ROYAL
COLLEGE
OF MIDWIVES

ISSN: 1479-4489 September 2013 Vol.11 No.3

EVIDENCE BASED MIDWIFERY

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COLLEGE
OF MIDWIVES

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September 2013
Volume 11 Issue 3

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EVIDENCE BASED MIDWIFERY IS A STANDALONE PEER-REVIEWED JOURNAL PRODUCED BY THE ROYAL COLLEGE OF MIDWIVES

Evidence Based Midwifery
Royal College of Midwives
15 Mansfield Street
London W1G 9NH
United Kingdom

Publishers:
Redactive Media Group

Occularcentrism and epigenetics: visioning the hardware and software of the human gene

Key words: Epigenetics, oxytocin, occularcentrism, birth technology, evidence-based midwifery

The ability to see the world is one of the most highly valued sensory gifts we possess. Our fascination with 'seeing' and the need for visioning what is hidden beneath the surface drive our occularcentric being towards more sophisticated technological advances (Sinclair, 2011). The drive to see what cannot be seen by the human eye alone is, without doubt, a relentless human endeavour. However, with regards to new technological advances, we can see them with the attitude of 'the glass is half empty or half full'.

Midwives – in their manifold roles as practitioners, researchers, scientists, epidemiologists or others – need to be able to comfortably vision technological advances with a mindset that sees the critical value of the applied technology to their individual sphere of work. This is how we, as midwives, develop our understanding of the psychological, physiological, sociological, cultural and, more recently, the epigenetic processes of childbirth. The role of epigenetics in midwifery research has to be staked out, so that our contribution to knowledge development, theoretical understanding and the practical relevance can be made visible in this occularcentric world, where seeing is believing.

The structure of our genes (our hardware) never changes, but epigenetics (our software) is one way that genes are programmed to either increase or decrease gene expression; affecting our physiology and our behaviour. Some epigenetic programming is heritable from generation to generation, giving genes a software memory.

The state of the science is such that we have little data on whether childbirth is an epigenetic event or not. However, evidence from animal and human research suggests two sensitive periods surrounding birth that may epigenetically alter stress, metabolic and immune systems (Zhang et al, 2013). These two periods are during gestation (for example, the fetus exposed to high maternal stress) and early childhood (for example, offspring exposed to high adversity). For instance, pregnant women living through an extreme famine may epigenetically alter the programming of their offspring's metabolics to prepare for famine-like conditions, by an increased risk of obesity for their sons in adulthood (Ravelli et al, 1976).

The EPIIC (Epigenetic Impact of Childbirth) is an international, interdisciplinary research collaboration, with expertise in fields including genetics and midwifery. In its recent publication, Dahlen et al (2013) hypothesised that events during the intrapartum period affect the epigenetic remodelling processes and subsequent health of the mother and offspring. They hypothesised that epigenetic mechanisms are at play in studies showing a relationship between mode of birth and increased risk later in life for metabolic or immune dysfunctions: obesity, type I diabetes, asthma, eczema and multiple sclerosis. If they are correct, then every aspect of interference with the normal physiology of birth in a supportive environment needs to be examined in a new light. Questions about the impact of a technological birth compared to a physiological birth on the future programming of the baby need to be addressed in robust scientific studies.

A recent study suggested that an aspect of childbirth could be an epigenetic event by showing epigenetic differences in the oxytocin receptors of placental tissue in elective cesarean versus vaginal birth (Kim et al, 2013). Researchers in Ireland (Brennan et al, 2011) have been exploring gene expression patterns in mothers who have caesarean section for dystocia. The gene ontology analysis revealed 70 genes differentially expressed between the two groups of caesarean section mothers leading the authors to suggest 'an underlying molecular basis for dystocia in first-time mothers in spontaneous labour'.

As new knowledge about pharmacological, environmental and epigenetic factors grow, public expectations for genetic profiling and personalised medicine will increase exponentially. Our role as midwives in this new world of opportunity is to engage with the scientists and clinicians and combine our knowledge about the human hardware and software to truly understand the impact of what we do in our childbirth practices that will enhance the quality of life for the newborn and mother.

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Implementing research evidence into practice: some reflections on the challenges

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This paper is based on a keynote lecture given at the launch of the Welsh Branch of the Doctoral Midwifery Research Society at Cardiff University on 23 November 2012. The author would like to acknowledge the student midwives at Cardiff University, whose insights inspired this paper.

