonomous subjects with a responsibility (or even an interest) to conduct their lives in appropriate ways' (p.284). This is posited as an alternative to control by a 'monolithic and all-powerful state' and domination over oppressed subjects. Citing Foucault (1973) and Miller and Rose (1990), Fournier suggests that the professions are 'central to liberalism, to the microphysics of power … through which the governed are constituted as autonomous subjects regulating their own

conduct' (p.284). Thus, a key issue to be clarified in midwifery's pursuit of professionalisation is whether the midwife is an autonomous practitioner. Professional status implies a minimum level of independence within a specific role which is related to the role of other professionals on an equal partnership basis.

McKay (1997) outlines an understanding of what it means to be an autonomous midwifery practitioner:

- working in partnership with the woman, colleagues and other professionals
- making decisions and being accountable
- using sound evidence-based knowledge and having the self-confidence and initiative to rely on the validity of judgements
- knowing how and when to act, being assertive and having firm moral convictions
- having managing skills and the ability to remain flexible.

This definition of autonomy can be interpreted on two dimensions. The first dimension depicts a model of midwifery practice which is self-sufficient and where the midwife can make her own decisions drawing on experience and knowledge in order to target the needs of the individual and to reflect the context in which the situation arises. The second dimension is about the midwife functioning autonomously within a sphere of practice that is limited specifically to normality. This would require a midwife to be able to relate to other professionals and their spheres of practice, should any deviations from normal be discovered. This implies not only that a midwife is *independent* and that her role is free-standing, but also that she has vital linkages with other professionals – that her role is *interdependent*.

Flint and McAnulty (1992) suggest the issue of midwifery autonomy has reached a critical point and suggest that midwives themselves are responsible for what happens in the future.

> Whether the role of the midwife diminishes … or achieves autonomous practitioner status will largely depend on midwives' commitment to the view that pregnancy is a normal life event and that care must be woman-centred (Flint and McAnulty, 1992, p.41).

To further add to the debate about the autonomous role of the midwife, Wagner (1997) draws parallels between midwifery and the medical profession. He claims that the roles of the midwife and obstetrician and their spheres of practice are clearly distinguishable, just in the same way as are those of a GP and a medical consultant. The role of the midwife is to provide care for normal pregnancy, including monitoring the extent to which each pregnancy is normal and detecting deviations, and then to refer complicated cases to the appropriate professional. Thus when a midwife is required under the EC Midwives Directives (1980) a) to assist a medical practitioner, where appropriate in cases where complications have occurred; b) to undertake care prescribed by a medical practitioner; and, c) to be able to 'interpret and undertake care prescribed by a registered medical practitioner' (UKCC Midwives rules (1998) 3c [v]), she is not subservient or handing up her autonomy. She is acting out the interdependence of her role, in just the same way as (to use Wagner's example), a GP refers to a cardiologist for conditions outside of his area of expertise. For the GP, referring in this way does not detract from his/her autonomy. Wagner also argues that midwifery is a profession in its own right and as such in order to be autonomous, midwifery practice must be supervised and backed up by midwives, not doctors. Wagner, himself a doctor but campaigner for midwifery, states that:

> …widespread, irrational, non-scientific statements by obstetricians against independent midwifery have nothing to do with safety, but everything to do with fear of competition (Wagner, 1997, p.18).

Returning to the debate about the professionalisation of midwifery, Hodkinson (1995) suggests that empowerment is a key feature of professionalisation that enables professionals to develop to their full potential and to meet the moral obligations of professionalism:

> Part of being professional is to deliberately maximise those (work-related) choices available to us in the best interest of the people we are employed to help. To be a professional means to develop expertise, in order to provide a high-quality service for society and for individual clients and pupils. The development of such expertise involves professional growth and independence (Hodkinson, 1995, p63).

Hodkinson relates this empowerment to a holistic concept involving *personal effectiveness, critical autonomy* and *community.* Personal effectiveness relates to 'the ability 'to make things happen''. Critical autonomy is described as the 'essential proactive component' of personal effectiveness, 'the ability to think critically about one's own practice, the context in which that practice takes place, the purposes of that practice, the moral and ethical values which do/should underpin that practice' (p.64). The term *community* refers to an essential dimension to professional empowerment that takes it beyond the individual – teamwork and working with others, and understandings of communities in which practice occurs.

Sandall (1995) highlights some practical barriers to the notion of the midwife as an autonomous practitioner. She suggests that central to increasing autonomy is the ability of midwives to provide continuity of care. This requires a great deal of commitment, loyalty and time from midwives, and it may not be easy for midwives to combine a personal life with a professional life that requires total dedication and continuous availability (citing Benoit, 1991). The danger here, Sandall suggests, is that midwifery could become a two-tier profession where midwives who can meet with the commitments required, become the 'elite' amongst a larger body of rank and file midwives. The notion of midwife-led care is very popular with consumers and the Government but there is the danger that professionalisation could split the workforce, excluding 'the rank and file midwife who may be expected to pay the price for the professionalising elite' (p.207).

2.7 Conclusion

This review of the evolution of the role of the midwife positions the study of midwifery competence against the changing landscape of maternity care, both in terms of the way in which maternity care is organised, and the roles of and relationships between the key actors involved. This review suggests the midwife has a unique role to play in the provision of care for women with normal pregnancy and childbirth (the majority of women) working in partnership with women and that such a role is consistent with ensuring good outcomes for women and their babies. It is argued that the midwife has a distinct role in the provision of maternity care for women with normal pregnancy and childbirth, that is complementary to but different from that of other professionals. The traditional association between the obstetric model of maternity care and safer outcomes is disputed and it is suggested that this type of care is not appropriate for all women, and further that in terms of informed choice, all women may not want such care. It is suggested that in the future midwife-led care may well be the norm for the majority of women, with high-tech hospital-based care reserved for those most in need of it.

This review suggests that there are several benefits to the pursuit of professionalisation in midwifery including the development of a mechanism to protect the public from care that is less than competent. Several elements of such a mechanism can be seen to exist already in midwifery such as:

- a specific sphere of responsibility
- specific requirements for entry onto the professional register and obligations to be fulfilled in order to be maintained there
- an explicitly articulated understanding of the accountability of the midwife for acts and omissions in the course of practice
- a written code of practice and
- regulation of programmes of midwifery education.

In addition, the pursuit of professionalism can provide the licence within which the role of the midwife can be refined and developed over time to respond to changes in the needs and wishes of women and their families. This moves

thinking beyond a focus on ensuring midwives meet with minimum standards towards a focus on quality and excellence in the delivery of care.

However, the review also highlights some of the potential dangers of professionalisation. It suggests that midwifery needs to be careful to distance itself from notions of professionalisation concerned with the generation of capital and to emphasise the role of professionalisation in the development of midwifery practice for the benefit of women and their families. It is suggested that the improved status and esteem that comes with professionalisation could be harnessed in such as way as to improve the influence that midwives have as women's advocates in the development of maternity care and empowering the women who use services. Professionalisation can be based on 'the principles of service to others, the striving for expertise, the empowerment of workers, both as individuals and collectively, and the adoption of a moral code' (Hodkinson, 1995, p.63). In addition, Hodkinson (1995) suggests professionalisation can occur without excluding other professions who might have a valuable contribution to play in improving women's experiences of pregnancy and childbirth. The midwife must also be able to work along-side other professionals on an equal partnership basis, implying mutual recognition of roles and responsibilities.

This review also suggests that midwives collectively need to examine the path that midwifery is taking and the implications for midwives of professionalisation. This will include:

- clarifying the sphere of practice of a midwife and how it relates to other professions involved in the delivery of maternity care
- identifying the range of situations and contexts in which a midwife practises across the whole sphere of practice
- examining the practical arrangements for autonomous practice across the situations and contexts identified, including continuity of care and staffing arrangements.

Once clarity has been achieved across these areas, midwifery may be in a better position to evaluate its potential as a profession and to obtain commitment from all practitioners to a truly professional role.

One of the aims of this thesis is to inform the debate on the professionalisation of midwifery through the review of the nature, scope and range of midwifery competence, and how competence develops and is maintained over time. Having explored the evolution of the role of the midwife, its pursuit of professionalisation, and the obligations associated with being a profession, the professional status of midwifery will continue to be a theme throughout this thesis. For example, the findings presented in Chapter Five suggest that competence is limited at the point of registration. In view of the findings and the debate about midwifery as a profession, the chapter further explores: the appropriateness of the notion of competence as a minimum standard; the role of the midwife in the provision of care for women who are ill or have complications; and the midwife as an autonomous practitioner at the point of registration.

Chapter Three

Definitions of competence: a review of the literature

3.1 Introduction

Following the review of the evolution of the role of the midwife as a professional in the previous chapter and the cases made there for a definition of the competence required to fulfil the professional role, the range of perspectives on competence and what it means to be competent, are explored in this chapter. There are numerous concepts of competence outlined in the literature, varying in breadth and specificity and according to the philosophical perspectives of authors. In broad terms, competence can be understood as 'an umbrella concept to incorporate skills and attitudes, knowledge and experience' (Silver, 1988). Invariably, there is an emphasis in definitions on performance in a role – 'the ability to 'Do'' (Ellis, 1988). Being competent also implies effectiveness in a role (Scott, 1984) and the successful achievement of specific outcomes across a range of role situations and 'under the varied circumstances of the real world' (Benner, 1982a, p.304). To fulfil a role, individuals will require a repertoire of skills, knowledge and understanding that they can apply in a range of contexts and organisations (Jessop, 1991).

Midwifery is not alone in not having a clearly defined and articulated understanding of competence and it is suggested that many other professions have also yet to tackle this '… intriguing but relatively uncharted territory ...' (Ellis, 1988). Yet, as suggested in Chapter Two and by several authors including Jessop (1991), Burg et al (1982) and Cox (1988), a profession must be able to define and make public the competence that should be expected of individuals identified as members of that profession, and the range of practice situations and contexts. Defining and regulating competence for a professional role and ensuring effectiveness in a role can be seen as 'the ultimate justification for the existence of the professional and the profession' (Ellis, 1988).

A definition of competence is also required in midwifery education. Students need to know what is expected of them as developing students (Burg et al, 1982, Bradshaw, 1997) and to be able to provide the best quality care for women at the point of registration (Henderson, 1992). Bradshaw (1997) suggests explicit frameworks for student achievement are required in higher education especially given the shift from teacher-centred to student-centred approaches and a shift from such concepts as skills, instruction and conformity, to creativity, experience, discovery, 'living attitudes' and self-improvement. Those developing programmes of midwifery education and assessment schemes also require a definition of competence as a framework for curriculum development, to clarify the outcomes and goals of education (Burg et al, 1982), for the development of assessment schemes (Coates and Chambers, 1992), and for the selection of students to midwifery programmes who will be fit for purpose.

A framework for midwifery competence is also required to support lifelong learning and continuing professional development and to:

- provide a systematic approach to identifying and meeting learning and development needs
- support learning on, as well as, off the job
- strengthen existing schemes of preceptorship and clinical support, and workforce planning
- provide a means of eroding the practice-theory gap, moving practice closer to evidence-based care (O'Hanlon and Andrews, 1998).

Professionals also need to know 'with confidence' that they have the necessary skills and knowledge to practise and to be aware of their limitations, but also to map out further development on the 'basic standard' (Bradshaw, 1997).

The English National Board for Nursing, Midwifery and Health Visiting (ENB, 1990) describes competence as 'The ability to perform a particular activity to a prescribed standard'. The current frameworks in the UK for outlining what a midwife should be able to do and the qualities she must possess are contained in the UKCC's midwives rules and code of practice (UKCC, 1998). Midwives rule 33 contains eleven short statements describing the outcomes of programmes of

education. It states that a midwife must be prepared to assume the responsibilities and accountabilities for her practice as a midwife, that she must be responsible for her own professional development and that she must meet the requirements of the Midwives Directive (Appendix One). While these references provide a useful overview of the role and scope of practice of the midwife, they function more as a set of things a midwife should be able to do than a comprehensive understanding of the nature of competence, the attributes and qualities required to be competent, and the factors involved in maintaining and developing competence. In addition, these statutory definitions are broad and non-specific and make no distinction between levels of competence, for example, the difference between competence at registration and that after several years' practice.

3.2 The shift towards competence-based midwifery education

Midwifery education has seen a shift towards what is referred to as competence-based or competency-based education over recent years. This shift in thinking is not unique to midwifery or to health care professions and is endorsed by the ENB (1995a, 1996) and the UKCC (1998, 1999). In competence-based approaches, the focus is on what a midwife should be able to do, the range of practice situations that a midwife should be able to practise in and the scope of practice of a midwife - all of which are outlined in broad terms in the UKCC's (1998) Midwives Rules and Code of Practice.

Hollis and Clark (1993) outline several principles and definitions of competence-based approaches:

- 'People are either *competent* or incompetent, to do a task. The 'competent state' is capable of definition and assessment.
- People hold, or lack, a particular *competency* (which may be capable of definition at different levels of expertise).
- People have, or do not have, *competencies* to do a job. These competencies may include a wide range of particular competency areas and may specify levels of expertise within each competency.

- People demonstrate their *competence* by their occupational behaviour (performance)' (Hollis and Clark, 1993, p.102).

A shift to a competence-based curriculum, endorsed in assessment has support within nursing and midwifery. See for example Ashworth and Morrison (1994), who suggest it is perfectly logical and appropriate and has 'certain pedagogical potency'.

3.3 Issues in defining competence

In the midwifery literature there is a clear absence of consensus on what constitutes an adequate definition of competence (Worth-Butler et al, 1994,1995). Having made a clear case for the need for a comprehensive definition, how does one go about exploring the scope, range and nature of competence? Midwifery as an occupation is very complex, involving a broad range of tasks, abilities and clinical situations, and in such occupations it can be argued that there is no 'single right way to define competence' (Burg et al, 1982, p.64). It is suggested that given the complex interrelations between the various aspects of competence, there may not be a 'single general perception' of competence but more likely a range of acceptable variations in what is perceived to be competent (Bedford et al, 1994). Any definition would need to capture the complexity of midwifery competence and how practitioners integrate the various aspects into effective every-day practice. Similarly, the complexities of midwifery competence must be captured in approaches to assessment - the complex and 'elusive', ambiguous and multi-dimensional nature of competence (Burrows, 1989) does not lend itself easily to assessment.

One issue raised time and time again in the competence literature is the question of how broad or how narrow definitions of competence should be. It seems that it is difficult to strike a balance between competence statements that are not so broad that it is difficult to apply them to the situation at hand, or alternatively too narrowly defined such that some elements of competence are missed. Worth-Butler et al (1994) conclude that competence involves the mastery of requirements for effective functioning in the varied circumstances of the real

world and in a range of contexts and organisations. It involves not only observable behaviour which can be measured, but also unobservable attributes including attitudes, values, judgmental ability and personal dispositions; that is, not only performance but capability. This, along with the statutory requirements (see page 32 and Chapter Ten) serves as a useful starting point. However, there are several issues to be considered before attempting to construct a model of competence:

- how competence can be expressed as an integrated phenomenon
- the roles of knowledge, thinking and action in professional practice
- performance across the full range of contexts
- the role of reflection
- the role of tacit knowledge in professional action
- the role of the 'softer' aspects of competence
- the development of competence over time.

Each of these issues is considered in turn in the following sections.

3.3.1 Incorporating competence as an integrated phenomenon

One of the predominant concerns in the literature on approaches to defining competence is the risk of losing aspects of competence by adopting reductionist approaches. Competence is seen as an integrated phenomenon and greater than the sum of the parts. Indeed a key aspect of competence is being able to integrate all of the bits (Page, 1993), ultimately towards the fluent and intuitive practice seen in experts (as described in the analysis presented in Chapter Eight). As Gipps (1994) highlights, competence is complex not because of the number of constituents but because of the interactions between these constituents and 'the heuristics for calling upon them'. The criticism of behaviourist approaches is that they focus on the discrete behaviours associated with the completion of atomised tasks, and that they are 'not concerned with the connections between the tasks and the possibility that coming together of tasks could lead to their transformation' (Gonczi, 1994, p.28). The danger of such approaches is that by reducing complex roles and holistic care into a list of tasks or technical skills (Day and Basford, 1995, Storey et al, 1995)

- they do not capture the cognitive processes underpinning competence (Mitchell, 1993, Storey et al, 1995, Smith, 1995)
- they ignore the attributes and group processes underpinning performance and the complexity of the real world and the role of professional judgement in 'intelligent performance' (Gonczi, 1994)
- they endorse a mechanistic approach to learning and assessing by reducing complex roles to individual functions (Ashworth and Saxton, 1990, Field, 1993, Gorz, 1989)
- they result in disempowerment and indoctrination and stifle creativity and free will (Le Var, 1996).

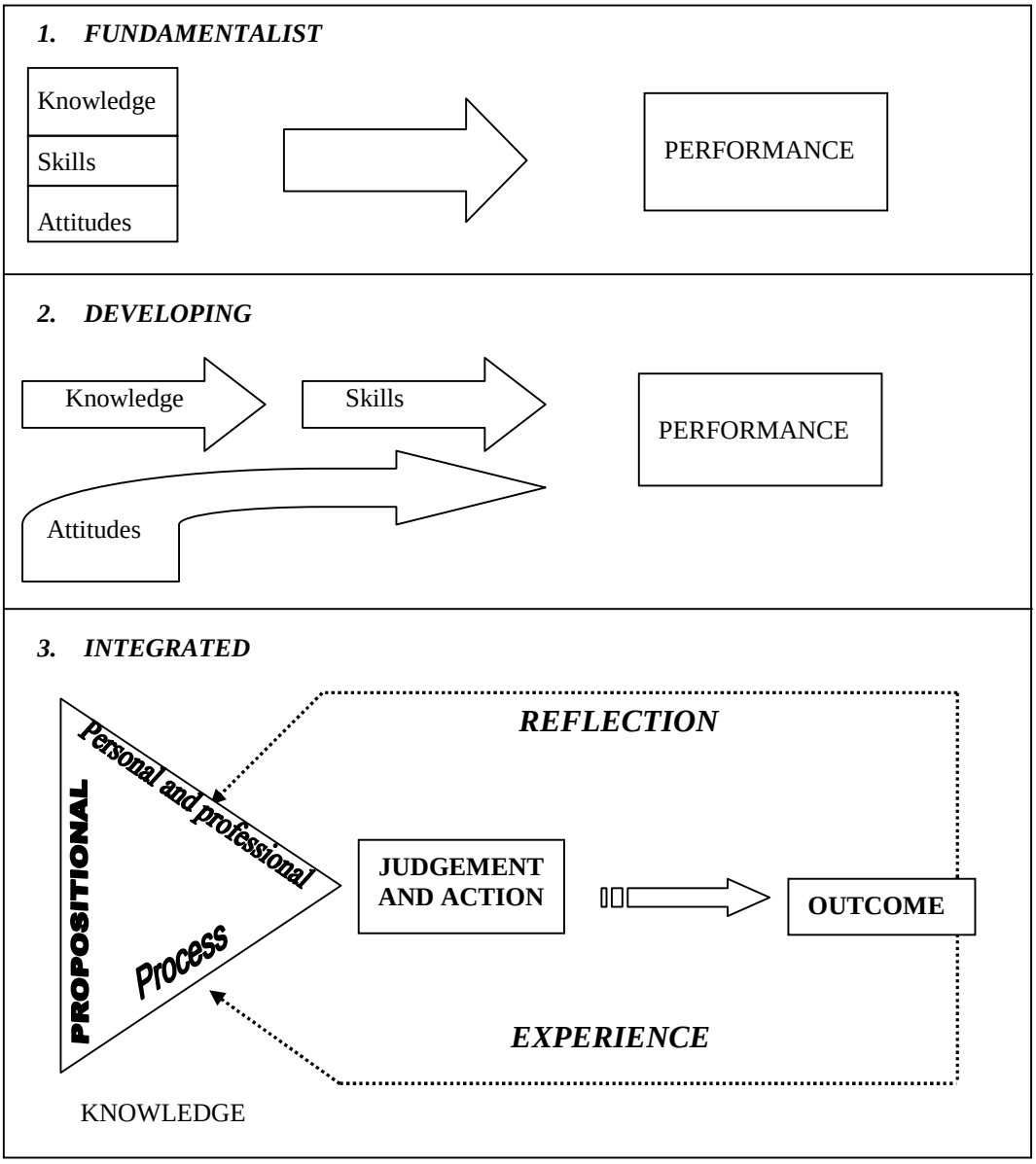
Thus it is suggested that in understandings of competence and, for effective and valid assessment of competence, the integrated nature of competence must be captured and promoted.

3.3.2 The roles of knowledge, thinking and action in professional practice

A central issue in the competence debate is the position that knowledge occupies in understandings of competence (as outlined in Figure 3.1) and the relationship between knowing and doing. One perspective is that knowledge, skills and attitudes are distinctly separate entities in competence, and seen as inputs to performance. This is later referred to as the fundamentalist perspective. Another view (later referred to as the developing perspective) is of knowledge being applied in practice to make sense of skills so that skills are used appropriately (Burg et al 1982, FEU, 1986). For example, Burg et al (1982) suggest that tasks need to be underpinned by knowledge and understanding, problem solving and clinical judgement, attitudes and work habits, interpersonal skills, and technical skills. Accordingly, midwives would be expected to be able to use knowledge and understanding in such a way that they can make complex decisions under conditions of uncertainty. Further stressing the links between knowledge and thinking, Greener (1988) suggests that an element of critical control is required in the application of skills in practice, and that cognitive and/or psychomotor competencies could be dangerous if they are not integrated with the ability to make appropriate management decisions.

As such, knowledge is seen to underpin all aspects of clinical practice (Akinsanya, 1981). A third perspective is that competence is an integrated phenomenon, where the elements of competence are linked inextricably in being competent consistently and across contexts and situations.

Figure 3.1 Perspectives on knowledge and its role in competence



If competence is seen as an integrated phenomenon, knowledge has a key role in performance and is expressed in terms of propositional knowledge, process knowledge and personal and professional knowledge. Each form of knowledge

is used in judgement, upon which action is based. Knowledge is further developed through use and reinterpreted on the basis of what has been learned in terms of experience of previous actions and judgements and involving reflection on action.

The terms knowledge and skills, and theory and practice, are frequently paired in the literature suggesting that *knowing* and *doing* are very different and distinct things. Black (1990) suggests that the distinction commonly made between knowing and doing may be the result of extensive use of Bloom's (1956) Taxonomy of Behavioural Objectives, which outlined four hierarchical levels of attainment, and has been interpreted as distinguishing knowledge '*per se*' from its use in higher order contexts – application, synthesis and evaluation. Certainly, the emphasis in assessment at diploma and degree level has traditionally tended to be on testing students' possession and understanding of facts and theory rather than on assessing the translation of that knowledge and understanding into appropriate and skilful practice in the occupational role. This was supported in the views of students interviewed in this study, where they were concerned that their performance in examinations and written work carried more weight in assessment than did their performance in the practice area. However, the competence-based approach, where the emphasis is on performance, has been criticised for going too far in the opposite direction.

Eraut et al's (1995) study focused on how student midwives and nurses learn to use knowledge. In their study, they were not only concerned with what knowledge is taught to students but 'whether students learn to use it in their professional practice' (p.3). They exploded the term 'theory-practice gap' into several types of gaps including:

- the gap between the ideal situation put forward by educators and the reality of practice. They suggest that this gap is due either to practitioners being unwilling to attempt the ideal or the ideal put forward being impracticable
- the gap between the generic taught and the specifics encountered in practice. This type of gap relates to difficulty interpreting principles that may or may not be relevant to the practice situation

- the gap relating to how students express theory in the practice situation. It is suggested that although students may know what best practice is, their credibility and seniority in the practice area will influence their empowerment to practise, and accordingly how likely they are to challenge traditional ways of doing things. Thus, 'Theory can be used to evaluate current practice, but that is best done in the safety of an essay rather than risk upsetting qualified staff in their placements' (p.4)
- the tendency to use the term 'theory' by sceptical practitioners for any knowledge regarded as irrelevant to practice.

Several authors distinguish competence from performance. Moon and Shelton Mayes (1995) stress that the two must not be confused and that the characteristics involved in the production of performance outcomes - knowledge, skills and qualities - must be acknowledged. Competence is identified as the capacity to perform or 'capability to perform' whereas performance refers to what is actually done (Senior, 1976, Eraut and Cole, 1993). As such, competence is seen as an 'intangible attribute manifested by performance in a particular situation' (Burg et al, 1982). Eraut and Cole (1993, p.1) describe capability in terms of 'knowledge', 'understanding', 'personal skills and qualities required for a professional approach' and 'the cognitive processes required for professional thinking' underpinning performance.

The key issue in the literature is whether the attributes – the capacities, dispositions, attitudes and values, underpinning performance - can be inferred from successful performance. Several current views emphasise that knowledge needs to be seen as something more than merely the possession of facts about a particular subject that can be used in practice. Such a stance on knowledge blurs the distinction traditionally made in views of competence between knowledge, skills and attitudes. Of particular relevance to midwifery competence, the traditional view of knowledge and skills as separate entities is questioned. Several authors make the distinction between the possession of knowledge of facts and theories (knowing that) and knowledge that is applied or used in practice (knowing how). Bartram (1990) distinguishes between declarative and

procedural knowledge, and Miller (1990) between knowing, knowing how, showing how and doing. There is also the distinction between knowledge in terms of outcome, content or process (Mansfield, 1990). Eraut's (1985) suggests that knowledge is a relevant way to view all aspects of competence including aspects that would traditionally have been viewed as skills, such as interpersonal skills, and communication. Understandings of competence based around the organisation and use of knowledge, link knowledge to effective and consistent performance across the range of contexts, conditions and situations in every-day practice.

It is perhaps Eraut who provides the most extensive exploration of knowledge, raising very fundamental questions about how different types of knowledge can be captured most effectively through assessment. Eraut (1985) identifies three dimensions in his conceptual framework for professional learning – source, mode of use and context of use. The first dimension refers to classifications of knowledge according to its source – so there is knowledge gained through book learning and knowledge gained through experience. Accordingly, Eraut cites Oakeshott's (1962) distinction between technical knowledge – which can be codified in writing, and practical knowledge – which is expressed only in practice and learned only through experience with practice. Technical knowledge is also referred to as *propositional knowledge* – 'knowing that'. There are various forms of practical knowledge including:

- *process knowledge* – 'knowing how', which is required to be able to function in practice and can be developed with increasing dexterity to skilful practice.
- *personal knowledge* - it is suggested that knowledge is developed and refined on the basis of experience, where with tacit knowledge and reflection, it becomes reinterpreted each time it is used. As such and relating to the chance element in experience, personal knowledge is idiosyncratic. In this way, competence can be seen to embrace the structure of knowledge and abilities and the development of competence to relate to the structuring and restructuring of knowledge and cognitive skills (Eraut, 1994a).

- *professional knowledge* – where knowledge is interpreted and related to the professional role. In this sense competence embraces professional values and knowledge (Oliver and Bourne, 1998).

In terms of mode of use, Eraut (1985, p.124) uses Broudy et al's (1964) typology to describe how knowledge acquired in schooling is used in later life. The typology includes:

- *Replication* – 'characterised by close similarity between the epistemological context in which knowledge is acquired and rehearsed and that in which it is used'. This type of knowledge will generally not need to be processed or reorganised by the user and is used in routine, repetitive tasks.
- *Application* - required in situations that are different to those previously encountered and as such is more than replication. Application requires the use of rules or procedures to enable knowledge to be translated into 'prescriptions for action on particular situations'.
- *Interpretation* – unlike replication and application, is identified with understanding and judgement. 'Concepts, theories and intellectual disciplines provide us with ways of construing situations: and our understanding is shaped by the interpretative use of such theoretical knowledge. Perspectives or 'ways of seeing' provide the basis for our understanding of situations and hence the grounds for justifying our actions, but cannot simply be designated as right or wrong'. Further, Eraut distinguishes between understanding and judgement where judgement also requires 'practical wisdom, a sense of purpose, appropriateness and feasibility'. He also suggests that the development of professional judgement requires significant professional expertise.

Eraut suggests that professional judgement also relies on a fourth category of knowledge – a*ssociation.* Associative knowledge is semi-conscious and intuitive and often involves metaphors or images. It relates to practical knowledge that has not been fully interpreted because of limited time for reflection. Eraut suggests professional judgement requires sufficient experience to avoid over interpretation from only a small number of similar cases but also 'an intuitive

capacity to digest and distil previous experience and to select from it those ideas or procedures that seem fitting or appropriate' (p.10).

This way of viewing knowledge is useful in understanding competence as an integrated concept. It proposes an intricate role for knowledge. According to Eraut it is generally accepted that the first two types – replication and application - are not considered sufficient for professional competence and that a considerable element of professional competence is professional judgement. This also emphasises the importance of experiential learning in the development of professional competence, as this view of competence suggests that understanding and professional judgement cannot be developed without adequate practical experience. Eraut's third dimension relates to the context of use and the transfer of knowledge from one context to another, which is discussed in the next section of this chapter.

3.3.3 Performance across the full range of contexts

There are several authors who argue that a defining characteristic of the competent individual is not only the possession of a range of skills and knowledge, but also the ability to use them across a range of familiar and new situations (Training Agency, 1988, UDACE, 1989, Moon and Shelton Mayes, 1995).

> A basic skill is the ability to perform steps necessary to accomplish a well defined task or goal under controlled or isolated circumstances, … competency, however, is the ability to perform the task with desirable outcomes under the varied circumstances of the real world. (Benner, 1982a, p.304)

In addition, Debling and Hallmark (1990) suggest that competence requires 'sustained effective performance' 'in different, if related contexts' and as such is likely to require 'owning relevant knowledge and understanding and applying it to good effect … truly competent performance which

displays durability over time and flexibility over different contexts requires well developed understanding within the occupational area' (p.10).

According to Newble (1992), research evidence suggests that being able to satisfactorily perform on one problem does not guarantee the ability to perform a similar task on a 'different problem, or even in different representations of the same problem' (p.72). In addition, the context in which competence is learned may be different to the practice context and learning is necessarily related to the specific context in which it takes place (Hodkinson, 1992). The ownership of knowledge is not enough. To be effectively applied over a range of situations and consistently requires 'sensitivity and recognition of situational variation' as opposed to 'rote learning of the steps of a procedure' (Benner, 1982a, p.304).

Eraut (1985) suggests that knowledge cannot be used in a different context without considerable intellectual effort, requiring a process of deliberation in action or prior to action. The way in which knowledge is originally stored will be determined by the encounter, but later processing depends on the context of use. The relevance of context of use varies across occupations. For example, whereas some occupations involve the repetition of similar tasks across similar situations and contexts, in occupations such as midwifery there will be considerable variations from one context or practice situation to another. In addition, there will be considerable differences between occupations in terms of whether or not 'problems' are well-defined.

Eraut (1985) distinguishes academic and policy discussion contexts, where knowledge is used in writing or as the basis of public debate, from action contexts. Action contexts relate to action that should be taken in the professional environment. The concept of action contexts is particularly relevant to midwifery, partly due to the degree of personal accountability that is associated with each action and partly relating to the degree of uncertainty of the practice context and the potential that each situation could potentially be a critical situation. Eraut makes the following points regarding action contexts.

- Actors have to believe in what they are doing because they are professionally responsible for the consequences of action taken. It is suggested that this results in 'an essentially pragmatic orientation that stresses first hand experience in preference to abstract principles' (p.128), resulting in a certain subjectivity, a belief that each case is individual, and a degree of scepticism relating to 'book learning'.
- In some professional contexts there is a degree of uncertainty and dealing with the unexpected. There is also a degree of urgency about action in some professional contexts that will limit the time available for deliberation. This may require decisions that are largely intuitive. In order to deal with individual cases, professionals will need not only to rely on general concepts and principles, but also to rely on their 'own senses' and their 'concrete clinical experience' (quoting Friedson, 1971).
- It is useful to bear in mind McLuhan's distinction between 'hot' and 'cool' action. Whereas there will still be some time restrictions in cool action, there is more scope for limited trial and experiment. In hot action, 'people have to develop habits and routines in order to cope; and self-awareness is more difficult as there is little opportunity to notice or think about what one is doing' (p.128).

3.3.4 The role of reflection

Another concept in the competence literature is that of the reflective practitioner. Donald Schön's (1983) work on the reflective practitioner suggests that the role of reflection in competence enables the professional to deal with the uncertainties of professional practice. Schön's model is meant to address the short-comings of the 'technical rationality' model associated with traditional models of professional practice. In the technical rationality model, professional practice is aimed at achieving specific and stable ends through problem solving and the application of a systematic knowledge base, and is operated in stable institutional contexts. Schön suggests that over the last fifty years or so, the technical rationality model has become troublesome for professional practice, as professions have come under increased scrutiny, and 'complexity, uncertainty, instability, uniqueness and value-conflict' have become increasingly recognised

as realities in the practice situation. Schön's issue with technical rationality is that it is based around problem solving but ignores the importance of 'problem *setting* – the process by which we define the decision to be made, the ends to be achieved, and the means which may be chosen. In real-world practice, problems do not present themselves to practitioners as givens (p.40)'. Problem setting also involves '*naming'* the things to be attended and '*framing'* the context in which they will be attended. Schön suggests that in the real-world practice the ends are not fixed and clear and may even be confusing and conflicting. Thus we come to Schön's well-known model of the high ground and the swamp:

> In the varied typology of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of human concern. Shall the practitioner stay on the high, hard ground where he can practice rigorously, as he understands rigor, but where he is constrained to deal with problems of relatively little social importance? Or shall he descend to the swamp where he can engage the most important and challenging problems if he is willing to forsake technical rigor? (p.42)

Schön's response to the limitations of technical rationality is to view professional action in terms of reflective practice. Firstly, he suggests that as with everyday life, the working life of the professional depends on 'tacit knowing-in-action' – in the spontaneous, intuitive action of everyday life we are knowledgeable in a 'special way':

> Our knowing is ordinarily tacit, implicit in our patterns of action and in our feeling for the stuff with which we are dealing. It seems right to say that our knowing is *in* our action (p.49).

Secondly, Schön suggests that professionals reflect *on* action, which will involve thinking back on a situation to 'explore the understandings that they have brought to their handling of the case'. The context is relatively calm, perhaps out of the practice situation; afterwards the situation and the insight gained may be used as the basis for handling future cases.

> Through reflection he can surface and criticize the tacit understandings that have grown up around the repetitive experiences of specialised practice, and can make new sense of situations of uncertainty or uniqueness which he may allow himself to experience (p.61).

Thirdly, Schön suggests that professional action involves 'reflection-in-action', which enables the professional to deal with uncertainty, instability, uniqueness and value conflict. This may also involve some degree of reflection on knowing-in-action. He also suggests that the focus in reflection-in-action is on the outcomes of action, the action itself, and the intuitive knowledge implicit in action.

Schön is not without his critics. For example, Eraut (1994b) questions some of the claims made by Schön and the methods that he has used to explore the roles of reflection and tacit knowledge in knowledge use and action. Eraut suggests that Schön's arguments are confused. He suggests that:

- The arguments made are largely based on attacking technical rationality and it is not clear whether the model that Schön presents is meant as an alternative or complementary to technical rationality. Further Eraut suggests that the debate is more concerned with 'escape from customary practice rather than escape from technical rationality'.
- Schön's focus is on reflection-in-action as a process that results in new knowing-in-action. Eraut suggests that this is not a new kind of knowledge and it would be more appropriate to thoroughly investigate knowing-in-action as an alternative epistemology to technical rationality.
- Schön's exploration of how professionals generate new knowing-in-action is based on the distinction between old and new knowledge rather than

> academic and tacit knowledge and is concerned with types of knowledge rather than distinguishing research-based knowledge from knowing-in-action.

Eraut also suggests that Schön's methodology is less than thorough. Firstly he suggests that the cases studied are taken from tutorial sessions rather than from 'the field'. The relevance of this is that in tutorial contexts both parties are obliged to engage in reflective behaviour requiring 'a much higher reflective content than that found in normal professional practice. This becomes problematic when the tutorial context is used as the basis for developing a model of reflection in practice contexts'. Further, he suggests that the analysis is incomplete, for example, that it 'fails to clarify what is entailed in the reflective process itself'. In addition it is suggested that the analysis focuses only on positive matches, and by neglecting negative cases overgeneralises and does not sufficiently discriminate between different forms of reflection contained in many examples. Ixer (1999), who spent five years exploring reflection in social work practice, is also critical of Schön's methods:

> Though Schön (1983, p.42) identified the 'swampy low-lands' in which professionals must work, his own research was based on professions which were likely, in fact, to occupy the higher ground of rationality and predictability, and hence to be less challenged by the demands of rapid problem solving than is social work. Engineers and architects, for example, are arguably less often called on to take immediate action in the context of complex decision making. In social work, the practitioner is faced with fast changing and highly challenging problematic information, and is required to exercise judgement under extreme pressure, knowing that the consequences of not 'getting it right' can be a child abuse enquiry or a judicial review (Ixer 1999, p.517).

Ixer also highlights Schön's failure to address the dimension of time in reflection, which Ixer suggests is currently viewed as highly significant.

Nonetheless, the concept of the 'reflective practitioner' has received good support in midwifery curricula in recent years. Across curriculum documents for twenty-three pre-registration midwifery education programmes, Mountford et al found:

> In summary, the view of an effective midwife adopted by all curricula is, broadly speaking, that they are reflective, research-based practitioners, working in partnership with women and their families, using at all times 'helping relationship' skills, relevant knowledge and appropriate attitudes to care. The courses all encourage life-long learning by the midwife to meet changing social, educational and professional needs (Mountford et al, 1995, p.3).

In fact, one of the objectives set out in the development of pre-registration programmes of nursing and midwifery education is to develop practitioners who are reflective, critical and enquiring, and who will challenge assumptions and by doing so strengthen and expand professional boundaries (Department of Health, 1994, Stuart, 1997, 1998). Cheetham and Chivers (1996) suggest that in many areas of professional education, Schön's 'new epistemology' and concept of the reflective practitioner 'is now frequently espoused as a professional ideal'. Perhaps an important issue in this regard is how the concept of the reflective practitioner has become so well adopted by nursing and midwifery if the concept is not yet well understood or explored. Several authors in midwifery and in other professional areas suggest that reflection has a key role in experiential learning and the development of expertise.

Ixer (1999) suggests that there is no such thing as reflection-in-action. He refers to Eraut (1995) and Bengtsson (1995) to suggest that reflection occurs not within action but *on* action. In other words, once the professional begins to engage in reflection or to 'turn it on oneself', action is interrupted and the professional steps outside of the experience, at least 'cognitively, if not physically'. At this stage the experience itself has already happened and the professional reflects back on the experience to himself or herself. Ixer also includes Van Manen's

view that interruption of action is paramount in critical, reflective thought, which takes place outside the time framework of action:

> Practitioners can only reflect if they are able to 'slow down the pace of action, go back and try again, and reduce the cost and risk of experimentation' (Van Manen, 1992, p.61, also 1995). This is the next nearest thing to stopping the action whilst reflecting on it and then taking subsequent action as a result of that reflection. Rather than acting intuitively, one first gains an element of control in thinking about the situation. This assumes a sort of role-play, where reflection is centred on action and is deliberately rehearsed for the purposes of trying out new action. Though, clearly, the principle of slowing down concurrent action is based on the here and now, it is seen as being guided by previous rather than current action, as was suggested in some of the earlier theorizing … Our preconceived ideas shape the way current action is framed rather than, as Schön saw it, experience being shaped by current action (Ixer, 1999 p.519).

This debate helps to unpack two different definitions of reflection – those relating to reflection-in-action and reflection-on-action. The former concept relates to thinking in action. In the second concept the emphasis is on reflection after the experience has passed, in order to make sense of what happened in the situation and to learn lessons to be used in future situations, thus continuously improving practice. While there are differences in opinion about the reality and merits of reflection-in-action, the concept of reflection-on-action is very useful in the light of the current interest in the notion of professionals as life-long learners.

3.3.5 The role of tacit knowledge in professional action

Ixer (1999) suggests that what is happening in Schön's 'reflection-in-action' is the application of tacit knowledge. Ixer's understanding of tacit knowledge is that it involves the professional taking intuitive and unconscious action in situations demanding an immediate response and as such involves a passive rather than critical approach to cognitive processes. He suggests that to move beyond this,

professionals must engage in metacognitive processes to take 'critical control' of their thinking. In this process the professional will reflect on the situation at hand whilst also being aware of their own knowledge in use.

It is suggested that experience, reflection-on-action and the development of *personal* or *tacit* knowledge are key factors involved in moving beyond competence to developing expertise. According to Rolfe (1997) (drawing on the work of Benner, 1984), experience is not a passive concept in the development of expertise, and although experts tend to be experienced it is not the experience alone but how it is used to generate new knowledge through reflection that enables them to become experts. Much of this new knowledge is tacit knowledge, knowledge that cannot easily be put into words, or which professionals may be unaware they possess.

Tacit knowledge is used in intuitive action, which is not mystical but 'the unconscious working of a prepared mind' and based on a 'deep background understanding of the situation' (Benner, 1984). Acknowledging that tacit knowledge is unique to each individual, given the idiosyncratic nature of experience and how that experience is internalised, Bennett III's (1998) definition of tacit knowledge is useful:

> Tacit knowledge can be conceptualized as an idiosyncratic, subjective, highly individualized store of knowledge and practical know-how gathered together through years of experience and direct interaction within a domain (Bennett III, 1998, p.590).

Rolfe also refers to a psychological concept called 'chunking' – 'the process by which larger and larger units of behaviour or cognition come to be seen holistically as a single unit of thought or action' (p.94). Quoting Gleitman (1991), one of the examples that Rolfe gives is that of a driver who in the beginning struggles to harmonise all of the elements of driving, such as changing gear while steering and braking. But after a while these individual movements become routine and subsumed into much higher chunks of behaviour such as

overtaking. The role of tacit knowledge in professional action is explored further in Chapter Eight.

3.3.6 The role of the 'softer' aspects of competence

There are several arguments put forward in the literature about the importance of the softer, interpersonal and motivational skills, not only in terms of competent behaviour but also in terms of developing and maintaining competence. Southgate (1994) suggests there are two components to competence. The first is the 'consistent ability to select and perform tasks employing intellectual, psychomotor and interpersonal skills' but the second, and most important is the 'consistent demonstration of appropriate moral and personality attributes'. This implies that it is not sufficient to be able to *do* or to 'know how', but competence also requires the *will* to act competently.

Emphasising the softer aspects of competence, Miller et al (1988) suggest competence is in fact a 'quality or a state of being'. Ho (1986) suggests there is a need in midwifery to re-assert the importance of the softer aspects of competence, suggesting that current midwifery training philosophy is centred on cognitive and psychomotor aspects and neglects the affective domain. Hollis and Clark (1993) suggest that a model of competence needs to incorporate 'soft personal qualities' such as 'assertiveness, impact, creativity, sensitivity and intuition, mutual support and collaboration between colleagues'.

Woodward (1997) outlines the importance of *caring* in nursing and midwifery, given the degree of dependence placed on NHS care, which she suggests represents a substantial investment in public confidence. She suggests that the concept of caring is important to shift services from practitioner-centred, which resulted from the move over recent times from covenant to a contractual obligation, to a patient-centred ideology. She suggests that there is a danger that practitioners may not take the challenge seriously or make the assumption that caring is an inherent part of practice. She outlines two elements to caring - the instrumental - the act of doing; and, the expressive - the aspect that makes a qualitative difference. Thus caring is a moral emotion, it is about respecting

autonomy and dignity and it is that which motivates and transforms action into caring.

Brown (1996) discusses the notion of conscience from the perspective of the health care professional. Using Childress's (1979) definition of conscience as being 'about keeping or losing selfhood, integrity and wholeness', she suggests responsible professionals make the ethics of a profession their own. She also suggests that thinking morally for the professional requires not only a buy in to the ethics of the profession but also 'an overwhelming sense of commitment' to the principles of the profession. Gough (1995) suggests that such commitment may require the professional to challenge the system from time to time, where professional ethics or principles are likely to be compromised. In such situations, good conduct is not about being compliant but having the commitment and courage to challenge other professionals and their ways of doing things, and even may involve 'challenging fundamentally the policies that constrain us'. As such she urges nurses and midwives that:

> The time has come to break out of the victim mode; to oust yourselves out of what may be a comfortable rut; to stick your heads above the parapet; to act as advocate where shortage of resources or dilute skill-mix place the patient at risk (Gough, 1995, p.25).

It is suggested that unobservable attributes such as motivation are vital determinants of whether someone will remain competent. Midwifery competence has become a more fluid concept, moving from competence as discrete, finite and stable sets of knowledge and understanding, to competence as something which the individual is continually developing, self-development being facilitated by the provision of self-development skills on training programmes (Bedford et al, 1994).

3.3.7 The development of competence over time

The discussion thus far has focused on the range of components of competence and their relationships in competent action. In addition, the role of context in

competence is discussed, with particular attention to the relevance of context in learning and action. Another important issue in the literature is the stability and development of competence over time. It is true to say that an individual can be competent at one point in time and not the next, and that competence will vary over the length of a career. In part, such variations relate to development and experience in a role, but a number of other factors also affect continuing competence and development over time.

Benner (1982a, p.304) identified five levels of practice from beginner to expert with competent as the mid-point. She differentiates *becoming competent* from *being competent*, with a particular focus on 'competency attainment and basic skill'. She describes basic skill as the ability 'to follow and perform the steps necessary to accomplish a well-defined task or goal under controlled or isolated circumstances'. She defines competency as the ability to perform across a range of situations 'under the varied circumstances of the real world' and 'with desirable outcomes'. Competence at registration is also described in terms of sufficiency or adequacy that can be developed further through various levels to expert status (Cockerill, 1989, Burg et al, 1982, Benner, 1982a, 1984), or as advanced, extended or specialist levels of practice (Bradshaw, 1997). Benner (1984) suggests competence is a standard where the individual has all of the skills and knowledge required but they are not very polished. For Benner, achieving the standard of competence is having the ability to consciously plan and prioritise, involving 'abstract, analytic contemplation of the problem' (p.27) and although someone at this stage is slower than the 'proficient' practitioner, they will have a 'feeling of mastery' and be able to 'cope with and manage the many contingencies' of clinical practice. She suggests the key difference between competence and proficiency is being able to achieve 'efficiency and organisation'. Hogston (1996) suggests that at registration a practitioner should be a 'knowledgeable doer' requiring analysis, synthesis and clinical judgement, such that being competent goes beyond being able to apply knowledge and skills. The nature of competence at registration is explored further in Chapter Five of this thesis.

The literature on expertise and its development suggests that there are a number of differences between professionals who are competent and those who are experts for example:

- the speed at which they are able to do things
- their ability to transfer knowledge and skills across the range of practice situations that they are likely to encounter
- the amount of experience that they have to draw on in decision making
- their ability to deal with uncertainty and surprises
- the likelihood that their decisions will result in good outcomes.

These are explored in further detail in Chapter Eight.

It is suggested that there would be clear benefits to defining what epitomises being an expert in order to facilitate a better understanding for the profession and to facilitate development towards expertise. In addition, a definition of expert would enable expertise to be rewarded, and educational outcomes for advanced programmes of education to be developed (Fox-Young, 1995).

The literature does not suggest that expertise develops automatically over time in clinical practice. Although experience provides opportunities for development, competence development and the maintenance of competence over time also relies on attributes such as commitment and motivation, as previously identified. In addition, skills and knowledge learned can be lost if not practised and refreshed and can become obsolete if not updated. Thus the consistency of an individual's competence is an important issue.

3.4 Towards a model of competence

This review of concepts of competence and issues in defining competence suggests a model of midwifery competence should meet certain criteria in order to be relevant to midwifery, to facilitate assessment, and to provide a framework for on-going development of the role of the midwife. The research carried out while working on the EME project involved the development of a tentative model of competence. This was based on:

- a review of the competence literature
- group and survey work with parents, teachers and practitioners to ascertain their views on competence
- a review of midwifery rules and guidelines
- a quasi-delphi approach using questionnaires and focus group work with midwifery experts (see Fraser, Murphy and Worth-Butler, 1995, 1996).

