Are student midwives influenced by the ‘traditional’ (non-evidence-based) practices of their clinical mentors?

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Introduction

This review was undertaken as part of a study that investigated whether pre-registered final year midwifery students were influenced by the ‘traditional’ (non-evidence-based) practices of their clinical mentors.

Evidence-based practice (EBP) is defined as an approach to health care that uses the best evidence: ‘The most appropriate information available, to make clinical decisions for individual patients... It involves complex and conscientious decision-making based not only on the available evidence, but also on patient characteristics, situations, and preference’ (McKibbon, 1998: 396).

Abstract

Aim. This paper provides a descriptive account of a structured review of literature undertaken as part of an investigation into whether pre-registered final-year midwifery students who were based at five universities in the north of England were influenced by the ‘traditional’ (non-evidence-based) practices of their clinical mentors.

Key questions. Do pre-registration midwifery educational programmes incorporate and advocate students to use evidence-based practice? Do students utilise their evidence-based knowledge in the practice environment? Do student midwives witness their clinical mentors using practices that are not based on current evidence?

Method. Electronic databases were used to access midwifery, nursing and educational journals. Textbooks and governing health professional websites were also accessed. Key words were typed into the search engines. Data that matched the inclusion criteria were scanned and, where relevant, the evidence was critically appraised to assess the study’s validity. In total, 122 studies were retrieved for detailed evaluation.

Findings. The literature review demonstrated that both professional and organisational constraints prevent students and practitioners from using evidence in practice. Some studies identified inconsistencies between what students were taught in the university and what was taught in practice and this may have contributed to widening the theory-practice gap. However, there is limited published data making specific reference to the influence of clinical mentors or student midwives’ practice.

Implications. Further research is needed that specifically explores the experiences of pre-registered midwifery students in relation to this subject.

Key words: Structured literature review, evidence for practice, students and mentors, educational and professional conflicts, theory-practice gap, midwifery
being exposed to a culture that encourages them to search the EB, analyse, critique and use evidence in practice and to disseminate research findings.

However, it is not possible to monitor and know with any real certainty that individual practitioners, who may be involved with mentoring students, employ practices that are based on best evidence. While the ethos of health care should be striving to ensure practitioners utilise EB care, this may not be as easy as it appears in that, it can be difficult and time-consuming for practitioners to keep abreast of the most recent research, which may or may not provide sufficient evidence to warrant its implementation. Additionally, there are a number of practices in midwifery that remain under-researched and as such, practitioners may have little else to refer to other than to adopt the ‘tried and trusted’ traditional practices. Indeed, in the context of clinical practice, the term ‘traditional practice’ has been loosely used to describe the handing down from generation to generation of customs, rituals and beliefs or, following customs or ways of behaving that have continued in a group of people or society for a long time without changing. As such, some of these practices may be of no benefit to service users or may even be detrimental.

While the purpose of this review was to find out if student midwives were influenced by the traditional practices of their mentors, this is a relatively broad concept, necessitating wider exploration of factors influencing practice.

**Search strategy**

The electronic databases, Blackwell Synergy/Blackwell Science, CINAHL and Science Direct were used to access midwifery, nursing and educational journals. Electronic textbooks that focused on adult teaching and learning theories were also accessed. Other databases included the NMC, Quality Assurance Agencies for Higher Education, the Department of Health and the National Institute for Health and Clinical Excellence (NICE, 2006; 2003).

The key search questions were formulated to find out what might influence student midwives to adopt the traditional practices of their clinical mentors:

- Do pre-registration midwifery educational programmes incorporate and advocate students to use EBP?
- Do students utilise their EB knowledge in the practice environment?
- Do student midwives witness their clinical mentors using practices that are not based on current evidence?


**Inclusion criteria**

All studies published in English from 1997 to 2007 were included on the basis that within the last decade there has been an increased awareness and advocacy towards the use of EBP. Studies that explored specialist disciplines other than midwifery and nursing such as psychiatry, dentistry, physiotherapy and or focused on patient care pathways for specific diseases were excluded.