Abstract

Background. The ideal of evidence-based practice is not always reflected in day-to-day midwifery care, which may be based more on tradition and clinical experience than research evidence. The history of maternity care shows that, even when evidence is available, it is not always implemented. It may be assumed that implementation will 'just happen' and, as a result, this critical research stage of the research process may be overlooked.
Aim. To explore the challenges that may be encountered when attempting to implement research evidence into practice, and consider what might enhance implementation.
Discussion. Implementation is not always related to the quality of the evidence. Weaker evidence may be implemented, while stronger evidence is neglected. This suggests that, between dissemination of findings and possible implementation, there is a 'black box': a complex process whose internal workings are unclear and, at times, puzzling.
Drawing on examples from research studies and implementation science, I explore what goes on inside this 'black box'. Various barriers and facilitators may influence whether evidence is put into practice. These relate to: i) the characteristics of the evidence, including the robustness of the research and its accessibility; ii) the context into which the evidence is to be introduced, such as resource implications and organisational readiness to change; iii) the issue and its significance to the holders of authoritative knowledge; iv) the potential evidence users, and how the evidence fits with other knowledge sources.
Implications. It is important that researchers pay attention to the processes within the 'black box' between dissemination and implementation, in order to optimise the introduction of evidence into practice. Dissemination strategies should be aimed at reducing the gap between researchers and knowledge users.

Key words: Doctoral midwifery research society, implementation, maternity care, evidence-based midwifery

Introduction

Recently, I led a session with bachelor of midwifery students focusing on the important contribution of midwifery researchers to the national and international portfolio of maternity research. I defined a 'midwifery researcher' as a midwife who is actively involved in designing, conducting and disseminating research. This is by contrast with a 'research midwife', who is usually employed as part of a research team, with a specific remit that often involves recruitment, gaining consent and data collection. Research midwives are less likely than midwifery researchers to have been involved in the bigger picture of writing the original proposal, creating the study design or disseminating the findings.

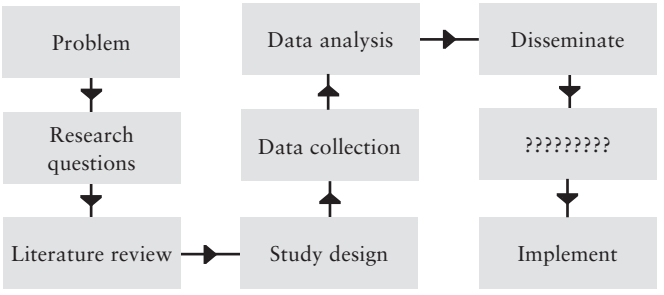
The students and I discussed what particular contribution a midwifery researcher might make to maternity research that might differ from the role of researchers from other disciplines. For example, what type of questions she or he might ask, whether these questions were more likely to arise from experiences in practice and the concerns of parents, and, importantly for this paper, whether they thought that research conducted by midwives would be more likely to be implemented in practice, especially by other midwives.

The students said 'yes', midwives would be more likely to implement evidence arising from midwife-led research, but when I asked them for an example of this, they were speechless. So we discussed the broader issues of implementing any research into practice. They were on firmer ground here: 'Yes', they said, 'we all provide evidence-based care'. 'All the time?' I asked. 'Is all the care you give based on evidence?' As might be expected, the answer was 'no', and the floodgates opened with examples of everyday practice that lack a sound evidence base – for example, restrictions on eating and drinking during labour, and directed pushing in the second stage. The practice they observed was often based on tradition and justified by clinical experience. So, for example, it was rare to see a woman being proactively offered immersion in water for pain relief in labour, despite the evidence for its efficacy (Cluett and Burns, 2009). 'So what was going on?' I asked. 'If the evidence is there, why aren't midwives using it in their practice?'

The animated discussions that ensued underpin the themes of this reflective paper. My key aim is to stimulate thinking and questioning about the many challenges of putting evidence into action. Although the paper is particularly aimed at doctoral students and others engaged in research, I hope that it will also spark interest in other midwives.

I will begin by considering what goes on in the 'black box' between dissemination of findings and implementation, illustrated by some examples. In the second part of the paper, I will draw on insights from implementation science and other research, in particular the various barriers and facilitators that have been identified. I will discuss what might enhance implementation and what this might mean for midwifery researchers.

Figure 1. Research process flowchart



Background

At the beginning of your research career, for example, when undertaking doctoral studies, the implementation of research findings may seem like a distant consideration. The other stages of the research process are the focus of one's concerns: planning and designing the study, obtaining ethical approval, conducting the study and analysing the findings, writing up the study – and, of course, the viva. It is difficult to see much further ahead than submission, and perhaps dissemination via a few papers. The thought that one's findings might produce evidence that is robust enough to affect policy, or that might be implemented in practice, will probably seem pie in the sky.