The research sought to develop a holistic and integrated model of competence needed to fulfil the role of the midwife. The research team was ever mindful of the criticisms of the national vocational qualification (NVQ) approach and the dangers perceived in constructing lists of competencies and several of the issues outlined earlier in this chapter. It was acknowledged that some degree of deconstruction of competence would be required in order to understand more about the components of competence and to enable the model to be used in assessment, but in doing so it would also be vital to preserve the links between the various components as the links themselves are critical elements of *being* competent.

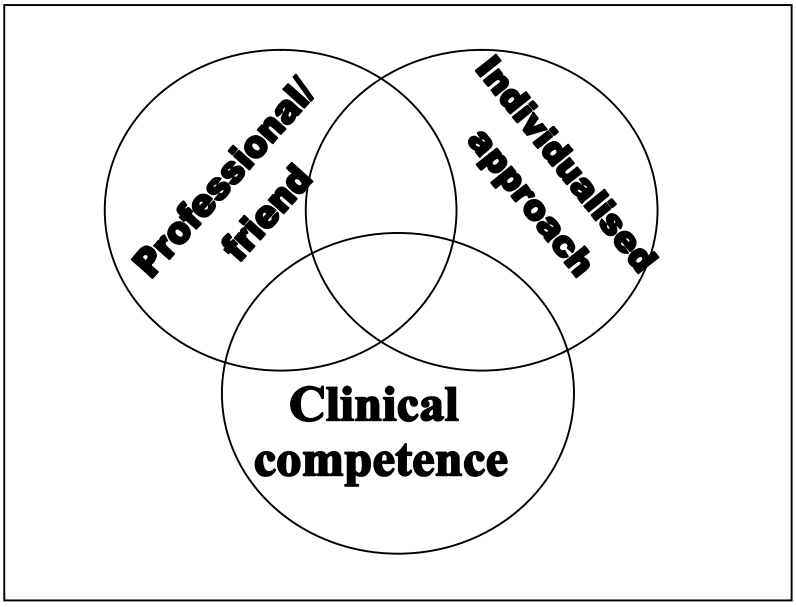
The development of the EME model also sought to move away from the traditional distinction between theory and practice and instead to say what is required to be able to fulfil the role of the midwife. From that three equally important and interlinked dimensions of competence were identified – the clinical competence dimension, the professional/friend dimension, and the individualised care dimension. Competence is seen as a fluid concept and, rather than weighting the three dimensions, it is suggested that there will be movement between and within the three dimensions depending on the situation in which the midwife finds herself. So, in one situation the midwife will draw heavily on the clinical competence dimension and less on the other two, whereas in another situation the reverse may be the case. Thus, the model is sensitive to context, situation and time. The model is illustrated in Figure 3.2.

The first dimension - *clinical competence*, focuses on the skills and knowledge required for the role. It includes the ability to use knowledge in practice to select

and apply skills appropriately to the situation and to use skills dextrously. In the second dimension - *the professional/ friend approach*, the emphasis is on the midwife as a professional, autonomous, accountable and responsible practitioner. It includes professional and self-awareness, effective functioning in a team, and commitment and motivation to midwifery as a profession and to providing a good standard of care. In the third dimension - the *individualised approach*, elements of competence enabling the midwife to work in partnership with the woman are emphasised. These include effective communication, being non-judgemental and advocacy.

Figure 3.2 A conceptual model of midwifery competence

A competent individual will draw on the three dimensions to varying degrees, reflecting situation variations.



Source: Fraser, Murphy and Worth-Butler, (1996)

Elsewhere, Cheetham and Chivers (1996) developed a holistic model of competence and tested and revised the model (Cheetham and Chivers, 1998) through further work with 'experts' and professionals across twenty professional groups. Their model is built around the concept of the reflective practitioner. The model encompasses four core components of competence – functional competence, personal or behavioural competence, knowledge/cognitive competence; and values/ethical competence - and a set of overarching 'metacompetencies'. Each of the four core components is made up of a number

of constituents. Metacompetencies are defined as a set of generic and overarching competencies, some of which may be prerequisites to the development of more role-specific competencies. It is suggested that metacompetencies 'appear to transcend other competencies, in some cases enabling introspection and self-examination' (p.268). They also suggest that metacompetencies may include 'meta-qualities' such as creativity, mental agility and balanced learning skills, which are competencies required to reinforce other qualities, and 'meta-skills', which are defined as 'skills in acquiring other skills'. Examples of metacompetencies identified in the revised version of Cheetham and Chivers' model include: communication, creativity, problem solving, learning/self development, mental agility, analysis and reflection.

Although Cheetham and Chivers state that their model is built around the concept of the reflective practitioner, this was not reflected in their original version of the model. The position of reflection is strengthened somewhat in the later version. While this supports the role of reflection in on-going development of competence, and is consistent with the notion of life-long learning in order to remain competent, this model is still not explicitly built around the concept of the reflective practitioner. In addition, explicitly separating out the four core components of competence, each with its list of constituents, gives the impression that they are four distinct entities. Perhaps it is useful to note that Cheetham and Chivers draw on the literature relating to the development of NVQs and occupational standards; Mansfield and Matthews' 'job competence model'; work on behavioural competence; and Schön's 'new epistemology' (without any reference to current debates about the limitations of his work and the methods used). Cheetham and Chivers (1998) report a number of 'specific weaknesses' identified in the model during the second phase of their work, including:

- the model's lack of recognition of the importance of context and work environment to competence
- the model being overschematic in its treatment of the links between core components with a consequent danger of compartmentalism

- the need for ethics and values to be seen as metacompetencies rather than core components.
- the need to include the following additional concepts: 'personality; attitudes, motivation and the will to change; professional duty to keep up to date; responsibility for providing appropriate role models and for inducting new members into the profession; justification of practice and procedures to newcomers; application of professional ideas to new problems and developing new theories; and the need to set the model within a broader 'systems theory' (p.273).

The work of Cheetham and Chivers came to light some time after the EME model had been developed and the insight provided by Cheetham and Chivers is encouraging for the EME model. All of the elements identified as missing in Cheetham and Chivers' models are included in the EME model. In addition, the model is considerably simpler than that of Cheetham and Chivers and the work to further develop the model into a matrix for assessment has shown that the EME model (see Fraser et al, 1996) can be applied practically for the development of assessment schemes.

3.5 Conclusion

Although the UKCC, EU Directives, and the World Health Organisation provide a framework for the scope of practice of a midwife and what she should be able to do, it falls short of a comprehensive framework of midwifery competence. Without such a framework or model, the profession cannot define midwifery competence which distinguishes midwifery from other related professions and which distinguishes safe practitioners from unsafe practitioners. This is a fundamental requirement if midwifery is to develop as a profession and would also bring several other benefits to midwifery education. In Figure 3.3 seven themes identified in this review of the literature on defining competence, and that informed the development of this exploration of competence, are summarised.

The EME conceptual model of integrated holistic midwifery practice provides a useful framework of midwifery competence against which the research findings

can be set to develop the debate further. The EME model was further developed during this study drawing on the analysis of competence at the point of registration and learning up to and beyond registration, as outlined in Chapter Ten.

Figure 3.3 Key issues in developing a model of midwifery competence

This literature review suggests the exploration of competence needs to accommodate seven key concepts of competence:

1. Competence as an integrated phenomenon	• reflecting the linkages between components • capturing the role of cognitive processes in translating knowledge and values into action
2. The roles of knowledge, thinking and action	• incorporating knowledge use and knowledge organisation for successful and consistent action • acknowledging the role of experiential learning in acquiring new knowledge and reinterpreting knowledge • taking account of the differences between propositional, process, personal and professional types of knowledge
3. Competence across the full range of contexts	• acknowledging the need to be able to use a range of skills and knowledge across a range of new and familiar situations • having sensitivity to and understanding of situational variations • including competence in action contexts and 'hot and cool' action
4. The role of reflection	• including the role of reflection-on-action in developing and maintaining competence
5. The role of tacit knowledge in professional action	• including the role of tacit knowledge and intuition in rapid response situations and stressing the need for critical control • identifying the differences between competent and expert practitioners
6. The role of the 'softer' aspects of competence	To include: • consistent demonstration of moral and personality attributes • assertiveness, creativity, sensitivity and intuition • caring and conscience • commitment
7. The development of competence over time	• the stability of competence and the development of competence beyond the competent state • being safe to practise as the minimum at registration, but not seen as minimum or lowish standard • recognising the differences in capability between practitioners at same stage of training

On the basis of this review of the literature on definitions and understandings of competence the conclusions drawn are that a model of midwifery competence must:

- capture the essence of midwifery competence
- promote professional learning and be consistent with the aims of education
- support and promote life-long learning.

It is suggested that midwifery competence is a complex, elusive and multi-dimensional phenomenon, where the elements, including knowledge and personal attributes, are inextricably linked in being competent. It is also suggested that being competent involves successful practice across a range of different contexts and situations, some of which may be unpredictable, unexpected or ill-defined.

It is argued that contexts and situations can be very different such that practice is not a case of repetition from context to context or situation to situation but interpretation of the situation and of knowledge before acting. This suggests that an integrated model of competence would be most appropriate for midwifery. In contrast, behaviourist or reductionist models are unlikely to capture the integrated and holistic nature of midwifery competence, and by outlining competence as a list of elements, would strip away the vital interconnections between elements of competence. In addition, it is suggested that they do not capture the interaction with the context and situation that occurs in successful practice.

On the basis of this review of the range of competence-based approaches it is suggested that the model itself must promote rather than hinder professional learning. It is argued that models of competence that focus on performance at the expense of the underpinning attributes, or that are reductionist, endorse a mechanistic approach to learning and assessing, and stifle creativity and free will. On this basis such approaches would not be appropriate for midwifery competence, as they would run counter to the principles of higher education and professional learning.

The debate outlined in Chapter Two suggests that a key aspect of professionalisation is a culture of life-long learning. Further it is suggested that

the concept of life-long learning is endorsed by the UKCC and the ENB, and is promoted in midwifery curriculum documents as an aim of midwifery education. The thinking explored earlier in this chapter suggests that the development of personal and professional knowledge, reflection on action, and the skills required for self-development are vital for life-long learning, and as such need to be captured in a definition of midwifery competence.

In the following chapter, the research design and methods used are outlined. This is followed in Chapter Five with an exploration of competence at the point of registration.

Chapter Four

Researching midwifery competence: study design and methodology

4.1 Introduction

In the previous chapter competence is outlined as a complex phenomenon that does not lend itself easily to exploration. The complexity partially relates to the notion that competence as a phenomenon is deeply embedded in the context in which it occurs. It is also suggested that competence as a phenomenon is elusive and is best understood through the judgements made by individuals about their own ability, the ability of others, or the capability requirements of a role or situation. In addition, competence is inconsistent, such that a person may be competent one minute and not the next, or in one situation but not in another. The purpose of this chapter is to provide an outline of the study design and methods used, and drawing on the literature, to argue that the approach taken is appropriate for a study of competence and that any findings will be the result of robust research.

4.2 Research focus

The initial research focus was to explore midwifery competence as a phenomenon and to explore the implications for assessment. Early in the study a wide search of the literature, an examination of curriculum documents and early interviews were the basis for the construction of a tentative model of competence in midwifery which developed throughout the life of the study. This work also helped to focus the research the following themes were identified for exploration.

1. What is the competence required at the point of registration to fulfil the role of the midwife and what are the final elements of development involved in becoming competent?
2. How does competence develop once a midwife has qualified, what are the factors that influence development post-registration?
3. How does competence develop to the stage of expertise?

4. How is it that some midwives are perceived as bad midwives, and what are the key differences between them and competent and good midwives?
5. What is an appropriate model of competence for midwifery and how can this be developed further for assessment?

4.3 Study design

The study design was interpretivist (qualitative), involving in-depth explorations of student capability at six case study sites. The research sought a rich and deep understanding of competence at the point of registration. It also sought to compare competence developed beyond registration, by exploring and contrasting the perceptions (the lived realities) of students, their teachers, assessors and colleagues. The emphasis in the research was on the researcher interacting with the researched in order to explore the issues raised by those involved. For example: what does competence feel like and what meanings do students, teachers, midwives and assessors give to it; or where students were failed, how are judgements about competence made and why are those who failed different to those who did not. The emphasis on discovery was seen as more appropriate than the pursuit of issues in quantitative terms such as: the proportion of students who felt competent, the proportion of students who were failed or who went on to practise in various settings. In addition, the aim was to get closer to the phenomenon rather than use tools to study competence at a distance.

The literature reviewed in Chapter Three suggests that competence is essentially a social phenomenon, best studied through an interpretivist approach. In the interpretivist approach, the researcher seeks to capture the *essentially different* nature of human life: 'Men and women are not particles acted upon by exogenous forces; they are 'purposeful, goal-seeking, feeling, meaning-attributing and meaning-responding creatures'' (Hughes, 1976, p.24). The central tenet of interpretivist research is to study phenomena and the social world from the point of view of those being studied - the '… subject matter is people and their reality [and, as such]… any attempt to understand it must be grounded in people's experience of that social reality (Bryman, 1988, p.52)'. The research

aims to view competence in terms of 'the constructs that people use in order to render the world meaningful and intelligible' (Bryman ,1988, p51).

The use of interpretivist research is often pitched as the anti-thesis to positivism and on the basis of some of the shortcomings of the quantitative approach. There are arguments from both interpretivist and positivist perspectives about the 'superiority' of one or other approach. Elsewhere, it is suggested that the broad elitist view should be avoided and instead the notion of superiority needs to be applied specifically to the aims of each research study. The researcher needs to select, from the range of possible methods, those that will best answer the research questions:

> … different kinds of information about man and society are gathered most fully and economically in different ways, and … the problem under investigation properly dictates the methods of investigation (Trow, 1969, p.332).

However, research does not take place in a vacuum and in selecting approaches and methods the researcher also needs to be mindful of the constraints and the time, resources and opportunities available.

4.4 Interpretivist and positivist perspectives of reality

Central to the interpretivist/positivist debate is the issue about whether or not reality exists independently of the human mind. Those in favour of the positivist approach favour the notion of an *external* reality, one which is best viewed from the high ground and as far removed as possible from as many sources of bias as can be identified. The positivist view that this external world can be subjected to endless description in terms of how it conforms with hidden natural laws is viewed as 'naïve realism' by Lincoln and Guba (1985). Positivism is concerned with verifying facts and causal relationships, its ultimate goal the establishment of general laws, without regard for the subjective status of individuals (Bogdan and Taylor, 1975). It is criticised for 'determinism' and 'reductionism', which Lincoln and Guba suggest contradicts the notion of human free will. They also

dislike its 'tendency to secularism, impersonality, abstraction and quantification' (p.25) concerned with testing theories rather than dealing with 'the genesis' of theories. In addition, the positivist approach is criticised because in its quest for objectivity, phenomena are divorced from their contexts (Mischler, 1979) and their meaningfulness in terms of every-day experiences (Schutz, 1967).

Proponents of the interpretivist approach propose that a phenomenon is not a reality existing outside of the mind and independent of it, but created by the mind and that all we have are representations of such reality. As such, reality is peculiar to each individual and how they perceive the world. The knowledge that each individual has of the world is idiosyncratic and their observation of the world is guided by the their unique interests (Hughes, 1990). Reality is, as suggested by Duffy (1985), a symbolic world. The notion of reality as an internal construct reinforces the notion of the independence of human beings, their active participation in the social world and their ability to influence reality. Such views of reality have serious implications for how we can capture and construct accurate descriptions of the social world. They suggest we cannot construct reality without exploring *how* it is perceived and *why* certain meanings are attached to events.

The concept of reality as an internal construct and knowledge of the world as idiosyncratic can be unnerving for the researcher who is keen to reconstruct an accurate account of a phenomenon. Murphy et al (1998) suggest that the 'knowability' of reality is the central issue for interpretivist research (scientific idealism) rather than the denial of a 'material existence' pursued in the quantitative approach (scientific realism). They argue that the central argument for idealism is that truth is context-bound and it is possible for multiple truths to exist. However, it is also suggested that the inherent danger with this view is that multiple and contradictory truths can exist side by side and can be overtaken at any time by new 'disruptive' insights. In such terms truth is seen as a 'socially and historically conditioned agreement' (Smith, 1984) and the researcher's account is seen as just another version of the world. It is argued that this notion, described as 'relativism' (Greene, 1996) or 'naïve relativism' (Hammersley,

1992a), is damaging to qualitative research as it encourages an 'everything goes' culture, renders research findings unusable and results in 'debilitating nihilism' (Atkinson and Hammersley, 1994).

Hammersley (1992a) proposes 'subtle realism' as a way forward and as an alternative to naïve realism and naïve idealism – 'a third position' (Murphy et al, 1998). This proposes that we should accept that we cannot study reality independently of it but that the objective of research should be to produce findings in which we can have reasonable confidence, based on judgements about credibility and plausibility. It proposes that research should represent reality as opposed to reproducing it. It also suggests that reality can be presented from a range of different perspectives – as multiple, valid versions of the same phenomenon, but which are not competing. Murphy et al (1998) suggest that this understanding of subtle realism is equally appropriate for qualitative and quantitative research and that the alternative, of analysing the current state of qualitative and quantitative research in terms of opposing ontological and epistemological view points, is inappropriate.

The concept of reality as an internal construct suggests that competence is experienced, interpreted and described by each individual on a very personal level and according to their own unique positioning in the world. It supports Schutz's (1967) views that reality must be rooted in the meanings that are constructed and attached to everyday life by individuals if it is to be explained accurately.

4.5 The interpretivist emphasis on discovery

As previously stated, the interpretivist approach, because of its emphasis on discovery and exploring uncharted territory, was selected on the basis that it would enable competence to be explored in-depth. In Van Maanen's (1979, p.10) terms the qualitative researcher seeks to construct good 'maps' of 'territories' - 'temporal and spatial domains'. This is done by moving closer to the territories as opposed to using 'artificial distancing mechanisms such as analytic labels, abstract hypotheses and pre-formulated research strategies'.

This deep exploration is partly facilitated by the interaction of the researcher with the phenomenon. In the qualitative approach the researcher is *the instrument*. Getting 'inside' the phenomenon is facilitated by the fact that the researcher is '… himself a social being and is likely to share at least of the social meanings of those he is studying and will have directly experienced analogous motives, reactions, emotions and feelings of his own ... such insight can only be obtained if the researcher is permitted fully to engage his subjects rather than to adopt a stance of committed neutrality (Walker, 1985, p.12)'. Getting inside the natural setting and attempting to see the phenomenon as the subjects do (Duffy, 1985), or 'interpretive understanding' (Hughes, 1990) is said to be essential to be able to reconstruct subjective experiences such as competence.

> The scientist who proposes to understand society must, as Mead long ago pointed out, get into the situation enough to have a perspective on it. And it is likely that his perspective will be greatly affected by whatever positions are taken by any or all of the other participants in that varied situation (Becker, 1986).

There are a number of suggestions in the literature that the ability of the researcher to get into the research situation pushes research beyond the descriptive to developing a deeper understanding of the social world. Firstly it is suggested that we need to focus on the meaning that people give to what they experience – how the actor perceives the social world and understand how those meanings have come about, how the actor interprets the social world. Murphy et al (1998) emphasise the importance of meaning and what people believe as the basis for understanding their actions. To illustrate the point, they tell Thomas and Thomas's story of a deluded murderer who killed people in the street randomly because he saw their lips moving and he thought they were saying insulting things about him. Thomas and Thomas follow the story with the maxim:

> If men define situations as real, they are real in their consequences (Thomas and Thomas, 1927 p.572).

Secondly, it is suggested that the ability of the researcher to interact with the research situation helps to access knowledge that otherwise might not be accessible. This is on the basis that the researcher can draw on 'germane tacit knowledge' which becomes more focused as the research proceeds (Lincoln and Guba, 1985). Lincoln and Guba refer to the process of 'mutual shaping' where, through interaction between the researcher, the researched, and the context, salient elements emerge from the data. Lincoln and Guba suggest that tacit knowledge has an essential role in the process of mutual shaping because not everything can be explained through language, and tacit knowledge becomes the base on which the human instrument builds many of the insights and hypotheses of a study.

The purpose of research is not just to discover and understand but, in reconstructing that discovery and understanding, to make it available to the reader. It requires faithful reconstructions and the interpretivist literature proposes a number of approaches to reducing the loss of data and meaning between accessing, interpreting and reconstructing the phenomenon. One point made is that the data should be collected and analysed in the natural language of the subjects, similar to Kirk and Miller's (1986) approach of 'watching people in their own territory and interacting with them in their own language, on their own terms'.

4.6 Using the case study approach to study competence in context

There were several factors involved in the selection of the case-study approach, relating both to opportunity and design. In terms of opportunity, I was employed from the outset as the main researcher on a three year national study to evaluate the outcomes of three year pre-registration midwifery programmes of education. This provided the opportunity to access the case studies for this research through the evaluation study (the EME study). The EME study required the selection of six pre-registration midwifery education cohorts as case studies (the criteria used to select the six case studies are outlined in Appendix Two). The six case studies undertaken provided insight into both intrinsic interests (the effectiveness of

programmes) and external interests (competence as interpreted by those within the case) (Stake, 1994). An extended case study approach (Gluckman, 1961) was used to follow students through the final stages of programmes to the end of their first year as practitioners, tracing both events and actors, and allowing the development of the phenomenon over time to be explored.

Several points can be made to support the appropriateness of the case study approach for a study of competence and as a method of incorporating the issues identified in Chapter Two. As proposed by Hughes the context in which the phenomenon exists is relevant and shapes how it is experienced.

> … to appreciate how the instances were gathered into the description used … depends on the indefinite context seen as relevant to the observer (Hughes, 1990, p.107).

The interpretivist, case study approach enables competence to be viewed in the context in which it occurs and the views of individuals to be compared. It enables the research to capture and understand the symbolic attachments that individuals have to their expressed interpretations of competence. The case study approach also enables complex phenomena, such as competence, to be studied in a holistic way, as suggested by Yin:

> … the distinctive need for case studies arises out of the desire to understand complex social phenomena … the case study allows an investigation to retain the holistic and meaningful characteristics of real-life events – such as individual life cycles …(Yin, 1994, p.3).

The case study approach is described as the process of learning about a specific, integrated, bounded system (Stake, 1994). Given the extent of co-operation and commitment that would be required of students participating in the study and in order to minimise the risk of losing students during the course of the study, students at the six sites were given the opportunity to opt into the study. Specific selection criteria were used to select the six cohorts in order to ensure that known

variations between institutions providing midwifery education programmes at that time were included in the cohorts studied. The thinking was that the six case study cohorts together were a representation of pre-registration midwifery education on England, but also, each site and each student was capable of standing alone as a single case, allowing for comparisons to be made. The purpose of selecting only six case study cohorts was to ensure that the research was feasible within the time and resources available. The research does not claim that the findings are representative beyond pre-registration midwifery education in England at that time, although the issues identified are expected to have implications for pre- and post-registration midwifery in England as a whole, on the basis that midwives registered are equal regardless of whether they have come through the pre-registration or post-registration routes.

Considerable variation was found in the resulting sample of thirty-nine participants, across several dimensions (see Figure 4.1). In terms of age on entry, a third of participants were 20 years of age or younger, 38 percent were aged 31 or more, and 28 percent were aged between 21 and 30 years of age. Just over a half of students were married and just over 40 percent were single. 56 percent had children. There was also a reasonably even mix of educational backgrounds with roughly a third of the sample each having either A levels, O levels/GCSEs, and BTEC or degree level qualifications.

The majority of participants had skilled (56 percent), or professional/semi-professional occupations (23 percent) before entry onto programmes, whereas 10 percent were school leavers. The area where there was least variation between participants was in terms of ethnic identity.

Figure 4.1 Biographical details of participants on entry to programmes

	n	*%*
AGE		
20 or younger	13	33.3
21 to 25	6	15.4
26 to 30	5	12.9
31 to 35	6	15.4
36 to 40	7	17.9
41 or older	2	5.1
Total	***39***	***100***
MARITAL STATUS		
Married	21	53.85
Single	16	41.03
Other	2	5.12
Total	***39***	***100***
DEPENDANTS		
Children	22	56.4
No children	17	43.6
Total	***39***	***100***
ETHNIC IDENTITY		
White British	35	89.7
Black British	2	5.1
White European/White Other	2	5.2
Total	***39***	***100***
ENTRY QUALIFICATIONS		
A level	13	33.3
O level / GCSE	13	33.3
BTEC / HNC / HND	9	23.1
Degree	4	10.3
Total	***39***	***100***
PREVIOUS OCCUPATION		
Skilled	22	56.4
Professional / semi-professional	9	23.1
School leaver	4	10.3
Unskilled	2	5.1
Other / not known	2	5.1
Total	***39***	***100***

Proposing that the different backgrounds that participants had are relevant, several references were made in interviews to social or age variations when talking about experiences on the programme, or in relation to perceptions of competence. For example, it was suggested that some students brought elements

of learning with them from other occupations, from life experiences or from experience with their own children, for example:

> I think I was organised and a good communicator before, to be honest, because that's what I did before … things like managing a ward hasn't been difficult at all because it's very much like I worked for a (…) company I had to do a lot of that so that hasn't felt difficult at all (student midwife).

> I felt that because I was older I was always quite good for the sociology aspect of it, that common sense was a great deal of sociology and life experience gives you, while you might not have the jargon, you've got the knowledge, so it kind of formalised that (student midwife).

It was suggested that some students came to the programme with well developed communication skills, whereas others would have had to work hard to develop their communication skills over the course of the programme. Several students talked about how much they had changed on the programme, for example:

> I think it's changed me as an individual and I think that's a good thing, I was very a sort of a quiet person when I came into the course, very timid, and didn't realise how much it would change me. … Family and friends notice the change more than you do sometimes! (student midwife).

> I'm more assertive and I know what I want now, and I find I can speak to people, I'm not so shy like before, I'd be frightened to speak to people if they had a career because I've never had a real career before … now at the at the end of the course I can speak midwifery to other midwives … and I give my opinion on things now (student midwife)

Several of the participants with children talked about the challenges of balancing personal responsibilities with full-time work and study. The EME study

identified such difficulties as a significant factor in attrition on three-year programmes.

The thirty-nine pre-registration midwifery students were interviewed four times each, twice coming up to the point of registration and twice in their first year as practitioners. In addition, data on student development, capability, and assessment were gathered from assessment records, documents, and from interviews with the students' teachers, assessors, other midwives and supervisors of midwives. The researcher also attended assessor preparation sessions and examination board meetings as a non-participant observer.

At the outset I was introduced to the participants as a research midwife, and in discussions it appeared useful to be able to discuss midwifery matters in the same language as the participants, and for them to be able to identify with me as another midwife. In addition, I would have been around the average age of participants and was clearly not a senior midwife or a midwife teacher. I was in on-going and personal contact with students to arrange and conduct each of the interviews, thus maintaining continuity throughout the study.

In the selection of key informants, it is suggested that consideration should be given to how those involved can provide a comprehensive and balanced perspective of the phenomenon and the focus is on selecting 'informants who have knowledge about specialised interests and concerns in a social setting (Burgess, 1984, p.75)', more so than the representativeness of the sample and generalisation to a wider population. Burgess suggests that the researcher needs to consider how partial accounts of a social situation can be avoided and he also highlights that individuals at different levels in a social situation perceive the cultural scene differently and may provide different accounts. The aim of matching assessors, teachers, midwives and supervisors for each student was to capture the range of views on each student's capability and on learning and competence in general. In addition, interviewing students four times helped to provide a fuller picture from each student's perspective and allowed changes in their views or experiences over time to be included.

There is a danger that in some research approaches the phenomenon can be disembedded from its context and that the phenomenon may even be a 'different animal' out of that context. In positivist approaches, context may even be viewed as a 'confounding variable' to be isolated or controlled. However, in the qualitative case study approach, the researcher specifically aims to capture context and the mutual interactions between phenomenon and context. In the case study approach, the researcher seeks to study the phenomenon in 'naturally existing units' to avoid separating the phenomenon from context and also to ensure that the assignment is manageable (Bogdan and Biklen, 1982, Hamel et al, 1992, Stake, 1994).

> Picking a focus … is always an artificial act, for you break off a piece of the world that is normally integrated. The qualitative researcher tries to take into account the relationship of this piece to the whole, but out of necessity, narrows the subject matter to make the research manageable. Detaching a piece distorts but the researcher attempts to choose a piece that is a naturally existing unit (Bogdan and Biklen, 1982, p.63).

Further, it is suggested that social life is best understood through the meanings assigned to it by actors – a view promoted by the Chicago School (Hamel et al, 1992). As such social *problems* must be explained 'as part and parcel of the life of that society' (p.16), implying that context and its role in the phenomenon is best explained by those involved in it.

The emphasis in the case study approach is also on depth and exploring the case from an in-depth perspective, aiming to 'highlight the features or attributes of social life' (Hamel et al, 1992, p.2). The combination of depth and of explicating the context in which the phenomenon exists helps the reader to have a deeper understanding of phenomena and experiences of them. In this sense the case study approach has the potential to provide the reader with *vicarious experience* - 'the reader comes to know some things told as if he had experienced them (Stake, 1994, p.240)'. It is suggested that the researcher can also help by allowing the

context to be represented in the researcher's reconstruction of the phenomenon. Stake (1994) suggests that this can help to avoid the *hazards of passage*, where understandings of a phenomenon are lost in 'the transfer of knowledge' during the process of construction from the case, through the research and the researcher, to the reader's interpretation.

One of the benefits of the case study approach is that it allows phenomena to be explored both in terms of conformity and atypical cases, and differences to be compared. In this study, competence was explored in terms of what it might look like in the typical case and what can be expected at the point of registration. Acknowledging the concept of multiple realities, the research also explored the range of variations that are acceptable. By exploring cases identified by students, teachers and assessors as atypical or untoward, the research sought to examine that which differentiates competence from being incompetent or not yet competent.

Conformity can be studied to highlight aspects of organisation, such as norms, values and routines and untoward events can provide insight into the different interpretations that individuals put on these events and the ways that they express 'nuanced' shifts in the balance of power (Bogdan and Biklen, 1982, Burgess, 1984). Murphy et al (1998) suggest that we can study order and regularity in the social world by contrasting the 'the typical, the everyday and the routine' with 'the exotic or the scandalous' to illuminate aspects of social life that normally go unnoticed because they are so regular and stable. Examples in this research of the typical, or of norms, values and routines were the experiences of students as they completed the programme, were successful in assessments and went on to take on the role of the midwife. However, within the same case study sites there were also untoward events, for example where a student had difficulty meeting the assessment requirements, or struggled to make the transition to midwife. In these cases interviewees were asked more probing questions, specifically about these events and their views and perceptions of the implications that these events had on judgements about student competence. Another example was where one assessor commented that a student had no experience of doing an episiotomy and

the researcher probed further about whether or not this was acceptable at the point of registration and whether or not it implied that the student was not competent. There were also examples where less obvious themes emerged by closer comparison of individual student experiences. For example, by focusing in on comments that students made about 'letting go of the edge and swimming' when asked about how they felt about being a midwife at the end of the programme, findings emerged that suggest that students undergo a significant transition process at the end of the programme and have various ways of coping with the process. Findings also emerged about how some students coped better than others and about how the programme could help students to be better prepared to make the transition.

The importance of the research resulting in a faithful reconstruction of the phenomenon was outlined previously. Stake (1994) proposes that triangulation can be used to *safeguard* the *hazardous passage* from perception on the part of the researcher to understanding on the part of the reader. He suggests that by presenting multiple perceptions, the risks of misinterpretation can be minimised and clarity can be enhanced. He also suggests that by providing adequate descriptions or by identifying specific comparisons, the researcher can enable the reader to better understand the phenomenon.

The benefits of viewing a phenomenon from a range of perspectives are that a 'more complete, holistic and contextual portrayal' of the phenomenon can be provided, the elements of the context can be illuminated, and new and deeper dimensions can emerge (Jick, 1979). It is also suggested that by observing a phenomenon through multiple perspectives, or by identifying more than one aspect of the phenomenon, one can add to the rigour, breadth and depth of the research (Campbell and Fiske, 1959, Jick, 1979, Denzin and Lincoln,1994 and Stake, 1994). Knafl and Breitmayer (1991) suggest that multiple perspectives can also add confirmability, the results of one method or viewpoint confirming the results of another, and adding completeness to the research. This notion of confirmability is useful given concerns about the incomplete nature of what we observe:

> Descriptions … are deeply sensitive to context and defeasible … but … always incomplete ... Whatever is included is always selective and one cannot exhaust all that could be said about an object, event or a person. (Hughes, 1990, p.106).

According to Lincoln and Guba (1985) where we look from affects what we see, and every time we look what we see is only partial. Thus, multiple perspectives are required so that we are not blinded by our own biases.

An important debate in triangulation is whether the researcher is seeking convergence on a single reality or is seeking to represent the range of different experiences or perceptions of the phenomenon. The term *triangulation* suggests that its purpose is convergence on a single external reality, from competing versions of reality. The use of triangulation for confirmability assumes that there is a fixed point, an objective and true reality that can be 'confirmed' (Richardson, 1994). However, Jick (1979) proposes that the benefits of triangulation are greater than mere convergent validation, also capturing 'a more complete, holistic and contextual portrayal of the units under study', to illuminate the elements of the context, and to allow new and deeper dimensions to emerge.

> Where there is convergence, confidence in the results grows considerably. Findings are no longer attributable to a method artefact. However, where divergent results emerge, alternative and likely more complex, explanations are generated (Jick, 1979, p.608).

Silverman (1985) proposes that the real value of triangulation is in the multiple perspectives affording an understanding of '… how that sense is accomplished rather than appeal to our other knowledge to discount it'. He argues against some of the assumptions of triangulation.

> Putting the picture together is more problematic than such proponents of 'triangulation' would imply. What goes on in one setting is not a single

> corrective to what happens elsewhere – each must be understood in its own terms (Silverman, 1985, p.21).

Those in favour of the notion of multiple realities see the use of multiple perspectives as complementary and additive rather than convergent or competing, and 'constantly seek to understand and interpret particular insights from an ever more inclusive context (Mannheim, 1936 p.105)'. In these terms, the function of the analysis is to present the range of interpretations and to explore divergent views. As argued earlier in this Chapter each interpretation draws on the unique positioning of the individual and their relationship to the social world. In this sense and as Brannen (1992, p.14) suggests, '… data sets do not add up to the same rounded unity …' and the differences between different data sets are likely to be as illuminating as their points of similarity. In this sense triangulation enhances the completeness and the comprehensiveness of the research (Jick, 1979; Silverman, 1985; Kirk and Miller, 1986; Oiler Boyd, 1993; Morse, 1994).

Thus the emphasis in this study was not on multiple methods to zero in on a single truth but to seek out and explore the multiple realities and perspectives of competence. This triangulation not only provided a degree of validation between what students said and that said by teachers, assessors and colleagues but the inclusion of each variation in interpretation or perspective added to the rich description. Critical incident interviews[2] with experienced midwives provided a further perspective on the most important attributes of a competent midwife at registration and helped to differentiate this from the sort of competence one might expect from a more experienced midwife. Thus the views of teachers were complementary to those of students, providing another stakeholder dimension to the phenomenon under study, as did the views of assessors and experienced midwives. The focus was not only on describing competence in terms of the

[2] In addition to research with the six case studies, twenty experienced midwives were interviewed. Each midwife was asked to think about midwives that they had worked with who they perceived to be either very good or bad midwives. Then they were asked to describe what it was about these particular midwives that made them good or bad. The third element of the critical incident interviews was to ask the interviewees to compare these attributes with what would be expected or accepted of a midwife at the point of registration. Further information can be found in Chapter Nine.

typical case but also in terms of the range of variations that exist, adding to the depth of understanding.

4.7 Research methods

The research design involved four key methodological strands: literature review; documentary analysis; interviews; and critical incident analysis.

4.7.1 Literature review

Throughout the life of the study, midwifery, nursing, medical, sociology and education literature was used to provide information on current thinking on the nature of competence and how it can be defined and assessed. Issues raised in the literature helped to shape the design of the study and the analysis, and to raise issues about competence to be included in the exploration. The literature on the legislation and guidelines governing midwifery and midwifery education provided data on the accountability framework within which midwives practise and the model of practitioner expected in law and being developed by educators. The bulk of documents used in the documentary analysis related to midwifery curricula and assessment, and provided further insight into the model of a midwife that educators were working towards. This analysis provided the background to midwifery competence in terms of an overview of the articulated objectives of midwifery programmes and the frameworks used to judge capability for the role of the midwife and fitness for award. The literature was also used, once themes in the data were identified, to explore the implications of the findings for midwifery practice, learning, education and assessment.

There are mixed views in the research methodology literature on the use of *a priori* knowledge. Murphy et al (1998) suggest that the reluctance to use *a priori* knowledge in qualitative research comes from a commitment to viewing the social world through the views and perceptions of those being studied. Those in favour of an emergent design (Lincoln and Guba, 1985) and progressive focusing (Atkinson, 1979) in qualitative research are particularly concerned that previously existing or inappropriate frameworks should not be imposed upon phenomena but that phenomena should be discovered (Bryman, 1988,

Hammersley, 1992b). On the other hand, it can be argued that it is not possible to begin research with a clean slate. Given that we perceive the world in terms of prior experiences and the meanings that we attribute to events and patterns, there is also the argument that it is better to be well informed than to base our interpretations on misconceptions. Miles and Huberman (1994) suggest that our interest in the research area dictates what we look for and the eyes that we look through. Qualitative researchers are selective in the aspects of participants' perspectives on which they focus and filter observations based their own theoretical perspectives (Bittner, 1973, Bryman, 1988, Emerson, 1981). Morse (1994) suggests that for researchers to ignore the findings of others in the area not only impedes the development of their own work but is naïve. She suggests that qualitative findings do not 'magically' *emerge* from the data but their interpretation requires considerable questioning of the data, perhaps drawing on prior theory and knowledge.

4.7.2 Interviews

Interviews were the main source of data and involved a range of individuals each with their own perspectives on midwifery competence. Interviews were used to explore the fit between the model of competence expressed in curriculum and assessment documents (*fitness for award* and *fitness for practice*) and that perceived to be required for the reality of midwifery practice and to undertake the role of the midwife (*fitness for purpose*). Interviews were used in preference to observation for three particular reasons. Firstly, a prolonged period of direct observation of students in their practice environments was not practical due to time and resource constraints and the need for the researcher to work across six distant case study sites. Secondly, there were ethical reasons why it would not be acceptable, to women or practitioners, for a researcher to spend time in the practice area as an observer. Thirdly, it was felt that the researcher would not be in a position to make judgements about what was observed in terms of competence. This third point is particularly relevant in terms of the arguments made previously about the need to study social phenomena through the meanings ascribed to them by those involved, which suggests that students, teachers and assessors are best placed to make judgements about competence. Moreover, it

emphasises the need for the research to explore judgements and related interpretations and understandings of competence. To help to understand these judgements, the researcher also attended assessor preparation workshops and examination board meetings as a non-participant observer. Semi-structured interviews[3] were used and, as anticipated, they produced rich data.

In interviews with students, the topic of competence seemed very relevant to them at that point in time in their midwifery careers. They were very clearly focused on how competent they felt to meet the requirements of final assessments, to take on the role of the midwife, and in terms of their own expectations of the sort of midwife they had hoped they would be. Most assessors had worked very closely with one or more of the case study students and had been involved in final assessments. Their interests in competence were in terms of students' fitness to undertake the role of the midwife. As women's advocates and professional guardians, they would have had a particular interest in protecting the woman and the profession from incompetent practitioners. However, their role would also have involved an element of student advocacy and doing what they could to ensure that 'their student' was ready to take on the role, and this sense of loyalty to students was evidenced in discussions with assessors. The immediate interests of teachers would have been in students meeting the requirements of the programme and reaching competence as defined in the curriculum and in programme assessment requirements. Their role would also have involved an element of professional guardianship, and indirectly, advocacy for women. Midwives and supervisors of midwives described competence in terms of their experiences working with students as newly qualified midwives, providing support and helping them to identify and address personal development needs.

Having previously made the case that observation would not have been practicable or ethical, there are a number of issues raised in the literature that

[3] As interviews were conducted mostly during working hours, semi-structured interviews were used to ensure that a specific range of issues were covered in the limited time available but also to allow some latitude in exploring the views of respondents.

suggest that interviews are a poor substitute for observation. These need to be discussed in order to demonstrate the value and appropriateness of interviews in studying competence, and also to identify ways in which some of the perceived short-comings of interviews were addressed through the methodology.

Four key themes can be identified relating to:

1. interpretation and inference
2. attribution
3. research direction
4. distancing from participants and the phenomenon.

It is suggested that there are difficulties in assuring accurate interpretation and inference from what is said in interviews. This is on the basis that the use of interviews assumes that both interviewer and respondent have the same understanding of language and messages (Becker and Geer, 1960) and of the responses which respondents give to the questions asked. Miller and Glassner (1998) also explore language and meaning in interviews and suggest that there is a danger in interviewing that the language can displace the very thing it is supposed to represent because what the subject tells us is shaped by our prior cultural understandings and language, which as our window to the subject's world, can play tricks (Quoting Denzin, 1991). They also suggest that the language can fracture stories told as the story teller's narratives will only be partial and 'coding, categorising and typologising' stories further fractures stories. Some meaning may be lost further as the researcher infers facts from interview statements during the analysis.

Understanding is also influenced, it is suggested, by who asks the questions and in what context (Strong, 1979). It is suggested that the researcher should be aware that what is said by respondents may be based on cultural assumptions rather than sociological insights (Silverman, 1993) and that interviewees will respond to us on the basis of who we are, both in their lives, and the social categories to which we belong (Miller and Glassner, 1998). Furthermore, the researcher may be selecting messages and interpretations from what is heard in the interview situation.

Issues about inference also relate to the meaningfulness of interview data beyond the interview context. Miller and Glassner (1998) dispute concerns in the research literature that interview data is not meaningful beyond the context in which interviews occur. They suggest that, by recognising and building on their interactive components, 'intersubjective depth and deep mutual understanding' can be achieved. They view the interview as a symbolic interaction and suggest that it may provide access to the meanings people attribute to their experiences and social worlds, and as such, can enable knowledge beyond the interaction to be obtained.

A second issue is that there is a difficulty attributing what people say in interviews to what actually happened or to how they actually feel. Responses given may be based on the respondent's interpretations of what is expected of them (Silverman, 1993) or what the interviewer would like to hear. Scott and Lyman (1968) suggest that the researcher should be aware that there may be other reasons for the responses given in interviews, that may distort the version of events or behaviour, whether intended or sub-conscious. They suggest that respondents may give excuses or justifications to account for actions or feelings, or to make themselves look good. Stimson and Webb (1978) found in their research that what was reported in interviews was at variance to what they observed in the same situations. The difficulty is that the interviewer has no way of knowing if respondents are screening information and no way of checking that what respondents report is not a distorted view of events (Becker and Geer, 1960).

A third point is that interviews may be subject to some degree of orchestration by the researcher, whether intended or sub-conscious. Walker (1985) argues (citing Dean, Eichhorn and Dean, 1967, p.302) that although the interview may be unstructured, it is in fact structured by the interviewer who constantly 'appraises the meaning of emerging data for his problem and uses the resulting insight to phrase questions that will further develop the implications of these data'. Circourel (1964) suggests that the researcher can sway responses by appearing to

agree with one view or another view expressed by the respondent. He suggests that there is the risk that the researcher will reveal private feelings, or mask feelings, and as a result the researcher may come across as insincere to the respondent. He also highlights the risks of unfriendly or hostile relations. The interview may also be influenced by *a priori* knowledge, especially where the researcher is required to make some pre-judgements about the nature of the problem, which is something that would not be required if observation were used instead (Denzin, 1970).

The fourth point is that some of the closeness sought in qualitative research is lost through the use of interviews. Walker (1985) argues that the interaction in interviews is 'essentially artificial' because the conversation takes place between 'total strangers'. He suggests that interviewing involves only a fleeting relationship with respondents and not the opportunity to move behind the 'public selves' of respondents. In contrast, it is argued that the researcher can get closer to the data in observation, can link cause to effect, and make better use of informal data and impressionist reactions. In addition it is suggested that there is more opportunity in observation for on-going analysis. These points are summarised in Figure 4.2.

The range of negative views expressed here would seem to dispute the value of the interview in exploring competence. However, Silverman (1985, 1993), while acknowledging the criticisms, is still a very strong supporter of interviews. He suggests that interview data is neither biased nor accurate but 'real'. He describes the interview as a social interaction that reflects social structures that are real 'in the sense that they are reflected in social relations which may be hidden from (though expressed in) the perceptions of the individual (1985, p.157)'. Adopting the 'realism' approach, he suggests interviews can provide rich data that can 'provide access to how people account for both their troubles and misfortunes'. Silverman (1993) quotes Brown and Sime (1981, p.160) who suggest that '… an account is neither naïve nor an apology for behaviour, but must be taken as an informed statement by the person whose experiences are under investigation … '. Further, he suggests that we should not 'hear' responses as true or false reports of

reality, but that we should treat interview responses as '*displays* of perspectives of moral forms' (Silverman, 1993, p.107).

Figure 4.2: Issues to be considered in the use of interviews

1. Accurate interpretation and inference
• Language
• Social and cultural assumptions
• Selection and interpretation bias on the part of the researcher
2. Attribution
• Variance between what is said by respondent and what actually happened
• Researcher screening information
• Responses influenced by expectations of what researcher wants to hear
• Respondent not comfortable or willing to disclose information
3. Researcher direction
• In interview
• Pre-judgements about the nature of the study
4. Distancing
• From participant
• From phenomenon

Silverman (1985) suggests it is better to harness the effects of the set of 'overt characteristics' that we each bring with us to the interview situation than trying to limit their effects. He gives examples of how researchers have gained access to situations and experiences by 'giving' their own experiences. He suggests it is far better to develop a relationship of trust and confidence than adopting the positivist approach of 'sanitising' the situation by building an unnatural relationship of subordination and control, in the name of avoiding bias. Thus the interviewer should take the role of the 'friend' and 'confident' showing interest rather than searching for scientific objectivity. Certainly, in this study there was on-going contact with the thirty-nine students and their teachers over a fifteen month period. Many of the assessors were interviewed twice and some even three times in cases where they went on to work with the individual students beyond registration. Therefore, it would not be accurate to describe the interviewer/interviewee relationship as 'fleeting' as suggested by Walker (1985).

Before agreeing to take part in the EME study, an outline of the proposed study was presented to students and teachers and students were given the option to participate or not. Written information was also given prior to interview which outlined the aims of the study and a set of ethical guidelines, covering issues such as confidentiality and the non-attribution of findings to particular individuals. Interviews took place at a location and time to suit the interviewee. At the beginning of each interview, the key issues to be discussed were identified and interviewees were given an opportunity to ask questions or to seek clarity on any outstanding issues of concern to them. Thus, every reasonable effort was given to make interviewees feel comfortable and to create a non-threatening environment. It is also possible the researcher, as a person independent of their midwifery programme or practice situation provided the opportunity for them to go through the process of reflection and debriefing in a non-threatening situation. Interviews were very much focused on them, their experiences, and the challenges that they faced, and anonymity and confidentiality was assured, and certainly as the researcher, I felt as though I was in the counsellor role from time to time.