The search strategy for ‘using EBP – nurses and midwives’ identified a total of 5115 citations. According to the title of the papers, and in the order of relevancy, 425 papers were scanned and 125 abstracts were read. Of this number, 90 papers made reference to some of the barriers to employing EBP within the clinical setting, four of which included the use of traditional practices as being a barrier. In total, 60 papers were retrieved for detailed evaluation and, of these, 28 were used in the review.

Some 1001 citations were identified in the search for the ‘theory-practice gap – student nurse/midwives’. According to the title and relevancy, 140 papers were scanned and 40 abstracts were read. Of this number, 47 papers made reference to students’ clinical learning experiences from a students’ perspective, and 76 papers were identified from a mentors/lecturers perspective. In total, 62 papers were retrieved for detailed evaluation and 17 were included in the review.

To assess the validity and rigour of the studies’ results and its relevance, the NHS Critical Appraisal Skills Programme (CASP) was employed.

Table 1 provides a summary of some of the main studies selected for review. Papers meeting the criteria for inclusion were classified according to subject, theory or outcome. Where studies explored more than one concept, these papers were duplicated and assigned to the relevant file. By including a brief summary of the study’s findings or theories on the appraisal tool, this system of filing not only enabled retrieval of the data, but allowed comparison of the findings of studies that had investigated similar concepts. This process led to the emergence of a number of themes and these will now be discussed.

**Discussion of findings**

**Employment of traditional practice**

Studies undertaken by Perez-Botella and Downe (2006), Cloherty et al (2004), Baxter et al (2003), Beasley (2001a) and Bick (2000) demonstrate similar outcomes regarding the value that some practitioners place on traditional physical aspects of care over and above current research evidence.

**Application of theory to practice among qualified practitioners**

Studies undertaken by Banning (2005), Rycroft-Malone et al (2004), Parahoo (1999) and McSherry (1997) report similar findings in that some practitioners lack knowledge of what is meant by EB or as MacGuire (2006) and Rodgers (2000) say, they may be unaware of which practices are EB. Alternatively, studies by Thompson et al (2005), Glacken and Chaney (2004), and Parahoo (2000) revealed that some practitioners were uncertain of how to use evidence to change practice.

According to Leeman et al (2006), this latter concept
Table 1. Summary of main studies