But here is the nub: Isn't that what you have really been hoping to do? From talking to other researchers, this is the common driver for doing research – to improve the knowledge base in your field and, ultimately, to find out how to make things better, for the users of the service, or for healthcare providers or the public. Whatever the research design or methodology, most midwifery researchers are undertaking applied research with the intention of making a difference. So it is very important to think about the implementation of evidence. But how does one get from dissemination of findings to implementation? What happens between these stages? I see this as a 'black box', indicated by a box containing question marks in Figure 1, which I hope to open up for inspection in this paper.

The 'black box' between dissemination and implementation

The *Oxford Dictionary of English* defines a black box as 'a complex piece of equipment with contents which are mysterious to the viewer' (Oxford Dictionaries, 2003). Transferring this to research, we could say that the stage between dissemination and implementation represents a black box: it is a complex process whose internal workings are unclear and, at times, puzzling.

It is often assumed that implementation will 'just happen' and that levering evidence into practice is a simple, linear and rational process (Hunter and Segrott, 2008). Hence we see a proliferation of protocols, guidelines, checklists and Cochrane reviews, all intended to support evidence-based practice. However, we also know that these tools may be ignored or overridden by the clinicians on the ground, for a range of reasons (Gabbay and Le May, 2011). As we saw in the introduction to this paper, the student midwives experienced a tension between an ideal of evidence-based care, and the reality that much of the care they witnessed lacked a sound research underpinning.

So why is some evidence implemented while other evidence isn't? It seems that it is not just a matter of good and bad research, or strong and weak evidence. Some strong evidence does get implemented, but so does some much weaker evidence. And some strong evidence fails to affect practice at all. This suggests that there is a complex process in action.

For an example of evidence leading to change, I can draw on my own midwifery history. When I trained as a midwife 30 years ago, it was routine for all women to have a perineal shave, bath and enema on admission to hospital in labour and all primiparous women had an episiotomy. Mothers and babies were routinely separated, with babies kept in the nursery until feeding time. Breastfed babies were restricted to three minutes 'on each side' for the first two days, progressing in incremental stages to a total feeding time of 20 minutes – and no longer. Care was far from evidence based – and, as I quickly found out, questioning of tradition was not encouraged.

The routine nature of these interventions seems shocking now. We know how unpleasant, unnecessary and, at times, dangerous they were. But these practices were about to be challenged through research, often undertaken by pioneering and influential midwifery researchers. For example, the midwife Mona Romney conducted a trial of perineal shaving which confirmed that this was indeed an 'unjustified assault' (Romney, 1980). Jennifer Sleep led a groundbreaking study of restricted versus liberal use of episiotomy with the National Perinatal Epidemiology Unit (Sleep et al, 1984). The findings of both studies were implemented and changed maternity care, so that, in the UK at least, these practices now seem archaic and even barbaric.

But much robust evidence does not seem to filter down into practice, whereas weaker evidence does get implemented. In their valuable book *Evaluating the impact of implementing evidence-based practice* (Bick and Graham, 2010), Debra Bick and Ian Graham cite the Term Breech Trial (Hannah et al, 2000) as a prime example of the latter. The aim of the trial was to give a definitive answer about the optimal mode for breech birth at term, by conducting a randomised controlled trial (RCT) to compare outcomes from planned caesarean section births with vaginal breech births. The large-scale study was conducted in 121 centres across 26 countries, with a sample size of over 2000 women. The results, which were fast-tracked for *The Lancet* publication, showed that planned caesarean section births resulted in significantly lower perinatal and neonatal mortality and morbidity rates at six weeks. No differences to maternal outcomes were noted. The conclusion of the research team was that planned caesarean section for breech babies was safer than planned vaginal birth.

As a result, there was a rapid change in obstetric practice, despite criticisms of the original trial. The criticisms included variations in standards of care between study centres, and a lack of adherence to the study protocol in some sites (Bick and Graham, 2010). A more fundamental critique is that important differences exist in maternity practice

and maternity culture globally, which are likely to have influenced the conduct of the study in individual sites and hence the results. This raises the question as to whether an RCT was the most appropriate research design.