Personally, I feel that my midwifery background helped me to gain access to individuals and to gain access to the language used in the interview situation. Miller and Glassner (1998) suggest that sharing membership with study groups can help to prevent issues relating to social distances, such as lack of trust and understanding of the questions posed, or, as they suggest, interviewees wishing to 'purposely mislead us in their responses'. Further, they suggest that if we do not have membership in interviewees' primary groups, we may not know enough to ask the right questions. Also, in terms of language, the dangers of technical language difficulties relating to midwifery were reduced because the researcher was a midwife. In addition, the research questions were worded in plain language and interviewees were given the opportunity to seek clarification where required. Where it seemed from the response that perhaps the question was not fully understood, the approach would have been to ask the question again in a slightly different way. There is no way to know the influence that social and cultural assumptions may have had in each interview situation, but providing pre-

interview information for interviewees and allowing the interviewee to raise questions was aimed at ensuring clarity about the purposes of the interview. To reduce the risk of the researcher only selecting a partial understanding of what was said in the interview situation, interviews were tape recorded and transcribed.

In terms of the issues raised relating to accurate attribution, the opportunity to interview students four times helped to monitor the consistency of what they said. In addition, seeking the views of teachers, assessors and other midwives alongside those of the students/practitioners enabled a degree of cross checking and perspectives of competence to be compared. Where there were inconsistencies between the views of matched stakeholders, the approach was to dig deeper to explore and explain the inconsistencies.

Some of the points made about the researcher directing the interview relate to the use of the semi-structured interview, which involves asking pre-determined questions about specific aspects of competence. However, interviewees were allowed to talk freely around the particular topics contained in interview questions and were only re-directed when they moved away from these topics. This was necessary in order to ensure that best use could be made of the limited time available to interviewees to explore issues relevant to this research and the EME study.

4.7.2 Analysing and interpreting views on competence

As previously stated, the purpose of the research was to expose the true nature of competence, and the realities of becoming and remaining competent. The discussion so far in this chapter has been about the appropriateness of the interpretivist/qualitative, case study approach to provide rich and deep data on the range of versions of competence that can be expected of midwives and the range of related issues and how they influence competence. It is also suggested that the case study approach enables the influence of context and time on competence to be included in the research. However, in order to achieve these aims, the method of analysis selected must make the most of the rich, thick,

descriptive and context-sensitive data yielded, and do justice to the phenomenon being studied and the lived experiences of the participants in the research. The analysis approach selected is critical to producing findings that are 'faithful' to the phenomenon (Strauss and Corbin, 1990) and 'the strengths of qualitative data rest very centrally on the competence with which their analysis is carried out (Miles and Huberman, 1994, p.10)'. On this basis Strauss and Corbin suggest that the researcher must have a good understanding of the theoretical basis of research and study of the social world, and must be able to use that knowledge in the research situation. They refer to this as 'theoretical and social sensitivity'. They suggest that in the research situation, the researcher must be capable of critical analysis, abstract thinking and interaction to interpret the situation validly and reliably, and to manage bias.

The constant comparative approach was chosen for this study to complement the interpretivist, case-study approach to data collection. According to Burgess (1984) the constant comparative method is concerned with saturation of data rather than the consideration of all data, and the generation of theory rather than testing theory. In the constant comparative method, theory is modified and reformulated rather than refuted (Glaser and Strauss, 1967). Strauss and Corbin (1990) suggest that the constant comparative method is designed to provide a 'rich and tightly woven explanatory theory' which is very close to the reality it represents through providing the 'grounding', building the 'density', and developing the 'sensitivity and integration' required.

Consistent with the aims of the interpretivist approach, the emphasis in the constant comparative method is on discovery and while the process is designed to ensure a systematic and rigorous approach, it also allows for creativity:

> Creativity manifests itself in the ability of the researcher to aptly name categories; and also to let the mind wander and make free associations that are necessary for generating stimulating questions and for coming up with comparisons that led to discovery (Strauss and Corbin, 1990, p.27).

May (1994) suggests that intuition and creativity are essential ingredients in scientific discovery. She suggests that they move the researcher beyond the limitations of method but that they must be contained 'within the context of careful and rigorous attention to method'. The researcher '… must turn to systematic data collection and analysis for evidence to substantiate or refute the tentative conclusion' (p.18).

The constant comparative method is strongly associated with the grounded theory approach to research. Nevertheless, the constant comparative method should not be confused with the grounded theory approach, which is about a total approach to research involving on-going analysis of interviews, the results of which influence each subsequent interview. In this study, interviews were done in batches using semi-structured interview schedules and, while analysis was on-going, the approach taken was considerably different to a grounded theory approach as described by Glaser and Strauss (1967) and Strauss and Corbin (1990).

There were close to 300 interviews in total and given the number of interviews it was more practical to use a computer package than cards to code interview segments. Software packages make the management of the data a lot easier, especially when it comes to retrieving segments for analysis, but analysis in the real sense is still carried out by the researcher. The analysis process broadly followed the four stage approach outlined by Glaser and Strauss (1967). The early stages of analysis involved interpreting and discovering the data, the later stages with describing and reconstructing the data. Three major categories were identified in the data: competence at the point of registration; becoming competent, and competence beyond the point of registration. The three categories form the basis of the reported findings in Chapters Five, Six and Seven. The analysis of critical incident interviews was carried out separately but using a similar approach and findings relating to competence expected at

registration were used in the analysis of competence at the point of registration.

The analysis began by reading a number of transcripts and identifying the broad themes contained in the data. For example, questions in the second set of student interviews related to their preparation to take on the role of the midwife, competence at the point of registration and what they understood to be their initial learning needs upon registration. On initial reading of the transcripts four broad themes were identified:

1. taking on the role of the midwife
2. what it takes to be a midwife
3. becoming competent
4. competence beyond registration.

Interviews were then re-read and the four broad codes or categories applied to the segments. The next stage of the analysis was to bring together the data for each category from across all of the interviews, and then by exploring each data set in turn, identify the range of themes within. The range of themes that emerged in this set of interviews is outlined in Figure 4.3. For example, for the first category, taking on the role of the midwife - three specific dimensions were identified, each including several themes.

The first dimension related to feelings that students had about midwifery and being a midwife at the stage where they were about to qualify and how their experiences met with their expectations. The second dimension concerned feelings about their own capability, while the third dimension related to experiences of taking that first step into practice. Using the emerging themes, codes were electronically attached to segments in the interview files. Segments were coded using the *looks like, feels like* approach. All sets of interviews were coded and analysed in a similar way.

Along the way new themes were identified or existing themes were refined or combined as seemed appropriate. Themes were listed on a discovery sheet.

Beginning with the most prominent theme, printouts of grouped segments, *virtual cards*, were read looking for coded segments relating to the particular theme, constantly comparing segments for agreement and contrasts. This provided further description and clarity to themes and emerging issues.

The analysis package enabled allowed comparisons to be made between individual students, cohorts of students, between students and their assessors, between students and their teachers and so on. It was during this comparative phase that the theory really began to build. For example, one theme that emerged on competence at registration was that competence is limited at the point of registration. However, it was only on reading and comparing each of the related segments that the various dimensions of the theme became apparent and each new insight helped to build the theory further.

There were insights into what the limited nature of competence at registration meant to each of the respondents. There were data on how competence was limited, for example that new midwives are likely to need support when caring for a woman with complicated pregnancy, and some of the reasons why competence is limited, such as lack of experience in that area.

By comparing student comments with those of teachers and experienced midwives, the research provided further insight on whether the limited aspect of competence at registration was considered acceptable and if it is something that respondents would expect as educators and as practitioners themselves. Thus the in-depth analysis of each of the themes enabled the theory around each to be constructed. This aspect of the analysis fulfilled one of Bogdan and Bilken's (1982) purposes of analysis - to provide many incidents of the themes and to see the diversity of the dimensions.

Once it was clear that there was no new data emerging on the theme, reading stopped and the focus switched to mapping out the key concepts arising. Using a matrix, theory on the particular theme was built up and propositional statements generated.

Figure 4.3 Student second interviews - competence at the point of registration

Code	Theme
Category One: Taking on the role of a midwife	
Dimension a): Feelings about midwifery and being a midwife	
FEELINGS	feelings about midwifery now and becoming a midwife
TIME	it's time to be a midwife
EXPECTATIONS	how being a midwife meets with expectations now
AGONY	the agony and ecstasy of midwifery training and becoming a midwife
Dimension b): Capability to fulfil the role	
FIT	how fit for the role students felt
KNOWERS	can assess needs, implement and evaluate care but need help to plan care
CAPABLE	capable of dealing with emergencies but would be very anxious
FRUSTRATED	frustrated as not able to practise in way has learned is best
IDEALISM	course built idealistic views and had to learn to cope with reality
HELP	specific areas where help is needed
Dimension c): Taking the first step into practice	
EDGE	letting go of the edge and swimming alone
CONFIDENCE	confidence is one of the last things to come in competence
OVERCAUTIOUS	more likely to be over-cautious at first rather than take chances
SITUATION	competence will vary from situation to situation
SHARP	knowledge is sharpest at registration
Category Two: What it takes to be a midwife	
VIP	most important attributes of a midwife
VITAL	communication is vital link in competence
CENTRAL	assessing, planning and evaluating care is central
EXPECTED	should not expect a midwife to know everything at registration
ASKING	fine line between asking for help and passing the book
MATURITY	a certain level of maturity is needed to be a good communicator
MOTIVATION	vital that students are motivated
BALANCING	balancing research findings with traditional practice
BOGGED	important to work within the rules rather than getting bogged down in them
ADVOCATE	need to be non-judgemental in order to be an advocate
Category Three: Becoming competent	
Dimension a): Development	
FINAL	final stages of development
CHANGED	the course changed me as an individual
CONFIDENCE	confidence was the last thing to come and still needs to be developed
UNEXPECTED	learning to cope with the unexpected
GAP	learning to cope with the theory/ practice gap
ADMITTING	learning to admit that you don't know
ISSUES	issues about the course related to development
Dimension b): Ways of learning	
ACTIVE/PASSIVE	students can be active or passive learners
EVALUATING	learning by evaluating the practice of others
APPRAISING	appraising and comparing own practice to that of others
BEING	learn by being a midwife / role playing

FAILING	failing was the trigger to committing self to learning
NORMAL	learning about the normal and comparing to abnormal
BRING	students bring some abilities with them rather than learn
Category Four: Beyond registration	
BEYOND	competence beyond registration

In Appendix Three, extracts[4] of the matrix developed in the analysis of data on the theme: competence is limited and conditional at registration, are provided as an example of how interview data were used to construct theory. Later stages of analysis involved clarifying the relationships between categories and major themes and further refining theory, sometimes by re-reading interviews. Analysis continued throughout the writing up process to allow follow up on gaps in the data or to further explore data relating to issues raised in the literature.

One notion raised in the literature, in particular relating to the constant comparative method, is that themes are allowed to *emerge* from the data. This could be said to be true to a point, in that themes come from the data as opposed to *a priori* themes being imposed on the data. However, May (1994) and Morse (1994) suggest that analysis is much more active than the acceptance of the concept of theory *emerging* from the data would allow. May suggests that the notion of data emerging is not appropriate as in reality researchers actually 'drag' theory out of the data. Morse suggests that there is a crisis in qualitative research with a tendency for qualitative researchers to not go far enough in their analysis. She suggests that recent concerns about the credibility of qualitative research have caused researchers to limit their analysis to the description of findings emerging from the data. She advocates a more active approach to qualitative analysis:

> (Analysis) … requires astute questioning, a relentless search for answers, active observation, and accurate recall. It is a process of piecing together data, of making the invisible obvious, of recognising the significant from the insignificant, of linking seemingly unrelated facts logically, of fitting

[4] The original matrix developed for this theme was 15 pages long and the example provided only includes sections relating to some of the themes identified. This example is provided to illustrate the general approach taken to theory building during the analysis.

> categories one with another, and of attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence (Morse, 1994, p.25).

The approach taken in the analysis of the data in this research was to read several interviews before beginning the initial coding, and by doing so to identify themes arising in the data. Not surprisingly, the initial categories identified reflected the topics included in the questions. The next round of analysis then focused on identifying themes within each category and then subsequently exploring similarities and differences between respondents for each of the themes. Thus in the analysis themes were actively sought and identified rather than allowed to emerge.

4.8 Concepts of quality in research

In addition to selecting an appropriate research design and methods for the study of competence, quality is an important issue in research. *Quality* can be described in terms of that which differentiates good research – rigorous research - from research that is not so good. It involves a commitment not only to do the right things (the use of an appropriate research design and methods) but also to use them well. The literature suggests that there are three key elements of good research. Firstly, it is suggested that good research requires an awareness or sensitivity on the part of the researcher of both the power of the research, and its limitations. It implies that the researcher is well aware of the assumptions and philosophies underpinning the approaches taken and that claims made on the findings are well grounded in the data. In the qualitative approach, the researcher also needs to be aware of the limitations that arise from the extent to which data is observable, access to interviewees, and the limitations on the knowledge of those interviewed (Duffy, 1985).

Secondly, it is suggested that good research is free from bias or distortions. While the qualitative approach is not concerned with sanitising data through distancing methods, keeping bias at a minimum is still a major concern in the literature. Becker (1967) suggests that the qualitative researcher cannot avoid

taking sides, '… so we are left with the question whether taking sides means that some distortion is introduced into our work so great as to make it useless …' (p.245). Duffy (1985) identifies several possible sources of bias or distortion such as:

- reactive effects of the presence of the researcher in the setting
- selective perceptions and inter-perceptions
- 'going native' where the researcher over-identifies with the researched
- biases from 'researcher-subject rapport'.

However, there are those who suggest that in qualitative research it is more appropriate to focus on being faithful to the data than to focus on the issue of bias. Similarly, Runciman discusses the 'authenticity' of qualitative research and its ability to 'bring home the experience to those who have not experienced it (Runciman, 1983, p.15)'. Guba's (1981) definition of *neutrality* is that the 'findings are a function solely of the informants and conditions of the research and not of other biases, motivations and perspectives' (Kefting, 1990, p.216).

Thirdly, it is suggested that good research is consistent with a number of principles that are appropriate and relevant for the research design and feasible in the circumstances in which the research takes place. The debate centres around whether or not there should be general rules to be followed in qualitative research, and if so how the principles that are appropriate compare with those accepted as appropriate for quantitative research. Murphy et al (1998) go into considerable debate on the appropriateness of using criteria or rules to quality assure research. They identify several stances on the issue including the following.

- There are those who believe that the notion of rules in qualitative research is not appropriate, on the basis that qualitative research is anti-realist and relativist and as such no rules can be applied and concerns about validity or reliability are irrelevant (Smith, 1984). Murphy et al suggest that this stance is likely to render research findings unusable to commissioners of research who are likely to be concerned to ensure the quality of the research. They cite a number of authors such as Silverman (1985), Phillips (1990), Hammersley

(1992a, 1992c) and Altheide and Johnson (1994), who have broken Smith's link between relativism and qualitative research suggesting that the use of criteria is appropriate.

- There is the argument that it is inappropriate to take principles from one paradigm and apply them to another (Smith, 1985), and that qualitative research represents a different 'form of science' than positivism. In this sense post-structuralists argue that an entirely new set of criteria needs to be identified, which is 'divorced' from both positivist and post-positivist traditions (Denzin and Lincoln, 1994).
- There are those who interpret or apply the rules differently in qualitative research. As such, it is suggested that they use the principles of validity and reliability metaphorically rather than literally.
- A fourth stance is where qualitative researchers use quantitative frameworks in their work, arguing that there is no distinctive philosophy underpinning qualitative research (Morgan 1983, Lincoln and Guba 1985, Guba and Lincoln 1989). It is suggested that this approach places the research under a number of constraints, particularly the emphasis on discovery if control and systemisation and *a priori* theories are imposed on the data (Marshall, 1985).

Murphy et al (1998) suggest standards are required to distinguish good research from bad but also suggest that while validity and reliability are relevant, they are difficult to establish in qualitative research. They also identify several criteria for the evaluation of research in the literature:

1. comprehensiveness, informational adequacy and completeness of data.
2. validity – the extent to which the research provides a 'correct' account of a group's attitudes, values and practices (quoting Shapiro, 1969)
3. appropriateness; relevance; and accuracy
4. efficiency
5. flexibility and interactive potential
6. reproducibility.

Elsewhere, it is suggested that the concept of reliability is not appropriate in qualitative research. Denzin (1989) suggests that it is not possible to reproduce

exactly the same findings again as reality is negotiated and the reality to which methods are applied is constantly changing. He describes reality as a 'kaleidoscope' revealing different colours and configurations of objects depending on the angle held. In the same way he suggests that each researcher has unique interpretations, brings a unique perspective relating to 'past experiences, personal idiosyncrasies, and current mood' (p.236). Murphy et al (1998) argue that phenomena are not static and realities are multiple, and it is likely that these realities, or the researcher's position in relation to those realities, will change along with changing insights and sensitivities. They suggest that it is important to accept such instability as real rather than 'methodological artefact' and they suggest that an alternative to the notion of reliability is 'trackable variance'. As opposed to the positivist concept of reliability, *consistency* in qualitative research is defined in terms of dependability. This implies that variability is 'trackable' and sources can be identified while including the full range of experience including atypical and non-normative experiences (Kefting, 1990). Agar (1986) suggests that terms like reliability and validity are not relevant to qualitative research, instead the focus should be on 'credibility, accuracy of representation and authority of the writer' (Kefting, 1990, p.125).

Interpreting a model put forward by Guba (1981), Kefting (1990) outlines four dimensions for the evaluation of the quality of research: truth value, applicability, consistency and neutrality. Truth value is concerned with the faithfulness of the researcher's accounts to the subjects and their lived experiences, multiple realties, and the context in which the phenomenon exists. Kefting suggests truth value can be enhanced through the researcher spending sufficient time with informants to identify recurring patterns, and triangulation, reflexive analysis, time sampling, and sampling a range of incidents. The case for using triangulation to view competence through the multiple perspectives of students, their assessors, teachers and midwives has already been outlined. In addition there are several arguments that triangulation can add to the rigor of research. Hughes (1990) focuses on 'intersubjective establishment' by comparing and contrasting individual perspectives and interpretations of 'the facts'. Jick (1979) suggests that the holistic view of the subject, the thick description, and the

opportunity to study behaviour in context, afforded by triangulation, add to the quality of research. Due to its comprehensiveness, it serves as a 'critical test' for competing theories. Comparison of multiple data sources does not lead to a 'single, totally consistent picture' but to different types and levels of data that reveal different aspects. In this sense, we should not ignore differences but attempt to understand and interpret them. Although views of the different stakeholders in competence were viewed as complementary, there was also the opportunity to pitch student views against those of individuals involved in assessing or working with them. In view of the points made here, it is suggested that this contributed to the truth value of the findings. In addition, the opportunity to explore cases that were different, for example, students who were extremely anxious about taking on the role, raised a number of issues about why they were different.

Kefting (1990) interprets *applicability* in terms of Guba's '*fittingness or transferability'*, suggesting that the decision about applicability should be made by whoever uses the findings rather than the original researcher. However, this relies on the researcher providing sufficient description to allow comparison. According to Kefting, variability is to be expected in qualitative research because of the uniqueness of the human situation, the multiple realities represented, complications of extraneous and unexpected variables and the researcher as instrument.

The lack of generalisable findings is often raised as a criticism of the case study approach. Mitchell (1983) suggests that generalisability takes on a different meaning in case study from that in the positivist sense, focusing on the adequacy of findings to represent the phenomenon under study against the backdrop of what is known about it.

> … no case can be prepared in isolation from the corpus of empirical information and theoretical postulates against which it has significance … the extent to which generalisation may be made from case studies depends upon the adequacy of the underlying theory and

> the whole corpus of related knowledge on which the case is analysed rather than on one particular instance itself (Mitchell, 1983, p.197).

Mitchell suggests that inferences made from case studies should be based on the validity of the analysis rather than on the representativeness of the events. Because of the contextual nature of case study, the researcher must present sufficient context description for the reader to be able to judge the validity of any generalisations made from the research. Stake (1994) reminds us that the 'purpose of case study is not to represent the world, but to represent the case (p.245)'. It is suggested that it is the thick description of context in qualitative research that provides the essential judgmental information for the reader to be able to judge whether the findings on the phenomenon studied in one context may be transferable to another context (Lincoln and Guba, 1985). Multi-site studies can be used to show generalisability or diversity. They can also provide for cross-site analysis so that 'idiosyncratic aspects can be seen in perspective, and self-delusion about conclusions is less likely (Miles, 1979, p.123)'.

Accepting the differences between the two approaches implies that standards for good quality research can be expressed in different but similar ways - ways that are appropriate to each approach. Figure 4.4 identifies a range of principles underpinning qualitative and quantitative research.

Figure 4.4: Concepts of quality in research

	Interpretivist	**Positivist**
	Truth value Authenticity Faithfulness Credibility Comprehensiveness	Validity
	Consistency Dependability Trackable variance	Reliability
	Applicability Fittingness or transferability	Generalisability

The analysis suggests that although there are differences based on different ideologies, essentially, researchers use similar concepts to make judgements about the quality of research and the methods used, specifically:

- that findings are what they say they are
- that the research is thorough and systematic
- that the way in which findings can be applied to other cases is explicit.

4.9 Conclusion

The aim of this chapter is to argue that the interpretivist, case study approach, including the constant comparative method of analysis, is an appropriate approach to study competence and learning in the terms outlined for the research presented in this thesis. It is argued that competence is a social phenomenon that is experienced, interpreted and described by each individual on a very personal level and according to their unique positioning in the world. As such, it is argued that understandings of competence are individualistic and best accessed by exploring the meanings and understandings attributed to it by students, their teachers, assessors and other midwives. In addition, the research sought to represent competence as multiple versions of the same phenomenon, rather than seeking a single truth. Another key benefit of the interpretivist approach is its emphasis on discovery which enables the researcher to build faithful representations of phenomena in the natural language of those involved. The researcher becomes a human instrument building insight by drawing on and focusing tacit knowledge.

The use of the case study approach enabled competence and learning to be explored in depth in the context in which they exist and enabled similarities and differences to be identified for further exploration. This exploration of competence through the range of multiple perspectives on it also added to the completeness of the data and the contextual portrayal of competence. Having outlined the issues around the design of the research and the methods used in this chapter, the findings of the research are outlined in the following chapters.

Chapter 5

Competence at the point of registration

5.1 Introduction

In Chapter Two, the historical development of midwifery is outlined, raising a number of issues about the nature of the role of the midwife and how it relates to that of other professionals. The review established a specific role for the midwife, as an independent practitioner working as a lead professional in the provision of maternity care, mainly in low-tech community settings. It is also argued that autonomy is a key requirement of being a professional. Building on the tentative model of competence presented in Chapter Three, the focus in this chapter is on the nature of competence at the point of registration. This was explored through interviews with students, and their assessors, teachers and midwife colleagues in the final stages of programmes of education. In addition, completed assessment profiles and examples of coursework were also obtained for each student. Interviews with assessors, teachers and other midwives (including supervisors of midwives) suggest that those interviewed generally knew the thirty-nine participants well and had sufficient experience with students to be able to make judgements about their capability and to be able to identify areas where further development was required. In fact, in several cases individuals were interviewed on more than one occasion, where for example they had been a student's assessor and later went on to work with them as a midwife, or had been a teacher first and later a supervisor of midwives.

In the following section the research findings on the nature of competence at the point of registration are presented. The approach taken is firstly to outline the findings and then to discuss the implications for the midwifery profession and midwifery education. This discussion also draws on arguments presented in midwifery literature and the literature from other professions.

5.2 The nature of competence at the point of registration

Benner's (1984) work on competence in nursing, which is based on the work done by Dreyfus and Dreyfus (1980) on competence across several professional areas, proposes that there are five clear stages of competence development: novice, advanced beginner, competent, proficient and expert. The five stage model proposed by Benner is not tested in this study but the findings of this research support the notion that there is a clear distinction between competence at registration and that of more experienced practitioners. The analysis in this research suggests that differences between competent and more proficient practitioners relate primarily to confidence, judgement and decision making, the speed at which things can be undertaken, the range of additional responsibilities that can be taken into the professional role and ability to function independently. These differences are explored in this chapter in terms of the limitations of competence at the point of registration. The theme is further explored in chapters seven and eight where the focus is on how competence develops beyond registration and the attributes of experienced and expert midwives.

In terms of the nature of competence at the point of registration, the first theme identified in the analysis is that competence at registration is limited and conditional. This suggests that the capability of a midwife at the point of registration will be limited and can be expected to continue to develop beyond registration. However, in order to be competent to fulfil the role of the midwife, there are a number of specific requirements or conditions to be fulfilled at the point of registration.

5.2.1 Competence at registration is limited

The views of assessors, midwives, students and teachers were broadly consistent, seeing competence as limited at the point of registration, and further noting, that limitations would be expected and considered acceptable by midwives and teachers. Several interviewees identified reasons why they would expect competence to be limited at registration.

Firstly, it was suggested that there are limitations of learning as a student because only so much can be learned within a three year period. In addition, it was suggested that there are some midwifery capabilities that cannot be learned as a student and that there comes a point where a student cannot develop further without *being* a midwife. It is suggested that learning to *be* a midwife is different to learning as a student, and requires an individual to act out the role and to function as a midwife, taking on responsibilities and making decisions. The data suggests that this type of learning will also involve a withdrawal of support, developing confidence and a type of introspective reflection. This theme will be explored further in Chapter Six, which focuses on the learning associated with becoming a midwife.

The second reason put forward for limited competence at registration is that students at the point of registration are lacking the experience required to be able to consolidate practice.

> It's something that has cropped up … I think the students themselves would be the first to say that they would want more experience, they feel as if they've begun to get that experience during their student centred allocation in most instances, but that's only five weeks, that doesn't equip you to go and take on an independent practice and I wouldn't feel entirely comfortable with that I've got to admit but I do feel comfortable that … they have achieved their competencies, that they are reasonably confident and … that level of confidence will increase (midwife teacher).

> I think perhaps from my point of view an improvement for me would be to have, to have had more time on labour ward. I've only been given two long allocations on there and I would have liked more time on there, perhaps just generally, perhaps looking at the students um as an individual and saying - towards the end of the course, Well what do you think you need to do now [name], rather than saying we're going here, there and here, we're going here. Perhaps sort of consulting them six months or so before the end of the course and saying Now where are you

> feeling less competent, where you know where, where do you need the extra, the extra time, rather than just giving us this, this two and a half weeks, three weeks at the end of the course (student midwife).

The views of interviewees were broadly consistent, that programmes generally prepared students with a good research-based knowledge base and all of the *'basic competencies'* such that the students had the potential to be good midwives. However, it is suggested that this knowledge was not always supported with adequate practical experience to enable students to 'put it all together'. Students, assessors, and midwives identified a small range of skills that students had not yet been taught, but most of these skills were considered to be 'extended skills'. Alternatively, several students had been taught skills 'in theory' but did not have the opportunity to apply them in practice, for example, episiotomy or suturing. Students were asked about the range of experiences that they had had over the programme and it is suggested that there were variations between students in terms of the range of practice areas covered and the extent of experience in each area. Students frequently suggested in interviews that they were least confident practising in areas where they felt experience was limited.

It is also suggested in several student, teacher and assessor interviews that it may be widely accepted by midwives and other professionals that competence is limited at registration. Several students said that they believed that they were just as capable as anyone else who had just qualified. It seemed important to them to stress this and this is expressed almost as a way of coping with competence being limited at registration. It was also suggested by a small number of students that on the basis that they had just qualified, new midwives could expect at least a minimum level of support, should 'anything go wrong'. In addition, the majority of assessors anticipated that new midwives would need support, given that they had only recently qualified.

However, the 'conditional' theme suggests that the limitations that are acceptable are specific. Two further qualifications to the acceptance of competence being limited at registration are raised in the data. Firstly, several students, assessors,

teachers and midwives stressed that qualifiers must be aware of their own limitations, and of the limitations of the role of the midwife and be prepared to ask for help should the requirements of practice move outside of these limitations. Secondly, it is suggested that this limited status is strictly temporary and that midwives would be expected to continue to develop once they have qualified.

Interviewees identified four key areas where they would expect competence to be limited at registration: providing care for complicated pregnancy, managing a ward, making decisions and being confident.

5.2.1.1 Providing care for complicated cases

The views of most students and assessors were that midwives at the point of registration would be competent to provide the full range of midwifery care for a woman with a normal pregnancy. In addition, most students and assessors suggested that they were confident that newly qualified midwives would be able to detect deviations from normal and would take the appropriate action.

In contrast, and differentiating the role of the midwife in the provision of care for women who are ill or have complications from normal midwifery care, interviewees suggested that new midwives would need support when caring for a woman who is ill or has complications. Examples given were: breech delivery, twin delivery, assisting with a forceps delivery, bereavement, a woman with diabetes or fulminating pre-eclampsia, or a woman who is 'specialed' – a woman requiring intensive nursing care. However, the emphasis in interviews is on midwives needing support more so than having any particular deficiencies in ability – someone they could contact quickly should they run into difficulties and who would give them some pointers on what they should be doing. Two interviewees (a student and a teacher) suggested that limitations in being able to provide care for abnormal cases is acceptable and that even midwives who had been qualified for some time would need support when caring for complicated cases and in emergency situations.

Several interviewees also suggested that student midwives do not get a lot of experience dealing with emergency situations as students, and yet they would be required to be able to deal with such situations as qualified practitioners. Aside from emergencies, the question is raised in the data as to whether providing care in abnormal cases is part of the role of the midwife. Pre-registration midwifery curricula are based on the ideal that the role of the midwife is to provide the full range of care for normal pregnancy, most likely in a community setting. This is reflected in the review of midwifery curriculum documents carried out for the EME study (Mountford et al, 1995). The reality is that in practice, most new midwives start their careers practising in hospitals, as was the case for almost all of the thirty-nine case study midwives. Midwives working in the hospital environment are more likely to be required to provide care for women with complications. Further, the proportion of complicated cases to normal pregnancy cases in hospital is likely to increase further in the light of recent reforms aimed at positioning the majority of care for low-risk women in community settings and reserving hospital-based care largely for women with complications. Three students raised the issue about whether midwives should be involved in the care of women with complications. Two students suggested that midwives should be prepared by programmes to do so because midwives would be expected to provide care for women with complications once they have qualified. One student spoke about specifically taking the initiative to do what she could to ensure that she would be prepared to provide care for women with complications:

> I wish I'd have been a bit more prepared there because of the abnormal, when you're having to assist, so I've used my reflective days for that. So I feel better able but saying that I don't think you're ever really fully prepared for that anyway even as if you've already done nursing within midwifery, because they're specialised areas, even in nursing like recovery, so no. I mean I know I'd be safe, but maybe need more experience. (student midwife)

However, another student suggested that providing care for women with complications is not the role of the midwife but that of the doctor.

5.2.1.2 Managing a ward

At least half of students said they did not have a lot experience managing a ward. More specifically, most had not been required as senior students to assign duties to others and supervise these duties. One assessor was concerned that students that she was aware of had no experience of doing drug rounds and would be required to do so once they qualified. Aside from the knowledge and skills required to manage a ward, one assessor felt qualifiers would not be able to manage a ward because they would not have the ability to provide midwifery care and, in addition, juggle all that was happening around them. However, assessors suggested new midwives would develop ward management ability with experience and maturity. Lack of experience was not a particular issue for a small number of qualifiers who felt they had the theory or were aware of what was involved and that they would be able to manage a ward even though they had no experience of it. There were a small number of students who said they had a specific management component in their programme, which they found very useful and which had been supported with actual experience of being in charge.

When asked about whether new midwives should be able to manage a ward, one experienced midwife felt they should. Once again emphasising that the students participating in this study, more likely than not, would find themselves working in the hospital situation, it was suggested that in this context ward management would be an important aspect of midwifery practice in a hospital. While some interviewees felt pre-registration midwives were less capable in this respect than post-registration midwives, there were interviewees who felt that pre-registration students that they knew were just as capable. It was suggested however, that a more important requirement would be that a new midwife is able to manage her own time and her own workload.

5.2.1.3 Making decisions

Three students were particularly concerned about having to make their own decisions. In one of the three cases, the student concerned identified that she had a particular difficulty with what she termed 'borderline cases'. Students and assessors also suggested that difficulties in decision making related to lack of confidence or willingness to take on responsibility, possibly more so than ability. While most students suggested they were not particularly anxious about making decisions, many students stated that they would like to know that someone more experienced would be available so they could double check decisions if they were unsure. Most assessors and experienced midwives also suggested that this level of support would be required, especially for tricky decisions. This is further illustrated in the following quote from an experienced midwife, working with new midwives:

> There are judgements that you should know and if you've done your training here in this hospital and then you're practising as a midwife, I would expect you to know the basic stuff on a normal delivery … that's routine stuff that should be drilled into your head ... but making judgements on things that do catch you out, then no that's fine but you've got your support there and that's what they're there for, we're all working as a team and not just as an individual. (experienced midwife)

One midwife pointed out that while students might have had experience of decision making as students, they would need to become confident making decisions as midwives. In one case the student's concern about making decisions was reiterated by her assessor. However, the issue from the assessor's perspective was the student's reluctance to take on the decision-making role, rather than her ability to make decisions:

> … she's been allowed to take a back seat in decision making because she's a student, she knows she doesn't have to make the decision and she can let someone else make it for her, instead of being forced to make it. Everyone just says oh they're a student and they just make the decision for them and then in a few weeks' time she's going to have to make the decisions herself, and she's found that really difficult… I've had to push her very very hard to become a decision maker (assessor).

5.2.1.4 Confidence

Confidence was another area identified where competence is limited at the point of registration. It is suggested in the data that confidence is one of the last aspects of competence to develop coming up to registration and that experience and support are critical factors in developing confidence. It is also suggested that to build confidence, qualifiers need some freedom to practise but within a supportive environment. Interviewees suggested that confidence grows towards the end of the programme as students gain some experience of consolidating practice and are given more and more responsibility to work on their own. However, a small number of students suggested that at registration confidence actually falls, as qualifiers become aware of the responsibility that they are taking on. One teacher suggested that having to make the transition from student to midwife alone would have a negative impact on confidence and a small number of assessors suggested that confidence is particularly fragile at this stage and could 'be knocked' easily.

Teachers and assessors said they would expect confidence to be limited because confidence is only developed through the experience of practising. A number of students were described as being very capable but lacking confidence by their assessors and teachers who felt they would need support initially until they became more confident.

The findings presented so far in this section suggest that pre-registration midwives are capable of fulfilling the role of the midwife in providing the full

range of care for women with normal pregnancy, detecting deviations from normal and referring such cases appropriately. However, it is suggested that newly registered midwives are not as competent as experienced midwives and that they will need support and will need to build confidence further, particularly in relation to making decisions. It is also suggested that pre-registration midwives are not at the stage where they can provide care for women who are ill or who have complications, or manage a ward alone. This is an issue to be explored further as it implies that there may be a fitness for purpose implication for practice in hospital situations.

5.2.2 Competence at registration is conditional

Interviewees suggested that although it can be accepted that capability is limited at registration, for a midwife to be competent to practise she must meet certain minimum requirements - the conditional element of competence at registration. There appeared to be a general expectation amongst interviewees that a midwife would have reached a certain level of capability across specific areas of practice by the time she qualifies. In fact, several assessors suggested that it could almost be taken for granted that a student would not have been passed if they had not reached this level. These *minimum* requirements are based around a midwife:

- being safe
- having the right attitude
- being an effective communicator.

In addition, other areas of practice were identified where a midwife would be expected to have some capability but which would still be developing. These include developing as a professional, being accountable, decision-making, being an agent of change and providing individualised care.

5.2.2.1 Being safe

Interviewees from all backgrounds suggested that the 'ultimate aim' of midwifery is 'a safe outcome'. It was stressed that 'first and foremost' a midwife must be a safe practitioner and 'must always ensure the safety of the mother and baby'. A number of students and experienced midwives suggested that, although

qualifiers would still have a lot to learn, being safe was the minimum acceptable standard at the point of registration and that being safe is synonymous with being competent.

> … well that we're safe, a safe practitioner, ... I think is probably the most important one because you know it's very nice if we're brilliant communicators or lovely to our patients and or superb at getting intact perineums every time but I think the most important thing is that you've got someone who's safe who knows both the basic midwifery skills and knows what to do when they don't go right (experienced midwife).

Students, teachers and midwives talked freely about what being safe meant to them, and raised similar points. These related to having a reasonable degree of self-sufficiency, having an evidence-based approach to practice, and self, and professional awareness.

HAVING A DEGREE OF SELF-SUFFICIENCY

A central theme identified in the data on being safe is that a midwife at registration should have a reasonable degree of self-sufficiency - being able 'to do the majority of tasks unsupervised'. The findings suggest that qualifiers would be expected by colleagues and managers to have reached a certain level of practical capability, to have an adequate range of skills, and to be able to practise with minimum supervision in a range of situations and within the scope of practice of a midwife. It was also suggested that qualifiers should have a good knowledge base and be reasonably confident.

In terms of skills, midwives and assessors stated that a midwife should :

- be able to carry out all the 'basic skills' to a good standard
- be skilful, that is - 'good hands on' and 'good at practical midwifery'
- not be too reliant on technology - suggesting that midwives should be well able to use traditional midwifery skills, such as listening to the fetal heart with a Pinard's stethoscope.

Several experienced midwives said they would expect midwives at registration to have a good grounding in the basic skills, which they would 'hone' with experience. In terms of the range of skills required at the point of registration, experienced midwives suggested that a midwife would need to have the skills required to conduct a normal delivery, and be confident and safe in doing so. This would include being able to deliver a woman 'well' in a standard position, although a new midwife would be expected to need support with alternative positions. Although a small number of experienced midwives stated that a midwife should not be qualifying if she could not perform a vaginal examination (VE), one midwife suggested that, based on her own experience as a new midwife, midwives may need some support with VEs when they first qualify.

In terms of the scope of practice of a midwife, the general view expressed by interviewees was that a midwife should be able to provide the full range of antenatal and postnatal care for a woman with normal pregnancy. As highlighted by two experienced midwives, this would be required for a midwife to fulfil her statutory obligations as outlined in the UKCC outcomes, the activities of a midwife and the midwife's code of practice. The areas of knowledge required at the point of registration identified by teachers, students and midwives reflected the requirements outlined for skills in the previous section. In addition, a number of views on being safe related to the way in which knowledge is used by midwives in practice. Several teachers expected new midwives to be able to integrate knowledge and practice – to 'use their knowledge skilfully'. It was also suggested that a midwife's skills should have developed in line with her knowledge, so that a midwife knows what she is doing and why, and is clinically able – so that 'everything about what they do is good'.

Linked in with being self-sufficient at registration, a distinction was drawn between qualifiers being able to manage themselves and their own workload; and being able to manage a ward. While the general view amongst midwives, assessors and teachers was that a midwife must be able to prioritise her own workload on a day-to-day basis, and that she should be able to manage a caseload with support, the majority of interviewees suggested that a newly-qualified

midwife should not be expected to be in charge of a ward without support. Some interviewees suggested that pre-registration midwives would find ward management more difficult than those who had been nurses previously and who would have had previous experience of ward management. However, other midwives suggested that all new midwives should be ready to manage a ward, at least with help, regardless of whether or not they would have had previous experience of ward management.

It was also suggested in interviews that a midwife should be reasonably confident at the point of registration. However, several interviewees were anxious to qualify such statements, suggesting that it is more important for qualifiers to have the 'right level' of confidence. That is, a midwife should be confident enough to carry out her role, but not over-confident, and she should still be willing to 'double check' or ask for advice from someone more experienced in situations where she is unsure. In fact, interviewees suggested that to be over-confident would be dangerous.

The analysis presented here suggests that a midwife should have a reached a reasonable level of competence and confidence to be able to fulfil the role of the midwife in the provision of care for women with normal pregnancy (including delivery). A number of students captured this in their descriptions of 'being ready' or 'feeling ready to practise'. Students generally felt they did have the all of the basic skills and took comfort from the fact that they had been assessed as safe, suggesting that they would not have been allowed to qualify had they not got 'a good degree of skill for midwifery care'.

EVIDENCE-BASED PRACTICE

A second theme in being safe is that the action that midwives take and the decisions that they make are based on up to date knowledge. There are three elements here: the first, that knowledge is up-to-date, second, that the knowledge is appropriate, and third, that knowledge is based on appropriate interpretation of research findings. This suggests that the way in which knowledge is used in a

particular context or situation is as important as the nature of knowledge possessed.

Interviewees emphasised that qualifiers would have been immersed in reading and learning for three years and would therefore be unlikely to ever again be so up to date with research. For this reason, they stated that they would expect a midwife to be 'completely up to date' at the point of registration. In addition to research-based knowledge, interviewees suggested qualifiers should also be aware of current trends in maternity care and in preferences for care. It was also suggested that new midwives should be able to enable women to make informed choices by providing information that is based on a sound interpretation of relevant research, and that is appropriate to their needs. Several assessors and midwives also highlighted the need for a midwife to be cognisant of the requirements of safe practice, when providing women with choices for care.

SELF AND PROFESSIONAL AWARENESS

Along with having a degree of self-sufficiency and basing practice on sound and up-to-date knowledge, a midwife's personal and professional awareness was identified as critical to being safe. In terms of personal awareness, it is suggested that a midwife must know what she is capable of, her strengths, the gaps in her ability, her weaknesses and her learning needs. Interviewees also suggested that midwives need to be aware of the limitations of the sphere of practice of a midwife and be prepared to practise 'within the bounds' of those limitations. This would require a midwife to understand and practise within the legislation governing midwifery, standards of care, guidelines and policies, and be able to keep good records. It was also suggested that a certain degree of confidence is required for a midwife to practise within her limitations and the bounds of the sphere of practice. For example: as outlined in the previous section, having the right level of confidence requires a midwife to be willing to ask for help, and also to have the confidence to admit to colleagues that there are gaps in her abilities or weaknesses that need to be addressed.

5.2.2.2 Having the right attitude

One of the attributes of a midwife identified by several interviewees as the most important was that a midwife should have 'the right attitude'. Interviewees from all backgrounds emphasised the importance of being motivated towards providing a good standard of care and to midwifery as a profession. The views expressed on the importance of motivation in being competent are reflected in the following quote.

> If you're enthusiastic about something, the expertise and knowledge will come. I think if you don't care about the women you're looking after and you're not enthusiastic about your job, that you could have all the knowledge in the world but it's just wasted really (midwife teacher).

In addition, several teachers and assessors raised the importance of motivation in developing and maintaining competence over a career. For them, life-long learning and self-evaluation are critical in a profession such as midwifery and especially at registration when a midwife would still have a huge amount of learning to do. The views of one assessor suggest that significant commitment is required.

> I think diligence … you're whole life surrounds it (midwifery) and its involved in everything (midwife assessor).

Interviewees also identified the need for a midwife to be committed to women in her care, and to other members of their families. This type of commitment is described in terms of having a genuine interest in the individuals for whom midwives provide care and having respect for women, their autonomy, and also for their informed choices. It is suggested that this type of commitment takes midwifery competence beyond the basics - the knowledge and skills – and enhances women's experiences of childbirth. It is suggested that personality, kindness, compassion, empathy, and the ability to relate to women are also essential aspects of being a good midwife, and reinforce the human side to midwifery competence, so that the midwife is both a professional and a friend.

Further, when asked, experienced midwives suggested that if a midwife lacks commitment at the point of registration, she should not be allowed to qualify, given the importance of commitment and that it is unlikely that someone who is lacking commitment at that stage will become more committed in the future.

5.2.2.3 Being an effective communicator

Several interviewees identified the importance of a midwife having good interpersonal skills and being good communicators, such as:

> … I started with this communication thing which I feel as though it's like the big thing, but I feel if you can't talk to people then you are never going to be any good (assessor).

> … being able to communicate definitely, you've got to be able to communicate with mothers, partners, families, colleagues, everybody. If you can't communicate then you're a dead loss really on a ward like this (assessor).

Midwives and assessors suggested good communication skills are vital 'because of the nature of the job', because a midwife needs to be able to put a woman 'at her ease' and because 'the job requires constant communication'. The importance of active listening was also stressed, emphasising that communication is not just about giving information. It is suggested that a midwife needs to be able to promote and facilitate a two-way exchange of information between midwife and the women during the provision of care. Many interviewees stressed the need to be able to listen over being able to give information and suggested that listening includes being sensitive to non-verbal cues.

Several other facets to effective communication were outlined. Effective communication was portrayed as a medium through which a midwife can 'reach' individuals in her care, and that:

> … if you can communicate with someone then the things like trust and co-operation … will come as a result (student midwife).

It is suggested that although a midwife may be caring, understanding and approachable, it is only in the way that she communicates that she can demonstrate these qualities and so gain the trust of a woman and her family. Thus it is suggested that effective communication will enable a midwife to be able to work in partnership with the woman.

In the previous section, being able to work in partnership with women and the importance of a midwife's commitment to giving women informed choices are identified as key elements of competence. It is also suggested that a midwife needs to be able to provide the appropriate information for the woman to make informed choices in a way that it is fully understood - a midwife needs to be able to 'translate knowledge' in such a way as to 'get the message across'. This will also involve flexibility in communication so that a midwife can adapt to meet the needs of 'anybody who comes in through that door', whether they be colleagues or other professionals. It is suggested that being able to communicate effectively is also required in order to be an effective team member and to be able to relate to other midwife and non-midwife team members.

5.2.3 Areas where there were mixed views

While the general view amongst teachers, assessors and experienced midwives was that students at the point of registration should, at the very least, be safe, have the right attitude and be effective communicators, there were five other areas of competence where either views were very mixed between interviewees about what would be expected of qualifiers, or where the general view was that qualifiers would vary in terms of ability.

5.2.3.1 Being accountable

The views expressed by students suggest that they were anxious about the prospect of having to take on accountability. All students stated they had an understanding of the legislation and rules governing their practice as midwives and that they had thought through what it means to be accountable. There were differing views on the extent to which midwives should be accountable at the

point of registration. Several midwives and students suggested a midwife, at the point of registration, must be prepared to assume the responsibilities of a midwife and to be accountable for her own practice. Experienced midwives pointed out that a midwife is 'clearly accountable' at the point of registration, for example:

> … because at the end of the day, they've got their number on the register and they have to be responsible for their actions (experienced midwife).

On the other hand, there were midwives who said that although they would expect a midwife at registration to understand what it means to be accountable, they would not be sure if a midwife, at that stage, would be able to 'use that accountability in action'. Two teachers were adamant that their students were not ready to take on the responsibilities of independent practice, at the point of registration. A small number of assessors suggested that midwives would need more experience before they could cope with the responsibilities in the community because they would have to work virtually alone there. The emphasis in these statements was on the lack of support available to midwives working in the community. The range of views suggest that, although a midwife is legally accountable for her practice at the point of registration and should understand the implications of that accountability, she would need support initially to assume that accountability 'in action'.

5.2.3.2 Decision making

Although it is suggested in the previous section that the capability of a midwife at registration is limited in terms of decision-making, a number of assessors and experienced midwives outlined specific minimum expectations relating to decision making at the point of registration. Two key themes were identified, the first is that a midwife should be able, and willing, to make general day-to-day decisions about care for a woman with normal pregnancy. Beyond that, it was accepted that a new midwife would need considerable support from a more experienced midwife. It was acknowledged that even experienced midwives would need support with decisions in complicated situations. The second key

requirement was that a midwife should be able to 'decide that things are not normal' and seek help.

5.2.3.3 Individualised care

As discussed, the need for a midwife to be able to provide individualised care was identified as a key element of competence. It is suggested that this involves respecting the autonomy of each woman and empowering women to make informed choices. While one experienced midwife said she would expect a midwife at the point of registration to be encouraging women to make informed choices, including those about whether to have interventions or not, most midwives and assessors acknowledged that a midwife would need support to provide individualised care. These interviewees suggested that a midwife should be able to adapt her practice 'to a degree' but further learning would be required for a new midwife to be able to adapt her care to the needs of all individuals and across the full range of practice situations.