<table>
<thead>
<tr>
<th>Author(s), date published</th>
<th>Research interest</th>
<th>Research method(s)</th>
<th>No. of participants</th>
<th>Key findings</th>
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</table>
| Begley CM. (2002)        | Student midwives’ views of the hierarchy in midwifery and views of their working role and relationships with qualified midwives and obstetricians | Individual and group interviews, diary-keeping, questionnaires                     | 125                | • Negative perception of hierarchical structure; Work environment not conducive to learning  
|                          |                                                                                   |                                                                                   |                    | • Fear of bullying                                                           |
|                          |                                                                                   |                                                                                   |                    | • Tension between traditional and EB practice                                |
| Camiah S. (1997)         | Use of nursing research in practice and application                               | In-depth individual and group interviews                                          | 100                | • Poor knowledge                                                            |
|                          |                                                                                   |                                                                                   |                    | • Resistance to change                                                       |
|                          |                                                                                   |                                                                                   |                    | • Lack of research training                                                 |
| Closs SJ, Baum G, Bryar RM, Griffiths J, Knight S. (2000) | Barriers to research implementation in two Yorkshire hospitals                   | Survey (Funk et al, 1991)                                                        | 712                | • Lack of resources and training                                            |
|                          |                                                                                   |                                                                                   |                    | • Negatively disposed                                                       |
| Corlett J. (2000)        | Theory-practice gap in nurse education                                            | Semi-structured interviews                                                        | 23                 | • Lack of collaboration between clinical areas and higher education institute |
| Crawford P, Brown B, Anthony P, Hicks C. (2002) | Community mental health nurses views of EBP and Barrier scale UK and US comparison   | Semi-structured interviews and focus group                                         | Ten                | • Lack of knowledge and resources                                           |
|                          |                                                                                   |                                                                                   |                    | • Conflicting information                                                    |
|                          |                                                                                   |                                                                                   |                    | • Lack of leadership                                                         |
| French B. (2005)         | Nurses role in translating evidence into policy                                   | Participant observation                                                            | 3 clinical work groups | • Prescriptive models of research are inadequate                            |
|                          |                                                                                   |                                                                                   |                    | • Tension between theory and practice                                        |
| Koh LC. (2002)           | Student nurses views of teaching by link lecturers                               | 3 focus group interviews                                                          | 24                 | • Positive outcome – enhanced integration of theory to practice              |
| Kyrkjebo JM, Hage I. (2005) | Nursing students’ experiences of improvement knowledge in clinical practice     | Six focus groups                                                                 | 27                 | • There were gaps between what students learnt in HEI and what they observe – they would do things differently when qualified |
| Le May A, Mulhall A, Alexander C. (1998) | Exploring the research cultures of practitioners and managers               | Semi-structured face-to-face interviews and telephone interviews                   | 30                 | • Individual and organisational factors affect research                     |
|                          |                                                                                   |                                                                                   |                    | • Practitioners and managers having differing perceptions                    |
| Maben J, Latter S, Macleod Clark J. (2006) | Impact of professional-bureaucratic work conflict on newly-qualified nurses | Longitudinal study in three HEIs between 1997 and 2000. Questionnaires and interviews | 72 students | • Barriers included obeying covert rules, lack of support, poor role models, lack of resource |
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<tr>
<td>Mantzoukas S, Jasper MA. (2004)</td>
<td>Relationships and organisational culture</td>
<td>Observation and analysis of reflective narrative</td>
<td>16 qualified nurses</td>
<td>• Practice dominated by powerful individuals</td>
</tr>
<tr>
<td>May N, Veitch L. (1998)</td>
<td>Placement experience of Project 2000 students</td>
<td>Observation interviews and analysis of programme documents</td>
<td>228 tutors; 498 students; 210 mentors</td>
<td>• Mismatch between practice and HEI</td>
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<tr>
<td>McSherry R. (1997)</td>
<td>Nurses and midwives perceptions about research</td>
<td>Questionnaire</td>
<td>275</td>
<td>• Consensus on value of research • Lack of research knowledge</td>
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<tr>
<td>Oranta O, Routasalo P, Happle M. (2002)</td>
<td>Identify and describe barriers to and facilitators of research use from the point of view of Finnish nurses</td>
<td>Survey (Funk et al, 1991)</td>
<td>253</td>
<td>• Most research was published in a foreign language • Poor research knowledge • Lack of collaboration</td>
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<tr>
<td>Parahoo K. (1999)</td>
<td>Comparing pre-Project 2000 and Project 2000 nurses’ perceptions of their research needs and of their use in clinical areas</td>
<td>Hand-distributed questionnaires</td>
<td>1368</td>
<td>• Pre-Project 2000 nurses did not feel prepared for using research • While Project 2000 nurses reported receiving more training, they did not report higher rates of research use than pre-Project 2000 nurses</td>
</tr>
<tr>
<td>Parahoo K, McCaughan EM. (2001)</td>
<td>Research use among medical and surgical nurses</td>
<td>Survey (Funk et al, 1991)</td>
<td>479</td>
<td>• Managers in control nurses unable to change practice</td>
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<tr>
<td>Pearcey PA, Elliott BE. (2004)</td>
<td>Student impressions of clinical nursing</td>
<td>Two focus group interviews</td>
<td>14</td>
<td>• Students learned role behaviour by observation</td>
</tr>
<tr>
<td>Phillips T, Schostak J, Tyler J, Allen L. (2000)</td>
<td>Evaluation of how assessors, assess students practice within the clinical setting</td>
<td>Multi-methods: • Field • Case studies • In-depth interviews.</td>
<td>One site</td>
<td>• Assessors perceived assessment criteria failed to recognise the real world of practice</td>
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<tr>
<td>Pulsford D, Boit K, Owen S. (2002)</td>
<td>Mentors’ attitudes toward nurse education</td>
<td>Postal questionnaire</td>
<td>198</td>
<td>• Lack of communication between HEI and clinical providers</td>
</tr>
<tr>
<td>Ramage C. (2004)</td>
<td>Negotiating multiple roles: link teachers in clinical nursing practice</td>
<td>In-depth interviews</td>
<td>28</td>
<td>Link lecturers experienced problems with: • Gaining access • Influencing or changing practices negotiating credibility</td>
</tr>
<tr>
<td>Randle J. (2003)</td>
<td>Exploring students’ self-esteem</td>
<td>• Interviews • Field notes</td>
<td>56</td>
<td>• Bullying was commonplace and the ‘norm’ • Students’ self-esteem was low</td>
</tr>
<tr>
<td>Retsas A. (2000)</td>
<td>Barriers to using research evidence in nursing practice</td>
<td>Survey (Funk et al, 1991)</td>
<td>400</td>
<td>Barriers were: • Lack of resources and training • Training critical appraisal skills</td>
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<tr>
<td>Rodgers SE. (2000)</td>
<td>To find out the extent to which student nurses use 14 research-based practices in their area of work</td>
<td>Postal questionnaire</td>
<td>680</td>
<td>• Scores on individual practices ranged from 60% of nurses never having heard of a practice to 83% always using a practice</td>
</tr>
<tr>
<td>Swain J, Pufahl E, Williamson G. (2003)</td>
<td>Do students practise what we teach? Manual handling practice among student nurses</td>
<td>Hand-distributed questionnaires</td>
<td>139</td>
<td>• Students unable to use recommended techniques in practice, due to the influences of other nurses; • Male students and younger students were more susceptible to socialisation</td>
</tr>
<tr>
<td>Veeramah V. (1999)</td>
<td>Use of research findings by graduate nurses and midwives</td>
<td>Cross-sectional survey using postal questionnaire</td>
<td>184</td>
<td>• Lack of resources and critical appraisal skills</td>
</tr>
<tr>
<td>Williamson G R, Webb C. (2001)</td>
<td>The effectiveness of clinical nurses employed in joint posts</td>
<td>Focus groups and telephone interviews</td>
<td>25 clinical support nurses; 6 managers; 34 pre- and post-registered nursing students</td>
<td>• Positive outcome – theory-practice gap reduced</td>
</tr>
<tr>
<td>Yearley C. (1999)</td>
<td>The clinical experiences of student midwives</td>
<td>• Field notes • Interviews</td>
<td>8</td>
<td>• Students learnt how to function and behave in order to ‘fit in’</td>
</tr>
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</table>