A two-year follow-up showed no difference between study arms in outcomes for either mothers or babies (Whyte et al, 2004). However, by then practice had fundamentally changed, and in the UK, it is now rare for a women to birth her breech baby vaginally. The current NICE recommendation (2011: 11) is: *'Pregnant women with a singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful, should be offered CS because it reduces perinatal mortality and neonatal morbidity.'*

An unanticipated consequence of the trial has been the loss in skills for attending vaginal breech births. This is problematic when there is an unexpected breech presentation when a woman is in advanced labour, and of course, is potentially even more problematic in developing countries where caesarean section may not always be possible. As Bick and Graham caution, the trial has affected not only clinical practice but also future research opportunities: *'The trial, which aimed to provide the definitive answer, has changed practice when perhaps it should not have done, given the concerns about the protocol and the presentation and interpretation of outcomes. What is clear is that this trial could never be repeated due to change in routine practice and loss of clinical skills'* (Bick and Graham, 2010: 10).

So how and why did the Term Breech Trial change practice so rapidly? This leads to the second half of the paper, in which I will dig deeper into the black box and explore factors that may influence how and when practitioners use evidence.

Barriers to evidence implementation: insights from literature

In order to better understand what affects the implementation of evidence, we need to appreciate and engage with complexity, in particular the complex nature of practice-based knowledge, knowledge transformation and cultural change.

These issues have increasingly engaged the minds of the research community, and a whole area of study known as 'implementation science' has developed. In brief, most who work in this field contend that there are many diverse barriers facing the introduction of evidence into practice. For many years, a popular approach to assessing nurses' perceptions of these obstacles has been the BARRIERS scale, developed by Funk and colleagues in the early 1990s (Funk et al, 1991) and linked to the Diffusion of Innovations Theory (Rogers, 1983). The instrument identifies four domains of barriers, covering a scale of 28 items. These relate to: the users of the research and their characteristics such as their research awareness; the characteristics of the setting in which the research is to be used; the characteristics of the innovation, such as the qualities of the research itself; and how the research was communicated, that is the information characteristics. This has been a useful way to consider perceived impediments to changing practice, and numerous studies have tested it in differing healthcare settings, particularly in relation to nursing (Kajermo et al, 2010).

However, recent thinking suggests that these categories are too general, and lack the specificity needed if change is to be effected, especially in relation to organisational obstacles (Kajermo et al, 2010; Bostrom et al, 2008). For example, responses related to nurses' 'lack of time' to read or implement research oversimplify the multi-faceted phenomenon of temporality. Such responses may reflect perceptions that are professionally acceptable ('we all know how busy we are'). They may also represent a shorthand version of a much more complex situation, which it would not be possible to capture via a measurement scale. As Bostrom et al (2008: 2) observe: 'Little is known about which barriers are valid, how these barriers should be identified, and what interventions are effective for overcoming barriers.' In addition, some barriers identified by Funk et al (1991) (such as lack of easy access to compiled literature), may no longer have relevance, given the rapid changes to research accessibility through advances in information technology and the production of research syntheses, such as those from the Cochrane Collaboration.

Other authors have suggested alternative categorisations, adding barriers related to the wider context of care and the needs of patients (Bosch et al, 2007). Others go further still. Wilkinson et al (2010: 42-3) propose a typology of implementation, rather than barriers. This consists of three overlapping model types: i) the 'evidence-based practitioner model', with a micro-level focus on individual practitioners accessing, appraising and utilising evidence; ii) the 'embedded evidence model', which assumes that evidence can best be implemented by side-stepping practitioners and embedding it into practice, via tools such as guidelines and protocols; and iii) the 'organisational excellence model', which focuses at a macro level on creating an evidence-minded culture at a managerial level, with an expectation of a filtering down effect.

There are also other relevant insights from studies that engage with complexity to explore the nature of clinical knowledge. For example, Gabbay and Le May (2011) synthesise findings from their ethnographic studies to provide rich insights into how practitioners develop and use knowledge in the field. They propose an intriguing alternative view, that clinicians develop 'mindlines': webs of 'knowledge-in-practice-in-context' (Gabbay and Le May, 2011: 64) derived from experience, interactions with colleagues and service users, local contextual knowledge, and research evidence. While mindlines include research evidence, their studies suggest that it is rarely at the top of a knowledge hierarchy.

I have combined these various insights to provide a simple framework to help look into the black box:

- Evidence characteristics
- The context
- The issue
- The knowledge users.

Evidence characteristics

The quality of the evidence would seem to be an important characteristic to consider. This is the 'so what' question: How strong is the evidence? How rigorous was the study? Should practitioners even consider implementing the findings?