Assessors and experienced midwives identified two key aspects of competence that would be expected at the point of registration in terms of providing individualised care. The first is that a midwife should appreciate that women have different needs and that she should aim to adapt her practice to meet those needs. This should include balancing women's wishes with what is required for safe practice. The second requirement is that a midwife should be able to make an accurate assessment of each woman's needs, and that this should include being able to assess women in the their own environment.

5.2.3.4 Agent of change

Statements of anticipated course outcomes in most curriculum documents included the notion that midwives once they had qualified would be agents of change (See Mountford et al, 1995). This implies that new midwives will bring new practices and theories, which they have learnt while on the programme, with them to the practice area, thus introducing new ideas to other midwives and to students. A number of students interviewed were keen to be let loose to develop their own style of practice. However, several interviewees also suggested that

being an agent of change can be quite difficult for new midwives. It may involve challenging the way things have been done for many years and will require midwives to be reasonably confident. Further it is suggested that new midwives may be tempted to take the easy way out and ‘go with the flow’ in order to avoid the wrath of disapproving experienced midwives who may not be receptive to new ways of working. As suggested in the following quote, qualifying midwives can face resistance from more experienced midwives:

> … again midwifery is a strange profession really, everybody does it their own way and there are lots of midwives who expect you to copy their way of doing things and if you don't then they think you're not doing it right but especially at this stage in the course when we've really adapted our own way of practice, we've picked little bits out what we've seen from various midwives and developed our own method of practice but some find that difficult to come to terms with, if we don't do things exactly their way then we get pulled up on it (student midwife).

In terms of what would be expected at registration, several experienced midwives suggested qualifiers should be able to question the ways things are done although, initially, they may not have the confidence to stand up to other midwives and professionals. It was suggested that new midwives should be developing their own style of research-based practice and that if midwives were not prepared to that at registration, they would never be. One midwife suggested that there are other ways in which a midwife can challenge practice without confrontation. For example, by asking a more experienced midwife to intervene where they are concerned about unnecessary intervention.

5.2.3.5 Teaching

The fifth area identified where it was suggested midwives would have mixed abilities at registration was teaching. The general view was that midwives at the point of registration would not be expected to have a role in teaching other students. However, assessors and teachers did say that they would expect

midwives to be able to provide education for women, at least on a one-to-one basis.

In Figure 5.1, the nature of competence at the point of registration is summarised, based on the analysis.

Figure 5.1 Competence at the point of registration

Limitations	*Minimum requirements*	*Areas where expectations of interviewees differed considerably*
• Experience • Care for women who are ill or have complications • Ward management • Making decisions • Confidence	*Safe* • Self sufficiency • Evidence-based practice • Personal and professional awareness *Attitude* *Communication*	• Being accountable • Making decisions • Individualised care • Agent of change • Teaching

5.3 Discussion: the nature of competence at registration

The purpose of this chapter is to present the range of views of students, midwives, assessors and teachers on competence at the point of registration, and to explore the key themes identified in the analysis. The first theme explored is the limited and conditional nature of competence at registration. On the basis of the analysis, it is proposed that it is acceptable for competence to be limited provided a midwife meets with several conditions. Using the three-dimensional model of competence developed during the EME study, the nature of competence can be mapped out according to the aspects of competence identified as being limited and conditional at registration, and aspects that are developing but where support would still be required (see Figure 5.2).

Beginning with the *clinical competence* dimension, it is suggested that a midwife is competent at the point of registration provided:

- she can do the majority of tasks unsupervised to provide the full range of care for a woman with normal pregnancy

- she can detect deviations from normal and take appropriate action when deviations are detected
- she is able to respond appropriately in emergency situations.

Figure 5.2 The nature of competence at registration

Dimension *Nature of competence*	**Clinical competence**	**Individualised care**	**Professional/ friend**
Conditional	▪ Majority of tasks unsupervised ▪ Full range of normal care ▪ Detect deviations and take appropriate action ▪ Use research-based and up-to-date knowledge appropriately in practice ▪ Respond to emergency situations	▪ Able to work with women, respect their wishes and communicate effectively ▪ Balance wishes with safe practice ▪ Accurate assessment of needs ▪ Aiming to adapt practice	▪ Right level of confidence ▪ Manage own workload ▪ Personal and professional awareness ▪ Right attitude ▪ Accountable ▪ Basic decisions
Developing but requiring support	▪ VEs ▪ Suturing ▪ Episiotomy ▪ Teaching	▪ Adapting practice to meet needs across a range of contexts	▪ Being accountable ▪ Decision-making ▪ Agent of change / challenging the conventional
Limited	▪ Providing care for women who are ill or with complicated pregnancies		▪ Managing a ward ▪ Decisions in borderline cases ▪ Confidence ▪ Autonomous practice

It is suggested that, in fulfilling these criteria, a midwife will need to be able to integrate theory and practice – to use knowledge in practice skilfully, and have knowledge that is up-to-date and research-based. The aspects of clinical competence identified where a midwife would be expected to be developing her ability but where she would probably still need some support, include suturing, carrying out VEs and episiotomies, teaching and dealing with complicated cases.

In terms of providing *individualised care*, it is suggested that a midwife at the point of registration should have a genuine interest in the women they provide care for and respect their wishes and autonomy, and that they should be able to

relate and communicate effectively with them. It is suggested that at registration, a midwife must be able to make an accurate assessment of a woman's needs and aim to adapt her practice to meet those needs. She should also be able to balance the needs and wishes of women with the requirements for safe practice. The area identified where a midwife is most likely to need support at registration is adapting practice to meet women's needs across the range of practice contexts.

In terms of the *professional/friend* dimension of competence, it is suggested that the midwife should be reasonably confident at registration, but not over-confident, that she should be able to manage her own workload and identify priorities, and that she should have the right attitude – being committed to midwifery and to doing a good job, being caring and kind, and able to relate to women in her care. It is also suggested that she should have professional and personal awareness, appreciate that she is accountable for her practice and be committed to life-long learning. She should also be able to make *basic* decisions. Aspects of the professional/friend dimension where it was suggested that a midwife is likely to need support to develop further were: being accountable, decision-making, confidence, and being an agent of change. The aspects identified where competence is most likely to be limited at registration were managing a ward, making decisions, especially in borderline cases, and practising autonomously.

The analysis suggests that the general view amongst midwives, midwife teachers, midwife assessors and students is that competence at the point of registration is limited but that the limited nature of competence is acceptable provided qualifying midwives are safe, can communicate effectively, have the right attitude and are motivated and committed to being good midwives. These views have a number of implications, which are discussed in the following sections under three themes: 1) competence at registration as a minimum standard; 2) the role of the midwife in the provision of care for women who are ill or have complications; and 3) the midwife as an autonomous practitioner at the point of registration.

5.3.1 Competence at registration as a minimum standard

The general views of interviewees were that competence at registration is limited and that this is acceptable, provided midwives meet a set of minimum requirements. In these terms, competence equates to a minimum standard which qualifiers must attain - fitness for practice. The analysis also suggests that it is vital that midwives are safe at the point of registration and this is strongly supported in the literature. In the data it is suggested that being safe is the minimum standard and there are examples of midwives in the six cohorts who were considered to be safe practitioners *despite* one or two shortcomings identified. On the whole, midwives were not considered to be ready to be autonomous practitioners either because they were lacking in confidence or because they had not been able to consolidate their practice. In addition, several new midwives suggested they were lacking skills such as episiotomy, VEs, topping up epidurals, and suturing. Yet their assessors and teachers suggested that they would be safe practitioners. However, if the ability of midwives at registration is limited, is it appropriate to consider them to be competent? This is particularly relevant in the light of the discussion in Chapter Two about the development of midwifery as a profession and the midwife as an autonomous practitioner. In addition, is it appropriate to think of competence at registration as a minimum standard? Is 'safe' the minimum standard? Are programme outcomes a minimum standard?

The UKCC's Education Commission (UKCC, 1999) (the commission) distinguishes between three concepts of competence: fitness for practice, fitness for purpose and fitness for award. In terms of competence at registration, the commission suggests that fitness for practice is what is required and expected of qualifying midwives. This is on the grounds that fitness for practice is the UKCC's primary concern and that which is endorsed through registration – on the condition that the individual concerned is keeping constantly up to date professionally. The commission suggests that it would be unreasonable to expect

fitness for purpose to be a function of pre-registration education, 'other than in the broadest sense', given the pace of change in clinical practice. The commission also suggests that although academic awards are markers of achievement, fitness for award does not equate to fitness for purpose. In this light the commission in its report describes competence as:

> … the skills and ability to practise safely and effectively without the need for direct supervision. This concept of competence is fundamental to the autonomy and accountability of the individual practitioner and, therefore, to the (codes, rules and guidelines governing midwifery) (UKCC, 1999, p.35).

Fitness for award implies that a midwife has been successful in achieving all of the assessment requirements over the programme of education and at the end of the programme has been deemed fit for the academic award associated with the programme of education. Thus fitness for award refers to a judgement of competence made at a specific point in time and referring to a specific level of competence. Fitness for practice implies that a midwife has, at the very least, reached the level of competence required to be a safe practitioner. It also implies that, in being safe, a midwife will continue to practise above a minimum standard, although there will be variations in her practice from situation to situation and over time. Fitness for purpose implies that a midwife is able to maintain and continually improve her competence over time, to respond to the evolving role of the midwife (including legislative requirements and the expectations of employers), the situations in which practice takes place, and to the needs and expectations of women and their families. Unlike fitness for award and fitness for practice, where the competence required is outlined in advance as outcomes of programmes of education (and in UKCC and EU requirements for registration), competence for fitness for purpose is not static. Fitness for purpose will mean different things to different midwives according to the situations in which they practise and the needs of the women in their care. This suggests that fitness for purpose involves an awareness on the part of the midwife of her own abilities in relation to the requirements of her role and the ability to identify and

address any learning needs that emerge. It involves life-long learning, being a reflective practitioner, commitment to and the ability to develop practice in the light of research findings, and may involve challenging traditional ways of doing things. In Chapter Seven, the development of competence beyond registration is explored, including fitness for purpose.

The interview analysis suggests that competence at the point of registration equates to fitness for practice. JM Consulting (1998)[5] suggest that fitness for practice comprises:

- appropriate educational qualifications
- clinical competence – ensuring appropriate and safe initial and continuing performance
- health – physical and mental health such that patients could not be harmed
- professional conduct – suitable ethical standards and behaviour (JM Consulting, 1998, p.48).

Fitness for practice implies that the individual is able to practise safely in normal clinical situations and is fit 'to be, and remain to be, registered'.

The other key concepts contained in the Commission's (UKCC, 1999) notion of fitness for practice are safety and effectiveness. It is possible that definitions of competence focus on the concept of being a safe practitioner and of defining a minimum standard because it is easier to achieve than to plot out the capability required for the full scope of practice across an ever-changing landscape. For example, the Commission defines the concept of fitness for practice as fitness to be a practitioner but they report that they did not achieve a consensus on the competence required at registration owing to the dynamic nature of the role of the practitioner. Sharp et al (1995) suggest that rather than trying to map out the extent of competence at registration, it might be more appropriate to focus on the key requirements in order to be competent. They emphasise that the fundamental

[5] JM Consulting were commissioned by the four UK Departments of Health in 1997 to carry out an independent review of the regulation of nurses, midwives and health visitors. The review involved wide consultation with professionals, educators, employers, government, other professions and patient and consumer groups. Their report contains a number of discussion points and recommendations that are relevant to competence at the point of registration.

purpose of assessing competence is to ensure that the individual is safe to be 'let loose' on patients. They suggest that concerns about safety have prompted the extension of competence definitions to include cognitive, psychological and psychomotor skills for safe practice. These issues relating to the specifics of assessment will be followed up in Chapter Ten.

Acknowledging that there will be limitations in capability at the point of registration, the concern of several authors is that, above all, it is vital that midwives are safe practitioners at this stage. See for example Henderson (1992), Ho (1986) and Maclean (1993). They suggest that being safe is the minimum acceptable standard at registration. Interestingly, most accounts referring to *being safe* do not actually outline what it means to be safe. According to Bradshaw (1997), in order to protect patients there must be confidence 'beyond reasonable doubt' that practitioners have the necessary and adequate skills and knowledge. In addition, newly qualified practitioners although they have been deemed fit for practice, purpose and award (Williams and Berry, 1997), will have limitations to what they are capable of and need to be aware of such limitations in order to practise safely. This does not suggest that newly qualified midwives should be limited to this minimum standard of practice. It is important that the term 'standard' should not be interpreted to mean that competence is a 'lowish or minimum level of performance' (Jessop, 1991).

It is suggested that some practitioners will be more capable than others at registration and that there will also be differences in terms of the expectations of other practitioners who will be working with them. For example, Williams and Berry (1997) set out to explore, with a range of experts from all areas of the radiography profession across the UK, at what stage radiographers should be expected to competently carry out the roles and responsibilities of a radiographer. A quarter of the sample expected qualifiers to be ready to practise immediately on qualification whereas the remainder of the sample were divided equally between one to three months and six to twelve months. The research suggested that qualifiers would not be ready to hit the ground running and highlighted the

need for a comprehensive induction programme for new qualifiers along with support and guidance.

Ho, Henderson and Maclean, quoted above, although stating that ensuring that a practitioner is safe is their ultimate concern, also refer to other aspects of competence required at registration. Thus while being safe is the essential requirement, there would also be a range of add-ons that would be desirable of students at registration. Newly qualified midwives will individually be at varying levels of development across the range of practice areas, depending on the range of experiences that they have had as students and on curriculum variations. This is supported by views in the literature outlined in Chapter Three about the idiosyncratic nature of experiential learning and knowledge generated in this way. It is also suggested that the emphasis at registration needs to be on developing competence further and building on the skills and abilities brought into practice at registration, rather than on amassing competencies. This issue has been of particular concern with the model of competence underpinning NVQs (Eraut, 1994a, Moon and Shelton Mayes, 1995).

Supporting the notion that 'safe' might be the minimum standard, the concept of safety is a central concern in the health care literature, particularly in relation to the quality of care, as suggested by Buchan:

> Safety is probably the one area where there is a universal shared belief of what quality in healthcare should encompass. Patients and their relatives judge how well the health system performs by assessing factors such as their access to care, the environment in which it is delivered, the information they are given and whether they are treated humanely and with respect. But they expect that when they are cared for, they will be safe. Safety also tends to be a baseline for clinicians. Judgements about levels of quality will vary depending on assessment of technical capacity and proficiency but ability to practise safely, both as an individual clinician and within a system, is seen as a minimum requirement (Buchan, 1998, p61-62).

Further endorsing the importance of safety as an issue in the regulation of midwifery practice, JM Consulting (1998) state that the first function of the council regulating midwifery should be to develop standards for practice, education and conduct and, where possible, standards 'should be expressed in terms of outcomes which are relevant to public protection' (p.17). This suggests that the minimum standard should be that a midwife is safe. In addition they suggest that, in regulating midwifery education, standards should be expressed in terms of outcomes that would lead to registration as fit for practice.

These findings seem to suggest that the articulation of competence at registration in terms of minimum standards is appropriate. On the basis of the research carried out by Eraut et al (1995) on the content of nursing and midwifery programmes, it is suggested that the effectiveness of teaching on programmes depends on there being clear, realistic goals specifying the level of competence expected at registration. However, one must consider if the use of minimum standards and the resulting focus on minimum rather than optimum standards could have a negative impact on midwifery competence. For example, could it result in lower standards of practice at registration? It is also suggested in the literature (for example, Reynolds, 1999) that versions of competence articulated in assessment criteria determine what is learned. This would suggest that expressing outcomes as optimum standards would be more likely to result in high standards of practice at the point of registration.

JM Consulting suggest there is a tension between aiming for high standards of practice and ensuring that anyone who is capable is not excluded from practising:

> The level that all members of a profession must achieve at initial registration for safe practice is defined by **threshold standards.** Regulatory bodies usually wish to raise standards and these should be developed to become **optimum standards** … but the initial entry threshold must not become so high as to exclude large numbers who are capable of practising safely (JM Consulting, 1998, p.49).

These views and the analysis of the nature of competence at registration suggest that the standard of competence required at registration in order to be safe is not a lowish standard but a reasonably sophisticated stage of development. The minimum standard is that a midwife must be reasonably self-sufficient, have the right attitude and be an effective communicator. The model of competence at registration as outlined earlier in this chapter is about being effective in addition to being safe, as endorsed in midwifery curricula. The analysis of twenty-three midwifery curriculum documents in the EME study provided a distillation of the model of an effective midwife targeted through pre-registration midwifery programmes at that time as:

> … reflective, research-based, autonomous practitioners who contribute to the development of their profession. They work in partnership with women and their families, using at all times a problem-solving, individualised needs-meeting approach, with relevant up-to-date knowledge and appropriate, flexible attitudes to care. They are accountable, evaluating their practice as part of caring and gaining confidence in the process. … Life-long learning by the midwife is essential if they are to meet the challenge of change both within and outside their profession (Fraser et al, 1997, p.23).

This model of an effective midwife goes beyond being safe as a minimum level and is consistent with the requirements to become fit for purpose. The expectation that midwives will go on from being fit for practice to become fit for purpose implies that competence at the point of registration also involves being capable of and motivated towards appropriate, self-directed and on-going learning. The UKCC Education Commission (1999) emphasise the importance of preparation to be reflective and responsive practitioners and life-long learners, particularly in the light of findings about the limited nature of competence at the point of registration:

> While misgivings may exist about fitness to practice at the point of registration, there is much agreement that the current programmes produce registrants who are better able to adapt to change and implement evidence-based practice than those who trained under the old, apprenticeship-style model (UKCC, 1999, p.4).
>
> The climate is right to pursue those objectives, and ensure that entrants to nursing and midwifery are adequately prepared for a career of changing roles, life-long learning and continuing professional development (CPD) (UKCC, 1999, p.2).

The UKCC Education Commission states that in addition to preparing students with the practical knowledge and skills essential for the 'art and science' of midwifery, pre-registration programmes must enable students to develop higher order intellectual skills and abilities.

5.3.2 The role of the midwife in the provision of care for women with complications or who are ill

The analysis of views on competence at the point of registration suggests that the role of a midwife at the point of registration is to provide the full range of care for a woman with normal pregnancy, to detect deviations from normal, and to be able to refer such cases appropriately. The review of the literature outlined in Chapter Two suggests that the midwife has a unique role in the provision of care for normal pregnancy, childbirth and post-natal care that is distinct from, but linked to, that of other professionals also involved in care in pregnancy. In the review of the curriculum documents across twenty-three institutions providing pre-registration midwifery education (Mountford et al, 1995), including the six case study sites, a common assumption was found in curriculum documents that most women of childbearing age are healthy and that childbirth is a natural process or an altered state of health. In addition, mothers, babies and families 'at risk' were deemed to be special cases. This concept of pregnancy being normal was supported in programme structures where the emphasis in the initial observation of practice was on the care of 'normal' mothers and their families

and later to ‘extend her practice to those who are ‘at risk’ or those who develop complications’ (Fraser et al, 1997, p.24). These findings may suggest that the role is evolving and increasingly more orientated towards normal pregnancy - led by an agenda in pre-registration midwifery education programmes.

In this study, the analysis suggests that the six pre-registration midwifery education programmes prepared midwives for a lead role in the care of women with normal pregnancy, with a responsibility to detect and refer deviations from the norm. The dominant view expressed by students was that they felt well prepared to be able to provide the full range of care for a woman with normal pregnancy, childbirth and during the postnatal period. Most assessors and students agreed that qualifiers would need support when caring for a woman who is ill or has complications, because experience is limited or qualifiers lack confidence in this area.

However, of the thirty-nine case-study students, only two began their post-registration practice in non-hospital practice situations, or where midwife-led practice would be the norm. In the hospital situation a large proportion of women will have complications. Recent developments in the organisation of midwifery care have resulted in increasing proportions of women with normal pregnancy being cared for in community settings by community midwives and GPs, increasing the concentration of women in hospitals with complications. It is also suggested that, if new midwives are practising within hospital situations, they are likely to feel under pressure to participate in providing care for women with complications, and this was reflected by a number of students in interviews. Five students suggested that not being prepared to provide care for abnormalities put them at a disadvantage because their colleagues and managers would expect them to be able to provide such care once they qualified. One student suggested that because of her inability to provide complicated care, she would not be able to provide the full range of care for women. On the other hand, a small number of students suggested either that they did not want to be involved in caring for complicated cases or that it was not the role of the midwife but that of an obstetrician. In addition, several midwives and assessors suggested that new

midwives should begin practice in hospital where they would have more support and a wider range of practical experience to help them to consolidate their practice.

There is a tension here in defining the role of the midwife that has yet to be addressed by the profession and by national policy makers. On the one hand, the model of midwifery practice being promoted by national policy is one where the midwife has a lead role in the provision of normal midwifery care. On the other hand, the way in which maternity care is organised is likely to involve the midwife supporting the obstetrician in the provision of care for women with complications or who are ill. The legislation governing midwifery does not take a clear stance on the issue, one way or the other, and allows national policy to be circumvented at local policy level. The implications for students is that there is a mismatch between the model espoused on midwifery programmes and that experienced in reality, which is a significant source of confusion and frustration. This raises questions about whether or not the role of the midwife includes the provision of care for women with complications or who are ill, and if a midwife should be prepared for such a role at the point of registration.

As previously stated, the legislation governing the role of the midwife is quite vague in terms of the role that the midwife should have in providing care for abnormal cases. Pope et al (1996) suggest that, as a result of this ambiguity, doctors are prone to confusing roles and responsibilities in normal and high-risk care. Pope et al's response is that midwives should take full responsibility for medical and obstetrical emergencies if they want to be practitioners in their own right. The UKCC Midwives Rules, Rule 33, states that a midwife must be prepared to meet the requirements of the Midwives Directive. The EC Midwives Directives require the midwife to be able to perform an episiotomy and a breech delivery and to provide emergency care in the absence of a medical practitioner. One could argue that these requirements do not expand the role of the midwife to caring for women with complications, because they involve an immediate and interim response in order to protect the life of the woman and/or baby in situations that may have been normal previously and which cannot be predicted

until they occur. Because of their sudden and urgent nature, all midwives would need to be able to deal with such situations. The EC Midwives Directives also require a midwife to be able to recognise abnormalities and refer them, and to provide assistance 'where appropriate'. In addition they state that the midwife must carry out all treatment prescribed by a doctor. Does providing assistance where appropriate refer to immediate care in emergency situations?

The scope of practice of a midwife is defined under Rule 40 (UKCC 1998), points 1-3. 'Sphere of practice' is referred to in Rule 33, and the rules clearly state that a midwife must not step outside her sphere of practice, except in an emergency, and that the midwife must call on the assistance of suitably qualified and skilled health professionals in such cases. Sphere of practice is outlined in terms of providing midwifery care to a mother and baby during the antenatal, intranatal and postnatal periods. There is no distinction made between the role of the midwife for normal and complicated cases. Point 3 states: 'In an emergency or where a deviation from the norm which is outside her current sphere of practice becomes apparent …'. Does this suggest that caring for complications is outside of the sphere of practice?

The Midwives Code of Practice (point 9) states that the needs of the mother and baby must be the focus of care and that the midwife must be able to effectively carry out emergency procedures, including resuscitation. Point 13 states that the midwife has a responsibility to maintain and develop the competence acquired during initial and subsequent midwifery education. It states 'Developments in midwifery care can become an integral part of the role of the midwife and then incorporated in the initial preparation of the midwife. You must be sure that you become competent in such skills.' In point 14 it is suggested that there are other developments in midwifery and obstetric practice requiring new skills that do not necessarily become an integral part of the role of all midwives, which may be covered in local policies and guidelines, but which should also conform with UKCC requirements and ENB advice and guidance. In such situations midwives must be aware of employer's policies and should arrange suitable training through their supervisor of midwives.

While point 13 suggests that programmes of education dictate the developing sphere of practice of midwives, point 14 suggests that the role may vary according to employers' specifications. However, the requirement that employer specifications must comply with national legislation and guidance provides a framework for local development of the role. The requirement for the midwife to be familiar with local policies, and to take the lead in identifying her own training needs, further emphasises that the ultimate accountability for the sphere of practice is with the midwife herself.

The statement found across curriculum documents as previously identified, that the sphere of practice of the midwife is to provide the full range of care for normal pregnancy, childbirth and the post-natal period, to be able to detect deviations from normal and to be able to take appropriate action when deviations are detected, has implications in this regard. It would require midwives to be able to carry out this range of care with reasonable confidence and to be able to carry out procedures such as VEs and episiotomies and to be able to provide immediate care in emergency situations. It would also require midwives to be aware of the limitations of their practice and the skills that they need to develop to be able to meet the requirements of local policies. JM Consulting (1998) note that the context of midwifery practice is physiology and normality and that pathology and ill-health are not normally the main focus. However, they also note that midwives do also care for women with complications or medical conditions. There are no suggestions from the review of midwifery curricula or midwifery legislation that a midwife at the point of registration should be able to care for women with complicated cases, outside of providing immediate care in emergency situations, including assisting the doctor. If such care is required under local policies, the midwife would need to consult her supervisor of midwives to arrange further training. Presumably this would also apply to tasks such as scrubbing in theatre, and managing a ward.

In terms of skills such as suturing, the code of practice suggests that where a midwife has had proper training to be able to suture effectively, suturing

becomes part of her role. However, if not she needs to refer the woman to a suitably qualified practitioner. Yet the code of practice also implies that if something has been taught on a programme of education, it becomes integrated into the role of the midwife. This notion suggests that the variation found within and between sites in the preparation that students received and their ability at the end of the programme to suture, carry out VEs and do episiotomies, is an issue to be addressed. The UKCC statements on the role of the midwife also suggest that perhaps midwives should be explicitly required to be able to respond to emergency situations, to suture and to carry out VEs and episiotomies to be fit for registration.

In summary, there is nothing within the legislation governing midwifery practice to suggest that the role of the midwife includes supporting the obstetrician in the provision of care for women with complications or who are ill. Further it is suggested that the sphere of practice of the midwife specifically relates to the provision of care for women with normal pregnancy and childbirth, detecting deviations from normal and referring such cases appropriately; and in emergency cases, the provision of immediate care in the absence of a doctor and then assisting the doctor. It is also suggested that in order to fulfil this sphere of practice, a midwife would need to be able to perform skills directly related to the role of the midwife as outlined above and this would include VEs and episiotomies. The legislation also allows for a midwife to expand her role in line with local policy, provided she receives appropriate training and attains the competence required. This suggests that midwives should not be expected to provide care for women with complications outside of the sphere of practice outlined above.

5.3.3 The midwife as an autonomous practitioner at the point of registration

As previously suggested, a midwife must be capable of safe and effective practice at the point of registration. The UKCC Education Commission suggest that this is fundamental to functioning as an autonomous and accountable practitioner. However, the research analysis suggests that midwives are not

always ready to practise independently at the point of registration and are likely to require support for an initial period, at least until they become confident in practice. These findings question whether midwives should be expected to be able to take on autonomous status at registration. In addition, students suggested that they found the notion of being accountable particularly difficult. Yet students are eligible to be independent practitioners once they qualify, and are accountable for their practice. Further, it can be argued that once a midwife is deemed eligible for registration there is nothing to stop her from practising independently. However, UKCC requirements that a midwife should not practise in any area where she is not able to do so in a safe and skilled manner, and the inclusion of midwives in preceptorship recommendations, effectively mean that it is unlikely that a midwife would practise independently at registration.

In Chapter Two the emergence of midwifery as a profession is discussed and a number of arguments are made that, for midwifery to continue its pursuit of professionalisation, midwives must be capable of functioning autonomously. Hancock (1997), identifies a number of common themes in the concept of being a professional:

- *a common value system*, placing the concern of others above self interest
- *responsibility*, which she differentiates from accountability, is concerned with 'answerability'. This is the ability to choose the correct course of action over others 'in a given set of circumstances'
- *accountability* refers to both personal and professional responsibility but which cannot be delegated, even if responsibility is delegated. Accountability requires authority and a degree of autonomy inherent in a role
- *autonomy* is described in terms of 'freedom' to make choices but involving self-discipline and self-restraint, in order to act conscientiously and 'to do the right thing'. Autonomy implies an awareness of one's self and surrounding personal and professional boundaries
- *codes of conduct*, which provide a point of reference upon which professional practice may be based.

The UKCC (1999) state that becoming a registered professional implies that midwives (and nurses) have accepted the responsibilities of registration, abide by professional standards and, through PREP, are continuing professional development. The UKCC is responsible for the government of the midwifery profession and highlights its role in protecting the public through professional self-regulation (UKCC, 1999). JM Consulting also supports this view:

> The principles of professional self-regulation include a responsibility placed on individual registered practitioners to put public safety first in all their actions. Nurses and midwives are expected to be mature, well-educated professionals and to be accountable for their behaviour and practice (JM Consulting, 1998, p.6).

The role of the UKCC in overseeing the professional register and the regulation of midwifery practice would suggest that the UKCC has a role in clarifying whether or not a midwife should be an autonomous practitioner at registration. The UKCC (1998), and in a number of its other publications, reiterates that a registered midwife is accountable for her practice. However the UKCC stance on autonomy or independent practice at the point of registration is less clear. The Royal College of Midwives (RCM) and the ENB, in 1997, issued a joint statement outlining their shared vision for the development of midwifery practice, a key feature of which would be the midwife practising autonomously and taking on increasing responsibility for the overall care of women in pregnancy and childbirth and functioning as lead professional for a client group. The shared vision also suggests that midwifery education will continue to enable midwives to move the boundaries of practice forward. However, the vision does not refer explicitly to autonomy at the point of registration.

There are those who would dispute whether a midwife can ever truly practise as an autonomous practitioner in the NHS. Hunt (1998) argues that in the 1980s only independent midwives fulfilled the complete role of the midwife by 'practising in their own right' and fulfilling the requirements of the EU Directive. She suggests that independent midwives are more fulfilled as practitioners, being

largely motivated by a desire to fulfil the role of the midwife more adequately. She also suggests that independent midwives experience increased self-confidence, linked with their style of practice, and that independence and autonomy are attractive features. In the wake of *Changing Childbirth* (Department of Health, 1993), she suggests that in the 1990s, NHS midwives too have the opportunity to practise much more independently with their own caseloads and though midwife-led care in hospital and community settings:

> The scene is thus set for NHS midwives to achieve the independent and autonomous practitioner status which has been an ideal for so long (Hunt, 1998).

Gough (1995) also suggests that midwives should take full advantage of the opportunity to be autonomous practitioners. She suggests that midwives should view accountability as something that needs to be exploited rather than fear the freedom that it offers. She urges midwives to break out of the culture that often constrains professional practice and, instead of thinking of practice in terms of its limitations and boundaries, to focus on fulfilling the scope and range of practice of a midwife. Further, she states that midwives have a duty to assert their accountability to protect the public interest.

These views support the notion of a midwife as an autonomous practitioner, but the essential question here is: should a midwife at the point of registration be an autonomous practitioner? In the UKCC *Midwives Rules* (1998), Rule 33 (2) states 'Programmes of education shall be designed to prepare the student to assume on registration the responsibilities and accountability for her practice as a midwife'. Does this mean that a midwife should be autonomous / independent at the point of registration? Accountability is not the same as autonomy, it means that a midwife is responsible to the UKCC, to her employer, to the law and to the woman in her care and that she should be able 'to justify her actions' (UKCC, 1996). Accountability is not an 'optional extra' (Pyne, 1994) and the twinning of responsibility with accountability by the UKCC reinforces the point that a

midwife's accountability extends beyond actions, to include omissions of activities for which she is responsible as a midwife.

Section 3 (C) of the *Midwives Rules* suggests a level of self-sufficiency; see for instance point (ii) 'the recognition of common factors… and the taking of appropriate action'; (iii) 'the ability to assess, plan, implement and evaluate care within the sphere of practice of the midwife …'; (iv) 'the ability to take action on her own responsibility, including the initiation of the action of other disciplines, …'; (viii) 'the ability to function effectively in a multi-professional team…'; and (xi) 'the assignment of …appropriate duties to others and the supervision and monitoring of such assigned duties'. They reiterate that the midwife is responsible for her defined sphere of practice, but also for actively handing over responsibility to the appropriate professional once the situation at hand moves outside her sphere of practice as a midwife. Rule 33 point (iv) suggests that there may be some grey areas where the midwife will continue to be responsible but will seek advice, where it refers to 'the ability to take action on her own responsibility … and to seek assistance when required'. As suggested in Chapter Six, acting as an accountable practitioner is an important area of learning in the early post-registration period, particularly if midwives are to harness the benefits of their autonomous status.

Although Rule 33 states that a midwife should be accountable and responsible, there is nothing to say that a midwife should be able to practise autonomously. The EC Midwives Directives (1980) (see Appendix One), in their minimum requirements of midwifery education programmes, do not state that a midwife should be an autonomous practitioner. As Rule 33 and the EC directives are used as the framework for what a midwife should be able to do at the point of registration, these findings would suggest that there is nothing requiring a midwife to be prepared to practise independently at the point of registration. The UKCC Guidelines for professional practice (UKCC, 1996) clearly state that a registered midwife must 'acknowledge any limitations in her knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner'. Although there is nothing stopping a midwife

practising at the point of registration as an independent practitioner, the UKCC's (1995) inclusion of newly qualified midwives working in private and independent practice in their guidance as those in need of preceptorship, suggests that independent practice might not be appropriate at the point of registration. Yet it has been said that the UKCC's promotion of preceptorship is at odds with its requirement in the midwives rules that midwives should be functioning as accountable and responsible practitioners (Jackson, 1995).

Hunt (1998) suggests that, strictly speaking, a midwife is required at registration to be capable of independent and autonomous practice but in reality a new midwife is likely to be given some breathing space:

> At initial registration a qualified midwife must be fit to practise, in any setting, independently and autonomously. In practice, it is in the first few months following qualification that the midwife finds her feet. With the support of a mentor, the newly qualified midwife emerges into a more confident and capable practitioner, (Hunt, 1998).

The debate suggests that midwives are accountable at the point of registration and should be capable of and fit for autonomous practice. However, none of the interviewees suggested that a midwife would be expected to practise autonomously at registration and a small number, including two teachers, were clearly opposed to the notion that midwives should practise autonomously immediately after registration. This issue will be referred to again in Chapter Seven, which explores midwife development over the first year in practice.

Chapter Six

Becoming Competent

6.1 Introduction

The main themes identified in the data in Chapter Five relate to the limited and conditional nature of competence at the point of registration. Building on that analysis, the analysis outlined in the three following chapters relates to learning in terms of becoming competent and learning beyond registration. In this chapter, the nature of learning coming up to registration and the experiences of students of taking on the midwifery role are explored through interviews with students, their assessors and teachers. This is followed in Chapter Seven by a study of the development and maintenance of competence in new practitioners and followed by a review of competence in more experienced midwives in Chapter Eight.

It is suggested in the analysis presented in Chapter Five, that most students participating in the study were perceived to be able to carry out the majority of tasks unsupervised in the provision of the full range of care for women with normal pregnancy, at the point of registration. In interviews at the end of programmes of education, the majority of students were very positive about their preparation for the midwifery role and appeared to be highly motivated and keen to take the next step into practice. A small number stated that they were 'fed up' being students, or that they found the student role restrictive and the time had come for them to practise as midwives. The majority of participating students suggested that although they felt ready to be midwives they were very nervous – which they suggested is to be expected, and that they would still need some support and advice once qualified. However, four students suggested they were not quite ready to practise, and although they felt capable to fulfil the role, they felt they could have done with more experience to become confident.

In tracing student experiences of learning and development over the final stages of programmes, and those of assessors, teachers and other midwives, several themes emerge in the data. The first relates to the transition to be made from student to midwife and the nature of that transition. The second theme relates to

differences between students in their readiness for the role and how this relates to the pace of learning over the programme and in particular, over the final stages of the programme. The third theme relates to specific areas where learning is focused in the final stages of programmes and how this relates to preparation to take on the professional role. A fourth theme relates to the role that expectations can have on how midwives feel about undertaking the role at the point of registration. Each of these themes is explored in turn in the following sections.

6.2 The transition from student to midwife

When students at the six case study sites were asked, at the end midwifery education programmes, how they felt about being a midwife, they talked about the transition to be made at registration from being a student to taking on the role of the midwife. Consistent with this, assessors and teachers also talked about there being a clear shift in role and responsibilities at the point of registration, and most interviewees described transition a very big step to be made to a status that would be very different from that of being a student:

> ... it's a big jump from senior student to actually being qualified, taking all that on board and having the time and support to come to terms with my new role (student midwife).

> … it's a big step from being a student midwife where you're given a certain amount of supervised responsibility and the next step is to take on those responsibilities… (assessor).

It was suggested that qualification involves moving from the largely passive student role, and the 'comfort you get from being a student' to the active practitioner status. This apparent shift from passive to active was also supported by references to 'taking that step', 'taking on responsibilities', 'I've got to make decisions' and 'getting on with things myself', as a midwife from 'being given responsibility', being 'allowed to take a back seat in decision making' and 'practising under some-one else' as a student.

Despite the implied scale of adaptation required, most assessors and teachers suggested their students were ready 'for the big wide world' although the suddenness of transition, or the sudden awareness of the implications of qualifying, could leave students feeling 'vulnerable'. It was also reported by a small number of students that although they felt they were ready for transition and had worked towards it in their final placements, they were always mindful that 'suddenly' they would be practising on their own. The fear of transition also related to having to take on responsibility.

> … it eventually hits you that you are going to be totally responsible for your actions (student midwife).

For several students interviewed, transition was also associated with an anticipated (sudden) withdrawal of support. Many students talked about letting go of support, usually reluctantly and described the prospect of being on their own in terms ranging from being 'a bit daunting', to 'frightening' to being 'terrified'. Several statements referred to having to make a leap, for example:

> .. it's about how people feel when they're about to hold their nose and jump off the edge.. (student midwife).

Teachers also referred to letting go of students:

> ..and what we've said to them is we've let you go, we're sure you'll fly, however we're still here if you need us… (teacher).

Teachers and assessors appeared to be aware of the difficulties that students would face in making the transition, and particularly in terms of the shift from being supported, to having to stand on their own with minimal support. For all students interviewed, it appeared that the anxieties about taking on the responsibilities of a midwife and the accountability associated with practising as a midwife competed with the excitement of finally being able to practise as a midwife.

> I feel excited but I feel scared ... part of me thinks. Oh it's fun, I ought to be confident about things, part of me thinks, Oh I ought to be more competent … I'm really scared about having a blue dress on and people asking me to do things and I don't know how to do them … I'm aware of huge gaps in my clinical experience (student midwife).

> Quite frightening really, because now this is where all the hard work starts, you know for the past three years. Not that we're not going to be well supported when we go out there but this is where, you know we've been well supported, we've had student status, it's going to be very different but exciting (student midwife).

In most cases, interviewees suggested that the excitement over-shadowed any anxiety and worries did not 'put you off wanting to go out' but merely 'holds you back a bit'.

Most qualifiers said they felt 'ready' or 'eager' to practise. In such cases, experiences in the final stage of the programme that enabled students to feel that they were safe and as though they could be a midwife (such as being given increasing amounts of responsibility) appeared to have been instrumental. A number of qualifiers were particularly excited that finally, they would have the opportunity to practise in their own right and to develop their own style of practice.

> I actually found the student status in the last few weeks a bit restrictive and I feel ready to go on a fuller role without having to justify to everyone else as well as myself why I'm choosing to do certain things, and to practise more in a way that I want to practise than the way other people dictate to me as a student (student midwife).

The analysis suggests that experience has a vital role to play in final preparation for the role, in so far as qualifiers who felt they had not had sufficient experience to adequately consolidate their practice, appeared to be more anxious about being a midwife. A small number of students appeared to be particularly anxious about qualifying. From their interviews and from interviews with their teachers and assessors, three factors were suggested to be largely responsible for their anxieties. The first related to not having had enough clinical experience to consolidate practice, such as having a caseload, working alone, or doing 'confidence' deliveries. One qualifier was particularly concerned about being expected to do things once she qualified that she had not done before. The second factor related to feelings about the enormity of the responsibility that is taken on with the role of the midwife. One qualifier was particularly anxious about this aspect of transition, in particular in terms of having to make decisions and be responsible for those decisions.

> It's just quite an enormous responsibility. I think the ideas I had at the beginning of the course were, shall we say, a bit idealistic. … But this year when you're given an increasing amount of responsibility and you have to start questioning your own judgement … and as the year's gone on and you realise more and more, and the more responsibility you're given, I think the more terrified it actually becomes (student midwife).

Thirdly, it is suggested that a small number of students may have had unrealistic expectations about what they should be able to do at the point of registration and set standards for themselves that were unrealistically high. For example, one qualifier expected to be ready to practise independently at the end of the programme, and finding that she was not ready to at the point of registration was a particular source of anxiety for her.

In addition, it is suggested that student expectations of capability at the point of registration may not match those of assessors and teachers. For example, another very anxious qualifier felt she would need at least another six months' experience

before she would be ready to practise and was very anxious about the prospect of practising alone. However, her assessor described her as excellent, very conscientious and very capable but said that she had a very anxious type of personality and that she undervalued herself.

The general views of teachers, assessors and midwives were that a midwife at the point of registration would be competent to practise provided she has support and views were generally consistent about what that support would entail. The main difference between the views of interviewees in this regard was whether or not qualifiers would need a preceptor, or someone specifically nominated to provide support for each midwife, during the first six months or so. Some interviewees suggested that new midwives should have a preceptor to 'sit and listen to their needs', 'give support until she gains her confidence', 'someone to say you're doing it right'. Other assessors and teachers felt the level of support needed by new midwives could be provided by other midwives working with them - 'someone else there to refer to' if a problem arose or if the midwife was unsure about something. An experienced midwife suggested that it is important for a midwife to know that support is available and for midwives to feel that they can approach colleagues for advice.

6.3 Differences between students in the pace of their development over the final stages of the programme

In the analysis of the views of interviewees on learning over this final period, three distinct types of development can be identified. For just over a quarter of students it is suggested that the pace of development was 'about right' and capability had developed gradually over the three years towards a point at the end where taking on the role of the midwife was the next logical step, as illustrated in the following quote:

> The last few placements we were on delivery suite … from then on really I felt … as if I was responsible for everything I did myself. So I think this course has really allowed us to gently seep into

> becoming a midwife rather than suddenly at the end being dropped (student midwife).

The second type of development identified was where learning was accelerated over the final six months of the programme. It is suggested that this applied to about half of the students across the six case study sites. The two following interview extracts suggest that this final stage of development made a big difference to students in preparing them to step into practice.

> ..even six months ago I would have said I don't know, I would have been unsure but I do feel a lot more confident and again you're taking action on your own responsibility but getting help when it's required … (student midwife).

> Well, I feel more ready now to practise. I think the last few weeks have changed me really, before I didn't think I could ever feel like I'd be a safe practitioner but I feel now that I'm safe and that I'm as ready as I'll ever be to take that step into practice… for the last six months of the course, being given the freedom and confidence by the midwife, the mentor, to undertake your caseload has helped … (student midwife).

A third experience of final development was reported by a small number of students, who suggested that they had struggled to be ready to take on the role or felt ‘things had only just come together’ at the very end of the programme. In two cases it was suggested by assessors that students were not yet ready to undertake the majority of tasks unsupervised and that one of those students could not be relied upon to recognise deviations from normal and take appropriate action. Another student was described as ‘only just’ capable by her assessor and assessors suggested that three students, although capable, lacked experience of putting it all together. While assessors were generally positive about students’ ability to provide individualised care, it was reported that three students needed to develop their communication skills more and that two students needed more

experience adapting their practice to meet the needs of individuals. Confidence was the biggest issue identified, with about as many midwives reported to be lacking in confidence as were reported to be confident. It was also suggested that two students might be over-confident. In addition, assessors suggested that three students would have difficulty managing their own workload. Six students appeared to be particularly anxious, but willing to take the step into practice. One was concerned about making a mistake, one felt she had only just begun to make decisions, and one was concerned about the sudden withdrawal of support.

6.4 Final preparation for the professional role

The analysis focused on areas where students appeared to have developed most in the final stages of the programme. In addition, students who suggested they felt ready to practise at the end of the programme were compared with other students who suggested they felt they could have been better prepared. The analysis also focused specifically on differences in experience and how these differences related to difficulties that students had at the point of registration.

Overall, three specific areas were identified where learning is focused towards the final stages of programmes: consolidating practice, developing as accountable and responsible practitioners, and providing individualised care. Consolidation was the term used frequently in the data to refer to students revisiting areas and drawing together and integrating all the elements of practice and the aspects of the midwifery role, and while doing so, acting out the role and making decisions. It is suggested that during this final period, students who felt well prepared were not learning new things but building their experience and fine-tuning their practice. They reported that they had been given experience of practising with increasing responsibility and less supervision, and of taking action, making decisions and using their own initiative. They talked about a growing awareness over this period of the limitations of the sphere of practice of a midwife and of developing confidence in recognising deviations from normal and being able to refer such cases appropriately. It is suggested that developing as an accountable and responsible practitioner also involved becoming a more effective communicator with other professionals and functioning as a team member, as

illustrated by one teacher:

> … the clinical staff and ourselves have been very impressed with the way, towards the end of the course, that they were assuming responsibility, getting on with the job and their decision making was perfectly sound (midwife teacher).

It was also suggested that in this final stage of the programme, students developed in particular in their ability to provide individualised care for a woman. Over this period, students reported that they became better able to balance women's wishes with the requirements of safe practice, to assess needs, and to plan care. A small number of students were also reported to be beginning to develop their own style of practice. Other areas of development identified included building confidence, learning to manage self and workload, developing as a reflective practitioner, and developing a better understanding of ethical issues.

In the analysis, several themes emerged relating to specific factors involved in final development and how differences in experiences might relate to difficulties that students had at the point of registration. It is suggested that senior students learn to *be* a midwife by taking on, and being given, more and more responsibility, including taking on a caseload.

> … to actually be a midwife on your own, it's not until you actually do things like confidence cases where you actually really have to think and know that you've got to make the decision and that you are on your own, because when you have got a mentor there they do take a lot of the responsibility and make the decisions for you (student midwife).

It was also suggested that students need to learn to take action on their own, but with support. For example, they need to be given experience of referring women with complications, rather than telling a midwife and the midwife referring. They

need experience managing labour and making decisions in labour, but with support and advice. However, it appears from the data that not all students had such experience. At one site, a number of students failed their exams and as a result were not allowed to take on a caseload while working on placements in the community. As a result, the students concerned went without such experience before qualification, although they felt it would have been valuable to building their confidence.

Several factors involved in student learning and experience towards consolidation and taking on the role of the midwife were identified. Students and assessors reported that some mentors/assessors may not be willing to hand over responsibility to students or that they may not have the confidence in a student to do so. The experiences that students have may also be influenced by other pressures that midwives face in the practice area, for example:

> … because generally things are a bit rushed and if it's rushed then they want the quickest solution and that's usually relevant to explaining to you how to do it, they let you watch them do it ... (student midwife).

It was also suggested that the students themselves need to be willing to take on responsibility and to ensure that they get adequate practical experience and that students may find it was easier to sit back and let an assessor make the decisions.

The structure of the programme was raised as an issue and, on some programmes students were not introduced to midwifery practice until the second eighteen months of the programme. It was suggested that this did not leave enough time for students to get all the experiences that they required in time to have some space at the end of the programme to consolidate practice, develop their own style of practice and build confidence. One teacher suggested that the organisation of clinical experience in the final stages could be better geared towards enabling students to consolidate practice:

> I just think the last year is a very important year. I think there's a lot of movement in the last year ... I think that's to do with there being … a lot more clinical experience as well as theory and I think it's also to do with prolonged allocations in terms of 14 weeks in areas which really means it gets their feet under the table and has been beneficial to both parties (midwife teacher).