may be due to the fact that many research publications fail to provide practitioners with information on ‘how to apply’ the research in practice. In contrast, where practitioners are knowledgeable of the EBP and know how to apply the evidence, they may choose to discount it if it does not correspond with their own beliefs (Furber and Thomson, 2006; French, 2005; Ring et al, 2005; Crawford et al, 2002; Thompson et al, 2001a, 2001b), or the beliefs and practices of their colleagues (Maben et al, 2006; Wilson et al, 2005; Veeramah, 2004; Nutley et al, 2003; Rodgers, 2000; Retsas, 2000) or their managers (Parsons, 2004; Parahoo and McCaughan, 2001, Parsons, 2004).

Similarly, Veeramah (2004) revealed that some practitioners felt they were pressurised to conform to ritualistic practice and that other team members were not supportive, were resistant to change or, were unwilling to try out new ideas. Much of these theories correspond with findings of surveys undertaken by Hutchinson and Johnston (2004), Oranta et al (2002), Parahoo and McCaughan (2001), Parahoo (2000), Retsas (2000), Closs et al (2000), Kajermo et al (1998) and Dunn et al (1997). These studies employed a 29-item ‘BARRIERS Scale’, which was originally designed and utilised by Funk et al (1991) to identify the barriers to research utilisation among registered nurses. While these studies were undertaken between 1991 and 2004 and had geographical difference and investigated varied nurse professions, the research findings revealed notable similarities. The most frequently cited barriers were:

• Nurses did not feel they had authority to implement research findings
• There was insufficient time on the job to implement new ideas and/or to read research articles
• Management and/or doctors would not allow and/or cooperate with implementations
• Statistical analyses were not understandable
• Facilities were inadequate for implementation
• Other staff were not supportive of implementation

Educational and organisational standards

The NMC (2004a) contain standards of proficiency for preregistration midwifery education, and a number of educational standards and proficiency statements that students are expected to achieve. The majority of these outcomes contain elements that require students to demonstrate their knowledge and application of EB findings into practice. The NMC (2008) also recommends that where students are allocated to clinical placements, the workplace should ensure the provision of care is based on relevant research. The NMC (2004a) and the RCM (2003) also emphasised that preregistration midwifery
should prepare midwives to be critical of the environment in which they practise.

Applying theory to practice
Finding out whether students utilise their EB knowledge in their practice environment, requires insight into students’ clinical learning experiences. While it is advocated that students should be critical of their environment and challenge practices that are not beneficial, Morrall (2005) argues this practice is highly improbable due to the fact that ‘the process of socialisation insidiously teaches students to conform to a set of pre-set norms, values, attitudes and behaviours which are difficult (if not possible) for the student to influence, and in those incidences where students dare to challenge such practices, they may run the risk of being labelled as ‘deviant’ and their ‘creativity, innovation and free-expression would be stifled’ (Morrall, 2005).

Swain et al’s (2003) study explored students’ knowledge of manual handling techniques and identified that most students were knowledgeable of the recommended practices. However, in practice where the students worked with mentors and/or other staff members who demonstrated bad manual handling techniques, the students would adopt those behaviours.

Similar perceptions were identified in studies undertaken by Kyrkjebo and Hage (2005), Begley (2001a, 2001b). They contend that, within the clinical hierarchy, students are often seen as being ‘at the bottom of the barrel’, and the students lack of power and desire to be accepted can outweigh students challenging and declining the adoption of bad behaviours. According to Begley (2002), the negative issues associated with clinical hierarchy are far more evident in midwifery than nursing.

Spouse’s (2003) and Welsh and Swann (2002) concur that students are not only powerless, but they are particularly vulnerable and Koh (2002) and Yearley (1999) state it is for this reason they are more likely to imitate the behaviours of their mentors.

Aspiring to change
The students in Kyrkjebo and Hage’s (2005) study and Pearcey and Elliott’s (2004) study believed that when they graduated, they would do things differently from what they had observed. However, the desire to ‘fit in’ and behave like others might be more compelling when students qualify and become part of the workforce. Indeed, Wilson et al’s (2005), and Mantzoukas and Jasper’s (2004) studies suggested that some qualified staff felt the need to comply with the ‘way things were always done’, regardless of whether that practice was believed to be good or bad. Randle’s (2003) and Begley’s (2002) studies highlighted that, where students were subjected to bullying by qualified staff, the students themselves also engaged in bullying activities.

While there are a limited number of studies that have explored this concept, such findings appear to contest Bandura’s (1977) theories of social and behavioural learning, whereby he maintained if someone witnesses a behaviour that violates their moral principles, or if it is socially unacceptable that person will not adopt that behaviour. Freire (2000) suggests there is an increased likelihood people will adopt bad behaviours if the culture is oppressive and discourages liberal thinking, creativity and self-determination. In these situations, the oppressed begin to deny their own identity and accept the attributes and qualities of those who are dominant.

Thomas’ (2006) study supports this concept, in that some midwives described situations where their moral principles were violated by the actions and commands of senior midwives and doctors. Instead of challenging these decisions, they opted to comply, but at the same time this resulted in them feeling ‘frustrated, powerless and angry’.

The oppressive environment
The idea that some practitioners perceived their work environment as ‘oppressive’ appeared to be evident in those studies that utilised Funk et al’s (1991) ‘BARRIERS Scale’. These studies suggested the clinical environment rarely offered practitioners the opportunity to use research in practice. While the rationale concerning this concept is broad, it suggests that if newly-qualified professionals attempt to challenge or adopt new ways of working, it is likely to induce conflict (Seymour et al, 2003).