In addition, there is the important issue of accessibility: Is the evidence easily accessible and understood by potential users? What was the quality of the dissemination? Where was it disseminated? How and to whom?

The accessibility of the evidence seems likely to be particularly relevant for hard-working practitioners. Although we encourage students to read and critique individual research papers, I would question how realistic this is in the everyday lives of qualified practitioners. So easy access to evidence summaries, such as Cochrane Reviews, where the evidence has been sifted and critiqued by experts and presented in an accessible and digestible form, is invaluable. In addition, as suggested by the embedded evidence model, organisations such as NICE then make recommendations for practice based on the evidence.

This all suggests that the quality of the evidence and its accessibility are fundamental to whether it is eventually implemented or not. However, in their systematic review of 63 studies which used the BARRIERS scale to investigate nurses' perceived barriers to implementation, Kajermo at al (2010) note that the quality of research played a minimal role; instead the presentation of the research findings and the setting for implementation were considered to be major barriers.

It is interesting to consider these points in relation to the Term Breech Trial (Hannah et al, 2000). Concerns were expressed early after publication regarding the strength of the study findings, nevertheless this does not appear to have deterred their implementation. It is likely that the fast-tracking of the publication in the highly regarded high impact journal *The Lancet* was partially influential. The following factors of context, issue and knowledge users are also important to consider.

The context

Many studies identify barriers related to the context in which evidence is to be implemented (Kajermo at al, 2010). Firstly, there are practical resource implications to consider, particularly with the competing demands of a busy and cash-strapped NHS.

Secondly, and more subtly, there is the readiness of the organisation for the changes that implementation will create to consider. Is the organisation 'research minded'? Does it embrace or resist change? There are also issues of organisational and professional culture. Who holds the power in the organisation? Is it held by a particular group of clinicians or a particular clinical speciality? Or in a target-driven and increasingly finance-conscious NHS, does power reside with the managers? The agency of these various actors and the social relationships between them may be critical to the implementation.

It is certainly possible that organisational context influenced the implementation of the findings from the Term Breech Trial (Hannah et al, 2000), as it may have been congruent with the values of those in more powerful roles. From a risk, management perspective, elective caesarean section appears to have many advantages over vaginal breech birth: it makes the birth more controllable and manageable, and eliminates the uncertainty of vaginal birth. It has the potential to reduce perinatal mortality and morbidity, thus decreasing the possible financial and reputational damage from litigation.

The issue

Closely linked to organisational context and culture is how important and relevant the issue is seen as being, and by whom. This is not merely an objective evaluation of how important an issue is, if such a perspective is achievable. Rather there will differing belief systems and knowledge hierarchies at play, with some issues identified as being of prime importance by some actors, while other concerns slip 'off the radar' and down the list of priorities. Underpinning these knowledge hierarchies is 'authoritative knowledge'; in other words, the knowledge that counts because it is held by those able to exert most power (Jordan, 1997).

Knowledge users

Last, but by no means least, are those who will be using the evidence. Again, there is no homogeneity here, and individual practitioners will vary in their motivation and attitudes to the issue and to research in general. As Gabbay and Le May's (2011) research ably demonstrates, practitioners draw on a broad range of information sources or 'mindlines', which include clinical and personal experiences, knowledge from communities of practice as well as research evidence. When asked what they would do in a certain situation and why, clinicians are likely to say: 'Well, it all depends…'

Gabbay and Le May (2011: 64) propose that the 'knowledge-in-practice-in-context', which develops over time, is a rich soup of personal and group evidence hierarchies. Research evidence may be far from the top of such hierarchies, particularly when it bumps up against strongly held views and personal experiences. This illuminates the experiences of the student midwives at the beginning of the paper, which are supported by findings from studies of the socialisation of student and newly qualified midwives (Hunter, 2005). Thus it would seem that when there is congruence between personal views and experiences and the evidence, implementation by individual practitioners will be more likely. When this is experienced by a community of practitioners, more widespread support for implementing the evidence is probable.

What might assist implementation?

In the final section of the paper, I will consider the practical implications of these discussions and what all of this means for midwifery researchers, at any career stage.

Findings from implementation science suggest that it is critically important to reduce the gap between researchers and knowledge users. Future research users need to be involved throughout the process, and can act as important research champions whether at grass roots or managerial levels. A two-way conduit between practice and research should create fertile ground for developing new research studies arising from practice concerns, as well as for implementing evidence. There are already many exciting examples of such initiatives across the UK, which work for mutual benefit; for

example, the Mother and Infant Research Unit founded by Professor Mary Renfrew at the University of York (Renfrew, 2010). The development of clinical academic careers should make reducing the practitioner/researcher gap a reality (Finlay, 2012).