The continuity of midwifery placements was also identified as a factor involved in student development over the final stages of programmes. Several students said they preferred study blocks rather than study days so that they could have longer placements and become more confident in the particular area before being moved on again. This was a particular issue on labour suite. A teacher and a small number of students also suggested that student experience in the final months of the programme could be more student-centred, enabling students themselves to identify the experience that they need, with the support required from others to meet the needs identified.

> It's something that has cropped up… I think the students themselves would be the first to say that they would want more experience, they feel as if they've begun to get that experience during their student centred allocation in most instances, but that's only five weeks, that doesn't equip you to go and take on an independent practice (midwife teacher).

As discussed previously in terms of the limited nature of competence at registration, the management of labour was often the area where qualifiers felt least confident. Yet students suggested that on labour suite, they were not given a lot of responsibility, or experience of making decisions.

> The one area where I am more apprehensive is perhaps labour ward and that's because that's the area in training where you've had less opportunity to work on your own where you have tended to sort of

> have a midwife coming in to check what you do, and you haven't really taken many decisions on your own (student midwife).

The need for students to be able to consolidate practice is supported by the findings of the UKCC Commission's review of fitness for practice (UKCC, 1999). They report 'disturbing anecdotal and empirical evidence' that newly-qualified practitioners were perceived to be lacking in practical skills literacy and in need of constant support. They link this perceived deficit in competence and, the perceived failure of programmes to facilitate the development of practice knowledge and skills, to the current structure of pre-registration programmes. The key issues reported are that practice is introduced too late in programmes, and that placements are too short and are lacking relevance. They suggest that more emphasis is required in programmes on the development of practical skills and recommend that:

> The sequencing and balance between university and practice-based study should be planned to promote an integration of knowledge, attitudes and skills. (UKCC, 1999, p39, Recommendation 16).

They recommend that students should have a period of consolidation of at least three months towards the end of the programme to assist them to make the transition to practitioner. They also recommend that this transitional period should be a period of supervised clinical practice with clearly specified, role-related outcomes attached.

It is suggested in the literature that consolidation is also vital to becoming a professional. Bucher and Stelling (1977) explored the characteristics of imminent graduates (medicine, psychiatry, biochemistry) and how they *become* (or are socialised into becoming) professionals. They suggest that professional identity is a 'crucial aspect of becoming a professional' and the feeling of competence and having confidence in one's ability to become a proficient practitioner in the field, are prerequisites to developing professional identity. Further, they suggest that commitment to one's work and to one's colleagues is intricately intertwined

with professional identity. Their findings identified that role-playing, 'with autonomy and responsibility associated with playing central, valued roles of the profession' was the most important activity in the development of professional identity and commitment. Further, by comparing differences between groups of graduates they found that those who experienced the greatest confusion and lack of clarity about the roles they were expected to play, had the longest period of initial confusion and anxiety after qualifying. They conclude that:

> Until one is actually involved in doing the work of the field, it is difficult to demonstrate to oneself or to others that one has acquired the requisite skills and knowledge. It appears, also, that for role-playing activities to result in a sense of mastery, they must involve some degree of autonomy and responsibility on the part of the trainee; the trainee must, at least, perceive that he or she is acting independently (Bucher and Stelling 1977, p267).

Using Fuller's (1970) concerns-based model of teacher development, Eraut et al (1985) suggest that before students can be socialised as professionals, they must first satiate a number of other concerns. Fuller's model contains three phases to teacher development:

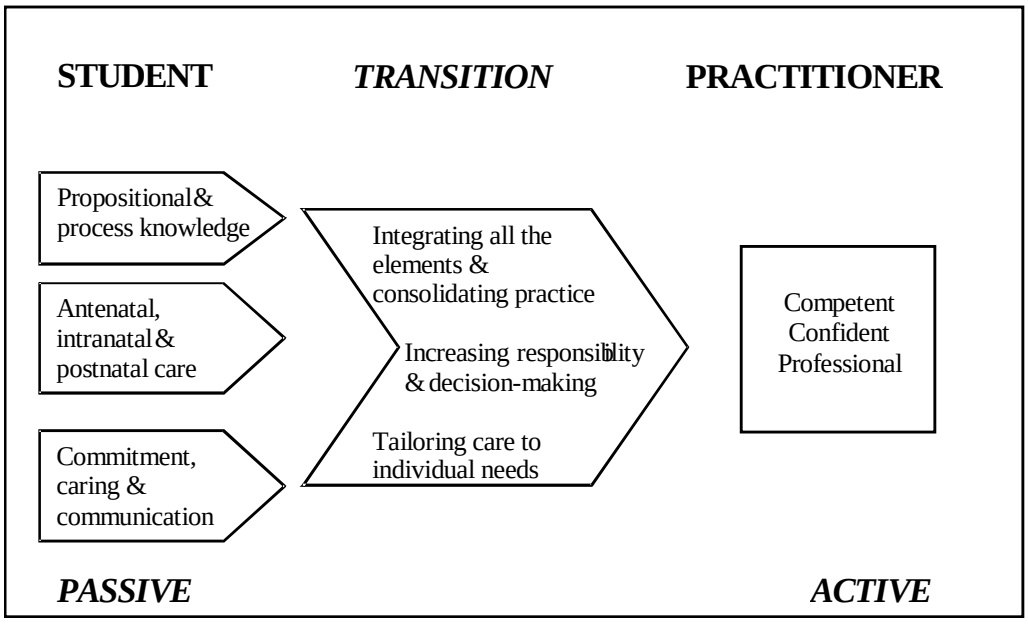
- *The early phase*
  - involving concerns about self. (stage 0)
- *The middle phase (competence)*
  - involving concerns about professional expectations and acceptance,
  - one's own adequacy, and
  - relationships with pupils. (Stages 1-3)
- *The late phase (professionalism)*
  - involving concerns about pupils learning what is taught,
  - pupils learning what they need, and
  - about one's own contributions to pupil change. (Stages 4-6)

Applying the model to nursing and midwifery, Eraut et al conclude that:

As students' competence and confidence develops, they begin to find space for other, more professional concerns (stages 4-6). Are the outcomes for clients more satisfactory, are all clients' needs being met, are they personally making the optimal contribution to the client's well-being? We have called these 'professional' concerns because they entail going beyond basic coping with routine demands to the beginning of client-centred practice based on reflection, personal theorizing and the practical use of scientific knowledge (Eraut et al 1995, p186).

This view is also consistent with the findings on *consolidation* in this study, suggesting that students need a period at the end of the programme specifically designated for them to role-play, with increasing responsibility but also within a supportive environment. It is also suggested that being able to adapt practice to meet the needs of the individual was a key concern for students. Drawing on the findings presented so far, transition from student to practitioner is outlined in Figure 6.1. This emphasises the importance of consolidation during the final stages of the programme.

Figure 6.1 Becoming competent



Source: Analysis presented in this chapter and in Chapter Five.

6.5 The need to manage expectations

Interviewees suggested there was a mismatch between what students, and their teachers and midwives, expected in terms of competence at the point of registration and the role that qualifiers should be able to fulfil. It is also suggested that this mismatch between expectations, and a mismatch between student's expectations of being a midwife and the reality of practice experienced upon qualification, was a concern for a small number of new midwives. This theme is raised again in Chapter Seven, which focuses on the experiences of midwives over the first year in practice.

As previously suggested, the aims of pre-registration midwifery education include preparing midwives to:

- take on a lead role in providing care for normal pregnancy, to detect deviations and to refer appropriately, as outlined in *Changing Childbirth* (Department of Health, 1993)
- be agents of change and knowledgeable doers, equipped for research-based practice and to be able to challenge conventional practices
- be continuous learners with skills of reflection, and able to recognise and address their own learning needs.

The (re)introduction of pre-registration midwifery education following closely on the heels of Project 2000, has provided an unprecedented opportunity for midwifery educators to outline a new curriculum to truly change the course of midwifery practice. The move of more and more providers of midwifery education in with institutions of higher education provided the licence for providers to enhance the theoretical underpinnings of midwifery education programmes by including subjects such as sociology and psychology as foundation elements of programmes. The focus of midwifery programmes is on health, education, and promoting health, and pregnancy and childbirth are seen as altered physiological states and normal activities (Mountford et al, 1995). In addition, the publication of *Changing Childbirth* by the Expert Maternity Group in 1993, gave further credence to the notion of the midwife as the lead professional in the provision of care for normal pregnancy and childbirth.

It is suggested however, that in reality the wheels of progress turned a lot more slowly in the development of midwifery practice and only two of the thirty nine new midwives in this study cohort found themselves practising in situations consistent with the new ways of working outlined in *Changing Childbirth* and reflected in curriculum statements.

In terms of becoming competent, it is suggested that the role undertaken by students at registration had not yet evolved in line with that espoused in curriculum documents and promoted over the duration of the programme. This was a source of frustration for a small number of students, who suggested that the role that they would undertake at registration would not be the same as that promoted on the programme.

It is also suggested that a similar number of new midwives felt under pressure to revert to conventional ways of doing things, rather than challenging practice. This is also reflected in concerns that a small number of participants had about not being able to provide care for women with complications or who are ill and concerns about fitting in within the practice situation.

However, it is suggested that most of the study midwives accepted and were able to cope with the realities of midwifery practice. Some new midwives reported that they would be happy to practise in the hospital situation initially and gain more experience so that they could move in the longer-term into community or team-based positions, which they anticipated would enable them to practise more along the lines of *Changing Childbirth.* Other new midwives suggested that they would use the interim period as an opportunity to learn more about other aspects of midwifery practice.

6.6 Conclusion

The analysis of the views expressed by students about the final stages of their preparation for the midwifery role and those of assessors, teachers and midwives working with them suggests that becoming competent involves a distinct and

sudden transition from the passive student status to the active practitioner role. It is suggested that transition is a significant event in the lives of students and the careers of midwives and that this time is an anxious but exciting time from students. Further, it is suggested that the final stages of learning in preparation for that transition to the role of the midwife involves consolidating practice, becoming reasonably confident, taking on accountability and responsibility, and providing individualised care.

Consolidation is a vital element of development in the final stages of preparation for the role of the midwife. The focus of consolidation is on further developing knowledge and practice through experience and with reduced support, as opposed to learning new things. Through consolidation students build confidence, develop coping skills and learn to be autonomous. Consolidation is more likely to occur where students are allocated a specific period at the end of the programme and where they have previously covered the full range of learning. In addition, consolidation is more likely to occur where practice allocations provide a degree of continuity for the student and where learning is explicitly student-centred over the final stages of programmes. The experience of transition from student to midwife can also be enhanced by ensuring that students have realistic expectations of the role they are likely to fulfil upon registration, the competence expected of them, and the type of support that they will have.

Chapter Seven

Learning and the development of competence over the first year in practice

7.1 Introduction

Following on from the findings discussed in the previous chapter, this chapter focuses on learning and the development of competence over the first year in practice. The chapter begins by outlining general themes on learning and development identified during the analysis, and then focuses on differences between students. The research took both prospective and retrospective views by asking interviewees at the end of programmes to identify specific learning needs that students had and also, at six months and a year following registration, asking interviewees to reflect on learning and what had happened over the year.

7.2 Learning over the first year in practice

The areas of learning identified by interviewees as priorities can be related both to fitness for practice and fitness for purpose, as outlined in Chapter Five. In terms of fitness for practice and providing care for a woman with normal pregnancy, the biggest priority for most respondents was to consolidate practice (along similar lines to that outlined coming up to registration in Chapter Six). This is reflected in the following quote:

> So I'd obviously want to learn some new skills, but nothing too daunting in the first six months. Really just getting the confidence, having the chance to work on my own, making my own decisions, and really just see how I go from there … really just, sort of don't expect too much of myself in the first six months, just give myself time to get into it, because it's a totally different role, student to midwife. Just to start feeling comfortable in that role as a qualified midwife (student).

It is suggested that individuals needed to consolidate practice before learning anything new because they did not have the opportunity to consolidate as

students, or because practising as a student was perceived to be different to practising as a qualified practitioner, for example:

> To be more independent, I mean to be truly independent, but at the moment although we're senior students you're not truly independent (student midwife).

> ... it's really confidence building and it's knowing you're taking the responsibility now, the buck stops here, there isn't someone else behind me who's going to take that any more (student midwife).

New midwives talked about learning by being on their own and taking on responsibility. This also involved making their own decisions, learning to trust their own judgement, and developing confidence in activities such as interpreting VEs and cardiotocographs (CTGs). Several interviewees identified working on delivery suite as a particular area where new midwives needed to consolidate practice.

The views of teachers and assessors were broadly consistent with the views of students, that consolidation was what qualifiers would require more than anything else. The need to consolidate practice was differentiated from being deficient in any knowledge or skills required to provide midwifery care safely. Consolidation was described in terms of a period of 'polishing off', or putting together all of the pieces and using theory in practice. It was suggested that midwives would build confidence through gaining experience of practising across the range of midwifery contexts. Assessors also suggested that new midwives would need to develop their own style of practice by basing their practice on research findings, by developing their ability to adapt practice to the type of care each woman wanted, and being able to assist women to make informed choices about their care.

New midwives (participants), their teachers and assessors said they did not anticipate that participants would have any particular learning needs in terms of skills for the role of the midwife in normal care and suggested that they would

just need more experience of being a midwife. Except for a very small number of midwives who had little experience doing episiotomies, catheterisation and hanging blood, this view was also reflected in interviews with other midwives and supervisors of midwives who worked with participants over the first year in practice. In terms of episiotomy it was acknowledged that changes in midwifery practice tends to mean that fewer women will have episiotomies and therefore there are fewer learning opportunities for student midwives.

While interviewees identified a small number of new skills that participants needed to learn during the year, the general view amongst midwives and supervisors of midwives was that these skills - suturing and topping-up epidurals, were skills for the 'extended role'. However, two students suggested that in order to be able to provide continuity of care for women so that they could function as an independent practitioner, they would also need to be able to top up epidurals and suture. In these areas there were new midwives who had been assessed as capable by the end of the first year but a greater number of new midwives highlighted that they did not have sufficient experience or any experience at all during that time. Pope et al (1996), in their study of the changing educational needs of midwives, found there was a particular issue in relation to the extent to which all midwives could provide holistic care, especially where specialist midwifery skills are required.

There were mixed views from midwives and supervisors about suturing and several interviewees did not seem too concerned that participants were not suturing by the end of the year. Along with suturing and topping up epidurals, interviewees identified areas where participants gained additional knowledge and skills during their first year in practice:

- ward management
- counselling and dealing with bereavement, pregnancy loss and stillbirth
- neonatal and adult resuscitation
- skills for neonatal unit
- intravenous cannulation and additives

- providing care for abnormal or complicated cases
- non-midwifery drugs and doing drug rounds
- 'taking a baby' and 'scrubbing' in theatre.

Pope et al (1996) in their study of the changing educational needs of midwives carried out a survey of midwives across all grades, regions and types of maternity units, supervisors of midwives, consultant and registrar obstetricians and general practitioners. They identified that priority areas for midwives to develop clinical expertise were intravenous cannulation, perineal suturing, ultrasonography, labour and delivery in water, and cardiotocography interpretation. To a smaller degree the survey identified epidural topping-up, adult and neonatal resuscitation, assisting with forceps and ventouse delivery, alternative therapies and neonatal care as areas where midwives had educational needs. The difference in emphasis on epidural topping-up and resuscitation between the findings here and Pope et al's findings possibly relates to the stratified sample of the range of midwives surveyed by Pope et al, whereas in this study the focus was on midwives in their first year as practitioners.

While the analysis as outlined here and in Chapter Five suggests that qualifiers were fit for practice at the point of registration, seven students suggested that they did not feel that they were fit for purpose because they could not provide care for abnormal or complicated cases. They identified learning to provide such care as a priority for them immediately after registration. Six of these students suggested that they would be required to provide care for women with complicated cases (or in one case to work on the neonatal unit) when they qualified and they felt they had not been prepared to provide such care. Another student was keen to get experience once she qualified of providing care for abnormal cases on delivery suite to get over a particular fear that she had in that area. Two students said they wanted to gain more experience of working in theatre, in particular dealing with caesarean sections.

Assessors and teachers also suggested that new midwives would need to develop in terms of fitness for purpose, on the following grounds:

- it was suggested that although new midwives were well prepared to be able to provide the full range of care for a woman with a normal pregnancy, the reality of midwifery practice was that midwives would be required to be able to do things for which they had little preparation, such as: managing a ward, siting intravenous cannulae, or doing a drug round
- it was also suggested that midwives would need to develop additional skills to be able to practise in contexts that are different to those in which they trained.

7.2.1 A different type of learning

New midwives talked about a different type of learning over the first year in practice to the type of learning they had experienced as students. Two participants suggested they had learned more over the year than they had over the three years, while others said that for them qualifying was 'just the beginning'. It seems that perceived differences in learning relate partially to taking on responsibility and acting out the role of the midwife on your own, which it is suggested, is something that cannot be done as a student.

> … you do most of your learning once you've qualified … As far as management and doing everything independently and stuff has been, very much once you're qualified you're on your own two feet - then you start learning (new midwife).

Several participants also suggested that they learned through being able to provide holistic care and being able to provide continuity of care, which they had little experience of as students. It was also suggested that learning as a midwife is different to learning as a student because the background against which midwives practise is different to that as a student. For example, interviewees talked about the pressures relating to studying, exams and assignments being lifted once they qualified.

> I feel as though I've learnt a hell of a lot in the last 12 months ...I feel that I took it in a lot easier, I mean whether that's because I'm

> more relaxed because there isn't the pressure of studying when you get home and things like that (new midwife).
>
> … everything seems to click into place and whether it's because you're not under as much pressure as a student to know everything, when you're qualified you can sort of relax a little bit … (new midwife).

Participants also referred to learning over the year plugging small gaps in their knowledge and having the time to read up on things of interest to them.

7.3 General trends in the development of competence

As previously stated, the findings suggest that during the first year in practice, midwives developed beyond the basic fitness for practice, to fitness for purpose, that is, being able to do all of the things required of midwives in the practice situation that they enter. The research also explored patterns of development over the year. The general pattern that emerged was that new midwives felt reasonably unsure and anxious at first but that by about three months into the year they began to feel confident again, as a result of experience and being able to consolidate practice. Most participants suggested that the first three months or so of the first year was the most difficult for them and that most development took place over the second half of the year. There is also the sense that towards the end of the year in practice, midwives were developing a more sophisticated style of practice that was more fluid and integrated. One example given related to communication:

> I think communication skills are an ongoing developing thing, I've learnt to stop and listen a bit more to the woman and the family and to other midwives, how they have thought the mother's been reacting, responding, noticing how they are with other people, that when the doctors come in how they respond … (new midwife).

Having to take on responsibility, described by some as the 'enormity of responsibility', appeared to have been the most challenging aspect of being a midwife for most participants in this study. The areas where midwives suggested participants developed most were:

- consolidating practice in relation to providing care for women with normal pregnancy
- becoming more confidence and having more confidence in their own ability, demonstrated for example by midwives being able to make decisions more easily (while at the same time being happy to discuss care) or beginning to put forward ideas within the team. This theme was, by far, the theme most mentioned by new midwives (almost all midwives) and other interviewees
- functioning as an independent practitioner or 'standing on their own two feet', taking on responsibility and working on their own initiative, especially on labour ward
- managing a ward, which was identified as a particular weakness for several new midwives at registration
- communication, especially in terms of sensitivity and being more assertive, and challenging medical staff where appropriate
- organising their workload and managing a caseload, including planning work, thinking ahead and prioritising.

Taking on responsibility, coping and judgement appear to be closely linked and each of the three themes was highlighted by over a third of new midwives. In addition, themes were identified relating to the development of knowledge and midwives 'fitting in'.

7.3.1 Developing confidence

The analysis of interviews suggests that confidence is both a product of development over the first part of the year and a precursor to further development, suggesting that the development of confidence has a vital and pivotal part to play in development beyond registration. In terms of confidence as a precursor to further development, it is suggested that a midwife needs to

build confidence in order to feel that she can take on responsibility and for her to fulfil the role of the midwife fully:

> … I'm trusting my thinking. Running a ward, things are coming rather than having to checklist all the time … It's more that I'm more confident in knowing what I'm doing (new midwife).

> … I look at her now and she's very different to how she was when she first came initially, and she's now performing better and I would say because she's more confident ….so she's obviously developed and she's feeling confident within the team (experienced midwife)

Experienced midwives gave examples of how confidence is required for an individual to be able to perform and of how lack of confidence can obstruct an individual from functioning as a midwife, such as:

> Well initially when I first started as preceptor to her, she didn't have very much confidence at all. She was using me a lot of the time as a mentor ... still in the student mode, not really wanting to take responsibility, and I had to really confidence build her a great deal really and initially in the first six weeks I was a bit concerned about her. I found that she was not sure of what she was doing and needed an awful lot of guidance, but to her credit she's done really, really well (experienced midwife).

> I must admit we just felt they were disastrous, … the transition from being a student to now a midwife … well the point is they were functioning as senior student midwives rather than staff midwives (experienced midwife).

Other examples were given of new midwives who felt that as they became more confident, they were able to use their knowledge more in discussions with women and with other professionals.

It is suggested that most midwives in the study experienced a drop in confidence when they first qualified.

> My confidence is just slowly improving, because I think you get to a certain stage as a student when you feel you're on top of everything, and the moment you qualify then it all falls down again really and I think you start again, building it up in a different fashion really, to be independent. (new midwife)

While midwives working with them stated three participants were confident at registration, the general view was that participants' confidence dropped initially at registration. Interviewees suggested that following the initial drop in confidence, it then took most participants three to six months to build confidence again to a level where they felt comfortable in practice. In interviews, participants appeared to be much more confident over their second six months in practice. However, a very small number of new midwives were still lacking in confidence beyond the six-month stage. The findings suggest that for these midwives, confidence did improve over the year but not as much as for other new midwives.

> Unfortunately (she) sometimes is (her own) worst enemy and it's very difficult to assess her in some things because she's very anxious, that's her personality … she's extremely anxious … but she's very good, very conscientious, her practice is quite good and she's very thorough… her anxiety levels have definitely fallen, she has improved (supervisor of midwives).

In addition, midwives and supervisors suggested that a very small number of participants may have been over-confident at the point of registration - in the sense that they appeared more confident than generally would be expected. It was suggested that to be over-confident could be dangerous as over-confident midwives might take on something beyond their capability. However, it was also suggested that by the end of the first few months this very small number of new

midwives had adjusted to a more appropriate level of confidence - ‘the right level of confidence’.

Consistent with the findings previously outlined on consolidating practice, it is suggested that the experience of being a midwife and taking on responsibility is very important in building confidence. Through this experience, midwives learn that they ‘can do it’ and that they can cope with the range of experiences that they are likely to experience on a daily basis. It was suggested that confidence also develops through familiarity with the practice area itself, suggesting that some degree of continuity in practice placements will help in the development of confidence. The importance of support networks was also identified, suggesting that new midwives may feel more confident if they know that there is someone available that they can turn to for advice or support. It was also suggested that new midwives should focus on consolidating practice first and become ‘comfortable’ with that before thinking of taking on new responsibilities and new areas of practice. Linking in with the theme on coping, building confidence was also linked by one interviewee with developing the ability to predict how situations would unfold and developing a feel for practice.

> (I feel) much more confident, not only with the way that I deliver care but just with talking with mums and making assessments, and being able to predict how things will develop, not being caught out so often with the multips who come in and sneeze and deliver. Just being able to assess more accurately really how things are going to go (new midwife).

The analysis suggests that there are both intrinsic and extrinsic factors involved in developing confidence beyond the point of registration. Intrinsic factors relate to feelings that new midwives have about their own ability to fulfil the role of the midwife. This also relates to how realistic new midwives’ perceptions are of what should be expected of them upon qualifying, which was highlighted by a small number of participants who had difficulties with confidence and who (unrealistically it is suggested) felt they should have been much more capable at the point of registration. Two such midwives had difficulty building confidence

and three midwives were assessed as over-confident. It was suggested that other intrinsic factors involved in confidence development over the year included the level of confidence at registration, individual coping skills and perceived gaps in skills.

A number of extrinsic factors involved in the development of confidence beyond registration were also identified relating to:

- the opportunities that midwives had to consolidate practice
- the amount of experience midwives had of making decisions
- the mix of normal and abnormal cases
- the stability of the practice environment
- the mix of routine and non-routine
- familiarity with the unit
- the number of hours worked per week
- whether the environment was supportive.

7.3.2 Taking on responsibility

Taking on responsibility was identified as a key area of development and was also linked closely with becoming confident and two other aspects of competence - coping and judgement. As discussed in Chapter Six under *Transition*, new midwives at registration are required to move from a relatively passive student role to the active practitioner role, which requires them to take on responsibility for the role of the midwife and to be accountable for what they do, for any omissions on their part, and decisions that they make.

The analysis suggests that at registration the new midwives in this study were aware of what it meant to be responsible and accountable as a midwife. In addition they had been given varying degrees of experience of taking on responsibility, towards the end of programmes. Interviewees suggested that with experience over the year, most new midwives became more comfortable with being responsible. It is also suggested that developing as a responsible practitioner occurs across several dimensions including:

- expansion of the breath of responsibility from providing care for one woman at a time or a small caseload to managing a larger group of women/caseload-requiring the midwife to be able to prioritise
- expansion of the scope of practice beyond providing midwifery care only for women with normal pregnancy or low risk cases to assisting with or providing care for women who are ill or have pregnancy complications and taking on non-midwifery responsibilities related to managing a ward
- taking on responsibility and becoming more independent/autonomous, including making decisions and developing a better understanding of responsibility and the midwifery role
- coming to terms with being accountable.

7.3.3 Coping

Also very closely linked with taking on responsibility was learning to cope with the realities of practising as a midwife. Several new midwives talked about the enormity of responsibility that they took on at the point of registration, how stressful they found the experience, and some suggested that they had been 'thrown in the deep end'.

> The first six months I used to come to work and I used to feel sick in the bottom of my stomach, because I didn't know what was gonna be there, but then I took a step back after six months and realised that no matter what was there, I coped. So why was I getting so panicky? And once I'd decided that I stopped feeling sick before I went to work and I actually started enjoying it (new midwife).

Examples were given of midwives having to cope with the types of situations in which they found themselves, in addition to functioning as a midwife. For example about a fifth of midwives found themselves having to contend with working on a very busy ward, while at the same time trying to deliver a good standard of care and having to develop as practitioners. One new midwife described having to 'juggle' all that had to be done and to ensure that everyone in a caseload got the care that they required.

Midwives also suggested that they had to learn to cope with the non-routine and the unfamiliar. It is suggested that as students, participants were largely protected from the more unpleasant aspects of the role, such as dealing with loss and bereavement, and after qualifying midwives had to cope with dealing with these more difficult aspects -often for the first time. Dealing with the unexpected also posed new midwives with a challenge. As new midwives, participants also had to cope with taking on wider responsibilities, many of which were not directly related to providing care or that they would not have been expected to deal with as students. A small number of new midwives also had to deal with staff shortages.

Several participants also talked about developing coping mechanisms and ways of dealing with situations, including building support networks.

> I tend to switch off, I go and find a quiet place, I look at my piece of paper and think now right, what do I need to do first and then start again, … (new midwife).

They also talked about developing the ability to pre-empt situations, thus reducing the impact that surprise held for them. One new midwife talked about being empowered to stand up and say that she could not cope and that she had too much to deal with. However, one new midwife suggested that at the end of her first year in practice she was still not coping. She suggested that the key issue for her was that she was unable to reconcile the reality of practice with her aspirations for practice.

> … I feel that I'm not available for the woman to ask me questions or give the information if I'm already caring for a couple of other women who also need the same sort of information to make choices … like some women say, ‘please stay with me’ and you've got to explain that you are caring for say one or two other women and you will be with them as

much as you can, and then you think oh, it's not matching up to their expectations (new midwife).

7.3.4 Judgement and decision-making

The fourth aspect of development identified is judgement and relates to new midwives making their own decisions and relying less and less on others. Participants talked both about developing the ability to make judgements and being willing and sufficiently confident to take on decisions. It is suggested that there may be a mutual link between building confidence and judgement, that is, as midwives become more confident they become more willing to make their own decisions. As they make more decisions and become more comfortable with decision-making, they begin to trust their own judgements and they also become more confident overall.

Generally it was suggested that new midwives found taking on decisions difficult at first and that they developed more in that respect in the second half of the year.

7.3.5 Other themes in development over the first year

FITTING IN

Several new midwives also talked out developing as a team member and fitting in during their first year in practice. They talked about being seen as one of the team, contributing to the team by sharing knowledge or support, being valued and being taken seriously by colleagues and other professionals, and being able to take on their fair share of work.

> I think I've learnt an awful lot and … I'm still learning, but I think I'm definitely, … I'm just one of the girls really (new midwife).

> I feel I have a place on the ward now. I get on very well with the other members of staff. I'm very confident about my practice although I know that obviously experience is the one thing I don't have. I always ask if I'm

> not sure about anything and they're always ready to help (new midwife – at six months).

Other midwives and supervisors of midwives also supported this aspect of development.

DEVELOPING KNOWLEDGE

Interviewees also discussed the development of knowledge and its use in action. It is suggested that during consolidation, knowledge is tried out in practice so that theory and practice are better integrated and practice becomes more fluent. It is also suggested that knowledge developed during consolidation becomes more focused on the context in which the midwife practises and that the emphasis is on developing process knowledge.

There were two suggestions that in this focusing of knowledge, knowledge that is not relevant or used may be lost.

> I could remember every single bone in the pelvis and, probably now I wouldn't be able to recall it as I could but I'm sure if I just went and read about it, I'd be able to top my knowledge up, but I think that's just with all learning you tend to forget something (new midwife).

In addition, several new midwives talked about broadening their knowledge to include some of the wider aspects of midwifery knowledge, such as professional or ethical issues, new areas of knowledge, or reading more around research to inform the development of their own style of practice.

SUPPORT OVER THE FIRST YEAR IN PRACTICE

Interviewees were asked about the support that new midwives had needed and received over the first year in practice. It was suggested that the type of support that midwives need after registration is not close supervision but to know that there is backup available - someone more experienced on hand to consult should a problem arise, or to double-check a decision if they are unsure. Most support is required initially but this need soon tails off as midwives become more confident.

Support is also required for midwives to meet their learning needs, for example to be supervised while they learn to suture and then later to be assessed. Midwives will also need feedback from colleagues and managers on their progress in order to build confidence and to identify learning needs.

During their first year in practice, it is suggested that new midwives received support from their supervisors of midwives to identify learning needs and to discuss career progression. Supervisors were also able to provide informed feedback on midwife development for the purposes of the research. Pope et al (1996) highlight the important role that the supervisor of midwives has in promoting continued development by monitoring standards of care and providing a support network for midwives. Stapleton et al (1998) in their study of supervision of midwives found that most midwives interviewed favoured the retention of midwifery supervision and found that midwives sought many types of support from supervisors. They found that mostly supervisors provided support to meet the 'longing to be heard' or to have someone to 'off-load' onto.

Only six of the case study midwives had preceptors and in three cases preceptorship did not work out because the midwife allocated was off sick or working on different shifts. In the other three cases, support was described as good. At one site, three midwives had a formal induction programme which was reported to have worked out well. Most midwives who were happy with the support that they received said they received support from other midwives and team members.

7.4 Comparative analysis of midwife development

The views of participants were obtained through interviews at six months and at the end of their first year in practice. For the purpose of the analysis, these views were compared with the views of midwives working with participants at the six month stage and with those of supervisors of midwives at twelve months post-registration. In the first stage of the analysis a profile was developed for each individual participant, comparing the views on their development at six months with those at twelve months. One finding was the consistency between the views

of participants and those of other midwives and supervisors (referred to as reviewers) where difficulties were identified. For example, one participant identified that she found taking on the responsibilities of a midwife particularly difficult when she first qualified and this was also identified by her supervisor. Comparing the views of other midwives and supervisors was useful in two senses, firstly, the views of supervisors tended to add on to those of midwives, thus helping to build a profile of student development over time. Secondly, where a particular issue was identified by other midwives in the first six months, the views of supervisors either provided further evidence that there was a problem or details of how the issue had been resolved (or not) in the second six months.

This stage of analysis also involved comparing students within sites and between sites. Differences in terms of participant development over the year in practice seemed to relate more to variations between individuals rather than apparent differences between sites. That is to say that similar patterns in terms of differences between participants were observed across all sites. Three types of midwife development were identified, the first type were participants who developed steadily and well throughout the year, met with the expectations of their reviewers and did not provide any surprises - the archetypes. This group of participants accounted for eighteen of the thirty-eight participants followed through to the end of the first year in practice. Two other types of midwife development were also identified - participants who developed rapidly and dazzled reviewers by their ability during or at the end of the year - the stars (n=7); and those who found their first experiences of practice particularly difficult and who struggled to take on the role of the midwife - the labourers (n=13).

In the next stage of analysis participants in each of the three categories were compared to identify the key features that distinguished them from each other. In this way a profile was developed for the archetype, the labourer and the star. It should be said that although three distinct groups of midwives were identified, there was variation within the groups. The analysis focused on the key

differences between midwives that suggested they ‘shone’, were pretty typical of what is expected, or that they struggled, and it is not suggested that each midwife in each of the three groups was a perfect fit or that they had all of the characteristics identified.

7.4.1 The Archetype

As previously stated, almost half of the participants fell into this category. The analysis suggests that although unsure at first, new midwives in this category were able to cope with the ‘enormity’ of responsibility and became confident. It was also suggested that these new midwives developed confidence in their own ability and in their own judgements, and were able to identify their own learning needs. By the end of the year, these midwives were described as being more assertive and beginning to challenge the system - for example, asking questions about interventions that they did not agree were necessary.

A number of positive personal traits were identified in this category of new midwives, including that they were keen, calm, nice people, and that the women they provided care for liked them. They were described as good communicators and it was reported that their communication had developed over the year, mainly in terms of communicating with doctors and other professionals. One particular theme that has arisen throughout the study is the influence of attitude on competence. Once again it arose in this analysis, and will be discussed in more detail later. There is the sense that new midwives in this category (and in the star category) were content with their current position in life, in their career and in their current status, a sort of acceptance that allowed them to focus on *being* a midwife.

There were several suggestions of midwives in this category developing their ability to make decisions on their own and having confidence in their own judgements. At the end of the year midwives were described as being good at decision-making and being able to use their own initiative. They were described as being able to manage their own work well and reviewers felt that by the end of the year, these midwives were very capable of managing a ward, although they would still need a small amount of support. Another theme that was identified

was that these midwives were able to cope with practising in a very busy ward environment, unlike a number of midwives in the labourer category.

Overall it was suggested that, by the end of their first year in practice, midwives in this category had become well rounded as practitioners and were able to function well on their own, in all areas of midwifery practice, for women with normal pregnancy and childbirth. It was suggested that they were reasonably proficient in skills such as suturing, episiotomy, and amniotomy, and would have no particular gaps in their ability. Reviewers were very pleased with their progress and development was described in terms of gradual progression in ability over the year. It was suggested that experience was all that would be required for them to develop their practice further to become more fluent and flexible in practice, and that they only required a minimal level of support. Supporting the description of this group of midwives as archetypes are the comments made by reviewers that midwives in this category were practising in line with the expectations of other midwives and supervisors - 'as you would expect'. In addition these expectations were based on the experiences of reviewers working with other new midwives over several years as practitioners.

7.4.2 The labourers

In this category there is the sense of new midwives struggling during the year, for one reason or another. Midwives and supervisors stated that they were disappointed with the progress that midwives in this category had made or that the midwives concerned had not progressed as well as other new midwives with whom they had worked. Some midwives were described as just 'getting there' or there are suggestions that development was slower than expected but that it was progressive.

In most of these cases, it was suggested that difficulties related to insufficient experience. Two midwives were working part-time and this may have been related to their slower progress. However, one of the midwives in the *star* category also did not have a lot of experience during the year. One midwife felt she had not been able to consolidate her practice because she did not have as

much experience delivering as she had hoped she would. In another case, a supervisor suggested that the experience the midwife had upon qualification was based around assisting with abnormal deliveries, when in fact, what she had needed was to consolidate her practice by dealing with some 'nice normal' cases on her own. However, two other new midwives practised on gynaecology wards for six months and there are no suggestions that this particularly hindered their development over the first year. A number of midwives started practising on a different unit or even a different part of the country to where they had trained. It was suggested that starting off in a new unit poses midwives with more to learn, for example finding out about local policies and procedures, who to contact and where things are kept, and for particularly anxious midwives, practising on a new unit may add to other sources of anxiety. However, it was suggested that with adequate support there should be no major negative impact on development. This is based on the finding that several of the archetypes and a small number of the stars moved to new units at registration.

For about half of the midwives in this group, their reviewers suggested that they were very capable midwives but transition had been traumatic and they had a particular problem with confidence and taking on responsibility. In most cases, this type of inability to cope with taking on the role of the midwife was linked to the midwife's personality and it was suggested that there was some progress over the year, for example:

> I was actually a bit disappointed I think, from other students I expected her to make better progress, … its self confidence, taking responsibility ... I think my feeling is that she's getting there, she found it very traumatic actually being a midwife and not being a student, and she is improving slowly but it's been slower than I expected. So she is definitely improving (experienced midwife).

Five midwives were reported to have had difficulty managing care for more than a small group of women. In two cases, it is suggested that the midwives concerned had difficulty reconciling what could be done within the time

available, with what they felt they ought to be doing in order to meet the needs of the women in their care. It is suggested that their difficulties related more to being able to cope with the realities of practice than being able to do what was required.

> … she as a person, cannot accept when she has done her best. She always will be wanting to try to prove something and in the end it turns the reverse because people just find somebody around them who's in an anxiety state, you see, I mean you have to draw the subtle line from being conscientious and really being in an anxiety state (experienced midwife).

One midwife appears to have struggled a lot more than other midwives in the labourer category and it was suggested that she still needed a lot of support at the end of the first year:

> She still needs a lot of mentoring. Just because I … still can't rely on her totally to recognise and pick up anything that might be deviating from the norm … Again, how much is the actual training … and how much of it is personality … you can try so hard that, because you don't want to be made to look a fool particularly, or be a failure, and sometimes I think she's just trying so hard that it came unstuck (supervisor of midwives).

In another case, it was suggested that although the midwife concerned was very capable practically, she was very defensive and may have been over-confident at registration and these factors had a negative impact on her development over the year.

At one site there were no midwives in the labourer category. The analysis does not suggest that midwives at this site found themselves in any easier a practice situation than at the other sites or that as students, they were prepared any differently for their roles as midwives. However, it may be more than a coincidence that at this site all new midwives felt they had good support in their

first year as practitioners and about half of the cohort of midwives had an induction programme.

7.4.3 The stars

Seven midwives were identified as stars because they stood out from other midwives because their ability and development surprised or dazzled other midwives and supervisors. Interestingly, all seven also stood out as students although not all star students made star midwives, and this issue will be discussed later. This congruence between star students and star midwives included midwives who moved from one unit to another at registration, where the views of other midwives and supervisors would not have been influenced by prior knowledge of the individual during her student days. In addition, interviewees suggested star midwives were very capable and had a high level of competence from the outset of the first year in practice but continued to develop over the year. Indeed interviewees highlighted the commitment of star midwives to being continuous learners and having a thirst for learning.

A number of distinguishing traits were noted of star midwives:

- *The pace of development*: Midwives in this category were reported to have developed very quickly, sometimes to the surprise of those working with them or exceeding all expectations of newly qualified midwives and in some cases this included providing care for abnormal cases. Reviewers also reported that some of these midwives were particularly good because they pushed themselves so hard and because they actively sought to address any learning needs that they had over the year. To illustrate this point, the two interview extracts below are about the same midwife.

> I'm quite impressed actually you know with her capabilities at the level that she's at the moment. She copes very well under stress and she works well on her own and as a member of a team. Very pleasant, very nice for patients, very nice for staff, respects everyone, a pleasure to work with basically… She communicated quite well, you know as a student but I certainly feel she's communicated better. Obviously she's

got a lot more confidence now than what she had as a student. She's gained that with experience of course. I just think she's really good. (experienced midwife - at six months into the first year).

... I think because of the kind of person that she is, she's developed very well. She'll push herself forward to be able to increase her skills and her knowledge. So because of the way she is, you don't need to push her, she does that herself. So she has actually developed very well ... She was always competent before, but she's more competent, and she's not afraid to kind of discuss things with whoever and argue the point (supervisor of midwives - at the end of the first year).

- *Actively taking on responsibility:* Midwives in this category were noted for working well on their own and being able to 'get on with it', and for actively taking on the responsibility of the role of the midwife. It was also suggested that star midwives were able to balance wanting to take on responsibility with being aware of their limitations, so that they could manage what they took on and they would ask for assistance if they could not cope with the workload.

  ... every area that she goes into she tackles equally well, so I don't think she's got any areas that are weak at the expense of anything else. And she certainly seems to analyse her practice to the extent that she knows what she needs to develop. She's undertaken further responsibilities … which has meant that she's had to look at time management as well, so she's actually had to think beyond the immediate and seems to have managed that on top of everything else, … but again she's coped and she's dealt with it in an adult and mature way. She's tackled it all very well (supervisor of midwives – at the end of the first year).

- *Developing advocacy and professional autonomy:* There were accounts of midwives in this category becoming more assertive and developing as women's advocates. Examples were given of midwives standing up to doctors when they felt interventions were unnecessary, or keeping them out of the

delivery room when there were no indications of deviations from normal. Some were also described as brilliant communicators, having respect for other colleagues and being respected within the team, and contributing to the team as an agent of change or a role model.

> … she's been in a few situations where she could have actually crumbled and handed over care to other people … where she's had to you know really stand her ground, ... I think she's able to take on a lot of responsibility, a lot more than I thought I'd expected her to. … she's in charge at the moment. I'm just in the background … you know she's done so well and everybody's really pleased with her. … she really is a credit really to the team (experienced midwife – at six months).

- *Coping*: Comments about this group of midwives included that they made the transition from student to midwife well, that they settled quickly into the role and that they were able to cope with the responsibility of being a midwife. They were also accounts of midwives coping well under stress and being calm, having an inner calm or having a calming way about them. Along with being calm, one star midwife was described as a good thinker in terms of being able to think clearly through whatever is going on. Being able to practise within a very busy ward environment was already raised while comparing archetypes with labourers. In the star category there were examples of midwives who excelled, almost rising to the challenge despite working in a very busy environment. One such midwife appeared to have had a very precarious first year practising as a midwife.

- *Developing own style of practice:* Having consolidated their practice, it is suggested that some of this group were beginning to develop their own style of research-based practice.

As previously stated, three students who were described in glowing terms by interviewees did not go on to be described as star midwives, although all midwives in the star category had been identified previously in very positive

terms as students. In the light of this finding, further analysis was done to take a closer look at the experiences that the three midwives had over the year and to identify any indications of factors that might have influenced development over the year. One of the three midwives moved to a different unit at registration and took time to settle down there seemingly because she met with hostility from staff who did not know what to expect of pre-registration midwives. In all three cases two common themes are identified. Firstly, other midwives and supervisors suggested that the three midwives appeared to be over-confident and naïve in relation to the role of the midwife. Reviewers were concerned that midwives who are over-confident might undertake things for which they were not quite ready rather than ask for assistance. Secondly in all three cases, the midwives themselves felt somewhat disillusioned about the reality of midwifery practice. This finding ties in with the suggestions in the previous section that star midwives accepted the reality of the practice situation that they found themselves in, perhaps enabling them to get on with focusing on their own development as a midwife.

The following section includes a number of quotes from interviews with the three midwives and midwives and supervisors of midwives working with them to illustrate the points made:

> I find that a lot of the time I'm fighting the system for the women that I'm caring for, I can think of numerous occasions when I haven't seen eye to eye with medical staff about augmentation for instance, and you know sometimes I've been proved wrong, sometimes they have, but it depends how you view being proved wrong … my aims as a practising midwife tend to conflict a little bit with what the system expects of me at the moment (new midwife #1).

> I've gone through stages of being fine and then through stages of being, you know, absolute confidence shattered, but I think it's very difficult because ... when I trained Changing Childbirth was coming in, and Changing Childbirth was what I cut my teeth on, I trained on Changing

Childbirth and I knew it inside out, and there's no way you can practise Changing Childbirth at the (…) Hospital. And I find that difficult … (new midwife #2).

I think all the actual practical side of being a midwife has become much easier when I'm looking after somebody in labour it's become much more automatic and when I'm on the ward it's become much more … fluent, but as a consequence of that I now have more time to think about the politics and basically, I am beginning to get more and more disillusioned I think, more with the system rather than with the actual work … I think the, the being at the bottom of the scale really and not receiving any respect for what you do and really being seen as some kind of bottom of the line handyman girl who sort of cleans up after everybody else, and I find that very very angry sometimes … (new midwife #3).

… she's quite a confident person anyway, and sometimes her confidence kind of overrides her ability maybe, so she might perceive that she doesn't need any extra ... help but maybe she does (midwife).

I don't know whether it was (her) personality or the training that I think perhaps put a rosy complexion on the life of the midwife, and I think it wasn't until she'd really started to practise and take on the responsibilities and work with other practitioners that she really found that it perhaps wasn't quite as she had imagined. And from going quite up she went quite down, I mean not very down, but for her she did go down and I feel that now she's in the going up again stage now (supervisor).

she's very confident anyway, and one of the things I've found with (her) is that there is a tendency for me to sort of think on the body language and her verbal language that she knows and is confident about far more than she actually does (midwife).

The differences in development over the first year following registration are outlined across four themes in Figure 7.1: pace of development and capability at the end of the year; confidence; personal demeanour; and management capability.

Although it was suggested that development may relate more to differences between individuals than to differences in practice environments and arrangements at the six case study sites, it was suggested that differences in arrangements between sites did impact in different ways on development over the year. Examples of environmental factors included the following.

- There were differences in the experiences that participants had over the year in terms of aspects of midwifery care, the types of units that they practised in and how what they did related to the role of the midwife. For example, a small number of midwives did not have experience providing care during labour in the first year and a small number of midwives began working on a neonatal unit or a gynaecology ward.
- There were differences in terms of the support that midwives had and some participants had preceptors whereas others did not. In addition, two midwives started practice working for an agency or on the bank, and as such could not have been sure of support. In contrast, several participants at one site had a structured induction programme. It is suggested that support can play an important role in the ease of the transition from student to midwife.
- Employment prospects were of concern to several students and were a particular issue at two sites both in terms of security and opportunities to gain experience as a practitioner soon after completing the programme. A small number of midwives started practice on part-time temporary contracts, most of them working at one particular site.
- The busyness of the practice environment was a concern for a small number of new midwives. This was either because of the impact it had on the support that they received or because of the demands it placed on them as practitioners and their ability to provide the standard of care for women that they wanted to.

Figure 7.1 Key themes in the comparative analysis of the development of competence in the three groups of midwives

	Registration	*Archetype*	*Labourer*	*Star*
COMPETENCE	Capable	• steady development • very capable on own • no particular gaps • well rounded • reasonably proficient suturing, epidurals etc	• development slower than expected but progressive • difficulty consolidating practice • safe practitioner but problem with confidence	• developing very quickly • was very competent at registration but more competent now • can deal well with normal and some abnormal on her own • developing own style of practice • good at holistic care/ individualised care
CONFIDENCE	Unsure	• right level of confidence • good decisions on own • own initiative	• anxiety/ traumatic transition from student to practitioner • fall in confidence after registration and slow to recover • needs more support • has not spread her wings	• actively takes on role and responsibility but aware of limitations • advocate - reasonably assertive and has confidence to challenge clinicians
DEMEANOUR	Assessed as being of good character	• keen, calm, nice, able to relate to women • good communication skills • functions well with the team	• nice person, able to relate to women but difficulty coping with reality of practice/ reality shock • afraid of failure	• development is practitioner-led and pushes self • copes very well, clear thinking, calm, assertive • relates well to women and good communicator • integrated well into the team and respected by other team members • agent of change • appreciates need to continue development and not afraid to discuss things
MANAGEMENT	Capable of managing own workload but little experience of ward management	• can manage own workload and a ward with support	• difficulty managing a ward and managing time • unable to cope with reality of practice and time pressures	• manages caseload and a ward well and will say if cannot cope with workload • good at organising

Source: Interviews with new midwives, other midwives and supervisors of midwives.