As a means to demonstrate to nurses the potential risks of being overly righteous and challenging, Fielding and Llewelyn (1987) used the myth of the ‘hero-innovator, who stormed the ‘Castle of Doom’ to free its inhabitants from the evil governance’. They warned nurses that organisations such as hospitals, ‘are like dragons, and will eat hero-innovators for breakfast’.

Likewise, Begley’s (2001b) study revealed that some students described their negative encounters with senior midwives as ‘being eaten from a great height’. Students in Pearcey and Elliott’s (2004) study also learned the need to either, restrain their thoughts or apply a judicious approach to questioning negative practices. For example: ‘The culture is to keep your mouth shut or you are seen as that bloody upstart of a degree nurse, so you have got to be careful, you have got to handle it very carefully’ (Pearcey and Elliott, 2004: 385).

Maben et al’s (2006) study highlighted the fact that, despite newly-qualified nurses emerging from their programmes with a strong set of nursing values, professional and organisational factors disabled them from utilising their knowledge of EB research in practice. Professional barriers included obeying covert rules, lack of support and poor role models. Organisational barriers included constraints such as time pressures, staff shortages, work overload and role constraints, such as their desire to ‘fit in’.

MacLeod Clark (2006) asserts that the reality of an over-stretched workforce is an inherent barrier preventing practitioners from changing practice and if this continues
to escalate, it will create a widening gap between theoretically-sound best practice and actual care delivery.

For the past ten years, researchers such as Russell (2007), Perez-Botella and Downe (2006), Symon (2003; 1998), Upton (1999) and Ashcroft (1998) have reported contradictions. Midwives can be torn between the need to adhere to their Trust policies, which may or may not be EB, and the use of their own professional judgement. Symon (2003) believes that abiding by the former can deny one the ability to act autonomously, to exercise power, and to support client choice. Ashcroft (1998) also believes that midwives maybe ‘expected’ to abide by a consultant’s preferences. In these situations Kirkham (2000) perceived the provision of EB client choice within an organisation that contains a strong hierarchical framework can be problematic, because institutional structures do not allow midwives to use a sound theoretical basis and their clinical judgement. Instead, ‘guidelines come to be interpreted as ‘rules’, and any non-compliance has to be defended’ (Kirkham, 2000: 231).

Symon (2003) adds that many midwives hold the assumption that adhering to a policy will provide a defence mechanism against litigation. However, he points out that midwives need to recognise the difference between a policy that, for instance, insists on two-hourly vaginal examinations and one that prescribes a care pathway for a defined situation. This concept is shared by Benner (1984), who claimed that novices, in particular, cope with their insecurity by adhering strictly to rules, allowing policies to govern their practice. According to Reid et al (1989), what students learn from their clinical placements has the most powerful and lasting impact on their learning. If the culture is to abide by the policies, the students will inevitably follow this line of practice.

The power of the hidden curriculum

Gordon (2003), Hinchliff (2001), Neary (2000), Charters (2000) and Taylor (1997) claim that in the clinical setting most of a student’s learning is acquired informally through role modelling and this has a very powerful influence on how students practice. According to Bruner (1966), role modelling is not just about imitating a model’s actions, it is where a model becomes part of a student’s internal dialogue and the model’s standards of style and clarity become part of their own standard.

This suggests whether a model’s standard is ‘good’ or ‘bad’, it will become part of a student’s standard (Armstrong, 2008). The hidden curriculum is imposed upon students and the nature of socialisation is such that a student’s... ‘actual experience is one of control and coercion that is internalised and eventually reproduced’ (Pitts, 1985: 39). This statement appears to echo Paulo Freire’s theories advocating the need to promote liberation and empowerment as a means to transform the conditions that lead to an oppressive, coercive educational environment (Freire, 2000).

The NMC (2008) recognises the need for students to be exposed to high-quality role models who can not only demonstrate best practice, but can empower students to be critical and challenging of the work environment. However, the application of empowerment is by no means straightforward, as those who seek to empower, must first become empowered (Jamieson, 1994; Chavasse, 1992).

Within the clinical environment, students are not only expected to abide by NMC (2004b) standards, they are also expected to abide by the cultural codes of their clinical mentors and ward managers. Lewis (1998) argues these cultural codes may not only conflict with the higher education institute’s (HEI’s) intentions, but more importantly, they can disempower students from thinking critically and voicing their opinions. While there is a need to take into account the ideologies of individual stakeholders (Higher Education Academy, 2006) this will always create tensions and generate debate between the different stakeholders. Moreover, these differences of opinion can be detrimental to students learning in that they may abandon their HEI’s recommendations of practice in favour of what their mentors believe to be more appropriate.

Preference and credibility

In line with this latter concept, there are number of explanations as to why students employ the practices of their mentors in favour of those recommended by the HEI. Studies undertaken by Richmond (2006), Pulsford et al (2002) and Neary (2001) suggested some practitioners believed that the students’ HEI competency tests were incomprehensible and unrealistic, and as such they elected to adopt their own ways of assessing students. The students in Calman et al’s (2002) study also felt that their assessors, despite attending an assessor’s training course, still had great difficulty understanding the assessment documentation and felt that if their tutors participated in the clinical assessment, it might be more objective. Interestingly, this was because the students perceived their tutors had more up-to-date knowledge of clinical treatments and procedures than many of their practice assessors. All of the students in this study believed that their clinical competence assessment tools were open to bias, and how it was completed depended on the assessor’s personality and knowledge of the student. The overriding comment was their assessment outcomes depended on how well they ‘fitted in’.

Correspondingly, Begley (2001b) and May and Veitch (1998) studies suggested that students learned to employ a variety of behavioural strategies that would increase their chances of acceptance. They also used these strategies as a means to achieve favourable assessments. In the short term, students admitted to ‘pulling their weight’, conforming, ‘keeping their heads down’, not asking questions, and forfeiting their learning opportunities to please their mentors for the medium, and/or long-term gains of achieving acceptance and appraisal. While the students were aware of the consequences of omitting valuable learning experiences, they perceived their mentors were not just ‘gatekeepers’ to learning, but more importantly, they were ‘gatekeepers’ to the profession.
Similarly, Calman et al’s (2002) study found assessors appeared to have valued a student’s socialisation dexterity in preference to their ability to perform tasks competently. Neary (2001; 2000) and Phillips et al (2000) stated practitioners perceived the students’ assessment criteria failed to recognise the ‘real’ world of practice. Watson et al (2002), Fraser (2000), May and Veitch (1998) suggested the students themselves perceived there was a mismatch between their HEI curriculum intentions and their practitioners’ expectations.

Morgan (2006), Bendall (2006) and Corlett (2000) claim that one of the common complaints made by students is what they were taught in the school was not practised in the wards and vice versa. Kyrkjebo and Hage’s (2005) study supports this finding in that, when the students asked their mentors why they did not practice in a way they had been led to expect they were told, ‘You may have learned one way in school, but it’s not the way we do it here’ (Kyrkjebo and Hage, 2005: 172).

Corlett’s (2000) study also highlighted the disparity of the HEI intentions with that of the workplace in that some students believed their teachers were out of date and of questionable credibility. As a result, the students gave credence to what they saw and learned in the clinical setting.

While much of these studies and opinions reveal comparable findings and assertions, these issues echo the opinions of the NHS Executive (1998) report a decade ago, when they announced there existed some inconsistency between what was taught in the HEI and what was taught in practice.

There have been a number of recommendations made to rectify this problem. These included the need to improve linkage and collaboration between the HEI and service-providers, by means of employing link lecturers or practice educators to work alongside students and practitioners in the practice setting (NMC, 2008; 2002). Studies have shown that the employment of link lecturers and clinical educators/facilitators, not only has a positive influence on students learning, but they were also perceived as providing support and guidance to mentors (Brown et al, 2005; Ellis and Hogard, 2003; Clarke et al, 2003; Koh, 2002; Williamson and Webb, 2001). These studies reported this role facilitated practitioners and students to use best practice within the clinical setting. Clarke et al’s (2003) study revealed a degree of conflict between the educationalists and practitioners, and the placement facilitators who felt both their authority and credibility were marginalised to the point they were unable to influence or change practice. Ramage’s (2004) study explored the perceptions of link lecturers working alongside students and practitioners and showed comparable findings.