Several personal differences can also be identified. The first relates to confidence at the point of registration with the findings suggesting that midwives

in the archetype and star categories were reasonably or very confident (but not over-confident) at the point of registration. It seems that the opportunity to consolidate practice before qualifying helped midwives to build confidence. Midwives in the archetype category were described as being confident to take on the role, to make decisions and to work on their own initiative. However, midwives in the star category seemed more confident overall and in terms of moving beyond taking on the role, for example, in terms of advocacy, actively taking on responsibilities, communicating and contributing within a team. The role of consolidation in building confidence has already been discussed but the analysis here suggests that at least some star midwives had gone beyond the consolidation process to developing their own style of practice.

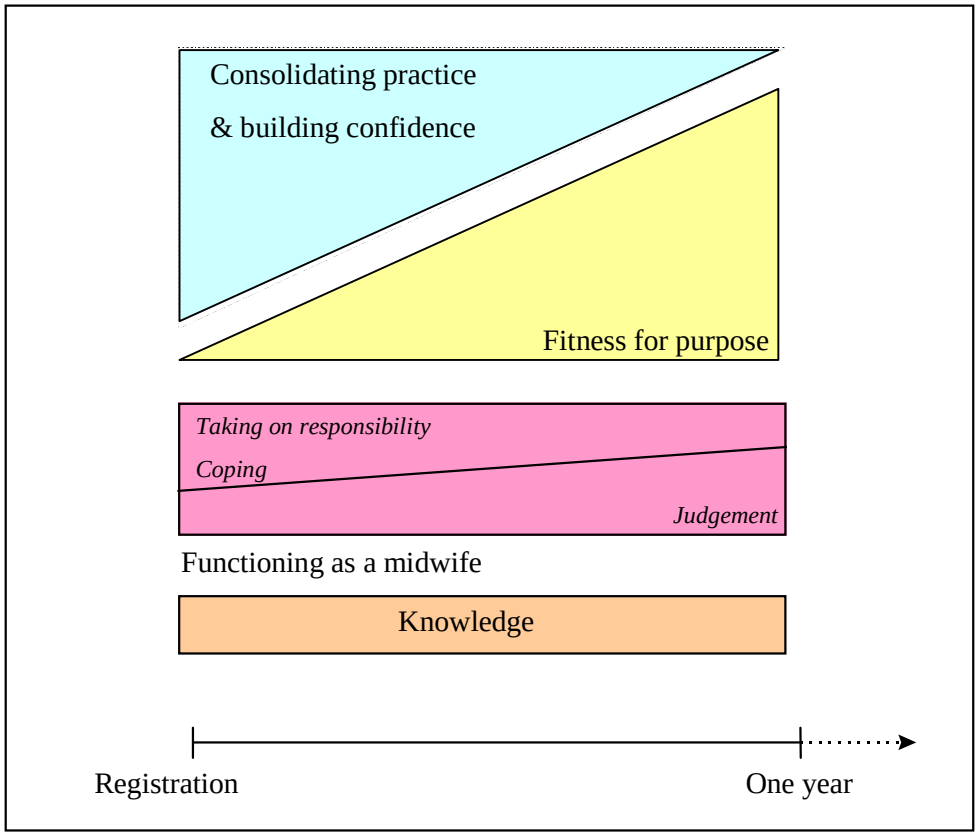
Coping was also another key theme in the differences between categories, with the biggest differences found between midwives in the labourer and star categories. It was suggested that half of the midwives in the labourer category had difficulties coping with being a midwife, taking on responsibility, practising in a very busy environment, and managing a caseload or reconciling the limited time to do things with the type of care that they would like to provide. In contrast, midwives in the star category coped well with transition and settled down quickly into practising as a midwife.

Several positive personal attributes are identified in archetype and star midwives relating to their ability to get on with other people, respect for individuals, and being nice people generally. In addition, it is suggested that one of the factors involved in star midwives doing so well was their commitment and drive to doing well. While there were no negative personal traits identified in labourer midwives, there were one or two examples of an unwillingness to actively take on the role or a reluctance to take on responsibility or to make decisions. It is also suggested that disillusionment may have been involved in three midwives not advancing as might have been expected.

7.5 Discussion

On the basis of the analysis of the views of participants (both as students and as new midwives), assessors, teachers, midwives, and supervisors of midwives, as presented here, it is suggested that there are three key aspects to the development of competence and professional learning after registration: moving from being fit for practice to being fit for purpose, functioning as a midwife, and the development of knowledge. These three aspects of development are outlined in Figure 7.2.

Figure 7.2 Development of competence over the first year in practice



Firstly, there is a period of consolidating practice and building confidence and by doing so, enhancing fitness for practice and preparing for further development as a midwife. It is suggested that this aspect of development occurs within the first three to six months post qualification and is a vital precursor to further development. Learning post-qualification is also concerned with fitness for purpose and involves developing competence to practise across the range of practice situations, contexts and range of needs of women that a midwife is likely

to encounter within the her role and area of responsibility. It is suggested that this may involve expanding competence to work with more complex cases and contexts. As midwives are likely to move to other practice situations and the demands of the job change over time, it is likely that this aspect of development is required on an on-going and career-long basis. The analysis suggests that in the first year of practice this aspect of development includes learning additional skills, gaining experience dealing with complicated cases, working in areas such as theatre, neonatal units or gynaecology wards, and ward management.

The second aspect of development over the first year in practice is concerned with the midwife further developing her ability to *be a midwife*, and her competence as a professional. It involves taking on responsibility as a midwife, developing coping and judgement abilities, developing process knowledge, and fitting in within a team. It is suggested in the analysis that this aspect of development is likely to continue to develop beyond the first year in practice.

Thirdly, it is suggested that learning post-qualification will involve the development of knowledge, which becomes more focused on the practice context, and may be expanded in some areas and may be lost in other areas.

The place of consolidation in the development of the archetype and star categories of midwives seems reasonably clear, with references to midwives being well polished or well rounded as practitioners at the end of the year. Indeed it is suggested that several star midwives were capable of a high level of practice at the point of registration, and as such would have consolidated their practice reasonably well before registration. The impact of consolidation in the labourer category is more difficult to discern. One theme in the labourer category was that midwives were less confident at registration and that in several cases confidence fell in the first few months following registration. The findings suggest that consolidation is required for midwives to build confidence and it was reported that one midwife in the labourer category had difficulty consolidating because she had few women with normal pregnancies to provide care for. However, lack of confidence in the labourer category appears to be

more linked to an inability to cope with the perceived enormous responsibility that comes with being a midwife and having to make decisions on their own. Participants talked about how daunting they found being a midwife and the difficulty that they had 'getting out of student mode'. Midwives and supervisors also talked about difficulties relating more to inability to cope with the reality of practice, for midwives to be able to balance what could be done with their own expectations of what they should be doing. Several interviewees suggested that the difficulties that midwives in the labourer category had were more related to personality traits, such as anxiety, than any inability to do anything in particular. In contrast, in the archetype and star categories there were references to midwives being calm and their ability to cope with a busy ward and to get on with practice despite working in a busy environment.

The influence of attitude on the development of competence was also identified in interviews with participants, assessors, midwives and supervisors. Two midwives were identified as being defensive or being afraid of failing and it is suggested that these traits may have prevented them from developing more during their first year in practice. The findings also suggested that three midwives who had stood out as particularly good as students became disillusioned or distracted and perhaps as a result did not progress to become star midwives (at least not by the end of the first year in practice). In contrast, midwives in the star category were noted for their enthusiasm and the way in which they pushed themselves to develop in a constructive way. In addition, it was reported that they actively took on responsibility at an appropriate level and at the same time could be relied on to ask for advice where their level of practice had reached their personal limitations.

The interview analysis identified considerable variations within and between sites in the level of support that midwives had over the first year in practice, (as described in section 7.3.5). It is not possible to make any clear conclusion on the role of support in how midwives developed over the year. The findings that all midwives felt well supported at one site and that at this site there were no midwives who struggled over their first year in practice on its own may suggest

that support is an important factor in development over the first year. However, when you compare the support that midwives had on an individual basis with how they were reported to have progressed over the year, there is no clear pattern. That is to say that there were midwives who said they had good support and who were in the archetype and star categories and those who said they had poor support and who were in the labourer category. However, there were as many midwives who said they had good support and were in the labourer category and those who had poor support and were in the archetype or star categories.

While a number of common themes were identified during the analysis, differences were also identified between participants. In some cases it was possible to explore some of the factors likely to be involved in these differences. In any case, it is important in interpreting the findings to acknowledge that each person is an individual and all new midwives should not be expected to conform to the patterns that emerged in the findings.

7.6 Conclusions

Based on the analysis of views of interviewees on learning and the development of competence over the first year in practice, a number of conclusions can be drawn. Firstly, it is suggested that consolidation is a key and immediate area of development, through which a midwife builds confidence and begins to develop her own style of practice. The findings suggest that building confidence is a vital precursor to further development as a midwife. It is suggested that midwives benefited where they had the opportunity to begin the consolidation process before they qualified. It is suggested that most midwives in this study did a lot of their consolidating after registration and this required having adequate support for the first three to six months, and being allowed to focus on providing care for women with normal pregnancy. The implications of these findings are that at registration a midwife is technically entitled to practise as an independent midwife (although it is highly unlikely that they will). Yet if they have not been through the consolidation process, this would question if they are fully prepared for such a role. Several midwives in the study moved to units new to them upon

qualification and a small number worked for agencies and 'the bank'. Institutions providing midwifery education programmes did not provide any follow-up arrangements to ensure that midwives got the support and experience that they needed initially to consolidate.

A second conclusion relates to fitness for purpose. Although it is suggested that learning over the first year included skills directly associated with midwifery such as suturing and epidural top-ups, it is also suggested that an important focus of development over that time was on becoming fit for purpose. Respondents suggested that areas of development included learning to provide care for women who were ill or had complications, nursing skills required for working on neo-natal or gynaecology wards, ward management and working in theatre. Although respondents generally agreed that the pre-registration programme prepared midwives for the role of the midwife, the findings suggest that there was a mismatch between curriculum outcomes and the requirements for the reality of practice faced by midwives when they qualified. Further it is suggested that currently there is a gap between the role of the midwife contained in arrangements for the delivery of midwifery care, and the role of the midwife outlined in national policy documents and reflected in midwifery curricula. It is suggested that the resulting tension between the two was a source of considerable stress for some new midwives and may have hindered their development, at least initially.

A third conclusion relates to functioning as a midwife. As discussed in Chapter Five, qualification involves taking a willing shift from the relatively passive student role to that of the active practitioner. The analysis suggests it can be a stressful time for midwives and involves taking on responsibility and learning to live with being accountable. It also involves the development of decision-making in terms of making better decisions, learning to trust their own judgement and relying less and less on others. Functioning as a midwife also requires a midwife to develop in terms of fitting into the team.

A fourth conclusion relates to the development of knowledge. The findings suggest that the development of knowledge post qualification is different to that as a student. It is suggested that midwives at qualification are equipped with a comprehensive spread of up-to-date and research-based knowledge but will be lacking in experience. Post-qualification then, the focus switches to using knowledge in practice and integrating knowledge gained through experiential learning with that learned in the classroom. Nonetheless, it is suggested that midwives must keep their propositional knowledge up to date and plug any gaps that they find in their knowledge base.

Themes identified in the comparisons between the three categories of midwives identified and in particular between star and labourer midwives related to confidence, coping, decision-making, personality, commitment and ability to drive their own personal development. These findings and the other findings will be followed up in Chapters Eight and Nine, which focus on the development and maintenance of competence over the longer term by exploring the development of expertise and how the attributes of good and bad midwives compare with those required to be competent.

Chapter Eight

Competence and expertise

8.1 Introduction

In this study, student midwives were followed from three months before the end of educational programmes to the end of the first year practising as midwives. The analysis of the views expressed by these participants, their assessors, teachers, supervisors of midwives, and other midwives working with them over that time suggests that midwifery competence goes through several stages of development over this critical but relatively short time. In order to set the findings outlined thus far in a broader context, and to contribute to the understanding of the development of competence over an extended period of time, the notion of expert is explored in this chapter through a review of the literature.

The findings presented thus far suggest competence at registration is limited and conditional, that over the first year in practice there is a significant amount of development, which is critical to taking on the role of the midwife. The analysis also suggests that there will be differences between newly qualified midwives and more experienced midwives on the basis that:

- at qualification, there are areas of practice where skills are not fully developed
- at the point of registration, capability and practising is largely confined to providing care for a woman with normal pregnancy and childbirth within a small caseload and with few management responsibilities. Before long, midwives take on further responsibilities such as managing a ward, additional midwifery-related skills such as perineal suturing, and providing care for women with complicated pregnancy, further developing capability and extending it across contexts and situations
- midwives may become more specialised, for example working on a delivery unit or in the community. This may involve a trade-off between gaining more in-depth knowledge and loosing knowledge that is not used. This suggests that the nature of knowledge changes and becomes more domain-specific

- knowledge is further developed through use in practice and experience. In support of this view of learning through using knowledge, Eraut suggests that every time we use propositional knowledge, we reinterpret and develop it further based on the situation at hand and on the basis of previous experience:

  > The meaning of a new idea has to be rediscovered in the practical situation and implications of action thought through (Eraut 1994, p.49).

  In this way knowledge is added to, further developed, and becomes more individualised.

In the literature, the characteristics of expertise have been identified as:

- an intuitive grasp of situations, identifying problems without wasteful consideration of a large range of alternatives, acting appropriately, based on their understanding of the situation, not on an analysis of its features, and applicable rules and principles (Benner 1984)
- something that may be equated with specialism (Castledine 1992)
- a combination of intuitive practice and specialism (Fenton 1992).

Butterworth and Bishop (1995) explored the term expert using open-ended questionnaires with more than 1,200 nurses, midwives and health visitor respondents. The key attributes of experts identified initially in the study were that experts are innovators, demonstrate leadership, have key personal qualities, can demonstrate positive communication skills, can demonstrate expertise and are able to work in a multi-disciplinary team. A range of attributes required for optimum practice was also identified.

Another term frequently used in the literature is ‘excellence’ although it is not always clear whether this has a meaning different from expertise. One could argue that it is possible to be excellent at one area of practice and not at another. Also being an expert is more than excelling in practice and is developed through experience. Coulon et al (1996) explored the concept of excellence through a literature review and an open-ended questionnaire survey of 150 practising and

qualified nurses. They suggest that the concept while 'extolled' by professions as a 'virtue', is ill-defined and elusive. They suggest that excellence can be interpreted along two planes, firstly in terms of upholding the highest standards, or something superior, exceptional, distinct, worthwhile or valuable; and secondly, in terms of the qualities of the excellent nurse. However, they suggest that patient focus at all times is the key to excellence in nursing practice. Excellence implies holistic care grounded in professional, competent care delivered 'humanistically'. They suggest that professionalism is the 'all-encompassing trait which most comprehensively exemplified excellence'. Although not all respondents could define professionalism, Coulon et al suggest that it emerged as an 'over-arching theme embracing personal qualities and practice'.

8.2 Using knowledge in action

It is also suggested in the literature that there are several key differences between newly qualified midwives and experts and that these differences relate to how midwives think, use knowledge, and the way in which thinking and knowledge is organised into models and concepts that guide action. Eraut (1994a) suggests that propositional knowledge reaches a plateau at qualification and that knowledge itself is not the critical factor in expertise, but the way that it is organised and made available for use. This is also supported in the analysis of the views of interviewees in this study, who stated that at the point of registration, midwives should be completely up-to-date and that propositional midwifery knowledge is likely to be at its highest point at this stage of career development. Other themes in the literature in differences between new practitioners and experts are differences in thinking and problem-solving, in particular, the way in which information is perceived, organised, stored, recalled and used in action, and the role of experience in becoming an expert. Eraut (1994a) also suggests that there will be differences between novices and experts in how they cope with the non-routine and ill-defined problems.

> Proficiency on routine is essential for competence, but it is the handling of non-routine matters which is responsible for excellence (Eraut 1994a, p.45).

Promoting a view of expertise beyond knowledge and its use in action, Wade suggests expertise involves a balance between coping and judgement and personal attributes:

> … it seems that those attributes ascribed to an expert need also to account for the social and moral nature of practice. This involves unique complex human interactions related to the expressive process of feelings, attitudes and personality, fundamental to both nursing and teaching … (Wade, 1998, p.94).

8.3 Critical thinking

In the nursing literature, Daly (1998) looks at the nature of critical thinking and its importance in nursing practice. He suggests that critical thinking is central to effective nursing practice and the ability to function across all contexts. It is described as an alternative to 'formula-driven' nursing practice and to involve nurses going through the process of 'think, apply, analyse, synthesise and evaluate'. He proposes that the thought cycle involves both critical thinking - as retrospective evaluation of information – and, creative thinking - the generation of alternative solutions. Critical thinking is described as autonomous, purposeful, reasoned thinking, requiring cognitive skills and moral and intellectual dispositions, or as described by McPeck (1981, 1990) - reflective scepticism underpinned by extensive domain specific knowledge. Daly also suggests that in addition to cognitive ability, critical thinking involves consistency and enables the individual to overcome human factors such as personal beliefs and biases in decision-making.

It is suggested that there are differences between experts and novices in how they think, the speed at which they make decisions and the likelihood that they will arrive at the correct conclusions. Wade (1998) suggests that experts develop a

sensitivity to perceptual information and take a more thorough approach to problem solving. This results in more creative and opportunistic outcomes than would be found for novices. Noyes suggests that there are differences between experts and non-experts in the way that they perceive and store information within a situation:

> The process of cognition engenders developing perception, attention, thinking, memory and language regarding the knowledge-rich domain … Experts appear to have a larger-scale understanding of the relationship between units of information and demonstrate an overall view of how the system works (Noyes 1995, p.801).

Noyes suggests that the perception of information will also involve experts making a qualitative analysis of the domain at the outset, marked by domain inferences that generate additional useful information. In contrast novices may fail to make inferences or make faulty inferences. Hackley (1999) suggests expertise requires an extensive domain-relevant knowledge base and a sophisticated set of rules for learning and problem solving in that domain.

8.4 Schemata and heuristics

It is also suggested that there are differences between experts and novices in how they recall information and use knowledge gained in previous situations. Wade (1998) suggests that experts are more efficient thinkers because their ability to use schemata frees up their 'facility' to deal with the unpredictable aspects of a task, thereby improving their capacity to ensure a positive outcome. Schemata are described by Wade as routines 'based on the complex knowledge structure and interrelated sets of actions that a skilled (practitioner) develops within their own personal repertoire or dossier of knowledge' (p.96). These routines require little cognitive effort in experts who have used them over and over again. She suggests that because experts use different schemata to novices they are able to think beyond the immediate evidence presented to make inferences about events and objects observed.

Referring to the work of Larkin et al (1980) and Simon and Simon (1978), Noyes (1995) compares the 'means-end' approach taken by novices to problem solving with that of experts. Whereas novices work backwards from goals to sub-goals and on to developing equations, and then forward again to solve the problem, experts eliminate the backward working phase and begin by choosing appropriate equations leading to the goals. The ability to eliminate the backward-working phase is related to being able to recognise problems and problem states from previous experiences and being able to accurately recall the configuration of a given problem-state. It is also suggested that experts focus only on particularly relevant information, thus enabling them to restrict their attention to a much smaller model than that of the novice. In contrast:

> …the novice … faced with a large complex domain, may tend to get bogged down with irrelevant detail in order to make up for his/her lack of experience (Noyes, 1995, p.803).

Noyes also outlines differences between novices and experts in the use of mental models, production rules and problem-solving strategies to organise and use knowledge in problem-solving and decision-making. It is suggested that experts are capable of thinking more quickly and can take short cuts by relying on knowledge gained through previous experience of similar problem states.

Cioffi and Markham (1997) suggest that midwives use heuristics to enable them to deal with the complexity of decision-making in midwifery and the related time restrictions. They describe heuristics as short cuts in reasoning, or rules of thumb that individuals develop through experience and that they rely on in decision-making. They examined midwives' use of heuristics and found that accurate diagnoses were made in 100 percent of the situations examined. They suggest that midwifery decisions are usually based on judgements about the most probable scenario based on personal experience and knowledge. They also found that as cases became more complex, midwives relied even more on heuristics:

> The results suggest that when uncertainty is not resolved by the patient information that is collected over the assessment period, the midwife relies increasingly on the use of heuristics in an effort to determine the patient diagnosis … judgement tends to be in terms of probability when the decision-making situation remains uncertain. Hence, midwives in conditions of uncertainty take short-cuts as a way of simplifying the complexities of their judgement tasks (Cioffi and Markham, 1997, p.270).

Cioffi and Markham found midwives tended to rely on the heuristic concept of representativeness, especially in more complex situations. They report that representativeness is the most commonly used principle in decision-making and relates to the probability that signs and symptoms presented indicate a particular clinical condition that the practitioner has encountered before. The practitioner assesses the possible alternative decisions based on the probability of each outcome, on the basis of prior practical and theoretical experience. They suggest that midwives with more previous experience could have an advantage in complex-decision-making situations because there is greater influence from prior clinical experience in the higher complexity cases. However, they suggest that there is an inherent danger with representativeness. This is on the basis that the principle is based on knowledge about base rates, of for example, postpartum haemorrhage, and an overestimation of the base rates may create bias in the judgements of midwives and their actions subsequently. Further, this emphasises the importance of midwives having up-to-date knowledge of base rates. Another heuristic principle is that of availability, also described as similarity recognition. This relates to the 'ease with which instances of similar conditions come to mind', on the basis that instances that are easily recalled are assumed to be more probable than those less easily recalled. Cioffi and Markham found evidence of this type of heuristic processes in midwives' decision-making and suggest that this type of thinking helps to counteract some of the risks associated with the representativeness process.

Cioffi and Markham (1997) discuss the implications of their findings that midwives use heuristics in decision-making and suggest that the accuracy of judgements relates to the range of personal experiences that practitioners have had. As personal experiences vary from person to person, there may be biases in decision-making unless there is continual updating of the information influencing decisions.

8.5 Memory and experience

It is also suggested that memory plays a part in expertise and that experts are capable of dealing with larger and more complex sets of information than novices. Hackley makes a similar distinction between novices and experts:

> Psychological expertise research takes a cognitive perspective on the way actors subsume the details of particular phenomena with abstracted concepts which are then applied, as forms of cognitive schemata, to problems of action … experts and novices differ in respect of the concepts they utilise in modelling problems: the expert's concepts are packed with contingent possibilities, while the novice's are rather threadbare, focusing on concrete operations (Hackley, 1999, p.723).

Wade (1998) suggests that experts are more flexible and reflexive in their solutions, building in contingency based on prior experiences (citing Berliner 1986). This is contrasted with the thinking of novices who focus on surface characteristics and who are unable to identify and use the cues that experts use. Wade suggests that experts are able to reflect on and in practice so that they can draw on and use previous experience and situations, 'so blending rationale and intuitive modes of thinking into one dynamic thought process' (p.96). This requires expert practitioners to acquire, save and revise information for future use at the same time as using it in practice. This concept suggests that expertise is developed through experience.

Linked also to experience, two sources suggest memory has a role in the development of expertise. Hackley suggests expertise is 'temporally mediated' - that expert knowledge is constantly evolving in memory and redefined on the basis of each new piece of experiential or theoretical knowledge that is encountered, 'subsuming knowledge within a larger and increasingly complex conceptual organisation' (Hackley 1999, p.727). Schmidt, Norman and Boschinzen's (1990) model of expertise in diagnosis is outlined by Eraut (1994, p.132-133). The model identifies four stages of development, each with a distinct type of knowledge structure. It is stated that all four types are complementary but experts draw more heavily on types three and four, which are the more complex forms. Stages one and two are concerned with the development of 'richly elaborated causal networks' using knowledge obtained from lectures and notes, and then the transformation of these elaborated networks into 'abridged networks using high-level causal models, with information about signs and symptoms being 'subsumed under diagnostic labels''. Stage three involves the accumulation of experience working with patients and the development of 'illness scripts' that have 'serial structures'. Stage four will then involve matching illness scripts with memories of previous patients, memories that 'are retained as individual entities rather than merged into the prototypical form'. In this model, memory is the most important factor in differences between novices and experts and memories of generalised experiences (illness scripts) are stored with an elaborate set of recollections of specific patients in episodic memory, which is easily accessible. Further, this model emphasises the importance of experiential learning in the development of competence, suggesting that without experience, one cannot become an expert.

Noyes (1995) states that being an expert does not relate to 'any unusual intellectual abilities' but to having 'appropriate domain-specific knowledge'. Hackley (1999) suggests that expertise comes from an interaction between knowledge, experience, time and individual predisposition, and that expert problem solving, involving heuristics, is based on 'experientially mediated concepts'. Each individual will have a knowledge base that is unique to him or her because knowledge is perceived, assimilated and stored differently by each

individual. In addition, individuals learn to use knowledge differently and knowledge use is dependent on differences in cognitive development, memory and recall. Knowledge is also developed through use in the practice situation as domain specific knowledge or specialist knowledge.

8.6 Intuition

Decision-making in the expert is linked with intuition and tacit knowledge by several authors. Marsden (1999) studied decision-making in expert nurses working in accident and emergency telephone triage and found they made decisions using a 'hypothesis-building strategy'. She also found that 'gut feeling' was involved and that experts looked for cues and read pauses and inferences of what was said or not said. She also reports that experts had little use for protocols which they found hindered this 'reading between the lines'. In contrast, less experienced practitioners felt protocols were of value to them.

Hackley (1999) uses the term 'tacit' to refer to 'those particulars of action which are necessarily omitted, to varying degrees, from abstracted theoretical descriptions, yet upon which the successful accomplishment of practical action depends' (p.723). He highlights the difficulties that tacit knowledge, by its nature, poses in teaching expertise. He uses the example of verbal models used in marketing science, which because they cannot make the tacit knowledge that is used in practical action explicit, fail to reproduce the 'experiential dimension of marketing':

> It cannot replicate the situational particulars which frame practical action, and the more case detail that is added to the teaching situation, the less likely the case will be to resemble any practical marketing situation (Hackley, 1999, p.723).

Underlining the individual nature of tacit knowledge, Bennett III's description of tacit knowledge suggests there is a strong link between the development of tacit knowledge and the subconscious interpretation of personal experience:

> Tacit knowledge can be conceptualised as an idiosyncratic, subjective, highly individualized store of knowledge and practical know-how gathered through years of experience and direct interaction within a domain … Experience makes people aware of very strong underlying patterns that transcend a wide variety of decision scenarios, scripts, and group cognitive maps, which are often below the consciousness of individuals and groups. One implication is that explicit knowledge becomes tacit in nature with years of experience and iterations, because knowing and understanding becomes nearly automatic and effortless. (Bennett III, 1998, p.590).

Marsden (1999) differentiates between 'cognitive intuition' - knowing without fully understanding, and 'empathetic intuition' - for example when practitioners 'just know' that something is wrong.

The differences between novices and experts have previously been outlined in terms of how they act, suggesting that an expert's thinking is considerably more developed, fluid and efficient. Bennett III (1998) makes the connection between the advanced thinking of experts and their stock of tacit knowledge and 'timely and proficient use of intuition and experience-based knowledge' (p.592). He suggests that in decision-making, tacit knowledge allows experts to limit the factors that they consider to be important in a decision. He suggests that this will require an 'intuitive access' to a personal and extensive stock of experience-based knowledge.

Bennett III reports that managers often find that there is a tension between how they are supposed to think and how they actually do. He suggests that with years of experience managers find thinking processes involving intuition are effective but they are taught that decision-making should be rational and logical, involving formal analysis. He suggests that current thinking in the research world is that both forms of thinking are required and that while 'numbers and analytical insight' are required, 'the path to a successful decision almost always involves a

daring intuitive leap' (p.591). While this statement stresses the value of intuition in decision-making, Bennett later stresses the 'absolute' necessity and value of 'rational sensing and thinking, and careful weighting of available tangible evidence' in sound decision-making (p.593).

On the basis of the views presented, my concern is to be clear about what we mean by intuition, its role in the competence of experts, and how we differentiate intuition from slap-dash practice. How can we know that someone did what they thought was the right thing to do on the basis of their previous experience and sound research-based knowledge, as opposed to doing what was easiest? If a practitioner cannot explain the reasons for their actions, surely this is not consistent with being accountable. In this study respondents referred to intuition when talking about practitioners who were intuitive about something and usually were right.

Price and Price (1997) explore the role of tacit knowledge in midwifery decision-making and how it relates to intuition. They talk about midwives drawing on knowledge when making decisions of which they may not be 'overtly conscious'. They argue that decisions about the competence and negligence of practitioners are based on the reasonableness of action in the circumstances prevailing (what peers would have done in such situations) and that this is not consistent with the acceptance of tacit knowledge as something that cannot be made explicit, or that as situations become more complex, midwives become more intuitive. They argue that midwives are accountable for their actions and as such they should be able to explain how knowledge was used in decision-making.

Eraut (1994a) discusses a range of cognitive theories and describes the development of expertise in terms of a 'gradual routinization' of aspects of practice in order to be able to cope in the practice situation and which is responsible for increasing efficiency in practice. This routinization is:

> …accompanied by a diminution of self-consciousness and a focusing on perceptual awareness on particular phenomena. Hence, knowledge of

> how to teach becomes tacit knowledge, something which is not easily explained to others or even to oneself (Eraut 1994a, p.111).

Nonetheless, this routinization is not mindless and is based on numerous rapid decisions made on the basis of rapid reading of the situation and rapid response, which is largely intuitive. However, Eraut refers to the need for 'critical control' of expert knowledge so that it does not decay or become dysfunctional. He describes the process for critical control as 'metaprocesses':

> The term 'metaprocess' is used to describe the thinking involved in directing one's own behaviour and controlling one's engagement in the other processes … Controlling one's own behaviour involves the evaluation of what one is doing and thinking, the continuing redefinition of priorities and the critical adjustment of cognitive frameworks and assumptions. Its central features are self-knowledge and self-management … During rapid interaction self-direction is necessarily intuitive, drawing on previous experience with little deliberation. But when there is time for deliberation, it involves the overall control of one's thinking, the informal scheduling of deliberation …. (Eraut 1994a, p.115).

8.7 Conclusion

In this literature review it is suggested that the particular characteristics of experts relate primarily to the way in which, and the speed with which, information /knowledge is perceived, organised, and interpreted, and the way that it is used for creative and consistently effective decision-making. Making decisions and building confidence in their own decisions was a particular challenge for midwives at registration and one that was reported to have developed over the year. Supporting the findings previously outlined about the role of consolidation and experience in learning and developing competence, it is also suggested that experience and the ability to integrate experience and knowledge have a vital role to play in becoming an expert, suggesting it is not possible to become an expert without substantial experience. Experience is also

identified as the way in which tacit knowledge is developed, which is the basis for the intuitive action described in experts.

In this review of the literature, implicit methods by which experts cope with the total range of routine and non-routine in the uncertain world of practice are also identified. In the analysis for this research, learning to cope was also an area where it was suggested that considerable development took place over the first year in practice. In experts it is suggested that coping is facilitated by the problem-solving approaches developed that enable them to focus on the salient issues in problem definition and to identify appropriate solutions without wasteful consideration of a large range of alternatives. It is also suggested that experts use mental models as short cuts in reasoning, developed through experience, that enable them to deal more effectively with complexity and the unpredictable when making decisions. It is also suggested that the range of routines used by experts in problem solving require little effort because they are used over and over again. It is also suggested that experts are more creative than novices in the solutions that they choose and are more likely to have successful outcomes.

The development of memory is identified as an essential element of becoming an expert, which it is suggested is required to enable the individual to use knowledge effectively in practice, and to interpret and develop knowledge further through experience. Several of the characteristics identified in this review of expertise reflect those identified as particular areas of learning and development over the first year of practice.

In conclusion, the key characteristics of experts identified are:

- the possession of extensive, domain-specific knowledge
- the efficient use of knowledge in action
- effective and creative decision-making that leads consistently to good outcomes
- the use of coping mechanisms and being able to deal with uncertainty

the use of intuition and tacit knowledge over which there is critical control.

Chapter Nine

The extremes of competence:

The attributes of very good and bad midwives

9.1 Introduction

Building further on the analysis outlined thus far, this chapter focuses on the extremes of competence, and by exploring views of the attributes that differentiate good and bad midwives from other midwives, aims to identify the factors involved in maintaining competence. The research involved interviews with twenty additional experienced midwives who were selected from four different units, half working in a hospital environment and half working in the community. Access was gained with the assistance of midwifery managers who were asked to select experienced midwives who would be willing to be involved. Interviewees were asked to think about midwives with whom they had worked, who were either very good or bad. Interviewees were then asked to focus on what it was about the midwives identified that distinguished them from other midwives. The third part of the process was to have interviewees compare the attributes that they identified with what they would consider to be acceptable or to be expected of a midwife at the point of registration. The findings from this third part were used in the exploration of the 'conditional' aspect of competence at the point of registration, as outlined in Chapter Five. The purpose of the analysis was to examine the relationships between the various dimensions of competence and how being competent at any point in time or in any context may be influenced by those relationships. During the analysis, the constant comparison of views and of the concepts of being competent and being good or bad, enabled several key themes in maintaining and developing competence to be identified.

Following the interviews, participants were also asked to carry a diary with them for a month and to note down each day, any examples of very good or bad practice that they came across and, what was good or bad about it. However,

some midwives said they felt uncomfortable about keeping a record of what their colleagues were doing and others felt that as they worked alone mostly they would not have experience of what others were doing. Seven diaries were completed, returned and analysed. While at first the response rate seemed poor, the material contained in the diaries returned was useful in providing another perspective to support the analysis from the critical incident interviews. However, many of the descriptions referred to examples of good or bad practice rather than the attributes of good or bad midwives.

9.2 Exploring concepts of good midwives

Interviews

Most midwives interviewed talked about particular midwives that stood out in their memory as being particularly good because of a certain way about them. The ability of good midwives to inspire others was identified, both in terms of gaining the confidence of colleagues and women in their ability to practise and to make good and safe decisions, and in terms of their ability to be a role model for other midwives and students.

> I think a really good midwife is someone who inspires other midwives, somebody that they enjoy working with, that they learn from the example that she sets, students and junior midwives … But there are a lot of adequate competent midwives … perhaps not so many who have those qualities (midwife).

During the analysis, nineteen characteristics of outstanding midwives were identified initially, and after further analysis themes were grouped into five categories: knowledge and capability, commitment and professional behaviour, judgement, coping, and being able to work with women.

9.2.1 Knowledge and Capability

Interviewees described good midwives as having really good knowledge that is up to date and research-based, and being able to use it skilfully in practice across all contexts. Along with having good knowledge, it was suggested that good

midwives are constantly developing their knowledge and keeping themselves up to date by reading midwifery journals or undertaking further study. Good midwives were reported to be good at seeking out new knowledge and were perceived as being continuous learners. It was also suggested that good midwives are interested in developing their practice further and learning about new techniques and that they are open to change. Good midwives were also portrayed as reflective practitioners, constantly thinking about what they are doing and relating it to research. It is also suggested that good midwives are keen to share new knowledge and discuss their findings with colleagues and that they are good teachers for student midwives, medical students and women, with an understanding of the needs of learners and knowing where to get further information. Overall, it is suggested that good midwives had the ability to integrate all of the bits into what they do so that they had become fluent in practice.

9.2.2 Commitment and professional behaviour

Good midwives were noted for their commitment to midwifery and to being a midwife and their dedication to providing good care for women. In one case it was suggested that the midwife's commitment went well beyond the call of duty.

> .. we've got one who will always put herself on call and always be there for (the women) and she's renowned for being THE midwife for such you know, because whether she's off duty or on duty, she will go out to her ladies, so midwifery is her life rather than her job (midwife).

It was also suggested that good midwives are really interested in what they do and developing their own practice, and that they enjoy their work. It was suggested that someone that is so motivated would have a positive impact on the morale of other team members. One respondent summed up a midwife that she viewed as a role model when she was a student and that struck her a being very good. She was very outgoing, very motivated and read a lot. She knew exactly what to do but was not afraid to ask if she didn't know. Her life was her work and

she knew everything so well she was not intimidated by doctors. The interviewee also stated that since then she had come across few such midwives.

Being committed to the midwifery profession and to behaving as a professional was also identified:

> .. and also the professionalism because sometimes I feel we have relaxed too much, and it's all gone a little bit too far, and I think the good midwives are the ones that know when to be professional, when to be relaxed with the women and as I say can adapt to the situation but still have that air of professionalism around them (midwife).

The ability of good midwives to fulfil their role as an advocate was also identified.

> … and I think they need to be quite strong in defending a midwife's role when they're looking after people, people that are quite confident in their own practice, and will protect the women that they're looking after (midwife).

It was suggested that good midwives have a good awareness of the midwives' rules and practise within the legislation governing midwifery, that they are aware of their accountability, and keep good records.

The role of the midwife within the team was highlighted and good midwives were noted for their ability to work well within a team and to contribute to the team. They were noted for their 'team spirit' and their ability to relate to other team members, and the respect that they had for other team members. In addition, they were noted for being aware of the capability of individuals in the team and their needs, and that they took this into consideration when allocating work or delegating.

9.2.3 Judgement

Several interviewees talked about good midwives making sound judgements and a type of higher thinking was identified by one interviewee:

> I think the midwives that I've thought were quite good and that I've admired have been quite lateral thinkers, they've been able to see a situation but think beyond the immediate situation, or think, apply previous experience to a situation which has sort of brought in different problem solving techniques (midwife).

Another interviewee described as 'intuition' something that she found difficult to describe exactly:

> I've got a whole list actually but there's one thing I've put at the top which I've called intuition - this sort of feeling good midwives get, they know what's going to be a problem, what isn't … there's one person in particular I can think of who just will always be right in her thoughts about a case for instance … you've heard them say midwives feel it in their water (midwife).

9.2.4 Coping

Another personal characteristic identified was that good midwives have a particular ability to cope and remain calm in difficult situations.

> I always admired the ones who never panicked, always kept their cool, no matter what the situation, and that's something that I've always tried to do (midwife).

> I think a lot of it tends to be personal qualities that make people good midwives. I think a lot of it is to do with how calm you are. I think that good midwives that I've worked with have tended to be quite calm so they kept situations under control because they

> appear outwardly calm, whether they're inwardly calm is a different matter but they appear outwardly calm (midwife).

One midwife gave an account of a good midwife that she had seen in action:

> I suppose one incident in particular with one midwife was an emergency situation with a shoulder dystocia, and you know, the ability to sort of like go in, I mean on this occasion I know the registrar was not very experienced, and it was actually this midwife that was doing the main input in the situation, I mean it was, the baby was sort of head out, we'd been pulling for about five minutes before … (midwife).

> So was it her ability to take command of the situation? (researcher)

> Yeah she did because she obviously sensed, that although there was a registrar there, and the senior registrar was contacted, she didn't wait for him to take action, she obviously realised that he maybe didn't have the expertise and experience to deal with the situation and somebody needed to take action (midwife).

It was also suggested that good midwives are confident in terms of being comfortable about what they are doing and passing over that confidence to the women in their care. Good midwives were also identified as being assertive and being an advocate for women, without coming over as aggressive to medical colleagues.

9.2.5 Being able to work with women

In several cases it was suggested that personal qualities stood out more than anything else about good midwives and the individual's personality:

> Well it's sort of personal attributes really that they can't learn but they are still important, like listening skills, I suppose they can be taught to some extent but some people are good listeners naturally and they give the appearance of giving people time (midwife).

> I think the things that make people good midwives aren't actually things that you can teach, you can teach all the knowledge, and you can learn about yourself, but I think that you have to have a certain sort of personality, and I think the particular one to me is this non-judgemental (midwife).

Midwives identified several personal qualities of outstanding midwives such as midwives being nice people, that they respected and informed women's choices, that they were non-judgemental, trustworthy and could be assertive without being aggressive.

> I see a good midwife as somebody who has confidence in the women, that they don't make judgements for them or think they know what's best, and they will give the woman the information, and let her make the decision … one person that I worked with when I was a student, she was very much like that and everything that she did, she would discuss with them …(midwife).

Interviewees suggested that good midwives are able to relate to women, colleagues and other team members. They were portrayed as being effective communicators, in terms of having the skills required and also being able and willing to listen to women, and being able to reach women and build up a relationship with them. It is suggested that through effective communication, good midwives are able to pass knowledge onto women in a way that is meaningful for them and that enables women to make informed decisions. Such midwives were also seen as approachable to women and other staff members and to have the ability to make women feel comfortable in the way that they deal with

them. Interviewees also talked about good midwives being able to adapt their practice to each situation and to accommodate the informed choices of women.

9.2.6 The role of experience in being a good midwife

One or two of the good midwives identified were senior students and it was also suggested that while competence generally improves with experience, some qualities are not related to learning but to personal dispositions that midwives have or have not from a very early stage.

Diaries

Six themes were identified in diaries relating to good practice; working with women; giving good support to other team members; clinical practice; communication; managing workload; and, extending existing services to accommodate special needs that women might have.

In terms of working with women, examples given included being kind, helpful and supportive to women in such a way as to enhance the experience that women had of childbirth or to enable them to overcome particular difficulties that they had, for example with breast feeding. Examples were also given of informing choice, providing total patient care and tailoring care to a woman's individual needs.

Examples were given of midwives providing good support to other midwives or doctors and in doing so being able to anticipate needs, say for example in an emergency situation. Descriptions suggested that these midwives respected the autonomy and capability of those that they were providing support for and were unobtrusive and willing to take on the support role, perhaps without having to be asked to provide support. In the following description, it is suggested that the woman and her partner benefited from such an approach:

> G2, P1 – normal labour, normal delivery – FH present just prior to delivery, clear liquor, membranes intact at second stage. Baby 4.110kg – Apgar 1 at 1, crash call paediatricians. Second midwife

> present at delivery (G grade). Kept in background – took care of baby with paediatricians. Baby very ill – asphyxia caused by blood loss needed intubating and drugs and blood transfusion in delivery room. Midwife very quietly kept me supplied with information on progress of baby to relate back to parents. Baby was 45 minutes of age before it was fit to be transferred to NNU. All of this time I received relevant information to give parents, so that they knew what was going on, and that they weren't left – the parents were so grateful. This midwife was discrete, didn't interrupt the paediatricians. Gave relevant information for me to give parents (diary entry).

One example was also given of an experienced midwife who came across a situation she had not met before, and sought advice from other team members about what they would do in the situation. The description suggests that she respected the views of her team members and listened to what everyone had to say.

The three examples relating to clinical practice were about being able to predict or detect that all was not right, along the lines of intuition. One example was given of a midwife who picked up that a woman had retained products. The implications of her actions were that the woman was spared the possibility of having a post partum haemorrhage later. A second example was:

> Baby transferred to ward from theatre grunting. Staff concerned about baby and reported grunting and observations to paediatrician. Baby then arrested on ward. Resuscitated quickly by staff on ward. It was good practice to closely observe baby and resuscitate it (diary entry).

The third example was of a midwife who picked up 'important' information about a woman's socio/psychiatric history on admission that had not been recorded in her notes.

Examples relating to communication included good liaison by a midwifery manager that enabled the mother of an abandoned baby to be identified and given support. Another example was of a good handover given between two different shifts that enabled consistent care to be given to women. Two examples were of midwives being efficient in managing their workload and by doing so avoiding delays for women later in the day. They included having notification of discharge and discharge letters done in good time for women to be discharged, and a midwife sending off bloods quickly when admitting a woman going for a caesarean section. One example was given relating to midwives extending existing services to accommodate the special needs of women living in hostel accommodation.

9.3 Exploring concepts of bad midwives

Interviews

In the interviews, the twenty experienced midwives were also asked about midwives that they had known who were not good midwives and what it was about them that distinguished them from other midwives. The analysis identified three key themes to not being good. The first theme is that bad midwives are not good practitioners. However, what is more apparent is the second dimension - that bad midwives often do not have appropriate attitudes and to a very large extent it seems that these attitudes either underpin the reasons why they are not good practitioners or overshadow their capability. In the latter case, it seems that for such midwives the most striking thing about them is the way they go about their work rather than any deficit in skills or knowledge. A third theme relates to the way in which midwives act out or fail to undertake aspects of the role of the midwife.

9.3.1 Poor practice

Initially in the analysis it seemed that interviewees were saying that the midwives that they had known who were bad midwives tended to have attitudinal problems more so than any inability to practice, but as the analysis proceeded examples of other types of poor practice were identified. In most cases, it was suggested that poor practice related to midwives not keeping themselves up to date. As such,

bad midwives had not updated their practice to include research findings, new techniques and ways of doing things, or had not learned new skills to suit the practice situation in which they were working.

Leaning more towards the attitudinal theme, several interviewees identified midwives who were not motivated to staying up to date and to continuous learning, who did not reflect on their own needs and abilities, or who were hostile to change, or felt threatened by change. Further:

> … some have been theoretically updated but still carry on using old practice, I mean particularly practice that is research based and that is proven but still run along with the old practice which, again puts extra pressure on their colleagues because they're saying one thing and their colleagues are saying another thing (midwife).

> I mean like this the third person I'm thinking of … because she's so far gone along the line of not developing herself professionally any more that she feels she doesn't have to or what have you, then you can't go back and that's where I feel she's at (midwife).

> Some old school midwives are reluctant to use research in their work or are hostile to research. They say ‘why should we change now, we've been doing it this ways for years and have never had any problems before?'. They also give students who quote research a hard time (midwife).

9.3.2 Attitudes

Another theme identified in bad midwives was their attitudes towards women and their co-workers including:

- *Their general manner and the way the treated women* - midwives who were unapproachable to women or other colleagues, were insensitive, abrupt or unkind to women, bullying and being very critical of junior staff. Two

accounts were given of midwives upsetting women and of GPs refusing to work with a midwife because of the way she treated women.

- *Midwives who were intolerant* - midwives who had biased views of or were intolerant of poor, single or teenage women, or women from ethnic minority groups.

- *A general lack of commitment to being a midwife* and to doing a good job was identified in some midwives. It was suggested that some midwives lacked a warmth when dealing with women, for example, visiting a woman at home and carrying out her checks with minimal communication and failing to build up a rapport with the woman. In other examples it was suggested that midwives could not be bothered to do more than the absolute minimum and this affected the quality of experience of care that a woman had.

- *Midwives who were burnt out*- examples were given of two midwives who had absorbed so much change over the years and had become so disillusioned that midwifery was just a job to them now and they were biding their time until retirement. As a result they did no more than the minimum required and did little to keep up to date.

- *Midwives who did not see themselves as part of a team* - Several interviewees identified midwives who were not prepared to work as a team member, to pull together with other team members and to relate to other colleagues. Examples were given of midwives who were not willing to share the workload fairly with other colleagues and to help out busy colleagues when they had spare time, or colleagues who left some of their work for other colleagues on another shift to do. There were also accounts of midwives who did not make the effort to get on with other colleagues or who were not supportive within the team.

9.3.3 Taking on the role

A third theme identified in interviews about the attributes of bad midwives related to acting out the role of the midwife. The first issue identified was that some of those identified as bad midwives could not communicate effectively. In one case it was suggested that a midwife was not coherent and as such she did not give women confidence in her abilities. Non-verbal communication was identified as a problem for some bad midwives. It was suggested that their body language did not make women feel comfortable or that they did not have the ability to listen and to actively empower women to make choices.

Other points about midwives who were not good related to the way in which they acted:

> … panickers, yeah I think certain people when they're faced with not necessarily an emergency situation maybe just day to day, running of the wards or whatever, some people tend to flap and panic, and that affects everybody else and I think that tends to make people less efficient with their time as well (midwife).

> ... not assertive, because midwives who haven't got the assertiveness skills tend to not put their point across, say for instance in a ward round or on delivery suite, if a midwife doesn't agree with what the registrar or senior registrar is doing, if she's not assertive enough she may not say anything, and she may be right, she may know something that that doctor doesn't, and if she's not assertive enough to stand and say what she believes, then the care ultimately might suffer so that's quite important really (midwife).

Interviewees also identified midwives who did not behave professionally - one example was given of a midwife sitting on a bin and swinging her legs while talking to a mother. In addition, examples of poor record keeping were identified.

One interviewee identified a midwife who did not always make good decisions, while three interviewees identified midwives who were reluctant to take on responsibility:

> … they are unwilling or unable to accept the autonomy of the midwife's role and constantly want to pass the buck if you like, despite maybe many years of experience they aren't willing to accept the responsibility for the decisions that they make and constantly want to either to involve a doctor or maybe on the labour suite the labour suite co-ordinator (midwife).

Diaries

In the analysis of incidents recorded in diaries, three themes were identified relating to poor communication, the provision of care, and functioning within a team. Communication was the theme that featured most in diary accounts and some examples related to communication between midwives and medical staff, GPs and hospital staff, hospital staff and social services or community staff and between midwives on other units and wards. Examples included a woman who was referred by a GP who made no reference to significant social and psychiatric problems that she had had in the past, a woman who had been drug dependent who transferred home without referral to social services, and a woman expecting triplets who was transferred to the ward from an antenatal assessment unit with only two CTGs and no reference to a third triplet. There were several accounts of women discharged to the community with inaccurate or incomplete discharge information. This included two discharges not being notified (and as a result one woman was not seen until day ten by a midwife), midwives being given the wrong address for two women, and one case where a midwife was told that a mother and baby had been discharged although the baby was ill and still on the neonatal unit. There were two other examples of poor record-keeping including one baby being recorded as the wrong sex and a rhesus negative woman being discharged without the results of her Kliehauer test. There was one account of a midwife not reporting abnormal blood results for a woman with pregnancy

induced hypertension. In terms of communicating with women there was one account a midwife getting consent from a woman to give vitamin K but without giving the parents enough information to give informed consent, and there were two accounts of midwives upsetting women – one by being abrupt and the other by unnecessarily getting a woman concerned about a rash that a baby had.

There were a range of accounts of poor practice relating to the provision of care. Some related to poor management of care, for example failure to take action where a woman failed to progress beyond six centimetres for five hours, and two relating to pain management in labour. One account is very scathing of a midwife's motives for giving an epidural top-up to a woman who was probably ready to push:

> Lady had an epidural for pain relief. Had urge to push (previous VE 6 cms) not 'time' for next VE. Top up given even though she had external signs of second stage (told to me by the midwife – anal pouting and very heavy blood stained show). When I examined her, she was fully dilated. Unable to push effectively as epidural (…). therefore forceps delivery – could this woman have had a normal delivery if she wasn't given a top-up and the midwife used her urge to push? All this happened towards the end of a night shift (I was on the early) maybe the midwife didn't want a delivery too close to the end of her shift and have to stay behind to do the records?? (diary entry).

Other examples included suturing a perineum with catgut rather than silk, failure to treat or refer a large naval stump, bottle feeding rather than cup feeding a breast fed baby, and leaving painkillers sitting on a locker for the woman to take later. There was also an example of a woman who was discharged after an unbooked delivery where no one had enquired as to the reasons behind her not being booked. As it turned out later, she had a drug problem and would have required additional support including the involvement of social services. There were two examples of midwives not giving due consideration to women, for

example forgetting about them when they were having a CTG performed, and a midwife propping open a door and leaning inside to make a query during a delivery and in doing so exposing the woman to anyone who passed her door. There was one example of inflexibility where a community midwife refused to give a bath demonstration to a woman at home and insisted that it should have been done in the hospital. There were three examples given of midwives not being supported within the team. One referred to a junior midwife who needed support not being given it. Another related to the attitude of a Sister towards a staff midwife:

> Caring for a twin G1, P0 lady. All well, having an induction of labour at 38/40 for IUGR. I was happy with management of labour, and as routine the sister in charge came to review and check on my lady (as is routinely done during each shift). The way in which she asked me about progress and general labour details was in a manner that when the sister left the room, both the woman and partner asked me if all was well!! – everything was well and going to plan but the sister's general attitude questioned their trust in me - their midwife (diary entry).

9.4 Discussion

By exploring concepts of good and bad the extremes of competence were examined and similar themes emerged, which in many cases were pairs of opposites – for example, it was suggested that good midwives have really good knowledge and skills that are research-based and up-to-date. In contrast, it is suggested that bad midwives were not up-to-date, or continued outdated practice. Differences between very good and bad midwives are outlined under the five key themes that were identified, in Figure 9.1.

The analysis of the views of experienced midwives involved in this exploration of the attributes of good and bad midwives suggests that while knowledge and capability are key aspects of competence, in many ways they are influenced by the other factors involved in one of two ways.

Figure 9.1 Comparison of themes across accounts of good and bad midwives

GOOD MIDWIVES	BAD MIDWIVES
KNOWLEDGE AND CAPABILITY	
Really good knowledge and skills, across all contexts and knows when to involve a doctor, up-to-date, research-based, continuous learner and actively shares knowledge *Able to predict/detect when things are not right*	Poor practice, not up-to-date, not fit for practice, not motivated to continuous learning, not reflect on own ability/learning needs, hostile to change – old school *Failure to detect/ report deviations*
COMMITMENT	
Commitment to midwifery and being a midwife, to providing good care, motivation to staying up-to-date and developing practice. Balance between professional and friend. Advocate. Practising within legislation. Contribution and support within the team. *Providing support to colleagues in situations, discrete and mutual respect.* *Seeking support and respecting the views of team*	Lack of commitment to being a midwife and doing a good job, lacking warmth, not bothered to do more than absolute minimum, burnt out midwives, midwives who did not see themselves as part of a team / not support colleagues / share workload fairly, passing own work onto others. *Not being thorough* *Not giving junior midwife support* *Attitude of Sister towards midwife and woman she was providing care for* *Undermining midwife in front of woman/partner*
WORKING WITH WOMEN AND WITHIN A TEAM	
Pleasant personality, respects and informs women's choices, provides care based on women's needs, fulfils role as advocate, able to accommodate choices in practice, non-judgemental, trustworthy and approachable. Effective communicator, able to listen Works well and contributes well within the team, team spirit, respect for other team members and aware of their needs *Kind, helpful, supportive to women,* *Enhance experience of care / help women to overcome difficulties,* *Informed choice and care tailored to needs,* *Total patient care,* *Good communication within team, good support to other team members and mutual respect*	Abrupt /unapproachable to women or colleagues, Upsetting women, intolerant, biased, Not see selves as part of team / not support colleagues / help out when busy / share workload *Not giving due consideration to women, inflexibility* *Abrupt with women / colleagues,* *Undermining colleague,* *Not supportive within team,* *Poor communication,* *Poor record-keeping/ communication within team* *Not giving informed choice*
JUDGEMENT	
Higher order thinking, making sound judgements consistently, intuition *Intuition* *Recognising/ pre-empting abnormal*	Not always making good decisions, reluctant to take on responsibility *Failure to take action where not progressing, inappropriate action*
COPING	
Confident – comfortable with role, able to remain calm in difficult situations, able to take charge in emergency situations, passing over confidence to women *Managing workload*	Unable to accept autonomy, panic with day to day situations, afraid to take on responsibility

Source: Interviews (normal font); *examples in diaries (italic)*

Firstly there are other factors involved in transforming knowledge and capability into being competent. This suggests that midwives need to be able to use knowledge effectively in practice, in judgement, and in making good decisions. It is also suggested that a midwife needs to be able to cope – to actively undertake the role of the midwife as an autonomous practitioner and with confidence. This will include remaining calm and focused in difficult situations. In addition, a midwife needs to be able to work with women and within a team so that care is focused on individual needs and the midwife fulfils her role effectively within a team.

Secondly, it is suggested that there are other factors or elements of competence involved in maintaining and further developing the knowledge and capability that midwives have at registration. It was suggested in Chapters Five and Seven, that this is required for a midwife to be fit for purpose. The analysis presented in this chapter suggests that commitment to keeping up to date and developing practice is a major attribute of good midwives and often lacking in bad midwives. It is suggested that midwives need to be keen to learn and be open to change. It is also suggested that a midwife needs to be committed to and have a genuine interest in the women for whom they provide care and also be committed to midwifery as a profession and to supporting other team members.

The themes identified in this chapter support those identified in other chapters, particularly in relation to the importance of the softer aspects of competence.

In the following chapter, the focus is on the development of a model of midwifery competence, drawing on the research findings outlined here and in other chapters.

Chapter Ten

Towards a model of competence in midwifery

10.1 Introduction

In Chapter Three, it is proposed that a holistic integrated model of competence is an appropriate concept for midwifery competence and the EME model of competence is outlined as the general framework for the exploration of competence in this research. The holistic integrated model of competence is presented in preference to traditional concepts of competence, where it is suggested, the tendency has been to focus on knowledge and skills, often as discrete entities or tasks, and to ignore the roles of the 'softer' aspects of competence, such as personal attributes. In addition, models of competence that focus solely on performance in the occupational area are also viewed as inadequate for midwifery competence as it is suggested that they fail to capture fully the use of knowledge, thinking and judgement involved in being competent.

Based on the themes identified during the analysis of views on midwifery competence and key themes in the review of understandings of competence, it is suggested that competence needs to be understood as an integrated and holistic phenomenon to incorporate the interaction between constituent parts in *being* competent. It is suggested that competence is complex because of the interactions between constituents rather than the number of constituents and that this complex interaction and integration is a vital aspect of professional competence. This understanding that the whole is greater than the sum of the parts in competence suggests that approaches to defining competence that reduce competence to an atomised list of tasks do violence to competence, and are disempowering and stifling to occupational roles.

The key features of the EME model of midwifery competence are that competence is understood in terms of three interlinked dimensions – the clinical

competence dimension, the professional/friend dimension[6], and the individualised care dimension. It is proposed that at any point in time, each dimension is involved in being competent but the midwife will draw on each of these three dimensions in different ways and to different extents depending on the situation at hand. In the model, the importance of the linkages between the three dimensions and between the elements within each dimension in being competent are emphasised. The purpose of this chapter is to pull together the findings from the research outlined in previous chapters towards the development of a holistic integrated model of midwifery competence. In addition, the key issues in the literature on assessment in midwifery and in other professions, and their implications in constructing an integrated holistic model of midwifery competence are discussed.

10.2 Competence at the point of registration

The analysis of views on the nature of midwifery competence and elements of competence required to be fit for practice at the point of registration was presented in Chapter Five (see Figure 5.2) under the three dimensions: clinical competence, individualised care and being a professional. In Figure 10.1, the conditional elements of competence at registration identified in the analysis are unpacked by dimension of competence.

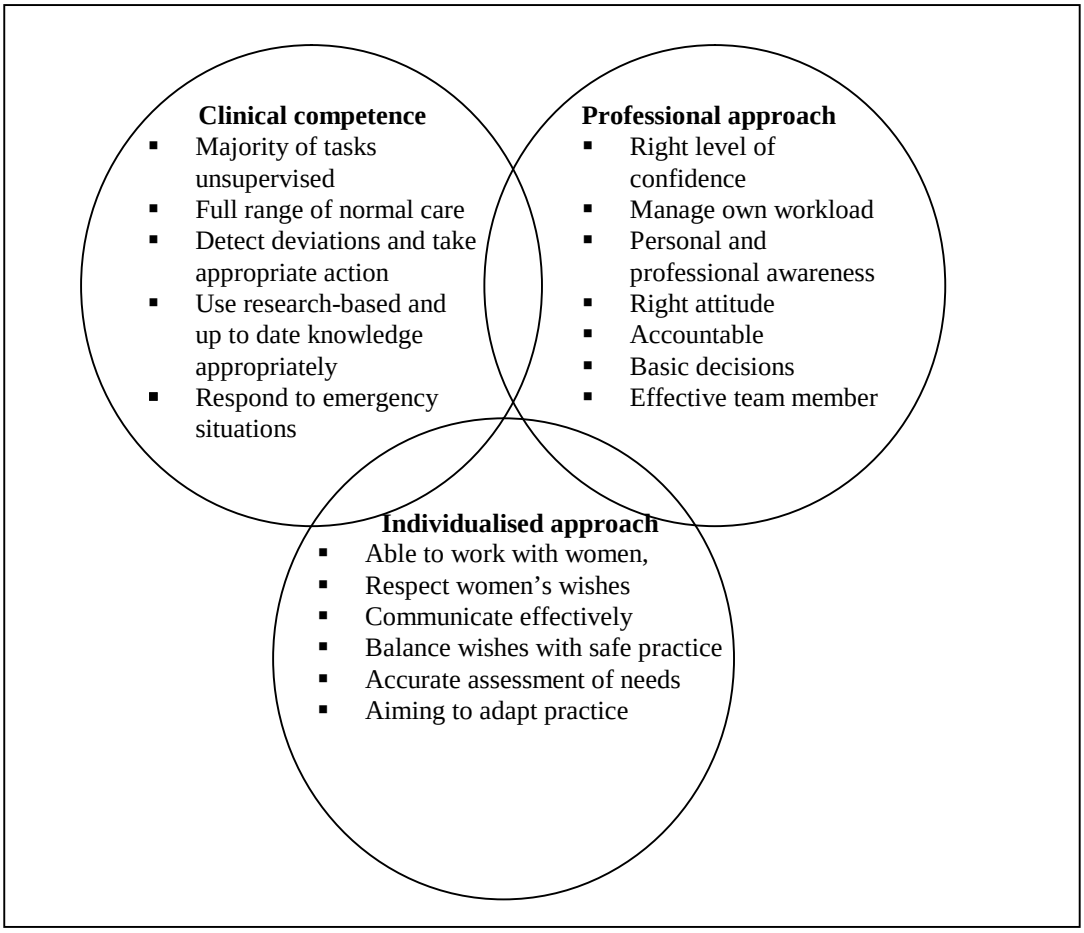
10.3 Building in the findings of competence beyond registration

The analysis of the development of midwifery competence over the first year in practice (as outlined in Chapters Six and Seven) suggests the focus of development over that time is on four particular areas:

1) Developing practice further to become more fluid and integrated, and addressing any outstanding skills for the midwifery role, such as suturing and episiotomy.

[6] The analysis in this study suggests that the elements of the 'friend' aspect of the professional /friend approach in the original EME model are better understood as part of the individualised approach, and therefore, the term 'professional approach' is referred to from this point on.

Figure 10.1 Conditional elements of competence at registration

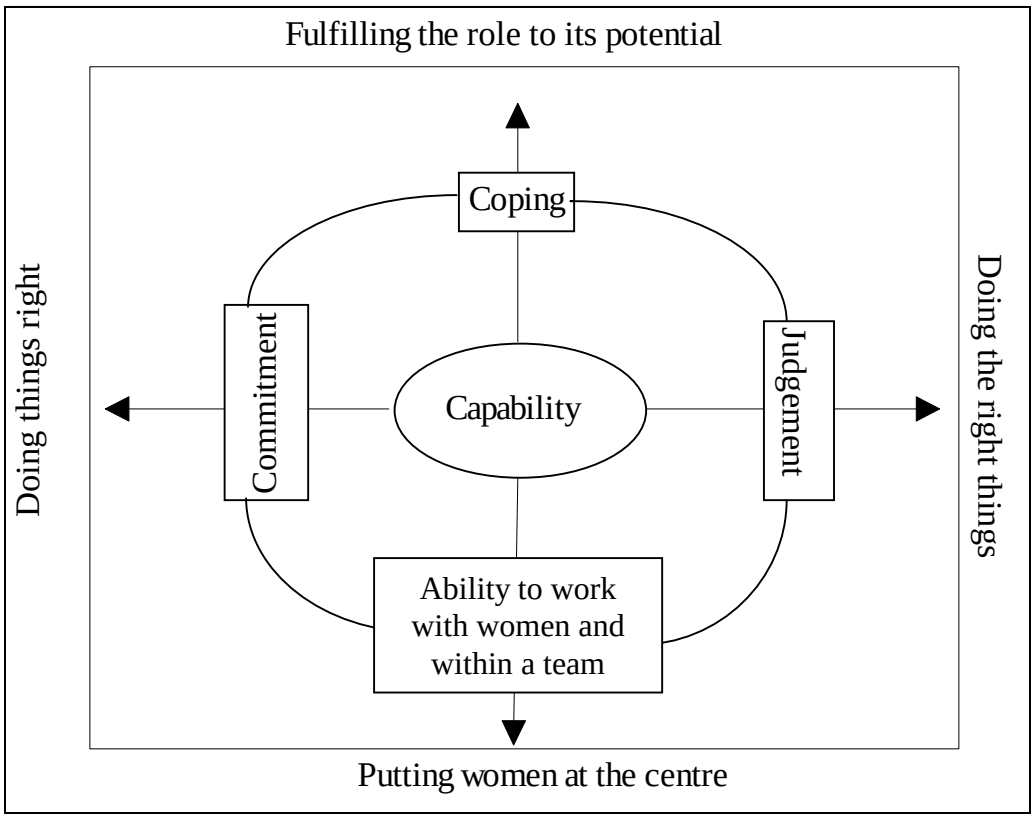


2) Becoming fit for purpose – learning additional skills to be able to practise within various practice situations. Examples included managing a ward, providing care for women with complications, and scrubbing in theatre.
3) Functioning as a midwife, with a particular focus on three aspects:
    - *building confidence*, which it is suggested is vital to functioning as a midwife, in communication and for advocacy.
    - *coping* in terms of developing coping mechanisms and building support networks, learning to pre-empt situations, and learning to live with the realities of practice and reconcile what is found with personal aspirations for the delivery of care.
    - *judgement and decision-making* in terms of taking on responsibility, effectiveness in decision-making, and becoming comfortable with decisions.

4) Developing as a team member - the importance of being an effective team member was emphasised by interviewees, which it is suggested involves mutual respect among midwives and providing support for each other as colleagues.

The analysis of competence at registration, learning before and after registration, and the attributes of good and bad midwives, suggests knowledge and capability are influenced by four other aspects involved in translating potential competence (capability) into actual competence (performance) and the success of that translation. The relationship proposed between the five aspects, on the basis of the analysis, is illustrated in figure 10.2.

Figure 10.2 Capability and competence: influencing factors



The analysis of the views on the development of competence suggests an individual's ability to cope is important in enabling them to take on responsibility and to work as an autonomous practitioner. This suggests that coping will influence an individual's capability to take on responsibility for the full role of the midwife and to practise across the range of midwifery contexts. Interviewees

also talked about coping in terms of dealing with the unexpected along with the predictable, and dealing with all of the other things that are happening in the background. It is suggested that coping involves being assertive and having the right level of confidence, and influences midwives' ability to remain calm in situations and to retain the confidence of women in them as practitioners.

The analysis also suggests that judgement plays an important role in enabling skills and knowledge to be used in the most appropriate way – doing the right things. It is suggested that this involves making sound decisions and being able to think clearly. The analysis also suggests that with experience comes intuition, which is seen as a higher form of judgement.

The third aspect is commitment and it is suggested that commitment and motivation play a vital role not only in performing competently but also in developing and maintaining competence over time.

The fourth aspect of competence, which it is suggested influences a midwife's capability, is the ability to work with women. This concept puts women at the centre of care. Interviewees emphasised that it is important that a midwife respects each woman's autonomy and that she is prepared to give women informed choices. It is also suggested that being able to work with women will involve being:

- pleasant, approachable, and helpful people
- non-judgemental and tolerant
- able to adapt practice to meet needs/wishes
- assertive enough to stand up for women but not aggressive in doing so
- an effective communicator, in particular being able to listen.

The model of competence outlined in Figure 10.1 can be expanded further to include the elements of coping, judgement, commitment and being able to work with women, and this is done in Figure 10.3. In addition, components of competence are further unpacked to differentiate the possession of knowledge and skills, from thinking and judgement, and personal attributes. This is to reflect the points made in Chapter Three that the roles of knowledge, thinking

and action and of the softer aspects of competence need to be captured in concepts of competence.

Figure 10.3 Fitness for practice at the point of registration

	Clinical competence	Individualised approach	Professional
Possession of knowledge and skills	▪ Propositional and process knowledge of normal pregnancy and childbirth and deviations from normal ▪ Appropriate skills for the full range of care for above	▪ Knowledge of the factors relating to variations between individuals and implications for practice	▪ Understanding of scope and sphere of practice of a midwife, boundaries within which practice can be developed and legislation governing midwifery
Thinking and judgement	▪ Ability to make sound decisions ▪ Ability to respond to situational and contextual variations in day-to-day practice ▪ Ability to detect deviations and take appropriate action ▪ Ability to recognise and address own learning needs	▪ Ability to balance the needs and wishes of women with the requirements for safe practice ▪ Interpersonal skills and effective communication	▪ Confidence ▪ Coping with the role and responsibilities of the midwife ▪ Balancing being a friend with being a professional
Personal attributes	▪ Motivation to doing a good job ▪ Motivation to life-long learning and keeping practice up-to-date	▪ Respect for individual autonomy ▪ Commitment to meeting individual needs	▪ Commitment to being a midwife and to contributing within a team ▪ Willingness to take on appropriate responsibilities ▪ Kind, friendly and approachable ▪ Ethics and values

Source: Analysis of competence at registration, of becoming competent and learning over the first year.

This unpacking of competence focusing on the conditional attributes of competence required to undertake the professional role at the point of registration highlights the importance of knowledge use and interpretation and personal attributes in being competent. This would suggest that models that focus solely on the possession of knowledge and skills, or on performance alone, fail to capture the essence of midwifery competence.

The analysis of the views of the range of respondents on the nature of competence as outlined in Chapter Five suggests that midwives at the point of

registration would be expected to be committed and motivated and to be able to work with women. It was also suggested that they should be able to make sound decisions on day-to-day issues but would require support with more difficult issues. Midwives would be expected to be reasonably confident and to be learning to cope with the realities of practice but that they would be expected to need some support initially.

10.4 Competence across the range of midwifery contexts

In the review of definitions of competence and of the literature on defining competence, as outlined in Chapter Three, it is suggested that concepts of competence need to incorporate competence across the full range of contexts. Several distinct elements of the role of the midwife were identified in the assessment matrix constructed during the EME study, through a review of the legislation and guidelines governing midwifery practice. Drawing on the areas identified in EME matrix, the role of the midwife is outlined across four distinct areas of maternity care in Figure 10.4.

Figure 10.4 The role of the midwife

Pre-conception care	Antenatal care	Care in labour	Postnatal care
• Family planning • Preparation for pregnancy • Health promotion	• Confirmation of pregnancy • Monitoring of maternal and fetal well-being • Preparation for childbirth and parenthood	• Confirmation of labour • Monitoring of progress in labour • Monitoring fetal and maternal well-being • Ensuring comfort in labour • Conducting delivery	• Immediate care of new-born baby • Monitoring normal progress and adaptation to parenthood • Monitoring normal progress of baby, including integration into the family unit

Source: Research findings and EME Matrix (Fraser, Murphy and Worth-Butler, 1997)

Within each of the four areas, specific responsibilities of the midwife can be identified. The challenge in constructing an integrated holistic model of competence is to capture all of the components of competence as broad and integrated criteria across the aspects of the role of the midwife. In Figure 10.5, the clinical competence dimension is applied to the midwifery role in antenatal care and the key areas of knowledge and skills required to undertake that role are identified.

Figure 10.5 Clinical Competence - Antenatal Care

	Knowledge and skills	**Thinking and judgement**
Confirmation of pregnancy	• Knowledge of physiology and signs and symptoms of pregnancy • Knowledge of methods to confirm pregnancy • Knowledge of formulae to calculate EDD	• Ability to effectively interpret findings to confirm pregnancy and accurately calculate EDD
Monitoring of maternal and fetal well-being	• Knowledge of physiology of pregnancy and of normal parameters • Knowledge of tests and their appropriate use • Knowledge of relevant treatments	• Ability to assess fetal and maternal well-being and to interpret findings accurately • Ability to take appropriate action when deviations from normal are detected
Preparation for a healthy pregnancy, childbirth and parenthood	• Knowledge of how individuals learn and effective teaching methods • Knowledge of the factors influencing pregnancy outcome and the promotion of health during pregnancy • Knowledge of knowledge and skills required for successful parenting	• Ability to meet individual learning needs and effectively promote health, well-being and a positive experience of pregnancy, childbirth and parenthood.

Source: Research findings and EME Matrix (Fraser et al 1997)

This analysis is based on the elements of competence identified in the EME matrix. However, to illustrate the proposal that emerged in the analysis of interview findings, that being able to use knowledge and skills appropriately is also vital to be competent, elements of thinking and judgement are also identified. This model suggests that having the propositional and process knowledge required to (diagnose) confirm pregnancy is not the same as being able to use it effectively in practice, so that a midwife effectively interprets test findings and accurately calculates the expected date of delivery (EDD). In Appendix Four, the clinical competence dimension (as outlined in Figure 10.1) is also unpacked for the other three areas of the role as identified in Figure 10.4. and in relation to dealing with emergency situations.

In a similar way the individualised care and being a professional dimensions involve the application and integration of underpinning knowledge, capability and attitudes. These are outlined in Figures 10.6 and 10.7.

As can be seen in Figure 10.6, knowing and understanding that each woman is an autonomous individual, and being aware of the factors involved in differences between people and what their needs are is only part of the equation in being able

to provide women with informed choice. In turn, being able to provide informed choice is only one element of individualised care, which will also require a midwife to be able to assess, plan, implement and evaluate care to meet individual needs/choices. In addition, it is suggested that, to be competent, a midwife must be able to ensure that the woman will have a safe outcome and this will involve informing women about the safety implications of the range of alternatives open to them and evaluating the safety of the choices that are eventually made.

Figure 10.6 Providing individualised care

Knowledge, capability and attitudes required for the individualised approach	Key constituents of providing individualised care
• Recognition of each woman as an individual with unique needs • Awareness of the factors involved in differences between individuals and the influence of those factors on the type of care that women will require • Awareness of the influence of factors on the uptake of antenatal care and health promotion opportunities • Appreciation of the need to plan care to meet assessed needs • Ability to communicate effectively • Respect for the autonomy of individuals • Personal qualities, appropriate attitudes, effective communication, including listening skills, responding to verbal and non-verbal cues, and counselling skills • Advocacy	• Ability to provide informed choice and to involve women in decisions about the type of care that they will receive • Ability to assess, plan, implement and evaluate care to meet individual needs • Ability to balance the expressed wishes of individuals with the requirements for safe practice • Ability to relate to women

Two key components of functioning as a professional are identified in Figure 10.7, and as illustrated, each component can be unpacked further to identify the range of elements that a midwife needs to draw on function effectively as a professional.

Figure 10.7 Functioning as a professional

Knowledge, capability and attitudes required to function as a professional	Key constituents of being a professional

• Understanding of the legislation and regulations governing the sphere and scope of practice of a midwife, accountability and the importance of record-keeping • Confidence, commitment and ability to take on responsibility and decision-making • Awareness of the limitations of own capability and willingness to seek assistance or advice in such situations • Ability to manage workload, including the ability to prioritise and time management • Ability to delegate appropriately, including effective supervision of delegated responsibilities • Ability to identify own learning needs, possession of learning skills and motivation towards keeping up to date	• Ability to function effectively as an autonomous professional
• Awareness of the role of other team members and how they relate to that of the midwife and respect for other team members • Ability to communicate effectively, including report-writing • Ability to work with others including personal manner and assertiveness	• Ability to function effectively within a team

Source (Figures 11.6 and11.7): Research data and EME Matrix (Fraser et al 1997)

10.5 Assessing midwifery competence at the point of registration

The United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) has national responsibility for the registration of midwives and the maintenance of that part of the register in the UK. The UKCC also outlines the standards of professional practice required of midwives in its Code of Practice and Midwives Rules. The UKCC stipulates a number of required *outcomes of programmes of education* in the Midwives Rules, Rule 33. Midwifery education in England is regulated by the English National Board for Nursing, Midwifery and Health Visiting (the ENB). The ENB approves institutions for the provision of programmes of education, and validates and monitors midwifery programmes. It also issues guidelines and regulations including those relating to the assessment of midwives. Although programmes are scrutinised and validated by the ENB, institutions design their own curricula and assessment schemes. This was reflected in considerable variations in assessment found between the six case study sites. While assessment schemes were more developed at some sites than at others, the general movement was towards the collation of evidence of student achievement throughout the programme in a *profile of achievement* as instructed

by the ENB (1995). The range of approaches to the regulation of midwifery competence is outlined in Figure10.8.

Figure 10.8 The regulation of midwifery competence in England

	Regulation Instrument	**Regulating Body**
Fitness for practice	• Requirements for entry onto and maintenance on the professional register • Outcomes of midwifery programmes, including EU requirements	United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)
Sphere of practice and professional conduct	• Code of practice • Midwives Rules	UKCC
Content of educational programmes and assessment	• Validation of midwifery education programmes • Validation of assessment schemes	English National Board for Nursing, Midwifery and Health Visiting (ENB)

Barlett et al (2000) claim that the development of agreement in nursing and midwifery on methods that can adequately measure competence has been hindered by confusion and concern about reductionism in relation to quantitative approaches and the perceived lack of definition and transferability between institutions in relation to qualitative approaches. In nursing and midwifery, the UKCC provides the broad framework in Rule 33 and the challenge for educationalists is to map out these outcomes and identify appropriate elements for learning and assessment. Specifically at registration the purpose of assessment is to provide the evidence upon which a final decision can be made as to whether a student is capable of fulfilling the role of the midwife and whether they will be deemed eligible for registration – *fitness for practice*. The analysis presented in Chapters Five and Seven suggest that competence at the point of registration is not an end-point but a key stage of achievement on the competence continuum. Also at the end of a programme of education, a decision is made as to whether a student is eligible for an academic award. There is no distinction between successful students on diploma and degree level programmes in terms of midwifery registration and regardless of which academic route midwives take, they have equal status as midwives once they have been deemed eligible for registration (Gerrish et al 1997). In addition, it is unlikely that there will be any

differences in terms of the role that new midwives undertake on the basis of whether they have a degree or a diploma level qualification.

While the primary concern at the point of registration is to ensure that a midwife is competent for the professional role at the point of registration, it must be acknowledged that fitness for practice is not the only purpose of education and the rationale behind educational programmes will include other concepts such as opening minds, changing attitudes, preparing students for further learning, and enabling individuals to achieve their intellectual potential. One of the conclusions made in Chapter Three is that a model of competence in midwifery must capture the essence of midwifery competence, promote professional learning, be consistent with the aims of education, and support and promote life-long learning.

10.5.1 The theory/practice issue in assessment in midwifery

In the midwifery literature there is a particular issue about the separate focus on theory (propositional knowledge) and on practice (action/ performance) in assessment. Part of the difficulty emanates from the fact that fitness for practice and fitness for award are both assessed at the point of registration, and it is suggested that the assessment of fitness for award can conflict with the assessment of fitness for practice. This is on the basis that the emphasis in assessing fitness for award tends to on the assessment of written assignments, projects or performance in examinations. This reflects traditional approaches to assessment for academic qualifications and perhaps has become more of an issue as providers of midwifery education have moved further under the umbrella of universities, and because on successful completion of programmes of midwifery education, midwives also receive an academic award. The tension arises because midwifery is inherently a practice-based profession and many believe that for valid assessment of competence to practise, at least fifty percent of assessment must take place in the practice area. In addition, the ENB (1995) and the UKCC (1999) state that theory and practice must receive equal weighting and be equally valued in determining whether or not an individual is fit for practice.

The principles outlined in the ENB's (1995) assessment policy are that:

- All students should undertake continuous assessment of theory and practice.
- Assessment strategies should reflect the principles of integration, coherence and progression. Therefore it is suggested that in assessment strategies:
  - the curriculum in which there is an inter-relationship between theory and practice should be reflected
  - equal value should be given to the assessment of both theory and practice
  - students should demonstrate competence through the achievement of learning outcomes in both theory and practice but through separate pass criteria.

Although the policy emphasises that the assessment of practice should be given an equivalent value to the assessment of theory, the requirement for separate pass criteria does imply that the two aspects of competence are very different entities. Milligan (1998) suggests that through this requirement the ENB has 'perpetuated' the theory /practice dichotomy. This notion of a theory /practice dichotomy was evidenced in our research on the EME study and is also reported in Gerrish et al's (1997) findings in their review of diploma and degree nursing and midwifery programmes that the emphasis in assessment was on theory. In addition, they found the tendency was for theory to be graded but not practice, and while some universities showed some flexibility in credit-rating practice, others refused to do so.

10.5.2 Integrating theory and practice in assessment

Several ideas are put forward in the literature for ways in which theory and practice can be better integrated in assessment, including the following.

- Fitness for practice and fitness for award should be assessed together (and presumably using the same criteria) and clinical assessment should be open to external scrutiny (Watkins, 2000).
- Practice-based learning should be included in assessment for an academic award (UKCC, 1999).
- More transparency is required concerning practice components, which should be spelled out in outcomes standards (Bradshaw, 2000a).

- A competency-based approach (portfolios) is required so that all can see precisely what students are capable of doing and practice is treated with equal importance. A portfolio can provide an overall view of a students' performance and development as a practitioner and highlight any defects, so that remedial action can be taken' (UKCC, 1999, p38). The portfolio will provide 'cumulative information' about achievement and progress 'demonstrating the inter-relationship of theory and practice' and including any cause for concern relating to progress (ENB, 1995).
- Addressing gaps between what is taught and how it is assessed (Sharp et al, 1995) and using assessment strategies to achieve greater congruence between what is learned in the classroom and on practice placements, and to ensure fitness for practice (UKCC, 1999).

The ENB (1995) requires a portfolio to be put together for each student where all learning and outcomes of assessment are recorded. The ENB's understanding of a portfolio is much more useful - referring to cumulative evidence of progress and achievement, than the UKCC's version, which refers only to practical experience. A portfolio would need to include all assessments, including the results and analysis of written assignments. The use of a portfolio in other disciplines is aimed not only at pulling together evidence of competence from a range of assessments and assessment approaches but also to encourage certain types of learning. Accordingly, it is suggested that portfolios can encourage autonomy (Wolf, 1998, Klenowski, 2000), reflection and preparation for life-long learning required for professionalism, and provide the student with insights into assessment for future roles as assessors (Klenowski, 2000). This suggests that portfolios could help to address some of the deficiencies relating to autonomy suggested in Chapter Five, and to further prepare midwives to be life-long learners, which is also identified as essential to remaining competent over time and in terms of fitness for purpose.

While a student portfolio would help to assemble evidence of performance over different contexts and over the duration of the programme, requiring assessment of theory and practice is not the same as integrating theory and practice. This

would require written assessments to relate to what the student would do in a particular situation, or drawing on experience in the practice area; and relating what is observed in the practice area to the knowledge underpinning decisions that are made.

10.5.3 The case for an outcomes approach to assessment

An outcomes-based approach to curriculum development is advocated by Watkins (2000) and, Jowett and Wellens (2000) also note that other professions are increasingly concentrating on outcomes-based curricula to convince key stakeholders that the learning pathway is directly related to what employers expect students to be able to do at the end of a programme. The UKCC (1999) promote the use of an outcomes-based approach to learning and assessment to:

- integrate theory and practical knowledge
- shift from teacher-centred, didactic, input and process oriented assessment to assessment that is student-centred, facilitative and output-oriented
- refocus on the importance of learning in the practice context, which is as valid as learning in the academic context
- support learning in widely different locations.

The UKCC suggest that although the current diversity in midwifery education is a strength, there is merit in having a common approach to defining outcomes for pre-registration education to ensure that all newly qualified midwives are fit for practice.

In the wider literature it is also suggested that an outcomes approach to assessment could:

- produce unambiguous and transparent requirements (Reynolds, 1999)
- provide a clear definition and standardisation of a role in terms of its purpose, function and core competencies. This would benefit patients (Bradshaw, 2000b)
- provide a reference point for the direction and scope of professional roles. For example, Bradshaw (2000b) suggests urgent debate is required in nursing

in the light of 'the current mutation of the nursing role and the increasing loss of its foundational place in the bedside delivery of 'total patient care''

- ensure that the boundaries of competence are clearly articulated. For example, Fraser (1997) warns that without an accepted definition of competence there is the danger that assessors will give borderline students 'the benefit of the doubt'
- make explicit the end products of a programme of study referring to outputs rather than inputs, and to what a student will be able to do. This would enable educational planners to isolate subject knowledge and skills to be developed by students that as explicit statements would be amenable to scrutiny and external assessment of their value or worth (Flanagan et al, 2000)
- reflect actual performance by assessing what is actually done in practice, rather than placing the professional in an artificial testing situation and assessing responses to hypothetical questions aimed at assessing potential performance (Wolf, 1995).

10.5.4 Competence-based approaches to assessment

A range of terms such as criterion-referenced, competence-based and competency-based assessment is used extensively in the assessment literature to describe outcomes-based approaches to assessment. Wolf (1994) suggests the competence-based approach became popular in England in the 1980s because of concern that assessment did not adequately test or record the competence required in employment and it was seen to be biased towards testing knowledge or skill rather than competence. Hager et al (1994) suggest that the competence-based approach provides a better way to assess knowledge than traditional approaches that tend to focus on the lower aspects of knowledge such as recall and understanding and to neglect other levels of cognition such as synthesis and application. 'Competency-based assessment can put candidates into situations in which they are required to comprehend, apply, analyse, synthesise and evaluate data and information' (Hager et al, 1994, p.13).

The crucial idea underpinning competence-based assessment is that one should look at the substance of what someone can do, in effect, compare a candidate's performance with some independent, free-standing definition of what should be achieved (Wolf, 1993). Wolf describes competence-based assessment as:

> … a form of assessment that is derived from a specification of a set of outcomes: that so clearly states both the outcomes – general and specific – that assessors, students and interested third parties can all make reasonably objective judgements with respect to student achievement or non-achievement of these outcomes: and that certifies student progress on the basis of demonstrated achievement of these outcomes (Wolf, 1994, p.5).

The espoused aim of competence-based assessment is to move assessment closer to the competence required in occupational settings.

10.5.5 Concerns about reductionism

As previously identified in Chapter Three, a major theme in the competence debate relates to how broad or narrow definitions of competence should be, and the danger of reducing elements of competence too much so that the subtle integration of the factors and the vital interconnectivity between elements required for true competence is lost. The case is also made in the literature that assessment should not be too constraining on the curriculum in such a way that it restricts understanding, freedom of thought and originality and that assessment should facilitate creative and flexible approaches to practice (Reynolds, 1999, UKCC, 1999). Mansfield and Mitchell (1996) promote the need for a broad approach which would allow for the inclusion of both propositional and process knowledge. While the UKCC (1999) warn about the limitations that outcomes-based assessment can have if it becomes too narrow in focus, they also warn about being too vague such that statements of competence lack clarity.

However, it is suggested that a challenge on an equal scale is how to include discrete skills such as giving an injection (Watkins 2000). Milligan outlines this 'dichotomy':

> In a sense, what is asked for through competence is nothing less than the successful integration of theory and practice, and NVQ-style assessment fails to focus on this. Yet within this dichotomy lies a trap; a trap in which the complexity of knowledge and the various forms of knowledge inherent in what are commonly called skills are lost (Milligan, 1998, p.279).

LeVar (1996) suggests the limitations of assessment due to reductionism include the following.

- The emphasis on the separateness of individual tasks encourages the practice of isolated components and does not encourage a holistic approach.
- The reductionist and disaggregated nature of assessment in NVQs does not facilitate the integration of values, knowledge, skills and reflection that promote learning (citing Broadfoot, 1995).
- Assessment cannot discover understanding and how this understanding is used in solving problems. The thinking is that assessment should aim to promote 'flexible thinkers, reasoners and intelligent novices' (citing and quoting Gipps, 1994). This suggests that a midwife might be assessed as being able to 'do' all of things that a midwife should be able to 'do' but it cannot suggest that a midwife will use knowledge effectively in decision-making or acting in an emergency situation. Nor does it suggest that she will be able to practise with confidence and as an autonomous practitioner.

10.5.6 Capturing the attributes underpinning performance in assessment

The importance of holism and taking an integrated view of competence has already been put forward. In addition, it is suggested that both traditional approaches and competency-based approaches, where the focus is predominantly on either knowledge or performance, run counter to the holism. One of the concerns about a competence-based approach to assessment is how the factors

underpinning performance, such as knowledge and understanding, can be accessed and demonstrated. This issue is of particular relevance in the light of the views outlined in this thesis regarding the importance of the less tangible underpinning aspects in being competent, and enabling professionals to remain competent over time and across contexts and situations. The issue at the heart of this debate is whether knowledge and understanding can be inferred from successful performance. Originally, the NVQ view was that successful performance is indicative of having and using knowledge and that therefore knowledge and understanding could be inferred from successful performance. This is consistent with the fundamentalist view of knowledge as an input rather than an output, and as such, something that is more relevant to the curriculum than to the assessment process (see Figure 3.1). The emphasis in the NVQ approach is on demonstrated competence regardless of how, when, or over what period, it was attained and the view is that there is no need to assess knowledge separately because a performance will not be successful without it (Black 1990). The NVQ concern about including knowledge explicitly in assessment is that it would result in a listing of knowledge in assessment standards, and in doing so 'the central commitment to performance in the workplace could have become difficult to sustain'. The other 'perceived danger' was that assessment would become dominated by factual recall, and therefore not reflect the original objectives of workplace assessment as an alternative approach to conventional approaches (Black and Wolf, 1990). Further, it was suggested that an approach which would include assessment of performance across contexts and involve assessment of selection from a range of alternatives and arriving at optimum decisions, would 'lock' knowledge more directly into performance rather than focusing on the recall of facts (Mansfield, 1990).

However, there is a concern in other schools of thought that successful performance could be by chance or the result of repetition, as opposed to the appropriate use or application of knowledge. The 'subordinate' view of knowledge and understanding in the NVQ approach is a concern for Eraut et al (1995) who give some thought to the NVQ 'knowledge problem' and to how knowledge could be built into descriptions of competency:

> The current approach, which simply lists knowledge separately from the competencies with little indication of when or how it will be incorporated into competent practice, is highly unsatisfactory (Eraut et al, 1995, p.183).

Eraut's (1990) view is 'that underpinning knowledge is such an important aspect of many jobs that its omission will lead to seriously inadequate descriptions of performance' (p22). He identifies a range of propositional and practical forms of knowledge that are significant in assessment, as outlined in Chapter Three. Eraut does not address how this knowledge should be assessed in detail except to give examples of approaches in medicine and teaching, where observation of performance is combined with questioning in order to assess underpinning knowledge such as 'situational understanding, self-awareness and the rationale for the chosen approach'. In addition he highlights the impact that assessors' knowledge will have on what they look for in assessment, what they notice, what questions they ask and how they interpret performance and the context.

In addition, authors such as Ashworth and Saxton (1990) argue that the inferred capability in the NVQ approach is limited to the specific context in which performance takes place, and that performance is a demonstration of competence in a particular circumstance. On this basis, one might suggest that competence is only inferred if demonstrated in successful performance over a range of circumstances and situations.

An alternative view to the fundamentalist view is that thinking is a vital component of competence and performance, as is the knowledge that informs that thinking. In this line of thinking it would not be appropriate to think of knowledge as a set of isolated facts but as an essential element of the thinking element of performance (Black, 1990 – citing Eraut, 1990). It is interesting that while both views of knowledge and how it relates to performance might seem very different, there would seem to be agreement on one fundamental issue – that it is not appropriate to think of knowledge as a stand alone part of competence.

However, there are clear differences in views on how knowledge should be included in assessment.

More recently there is a suggestion that the fundamentalist/standards approach may be softening its views on the use of knowledge in assessment. Firstly, it was suggested that knowledge could be assessed as a substitute to the assessment of performance (Mansfield, 1990). So in cases where it might not be possible or feasible to assess performance – where there is an 'assessment gap', knowledge could be used as a source of evidence. Secondly, it is suggested that it might be appropriate to look for evidence of knowledge, and in particular, understanding, while assessing performance (Debling and Hallmark, 1990). They suggest that effective performance will depend on ownership of knowledge and understanding in order to display durability over time and flexibility over different contexts.

Further, Mansfield concludes that:

> There is no sinister plot to deny or denigrate knowledge – simply to recognise and locate knowledge in its rightful place – as a source of evidence, together with performance evidence.
>
> The purpose of this paper has been to suggest that the previous domination of knowledge as a substitute for performance standards and a dominant mode of assessment has done little to recognise the essential role that knowledge has to play in underpinning performance. Knowledge – simply stated as knowledge means little. We suggest that a simple classification which locks knowledge more directly into the performance to which it relates does more justice to its essential character. We also suggest that the contribution knowledge makes to cognitive processing, as well as 'available content' and direct linking with outcomes is more comprehensively described by another simple classification which will illuminate the role of knowledge in standard setting (Mansfield, 1990, p.21).

However, one of Hyland's (1994) criticisms of the NVQ model is the lack of clarity, or 'fuzziness' about the nature of knowledge and its relationship with competence. He suggests the NVQ model takes a narrow view of knowledge, focusing only on that which is thought to underpin competent performance, and excluding aspects such as cognitive ability and values. In addition he questions how assessment can distinguish between declarative and procedural knowledge on the grounds of inference from activity. Further on the subject of recent revisions to the NVQ view of knowledge, he suggests that it is not the failure to include knowledge in assessment that is flawed but the behaviourist view of knowledge itself:

> All of this confusion and equivocation seems to be the outcome of trying to capture and describe in behaviourist terms something which is not altogether behaviourist, namely the development of knowledge and understanding … In order to maintain the desired contact with behaviour and observable performance, competence theorists have clearly been forced to manipulate knowledge so that it fits the desired framework. The upshot is a conception of knowledge, understanding and human agency which is not just viciously reductionist, but utterly naïve and simplistic (Hyland, 1994, p.48).

10.5.7 Capturing the least tangible aspects of competence

Oliver and Bourne (1998) suggest that there are two challenges in the assessment of professional competence – developing mechanisms to assess the value base that informs ethical and reflective practice, and assessing ability to remain competent in the future. They regard these two aspects as crucial to professional competence:

> Continuous professional development rests on our ability and willingness to adopt a reflective approach in order to think creatively and critically about our work … reflective practice … involves coming to terms with the complexity, variability and uncertainty of our work, and of

> constructing solutions rather than passively following procedures and guidelines (Oliver and Bourne, 1998, p.18).

The importance of personal qualities in competence is stressed in the findings outlined in Chapters Five to Nine. Yet these aspects of competence are perhaps the least tangible and most difficult to access in assessment. Barlett et al (2000) highlight the difficulty in measuring 'deeper personal perceptions' including 'such fundamental aspects of competence such as caring, interpersonal interaction and decision-making' (p.370). Determining that someone has reached the competence level indicates what they are capable of doing, but as Manley and Garbett (2000) suggest, it cannot predict what they actually will do. Personal attributes are very individual and personal, and free will is central to human behaviour. Two types of personal attributes were identified during the course of this study. Firstly there are attributes relating to motivation and personal disposition – including commitment, interpersonal skills and being kind and caring. It is suggested that such attributes are essential aspects of fitness for practice and as such it is essential that the assessment of midwives at the point of registration should include assessment of these characteristics. This is supported by authors such as Phillips and Bharj (1996) who suggest that the ability to deal with a wide range of people in a tactful and sensitive manner, and commitment to becoming a midwife, working with women and their families, and to achieving high standards in clinical care are essential for midwifery practice. Runciman (1990) suggests that in nursing, the most important 'skills' are being able to relate to others, to empathise, and being caring.