**Two sectors: two different ideas**

Morgan’s (2006) and Lander’s (2001) study identified that when students attended their clinical placements, the skills students had learned in the HEI were threatened when they observed the different and sometimes imperfect practices of qualified practitioners. Morgan (2006) acknowledged that the students were novices, but argued they would be the professional graduates of the future and would be responsible for teaching others.

Le May et al’s (1998) study reported that individual and organisational barriers are closely entwined. Nurse managers considered that if they applied research to practice, it would induce the negative consequences that are associated with constant change, such as resistance and ‘destabilising even the most committed staff’. In this study, some nurses perceived those who occupied senior clinical positions created the principal barriers to using EBP. Dunn et al (1997) and Camiah (1997) believe the problem may be due to the fact many senior nurses may not have received training and therefore have limited experience of finding and evaluating research. Seymour et al (2003) reported that it can be difficult for senior nurses to support and guide less experienced nurses who, although they are more likely to be educated in research, they are less likely to be able to change practice due to their clinical inexperience and hierarchical position.

**Being at odds with EB practices**

Kitson (2002), Benner (2001), Coyler and Kamah (1999), Upton (1999) and Berangan (1998) consistently draw attention to the fact that midwifery and nursing practice is not solely informed by EB research, but practitioners draw upon several different ways of knowing. They suggest that practitioners often exercise their clinical judgment, intuition, and person-centred, humanist approaches to their delivery of care, and while these do not readily lend themselves to scientific measurement, these models of care can often be at odds with that of EB. Similarly, Sackett et al (1996) point out that practitioners need to draw on their clinical experiential knowledge when making decisions about the care they give to their individual clients and while it is important to be aware of the best external evidence, neither is enough on its own. Muir Gray (1997) points out that there are areas of care that are under researched and to advocate a change in practice based on limited evidence is unjustified. Moreover, the decisions made should take on board the wishes of their clients, which may well be at odds with the evidence, limited or otherwise. Enkin and Jadad (1998) reports that anecdotal information has an important role to play in healthcare decisions and Seymour et al (2003) contend that, to view EB research as the end product of nursing suggests nurses who are not research-aware are not good nurses. However, the NMC (2008) appears to imply that practitioners who do not utilise EBP may not be good role models.

Upton (1999) claims that the educational curriculum exposes students to two different models: the ideal versus reality, or ‘nursing as it ought to be’, versus ‘nursing as it is’ (Upton, 1999: 552). With educationalists advocating the former and practitioners the latter, they are often at odds with one another, Maben et al (2006).
agrees claiming that this contributes to the theory-practice gap, which in turn creates difficulties with applying EB research into practice.

This latter concept, alongside those studies that have highlighted the underpinning barriers to using EBP, collectively account for the widening research-practice gap. The findings of these studies provide some insight as to why students may adopt or be persuaded to employ the traditional beliefs and practices of their mentors. However, given the complexity of this research subject, it is not possible to ascertain that students are influenced by the traditional practices of their mentors.

Conclusion

While much of the data provides an awareness of the key issues that might influence students to adopt the traditional practices of their mentors, most of the studies investigated the experiences of pre-registered nursing students and nurse practitioners and many used a qualitative approach. Therefore it is not possible to make generalisations of how the midwives may behave.

Our midwifery students are our professional graduates of the future and will eventually be responsible for mentoring others, and where there is an embedded use of traditional practices and a strong hierarchal structure that opposes the use of liberal thinking, these behaviours may be passed on to the next generation.

It is hoped this literature review may incite researchers to explore whether some of these issues are pertinent to midwifery students in terms of mentorship, educational and professional conflicts and that of organisational constraints.

References

References continued

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