The analysis of competence over time in this study suggests personal attributes such as motivation can vary, suggesting that it may be appropriate to feature personal attributes in assessment throughout the life of education programmes and possibly beyond registration. It is also suggested in Chapter Six that these attributes are required on entry to programmes for students to be fit for purpose as students and that they will be developed further over the course of the programme. Several interviewees suggested students came to the programme with some of the personal attributes concerned and were very capable. These

were then developed further or the attributes were 'brought out' by the programme. These aspects included:

- motivation
- working well with and getting on with people, appreciating their differences, being non-judgemental
- being trustworthy and honest
- understanding ethical issues
- organisation, and
- communication.

The impact that personality can have on student ability was also raised by teachers who referred to particular students who 'shone' more than others. It was suggested that some students bring certain traits with them to the programme which give them a 'head start'. These traits include enthusiasm, commitment, experience in other occupations or with families of their own, and communication skills. While teachers suggested that some traits, for example communication skills, could be improved on the programme, they also identified some traits that they would actively screen for in selection interviews.

Phillips and Bharj (1996) suggest that certain attributes are required of entrants onto programmes for them to be fit for purpose as students. They argue that while the purpose of midwifery education is to provide the learning opportunities to enable students to become competent midwives, the success of programmes depends on selecting students with the right attributes – students who are fit for purpose. Adapting Rodger's (1974) 'seven point plan', they identify essential and desirable characteristics to be used as the basis of student selection. Among the list of essential characteristics are:

- the ability to deal with a wide range of people in a tactful and sensitive manner
- consideration given to readjustment to student status and student responsibilities
- commitment to becoming a midwife and working with women and their families

- the importance placed on achieving high standards in clinical care.

The second type of personal attributes identified in this study relate to coping with the realities of being a midwife and making sound judgements. The analysis of views of the competence of midwives at the point of registration and learning, presented in Chapters Five, Six, and Seven, suggest that it may be difficult to assess midwives in terms of coping and making judgements. This is because students are not given full responsibility for practice until they qualify and until they do, they will have very little experience of *being* a midwife. In addition, midwives will have limited experience of decision-making initially, and will be lacking confidence.

10.6 An integrated approach to assessment

In response to issues about atomisation in assessment and in the pursuit of holism, Hager et al (1994) outline the thinking behind the development of an integrated approach to assessment in professions such as teaching and medicine in Australia. They suggest that the terms 'atomistic' and 'holistic' used in assessment are little more than relative terms and warrant further discussion. They note that classifying assessment as atomistic is often seen as reason enough to reject it without further argument. They emphasise that on the one hand, the fragmentation of an occupation into 'a myriad of tasks' is overly atomistic and destroys the 'distinctive character of an occupation' because it fails to capture actual work practice which is much richer than a sequence of isolated tasks. However, on the other hand, 'the opposite mistake is adherence to a rigid, self-defeating monistic holism that rules out analysis'.

Hager and Beckett (1995) suggest that their primary concern in the development of an integrated approach to assessment is the development of 'educationally defensible' competence 'standards'. They suggest competence standards must meet three criteria in order to be educationally defensible:

- *The integration of key intentional actions with personal attributes:* This emphasises the importance of personal attributes and abilities in concepts of competence, elements that enable performance in some tasks and not in

others. They suggest that for competency standards to be educationally 'valuable', tasks should not be thought of in the narrow sense. They point out that while all occupations will include the performance of some relatively specific tasks, many will also require the performance of broader and more generic tasks such as planning or contingency management, or broader still, 'an overall conception of what one's work is about' or working ethically. They suggest that these tasks are equally, if not more, important. This criterion requires competence to be understood as 'essentially a relationship between abilities or capabilities of people and the satisfactory completion of appropriate task(s)' and the 'essential relational characteristic of competence' (p.2).

- *Holism of several kinds.* Along with the integration of attributes and tasks, as outlined in the previous criterion, holism also requires that the key tasks or 'intentional actions' are at an appropriate level of generality and that tasks/intentional actions are not discrete and independent. It also requires that intentional actions involve situational understanding. Situational understanding is a key theme in the findings on the development of competence and in the characteristics of the expert.
- *The encompassing of cultures and contexts:* In outlining this third criterion, there are several references to professional competence and the understanding that professional competence is governed by 'covertly cultural determinants', including rules, rituals and conventions. As such, professional competence is underpinned by an emergent concept of cultural formation, which as well as being influenced by, the professional may participate in. In this way, they suggest that cultural formation can be understood in terms of the professional recognising and contributing to his or her 'construction as a professional' and professionalism means that individual practice is more likely to overtly display 'an eclectic epistemology and a sensitivity to a shared ontology'.

Gonczi (1994) suggests that the integrated approach 'overcomes all the objections' to the competency movement in that it allows ethics and values to be incorporated as elements in competent performance, along with reflective practice, context and the notion that there may be more than one way of

practising competently. ‘Thus competence is conceived of as complex structuring of attributes needed for intelligent performance’ (Gonczi, 1994, p.29).

In terms of the validity of the integrated approach, Hager et al (1994) argue that:

> … competency standards based on the integrated approach can reflect the actual richness of work, the use of knowledge in action and the intelligent judgement which is the hallmark of occupational competence. This integrated approach, in other words, gets as close as possible to delineating what competence in an occupation actually consists of (Hager et al, 1994, p.6).

Gonczi (1994) also claims that the approach is potentially more valid in the assessment of professionals than traditional approaches, in that it enables assessment to focus on what professions want to assess – ‘the capacity of the professional to integrate knowledge, values, attitudes and skills in the world of practice’ (p.28).

Further, Hager et al (1994) suggest that it is not just the integrated approach to assessment that relates to its validity and that there are several issues to be considered when designing assessment schemes in order to optimise the validity of assessment. From their work and the work of Gonczi (1994) a number of guiding principles for integrated assessment can be identified, as follows.

- The first principle would be to establish that valid integrated assessment is feasible and there is nothing about the nature of what is described that would prevent it being measured. However, the approach requires a greater emphasis on the application and synthesis of knowledge and the components of competence involved in professional judgement.
- Secondly, assessment methods used should be the most direct and relevant to what is being assessed. Gonczi (1994) suggests that the rationale behind ‘directness’ relates to ensuring that ‘the learning efforts of learners will not be misdirected, the criteria for judgement will be clear to learners’ and on the

basis that work undertaken in cognitive psychology suggests that problem-solving is context-specific meaning that problem solvers rely on specific rather than general strategies.

- Thirdly, the narrower the base of evidence used to assess performance, the less generalisable it will be to the performance of other tasks. Quoting Sadler (1987), Hager et al warn against a preoccupation with objective testing, which can encourage the use of indirect measures or substitutes for the 'real thing'. In addition, they recommend a mix of assessment forms to provide evidence on which to infer competence. Gonczi (1994) likens this idea to the triangulation approach used in research. In this approach, integrated assessments are used to cover multiple elements.
- Fourthly, assessment should include criteria by which competence for carrying out processes is assessed. Examples given are: accuracy and lack of error, speed of performance, choice of the correct techniques, the proper sequence of techniques, and adherence to health and safety standards.
- A fifth principle is that attitudes and values should be included in assessment criteria. Hager et al (1994) suggest that valid assessment of attitudes and values can be achieved by including them in performance criteria, because they can be assessed as a part of performance, and through longitudinal and multiple evidence, rather than in abstract terms. Examples they include are: direct observation of work activities, supervisor assessment/ratings, evidence from prior achievements, oral questioning, written tests, self-reports, and practicum. Further, they state that 'far from being a weakness of competency-based assessment, it may well turn out that a major advantage of well-constructed competency standards of the integrated kind is that they facilitate the reliable assessment of attitudes and values' (p.15).

However, this *third way* is not without its critics. Hager and Beckett (1995) refute a number of the criticisms of the integrated approach. Firstly they seek to establish integrative inference in the model and to refute criticisms of closet behaviourism, technicism and circularity. They suggest that claims that the approach is behaviourist and based on access to knowledge and underpinning attributes through inference from performance, are unfounded and based on a

belief that all performance-based approaches are behaviourist. As they point out, what is objectionable about behaviourism is not that it draws on performance evidence but its denial of any other form of evidence, thereby dismissing other elements involved in competence such as mental and related phenomena. The approach is criticised as being 'concerned with what is observably being done right here, and right now' and that it may pin down the specific criteria for assessment so much that professional discretion is eliminated from the requirement to make unique judgements. As such the '*sui generis* nature of much professional actions is also eliminated' and the experiential richness that the integrated model intended to capture would be lost. In addition, the approach is criticised for defining competence in terms of competency. It is suggested that this reinforces the gap between theory and practice, inappropriately separates occupational competency from the knowledge bases, values, attitudes and occupational philosophy (suggesting that these should be seen as part of, rather than separate from, occupational competency), and rejects wider doctrines of professional responsibility (Walker 1992). In response Hager and Beckett (1995) suggest that these claims can be overcome by analysing professional practice as cultural formation and its influence on professionals acting intentionally, and the collaborative learning that professionals engage in.

They also respond to criticisms about the limitations of the integrated competence model in defining generic competencies. Emphasising the importance of context and situatedness in the model, they suggest that it is not appropriate to uncouple practice from its situation at a specific time and place, or to think of competence as a generic construct 'beyond the practice or even performance that assembled it'. They suggest that generic attributes can be identified, such as the attributes of best performers that are generalisable without collapsing the model into 'mindless role-modelling'. But the context-dependent nature of the integrated approach means that generalisations or generic competencies are only valid when related to the context at hand. That is to say that generalisable or generic competencies can be identified for roles but they will be combined and used in a variety of ways by different professionals with different styles of practice.

> Generic competencies have meaning and value in all settings, but are not necessarily by themselves sufficient for competent performance in any setting (Walker 1992, p.95, quoted in Hager and Beckett, 1995, p.14).

Hyland (1997), commenting on the integrated approach as a possible solution to the competence-based 'problem', suggests it is little more than an attempt to add on or to alter 'existing behaviouristic models in order to meet a broader range of educational criteria' rather than describing actual practice. Thus:

> Such alternative accounts do not, however, alter the behaviouristic thrust of CBET strategies but rather prescribe ways in which such strategies may be *supplemented* (original emphasis) by non-behaviouristic approaches so as to remedy some of the main findings and weaknesses of CBET. (Hyland, 1997, p. 495).

It seems that the crux of Hyland's arguments is that the competence-based approach and the connotations of the term 'competence' are not consistent with nor reflect the aims of education. In fact, it is suggested that they have undesirable implications for education, including the separation of means and ends in educational activity and a distortion of the 'dynamic relationships between teaching, learning and assessment'. Giving further insight to his difficulties with CBET, Hyland suggests that:

> Underpinning such implications is a reductionist view of human agency which assumes that knowledge, skills and values can be codified in terms of lists of competence statements and measured objectively in abstraction from everyday experience. This leads to an excessively instrumentalist conception of knowledge and skills – 'there is no justification for assessing knowledge for its own sake but only for its contribution to competent performance' (Jessop, 1991, p. 129) – in which the process and evaluation of learning are divorced

from the accreditation of competence (Hyland, 1994), (Hyland, 1997, p.495).

However, in reading Hyland's (1997) critique of the integrated competence approach, the criticisms do seem to be confused with those of competence-based education and training (CBET) in general, and several of the criticisms raised would appear to have been addressed by Hager and Beckett (1995). In addition, Hyland (1997) does not outline an alternative approach to the integrated approach or to CBET but he does provide are a few clues about key considerations in constructing one:

- The first relates to the extended uses of competence and failure to distinguish between competence as a broader capacity and in terms of narrower dispositional uses, which Hyland suggests constrains applications particularly in the area of morality and autonomy. This also applies to the use of generalised skills, domain-independent critical thinking, and descriptive terms such as 'adequate' or 'careful' which he suggests are meaningless without reference to the context and application. It is suggested that in such uses the basic minimum concept is given much more weight than appropriate, and that there is no evidence of the existence of competence in the 'generic' form or in terms of general abilities. It would seem that Hyland's (1997) implied criticism of the integrated approach on this basis is unfounded and Hager and Beckett (1995), Hager et al (1994) and Gonczi (1994) also make these points and discuss the limitations of generic competencies and their validity only with reference to the domain.
- Secondly, it is suggested that competence models or 'systems' need to relate to the accreditation of competence and the processes of learning and development. In addition, it is suggested that systems need to be sensitive to 'key epistemological and ethical dimensions' of professional practice to prevent the de-skilling and de-professionalisation. The central inclusion of 'cultural formation' in the integrated approach certainly addresses the issues raised in the second part of this point.
- Thirdly, it is suggested that competence systems need to be able to capture morality and personal values. Hyland argues that the CBET approach cannot

do this due to its 'reductionist', 'technicist' and 'excessively individualistic' features. He argues that CBET is essentially an industrial model and attempts to reduce moral values to skills or competences cannot capture the 'complexity of moral development or the processes of moral reasoning', and that virtues cannot be separated from the person in the same way that skills can be. Once again, the concept of cultural formation could be developed in integrated competence models to include this aspect in assessment.

- Fourthly, a similar point is made about the danger of 'marginalising' other 'intimate' aspects of competence such as knowledge, understanding and conscious decision-making. It is suggested CBET 'transforms' the aspects into 'commodities which are somehow independent of human agency'.
- Following on from the previous point, Hyland suggests that the individualistic nature of CBET which reinforces knowledge as a personal commodity, undermines teamwork and ignores the fact that knowledge, skills and values are the a product of joint social action.

In his conclusion, Hyland asks:

> A central and intriguing question, therefore, is why so many people still seem, in varying degrees, to want to support such approaches to education and training. Why, after all, if educators are truly committed to 'holistic assessment' (Hager and Beckett, 1995, p.19) to the educational implications of 'Wittgensteinian approach to mental acts' (Leicester, 1994, p.113), or to 'more vigorous attention to the doing dimension of human being in education' (Bridges, 1996, p.364) do they simply not make proposals and recommendations designed to achieve such objectives rather than trying to merge them with competence strategies which (where they are not totally discredited or outright failures) are self-evidently incompatible with these ends? (Hyland, 1997, p.498).

This may well be fair in relation to CBET in general but it is not suggested by any of the advocates of the integrated competence approach that the approach is

an attempt to patch up failing CBET systems. Further Hager and Beckett's (1995) starting point for a conceptualisation of integrated competence is the analysis of the cultural formation of a profession.

10.6 Discussion: The integrated model as the basis of assessment

The integrated competence-based approach as described by Hager et al (1994), Gonczi (1994) and Hager and Beckett (1995) would seem to address many of the issues already outlined in the debate on assessing midwifery competence, such as:

- the need to access competence across the range of likely contexts
- the importance of knowledge, thinking and the personal attributes in being competent and that the practitioner brings to 'the doing of the job'
- the importance of the cultural context within which the professional functions and its role in the quality of performance and the characteristics of the context in which the professional practises, accounting for the 'situatedness' of professional competence.

Hager and Beckett state that the whole approach (integrated competence) hinges on the integration of three 'essential' dimensions - what is done in a job, the practitioner's attributes, and the characteristics of the context. Hager and Beckett's inclusion also of cultural formation and its influence on competence is of particular interest, given the previous debate about the nature of professions and the role of a profession in defining and governing professional competence. The notion of cultural formation proposes that:

> … particular professions will evolve a filtering, or mediation of their epistemological and ontological frameworks, … practitioners will develop their individual versions of these as specific workplaces (or 'locations') (which) are made sense of in the daily round of decision making and judgements which substantially constitute the 'acting intentionally' of professionalism (Hager and Beckett 1995, p.11).

It is suggested that the concept of cultural formation acknowledges 'the social nature of learning', and 'deals centrally and holistically with the complexities and dynamics of values, both individual and social' (Hager and Beckett 1995, p.6).

In the light of several points already raised in this thesis about the dangers of losing the integrated nature of competence in assessment, it is important to highlight how the emerging model of midwifery competence could facilitate the assessment of competence as an integrated phenomenon. Firstly, the three dimensions of competence are seen as complementary and fluid so that no one dimension is dominant and a midwife in any particular situation will draw on all three dimensions to varying degrees depending on the particular circumstances at hand. In this way, a midwife will always be required to function as a professional, to be clinically competent, and to provide individualised care regardless of the situation and regardless of the stage of pregnancy or the care setting. However, the particular interaction between the three dimensions will relate to the specific circumstances at the time. In this way being competent is not seen as a list of tasks to be performed in sequence and to be assessed separately, but an integrated and dynamic concept.

The integrated nature of competence can also be promoted in the selection of methods to assess the components identified in Figures 10.1 to 10.7. The views presented so far suggest that assessment will need to include both the elements underpinning competence and competence that is demonstrated. Combining the assessment of performance with the assessment of the elements underpinning performance can reinforce integration. For example, in assessing that a student can effectively interpret findings to confirm pregnancy and accurately calculate EDD (as outlined in Figure 10.5) an assessor could ask questions that test a student's knowledge of the physiology and signs and symptoms of pregnancy, of methods to confirm pregnancy and of formula to calculate EDD. Similarly, assessment of written work can access knowledge use in action through the use of scenarios and case studies. Unlike the NVQ approach, it is not suggested that each element should be assessed individually and across every possible context. Instead, competence is derived from the role of the midwife and the nature of

competence, and several elements of competence could be assessed at once. This approach acknowledges the complex and integrated nature of midwifery competence and includes context and situational variation as an integral part of the competence being assessed.

This review of definitions of competence and approaches to assessment suggests the holistic, integrated model of competence is the most appropriate concept to encapsulate midwifery competence. In addition, the EME model has been developed further by drawing on the analysis of competence at registration and learning up to and beyond registration and the findings outlined in the EME assessment matrix (Fraser et al 1997). A review of current thinking on assessment in midwifery and in the wider literature identifies a range of principles for effective assessment, several of which were identified in the analysis of the views of those interviewed over the course of this study, and it is suggested that these principles can be supported in the developing model of competence.

Chapter Eleven

Definitions of midwifery competence: implications for professional learning

11.1 Introduction

Early in this thesis the case is made for a definition of midwifery competence to protect the public, for midwifery to develop as a profession, for curriculum development and the development of assessment frameworks, and to guide student and midwife development. Towards the development of such a definition, this research set out to explore midwifery competence as a phenomenon and to examine the nature of competence at the point of registration, its development over time from becoming competent to becoming an expert, and the factors involved in the maintenance of competence. The emphasis was on exploring competence through the experience and lived realities of those involved - student midwives over the final stages of programmes of education and to the end of their first year in practice, and interpretations made by other midwives and teachers working with them.

Having set out the analysis and findings in the previous chapters, which are brought together towards a model of competence in Chapter Ten, this chapter seeks to reflect on the research process, the themes and particular issues that emerged, and the contribution made by the research to the knowledge base.

11.2 Definitions of competence

The key stimulus for undertaking this research study was the discovery, at the beginning of the EME study, that midwifery competence had not yet been defined in any comprehensive way, and that definitions that existed appeared to be based largely on legislative requirements, or negotiation between those involved in the regulation of midwifery practice and the development of midwifery curricula, or on tradition or incremental development, rather than on research findings and analysis of the role of the midwife. The lack of a

comprehensive definition of competence in midwifery is not surprising when one studies the literature on competence across a range of other professions and occupations to note the apparent lack of agreement on issues as fundamental as what it means to be competent.

From among the range of definitions, several common themes can be identified. Firstly it is suggested that competence is concerned with the relationship between certain elements involved in functioning within a role - the most commonly identified elements are knowledge, skills and attitudes. Secondly there is the understanding that someone who is competent is effective within a role. Effectiveness is sometimes referred to in terms of achieving successful outcomes or performing to acceptable, usually predefined, standards. A third theme relates to the ability of someone who is competent to take account of the situation at hand in the action that they take and decisions made. This is often referred to as ability to transfer skills from one context to another.

The argument that develops during this thesis is that it is not just the possession of knowledge, skills and attitudes that makes someone competent but the ability to integrate these attributes appropriately and effectively in action. It is suggested that this integration is required across different dimensions. One dimension is the relationship between knowledge and action, and current thinking on professional competence is that knowledge and skills are not separate entities, but different types of knowledge. In this view of knowledge, propositional knowledge (theory) is developed further as process knowledge (how to do it), which is used in action.

It is also suggested that to be competent requires sustained effective performance across the range of contexts relating to a role. Thus, an important element of competence is the ability to use knowledge appropriately from situation to situation. It is suggested that this will involve assessment of the range of relevant context and situational variations, and on the basis of what is found, interpreting knowledge and selecting the most appropriate course of action from the range of possible actions. It is suggested that the relationship between knowledge use and

the action context is reflexive, and that understanding of the situation in the first place is also dependent on the possession of knowledge of the range of variations that are likely to be found. This knowledge is the basis for recognition of situational cues and appropriate interpretation of what is found in the situation, which in turn is used to inform action. This portrays competence as a dynamic concept, which is particularly relevant to an occupation such as midwifery where each situation is different. This understanding of knowledge use is relevant both in terms of a midwife being able to provide care for a women across the range of practice contexts from the pre-conceptual stage through to the end of the post-natal period, and the range of situations in which a midwife practices. It also relates to the individualised dimension of midwifery competence, where a midwife can assess needs, plan and provide care on the basis of needs and the choices made, and evaluate the effectiveness of that care, revising plans where required. It is particularly relevant in the light of the analysis in this study, which emphasises the importance of a midwife being able to detect deviations from normal and take appropriate action. The analysis also suggests that knowledge use becomes more sophisticated with experience and the ways in which the expert uses knowledge are more developed than that of the new practitioner. The review of the literature on the nature of expertise identifies a range of techniques used by experts, that it is suggested, enables them to be more efficient thinkers.

It is suggested that knowledge is also developed and reinterpreted in each situation on the basis of what was understood to have happened in previous situations. Because of the random nature of experience and the unique interpretation of what is discovered in each experience, knowledge is idiosyncratic and personal. This understanding of experiential learning emphasises the role of experience in knowledge accumulation.

On a second dimension, there is the integration of knowledge and attitudes and it is suggested that attitudes have a vital role in competence, such that an individual may have a vast range of appropriate knowledge and skills, but not be competent if they are not motivated to providing a good standard of care.

The integrated nature of midwifery competence is also emphasised in the model of competence developed during the research. Three dimensions of competence are identified which it is suggested, are inextricably linked in being competent. At the point of registration, it is suggested that the most important considerations in whether a midwife is competent or not to fulfil the role are whether she is safe, has appropriate attitudes and can communicate effectively. The debate outlined in Chapter Five suggests that it may be best to view these requirements as threshold standards, rather than minimum or 'lowish' standards, implying that a midwife would usually exceed these standards in several areas. In addition, it implies that competence at registration is not an end-point in the development of competence and a midwife would be expected to continue to develop her competence and learning beyond registration.

11.3 Implications for midwifery and professional learning

In terms of the clinical competence dimension, the analysis of views expressed by those involved in this study suggests that, at registration a midwife is competent if she can provide the full range of care for a woman in normal pregnancy and childbirth, and is able to identify deviations from normal and take appropriate action. This will involve referral to a medical practitioner where deviations from normal are detected, and taking immediate action in emergency situations. On this basis, one issue that could be explored further is the role of the midwife in the provision of care for women with complications or who are ill. The tension identified in Chapter Five is that whilst the model of care being promoted by national policy and on pre-registration programmes is midwife-led care, the reality is that midwives are unlikely to find themselves practising in such situations at the point of registration and are likely to be required to support the obstetrician in the provision of care for woman who are ill or have complications. In practical terms, the analysis of the views of students suggests that this issue can be a source of anxiety for students who may feel that they have not been adequately prepared for the role in which they begin practice. It is suggested that it may also be a source of frustration for new midwives who would prefer to practise in midwife-led practice situations, as promoted on programmes. On a more fundamental level, it is suggested that in the light of the

development of midwife-led care, clarification is required on whether it is appropriate for the midwife to have a role supporting the obstetrician in the provision of care for women with complications or who are ill, and if so what is the nature of that role. The analysis of the literature outlined in Chapters Three and Five suggests the situation is very ambiguous at present.

The analysis of competence at the point of registration suggests there were variations between and within the six case study sites in terms of student capability at the point of registration to carry out VEs, suture and perform episiotomies. There were mixed views between respondents about whether students should be fully capable in these areas at the point of registration. Arguments for students being able to perform these tasks related to midwives being able to provide the full range of care for a woman with normal pregnancy and continuity of care, and a midwife being able to practise independently. Arguments against related to practical difficulties ensuring a midwife would have the range of experiences because of diminishing opportunities to perform episiotomies and suturing, due to changes in midwifery practice. The views on VEs were slightly different where it was suggested that midwives would be expected to be reasonably proficient in carrying out VEs, but that in real terms they may need some support to become confident initially. On the basis of the analysis, it is suggested that whether a midwife should be able to perform an episiotomy and suture at the point of registration is an area to be explored further, beyond the remit of this research. This might include the implications for midwifery as a profession, professional learning, and the support required before and after registration required for a midwife to become proficient.

The professional dimension to competence proposes that in order to be competent at the point of registration, a midwife must be able to undertake and act out the role of the midwife. It is suggested that this will involve an individual:

- having the right level of confidence
- being able to manage their own workload
- being aware of the regulations and rules governing midwifery practice and

the limits of the sphere of practice of a midwife

- being aware of their own learning needs and how to address them
- being aware of their own limitations as a practitioner and being willing to seek assistance and advice where required
- having the right attitude towards midwifery as a profession and women in their care and their families
- being accountable for practice
- being able to make day-to-day decisions.

The analysis also suggests that a midwife would be expected to need support and advice from more experienced midwives in relation to managing a ward, and making decisions in borderline or difficult cases.

A key issue identified to be explored further is whether a midwife should be expected to be an autonomous practitioner at the point of registration. On the basis of the literature review in Chapter Three about the nature of professionalism, it is argued that if midwifery is to continue its pursuit of recognition as a profession, a midwife would need to be capable of acting as an autonomous practitioner at the point of registration. It is argued that autonomy is a key element of being a professional and involves independence in a particular role and interdependence with other professionals. It is argued that autonomy and the empowerment associated with it are essential to being a professional because they enable professionals to protect the interests of the people they are employed to help, and also enable the professional role to be developed further. However, the analysis of views of midwives, teachers and supervisors of midwives suggests that midwives are unlikely to be ready for autonomous practice at the point of registration.

The review of the legislation and the literature suggests that although a midwife is expected to be accountable at the point of registration and could become an independent practitioner immediately, the requirements that a midwife should not practise beyond her capability, the inclusion of midwives in the guidance on preceptorship, and current arrangements for maternity care, mean that it is

unlikely that a midwife would practise autonomously at the point of registration. However, the debate about the professionalisation of midwifery suggests that clarification is required on whether a midwife should be required to be capable of autonomous practice at the point of registration. If it is argued that midwives should be capable of being autonomous at the point of registration, consideration would need to be given to what could be done on midwifery programmes to better prepare midwives for that. If the opposite is argued, clarification would be required in relation to: at what point a midwife would be expected to practise autonomously, and there may be implications to be considered for midwifery registration.

On the basis of the analysis of views on the transition from student to midwife and of development and learning over the first year, it is suggested that three key aspects of competence play an important role in undertaking the professional role and being an autonomous practitioner: coping, confidence, and decision-making. The analysis also compared those who appeared to be better prepared to undertake the role with those who appeared to be less prepared. It is suggested that a key factor in learning to cope with the realities of practice, building confidence, and becoming more comfortable making decisions, is students being able to consolidate practice before qualifying. Several students linked not having the opportunity to consolidate practice before registration with not feeling fully prepared to take on the role of the midwife. Consolidation was also identified as an important element of development and learning in the initial period beyond registration. During the analysis a number of factors relating to consolidation and the ease of transition were identified, relating to the organisation of practice and the structure of the programme, and the support that midwives had initially when they qualified. In addition, it was suggested that inconsistencies in the range of expectations about what a midwife should be able to do at the point of registration was troublesome for new midwives.

The analysis of the *individualised approach* dimension of competence suggests that this is an area where study midwives developed considerably beyond registration by undertaking the role, integrating the elements of midwifery

practice, and tailoring care to the needs and wishes of women as individuals. It is suggested that, at the point of registration a midwife should appreciate fully the principles of individualised care, be working towards adapting practice to meet the needs and wishes of each woman, and be able to balance the wishes of women with the requirements of safe practice when planning care. However, some elements of individualised care may be more difficult for someone who has just qualified, and who has yet to establish themselves as a professional, such as using new approaches to care and acting as a woman's advocate.

The analysis suggests midwifery competence is highly integrated and a review of the assessment literature explored how this integration could be reflected and accommodated in assessment. It is suggested that, when compared to traditional and performance-orientated models, the holistic, integrated model of assessment appears to be the most appropriate concept for midwifery competence. Towards the development of a holistic, integrated model of midwifery competence, the analysis in Chapter Ten attempts to bring together the various strands of analysis on the nature of competence at registration and the development of competence up to and beyond registration, to identify the components of midwifery competence. These components are outlined under each of the three dimensions identified in the EME model and unpacked further to identify the key constituents, while preserving the relationship between elements. In order to develop the model further, further work is required to examine how best the constituents and components could be effectively assessed, without losing the integration across the dimensions identified.

11.4 Dominant themes in the analysis of midwifery competence

There are three dominant themes that thread their way throughout this thesis. The first theme relates to the role of the softer aspects in being competent, becoming competent and maintaining and further developing competence and, it is suggested that although these elements are less tangible, they are just as important as aspects such as knowledge and skills. In terms of being competent, it is suggested in the analysis that motivation to doing a good job and commitment to women for whom care is provided and to midwifery as a

profession, are essential to translate capability into competent practice. This is supported in the literature where it is suggested that there are two key aspects to competence, the instrumental - also referred to as know how; and the expressive – that which makes a qualitative difference. In addition, the analysis suggests motivation and commitment are also required for student midwives to be fit for purpose as students, in terms of wanting to learn and being motivated to identifying and addressing learning needs.

The role of motivation and commitment are also identified in maintaining competence beyond registration and a midwife developing her competence further towards proficiency and becoming an expert. In the literature, motivation is promoted as a key element of being a professional, where professionals make the ethics of the profession their own and have an overwhelming sense of commitment to the principles of the profession. It is also suggested that being competent in the professional sense will require midwives to challenge the system from time to time where the ethics or principles of the profession are likely to be compromised. Other related personal qualities identified in the research are that a midwife is a nice person, is kind, has appropriate attitudes and is able to relate to women in her care. One particular issue identified in the analysis of views and of current thinking on assessment in the literature is that it is very difficult to access these attributes in assessment. In the debate outlined in Chapter Ten it is suggested that such attributes cannot be inferred from successful performance alone, and that they will need to be included as explicit requirements in assessment. Another issue raised is whether someone could learn or be taught to have these attributes on programmes of midwifery education programmes, or whether they should form the basis of initial selection onto programmes.

The second theme relates to the role of experience in learning. The analysis of learning over the final stages of midwifery programmes at the six case study sites suggests that consolidation is a vital element of learning to take on the role of the midwife at the point of registration. It is suggested that this phase of learning enables a midwife to integrate all of the elements of practice into acting out the

role of the midwife in the context of the gradual withdrawal of direct supervision. It is also suggested that through the consolidation process midwives become more competent and confident and learn to cope with taking on the role and responsibilities of the midwife. Consolidation was also identified as a dominant part of learning in the early days beyond registration. On the basis of the analysis of consolidation and participants' experiences of it, it seems that the essential focus of consolidation is on learning by doing and reflecting on the results of action.

Beyond registration it is suggested in the literature that experience also plays a key role in the development of expertise, where learning involves reinterpreting knowledge on the basis of the outcomes of actions taken, the accumulation of extensive domain-specific or specialist knowledge and repertoires of tacit knowledge which experts draw on in action. It is also suggested that a considerable element of professional competence is professional judgement, which it is suggested cannot be developed without adequate practical experience, because it is based on interpretation from previous similar cases and intuitively selecting from that experience, ideas that seem fitting or appropriate. Experiential learning also enables midwives to build banks of personal or tacit knowledge, which they can draw on in action, particularly in hot action contexts. It is emphasised in the literature that although intuition may be seen as a passive rather than critical process, tacit knowledge is structured and well-developed and meta-cognitive processes are involved in critical control. As such, intuition in experts is seen as 'the unconscious working of a prepared mind (Benner, 1984)'. It is also emphasised that it is not the amount of experience that enables someone to become an expert, but the way in which that experience is used as the basis for learning.

The third theme relates to the roles of context and time in competence. As suggested by Debling and Hallmark (1990), 'truly competent performance … displays durability over time and flexibility over different contexts'. In terms of context, it is suggested that the midwife practises in 'action contexts', the key features of which are the degree of professional responsibility attached for what

happens in the situation, the degree of urgency often found, and the unexpected nature of situations that the individual is likely to have to deal with. This also requires midwives to be able to deal with each case as an individual, which requires them not only to rely on general concepts and principles, but also on their own senses. Situations will be a mix of the hot and the cool, the cool allowing for some degree of trial and experiment, but the hot requiring midwives to develop habits and routines to cope. Learning to cope was a key element of learning identified in the analysis of becoming competent and midwives' experiences in the initial period following registration. Competence over different situations and contexts also involves decision-making and judgement, which it is suggested are key aspects of learning coming up to and following registration. The review of the literature on the expert suggests that judgement is one of the areas where there are key differences between novices and experts and that experts have developed the ability to make rapid decisions which are much more likely to result in successful outcomes. However, it is suggested that it may be difficult to assess coping and judgement/decision-making at the point of registration because student midwives will not have had a lot of experience in this regard.

This research also explored the factors involved in maintaining and developing competence over time. It is suggested that there are four factors involved in translating capability into being competent – commitment, coping, judgement and ability to work with women. As previously stated, judgement and coping are key areas of learning identified in becoming competent and, beyond registration, in becoming proficient or expert. In the review of good and bad midwives, it is suggested that the key factors involved in maintaining competence (that is, once someone has become competent) are commitment to life-long learning, to refreshing knowledge and keeping up to date with research and new ideas, and commitment to being a professional/midwife and to women for whom care is being provided. Commitment to women and to being a professional also implies that a midwife has appropriate attitudes, is a nice person and is able to relate to women.

11.5 Final reflections

This research set out to explore midwifery competence as a phenomenon, in response to the identified need for a definition of midwifery competence. Midwifery competence is explored from a range of perspectives, including:

- student midwives – from the perspective of someone learning to become competent,
- midwife assessors – from the perspective of someone who is required to make judgements about whether a student has met specific assessment requirements,
- midwife teachers – providing the educational input for students to become competent and making final decisions about whether or not students are eligible for registration,
- midwives working with students – from the perspective of existing members of the profession and as fellow team members, and
- supervisors of midwives – with an explicit role to oversee standards of midwifery practice.

The opportunity occurred to undertake this research on the back of a commissioned project to evaluate the effectiveness of pre-registration midwifery education programmes. This provided access to the sample of student midwives, their teachers, assessors, supervisors of midwives, and other midwives working with them, that would otherwise have been difficult to obtain. Also, the research had the support of the ENB, and as such was probably more likely to be seen as legitimate research, thus enabling the researcher to gain the co-operation of prospective participants. However, involvement with the EME study also imposed limitations on the research because the design and methods chosen needed to fit in with the design of the evaluation study and the use of the six case study sites, chosen by criteria used to select case studies for the evaluation study. Nevertheless, this is not to suggest that the design and methods were in any way less appropriate to those that might otherwise have been used, and the case to support the appropriateness of the qualitative/interpretivist, case study approach and the quality of the research is presented in Chapter Four.

The research aimed to contribute to the debate on midwifery competence in several ways. Midwifery competence is described through the analysis of the meanings ascribed to competence by those who are closest to it and plotting out the key features of competence identified in the multiple perspectives of participants. In addition, the analysis identified particular concerns amongst participants about competence as a phenomenon or as it applied to them or to other participants and areas where further debate may be required. The particular aspects of competence examined include the competence required at the point of registration to fulfil the role of the midwife, and the limited and conditional nature of competence at this point in time. This is compared to the competence of experts.

The analysis provides particular insight into learning to become competent and to take on the role of the midwife, identifying difficulties that midwives can have at this stage and some of the factors involved. It also provides insight into the nature of learning in the first year beyond registration and by exploring differences between individuals in progress made over that period, identifies several factors involved in the success of learning during that period, and perhaps longer-term. The exploration of the attributes of good and bad midwives identifies several factors that may be involved in maintaining competence over the length of a career and in life-long learning.

Aspects of competence identified for midwives to continue to develop as practitioners beyond registration and to remain competent are also built into the model of competence at registration. It is anticipated that the findings outlined could usefully inform understandings of competence and the development of assessment frameworks for midwifery education. At the very least, it is anticipated that the model could be used as the basis for discussion and debate about the nature of midwifery competence, and the requirements at the point of registration. In addition, by outlining the nature of learning coming up to registration and the process of transition from student to midwife, the research could raise awareness of the factors that influence learning and final preparation for the role and some of the issues that students face during that process.

11.5.1 Reflections on the case study approach

As outlined in Chapter Four, an interpretivist, case study approach was adopted aimed at discovering the nature and scope of midwifery competence as a phenomenon. The emphasis was on discovery because no in-depth study of midwifery competence was found prior to embarking on the study. In addition, as outlined in Chapter Three, midwifery competence is a social phenomenon that is deeply embedded in context, and although professionals, managers and women would say that they understand what is means to be competent, the concept is not easily described as an abstract concept. Thus, it is suggested that competence is best understood, and reconstructed, in relation to the context in which it exists and through the interpretations and meanings - the multiple perspectives of it of those closest to it. Thus the research focused in on the understandings of students of competence as they aimed and prepared to become competent, those of assessors and teachers charged with making assessments of students' competence to fulfil the role of the midwife, and the understandings of competence held by midwives and supervisors of midwives working with students. The use of the case study approach enabled data on each student participant to be drawn together from different sources so that comparisons could be made between students.

Comparisons could be made between the six case study sites, between individual students, and the longitudinal nature of the study enabled data from different time periods to be compared, enabling learning and the development of competence to be mapped out over time. In understanding competence as a phenomenon, different pieces of knowledge about competence were brought together to build theory on different dimensions of competence, the parameters of competence, and the range of variations of being competent or of what is accepted as competence at the point of registration. In addition, negative cases were sought – students who did not fit with the general pattern, or differences between sites, thus enabling the emerging theory to be tested, refined and expanded continually. Theory was further expanded by drawing comparisons between what is understood to be acceptable at the point of registration and the attributes of

experts and good midwives and of those of midwives who are considered to be bad midwives. The emphasis on comparison was further enhanced by the constant comparative method of analysis, which enabled variation within emerging themes to be identified. This process of using a case to generate theory is described by Mason (1996) as *theoretical generalisation*, who suggests that the more cases the theory can be applied to, or that can be used to thoroughly test it, the more generalisable the theory will be. Mason suggests that theoretical generalisation is more likely to be productive in qualitative research than the concept of empirical generalisation (generalisability from one population to a wider population).

One of the perceived limitations of qualitative research and the case study approach is the lack of generalisability of research findings. However, in response to these concerns, it is argued either that generalisation is not an important consideration in qualitative research, or that findings can in fact be generalisable but in different terms to generalisation in quantitative studies. Stake suggests we should not become too pre-occupied with generalisation in qualitative research least we lose sight of the objectives and purposes of case study research:

> Damage occurs when the commitment to generalize or create theory runs so strong that the researcher's attention is drawn away from features important for understanding the case itself (Stake,1994, p. 238).

It is argued that quantitative and qualitative approaches differ in terms of how generalisability is sought. Quantitative research is essentially *nomothetic*, seeking to generate law-like statements that apply across events and settings and that are relatively free from particular contingencies of time and space. In contrast, qualitative methods are *idiographic* - seeking to 'elucidate unique aspects of particular phenomena' (Seale, 1999, p. 106), and the research aims to make sense of a phenomenon, 'without thinking that the solution should represent a general causal law' (Alasuutari, 1995, p.12). Accordingly, the emphasis in qualitative approaches is on depth whereas in quantitative approaches the emphasis is on

representativeness and the reliability of facts. Stake (1994) suggests qualitative research should be concerned with *naturalistic generalisation,* where the aim is to generate and transfer knowledge about the particular rather than to represent the general. Yin (1984) suggests external validity has been perceived as a major barrier to using case studies, even though the purpose of case studies is to expand and generalise theories (analytic generalisation) rather than to enumerate frequencies. However, he warns that generalisation is not automatic and it must be tested in a second or third case using the same replication logic that would be applied in experiments.

The use of six case study sites in this study helped to know more about the range of variations that can be applied to competence across different sites and, as discussed in chapter four, factors that might contribute to differences between sites were considered in the selection of the six case study sites. But rather than seeking to control for variations, the emphasis was on including the range of variations that could be expected on the basis of what was known about the organisation of pre-registration midwifery programmes at that point in time. With this in mind, a surprising finding for me was the apparent lack of variation in perceptions of student competence and learning between sites, with the odd exception. This was despite local variations in curricula, programme structure and the organisation of practice placements.

It is suggested that qualitative research studies that explore a phenomenon in depth, such as in a case study, will naturally build in generalisability by seeking out the essential elements of the phenomenon, combining raw observations, and exploring the topic through several versions of the same theme (Alasuutari, 1995). Thus 'a typology' is constructed by drawing on all examples of it within in a case or cases. Cases are not isolated cases and the research seeks to cover all of the variation amongst the cases. Further Alasuurtari suggests the typology goes beyond the cases found in the research and as it is completed by way of logical inference to cover all imaginable versions and variations. The emerging typology can also be tested in the process by seeking out negative or contrary cases. The research aims 'to explain the *essence* of the phenomenon, although

possibly captured with the help of very untypical and unrepresentative examples' (Alasuurtari, 1995, p. 150). In this way, it could be said that the research seeks to construct a theory that is generalisable to a particular phenomenon.

On a similar theme, Becker (1998) suggests the concepts generated in qualitative analysis are in fact empirical generalisations. He suggests that by drawing on the study of particular cases and allowing concepts to emerge from the cases, concepts can be broadened by choosing words more general than the specifics of the case. They can be used to generate broader 'theories of the middle ground' (quoting Robert Merton). Concepts are shared understandings of a phenomenon. Concepts usually have multiple criteria but phenomena in the real world rarely have all of the criteria to be unambiguously considered to be members of the same class defined by the multiple criteria. As such there are similarities between examples of social phenomena, they are varying mixtures of criteria referred to a 'family resemblances'. He suggests that to construct 'the generalisation that is a concept' we must isolate the generic features of a series of cases that we think have something in common. Once defined, we can then look for the same phenomenon in places besides those where we found it.

Alasuutari (1995) identifies *local explanation,* where the cases from the research material are slotted in as examples, as a generalising operation. This enables the phenomenon to be related to 'the whole cultural structure' to which it is related.

> While local explanation focuses on a particular phenomenon, the *relating* of that phenomenon to a broader entity is a generalizing operation in which the analysis of the specific phenomenon aims at conceptual appropriation of the broader phenomenon (Alasuutari, 1995, p. 148).
>
> The model of explanation must fit in as neatly as possible with the empirical material in the study. It must be coherent, logical, and it should be supported with as many observations about the material as possible. To demonstrate the broader meaning and relevance of the

> results is a separate task. The research result is examined in one way or another *example* of more than just the individual case concerned (p.152).

Mason (1996) suggests a phenomenon can be studied within a specific context but still be generalisable to a wider universe. She suggests research can provide a close-up and meticulous view of particular units, which are selected to demonstrate in a rounded way, operations of a particular set of social processes in a specified context. Alternatively, research can be designed to encapsulate a relevant range of units in relation to the wider universe but not to represent it directly, so that there would be a strategic purpose for selecting the relevant range. In such cases the researcher may decide that the particular units have pivotal significance for the study, because they occur in the wider universe and are 'empirically significant'. They are selected to enable key comparisons and to test and develop theoretical propositions.

Hamel et al (1992) talk about the notion of 'singularity' characterised by a concentration of the global in the local. Thus, rather than a case being a particular feature of a thing, it characterises a thing. They suggest that global problems are resolved in case study research by reducing them to typical local situations and through description, understanding and explanation.

As stated in Chapter Four, the purpose of this research was to generate theory about the nature of competence and learning that could be applied to pre-registration midwifery education in England, at the time the case studies were conducted (1994-1996). The point is also made that the findings could be more widely applied, for example, to midwifery education in general (as the definition and registration requirements are the same for all midwives, regardless of whether they took the pre-registration or post-registration routes). However, as suggested here, the decision about its applicability would have to be made by whoever decides to use the findings. The aim of the researcher was to provide sufficient contextual description for judgements to be made by the reader about the transferability of concepts. It is also possible that some aspects may be

applicable to other professional or occupational areas. Alasuutari (1995) suggests that wider resonance might still be a valid consideration for qualitative findings, and that there is no reason why idiographic explanations 'could not hold true also in other cases' (p. 12). The example of this provided by Yin (1984) is Whyte's (1943) study of *Street Corner Society*, which although conducted as a single case study:

> The value of the book is, paradoxically, its generalisability to issues on individual performance, group structure, and the social structure of neighborhoods. Later investigators have repeatedly fond remnants of Cornerville in their work, even though they have studied different neighborhoods and different time periods (Yin, 1984, p. 15).

Alasuutari (1995) further suggests that theory and the in-depth understanding generated through qualitative studies can be extended through subsequent analysis, perhaps involving statistical methods. The generalisability of qualitative research is also related to how phenomena are reconstructed by the researcher, and the thick description provided (Seale, 1999). The thick description is achieved through the researcher becoming immersed in the research and the ability of the researcher to enable the reader to obtain a 'vicarious experience' of the research.

Although Alasuurtari (1995) suggests that '… it is particularly important that the researcher personally clarifies in what way and in what respects he or she argues that the results have more general validity …' (p. 150), it is suggested (Seale, 1999) that the ultimate decision about the generalisability of the findings and the external validity of the research should not be made in advance by the researcher, but by the reader, based on the description of context provided by the researcher. Seale (1999) describes both 'sending' and 'receiving' contexts for the research findings. The researcher sends the context in the thick description provided and this enables the reader to make judgements about the similarity of contexts and therefore whether transfer is possible to the receiving context, to which the reader may wish to apply the research results.

Another factor that influences the generalisability of qualitative research is sampling. Mason (1996) refutes the notion that rigorous or systematic sampling strategies are not really important in qualitative research. She describes them as 'vitally important strategic elements of qualitative research' (p. 83). But as with generalisability, the concept of sampling differs from that that in quantitative approaches, which are concerned with providing a representative subset of a wider population to support statistical analysis. In qualitative approaches, the emphasis is on *theoretical sampling.* Theoretical sampling involves the use of theory to select the research setting, the research focus, and wider generalising (Silverman, 2000). Unlike sampling approaches used in quantitative research, the concern in qualitative research is on representing the wider universe of social explanation or theoretical debate. Selection will also be guided by the researcher's broad ontological perspective, for example, the researcher may be interested in the experiences of individuals, on the basis of their belief that experiences are meaningful. Mason (1996) also suggests that sampling is likely to be multidimensional and some relevant dimensions identified are: temporal, spatial or geographical, and organisational, administrative, social, cultural or linguistic dimensions. Alasuutari (1995) suggests that theoretical sampling can enhance generalisability. That is, results are related to broader contexts and possibly to broader populations by comparing isolated cases with the 'more ordinary' to suggest which aspects are exceptional and to what extent, and which are comparable to other 'solutions' or population groups.

> In short, then, a narrow case-analysis is broadened, at the stage of resolving the mystery, through the search for the contrary and parallel cases, into an example of a broader entity (Alasuutari, 1995, p. 156).

As previously discussed, specific selection criteria were used to select the six case study sites in an effort to include the range of major variations that were known at the time and that were seen as likely to influence differences in programme outcomes.

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Appendices

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