At the level of the individual researcher, there are some practical points to consider. Firstly, it is important to ponder whether your plans for dissemination will engage authentically with all stakeholders. This will mean publications and presentations aimed at a variety of audiences, as well as the usual academic papers, and entail ensuring that your research output is 'digestible' and relevant for your target audience.

When presenting your research, think about whether there are opportunities for potential users to engage with you personally, in order to ask questions, clarify points and consider what the study means for their practice. Although information technology and social media may offer innovative ways to disseminate evidence, social relationships remain crucial. Wathen et al (2011) investigated knowledge translation in relation to their research into violence against women. They found that dissemination activities needed to acknowledge and respect the values of knowledge users. Their key finding was the importance of the three Ts – talk, trust, time for knowledge translation; all require researchers to make time for authentic engagement with evidence users.

Conclusion

In this paper, I have reflected on what takes place in the 'black box' between dissemination of findings and implementation, drawing on examples of where evidence has become readily implemented in practice and where it has not. I have drawn on insights from implementation science and other studies to highlight the various barriers and facilitators that have been identified. These can be categorised as relating to evidence characteristics, setting, the issue and knowledge users.

It is evident from the literature that implementation involves complex processes, which researchers need to acknowledge. Implementation won't 'just happen'. Theories of implementation and knowledge translation suggest that we need to be mindful of organisational context and culture, and how practitioners and communities of practice make sense of evidence and use it (or not) in their practice. These issues appear to be at least as critical for implementation as the quality of the evidence.

Implementation of evidence requires change. Change is a complex process, not a one-off event. Some research evidence gets implemented readily and change happens, despite the research quality, while other evidence remains merely 'academic'. Why this is the case requires much more study – what goes on in the black box between dissemination and successful implementation needs careful unpacking, exploration and attention from all researchers.

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A conceptual understanding of the factors that influence breastfeeding cessation

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This study was funded by a Ruth Davies Bursary from the RCM. Concept maps to accompany this study are included in the online version of the paper at: rcm.org.uk/ebm

Abstract

Background. Repeated infant-feeding surveys have indicated that, while there is an apparent willingness to initiate breastfeeding, rates of breastfeeding at three and six months fall well below targets. There is general agreement about the need to explore the benefits of interventions including public health programmes, clinical support and local interventions.

Aim. This study set out to better understand the views of three key breastfeeding stakeholders: women, partners and midwives. Specifically, it aimed to understand to what extent, if at all, the views of the three groups differ, and how much importance the key stakeholders place on different elements of the breastfeeding experience.

Method. Concept mapping is a mixed method that uses structured focus group activities where ideas are brainstormed, organised and rated. The relationships between ideas are then explored using a sophisticated multivariate statistical analysis software package. The number of focus group participants were: seven midwives, seven women and five partners. Full ethical approval was gained from Norfolk Research Ethics Committee.

Analysis. Ariadne software generated mean preferences for each individual stakeholder group, and produced concept maps to demonstrate the relationship between statements.

Findings. Six key themes emerged when statements from the whole group of participants were clustered: the physicality and unpredictability of breastfeeding; shared experience of breastfeeding; role of health professionals; lack of skin-to-skin contact at birth; external influences; and lack of available breastfeeding resources in the community. However, in the individual groups, different priorities emerged. Partners of breastfeeding women created a separate cluster of statements that related to their own needs. The influence of health professionals rated lower for women and their partners than for the group of midwives.

Implications. The emotional impact for women of breastfeeding rated more highly than the physicality or external influences and suggests that breastfeeding motivation arises from a complex personal experience that is unique to individual women.

Key words: Breastfeeding, cessation, focus groups, concept mapping, evidence-based midwifery

Introduction

The Infant-Feeding Survey indicates an increase in breastfeeding initiation rates in the UK from 76% in 2005 to 81% in 2010 (McAndrew et al, 2012). However, the figure for exclusive breastfeeding at six months remains unchanged at 1%. Increases in shorter term breastfeeding rates (at three months an increase from 13% to 17% and at four months an increase from 7% to 12%), suggest that the public health breastfeeding agenda may be having an impact (McAndrew et al, 2012). However, this is not yet translating into increased long-term breastfeeding rates. Once again the initiation and attrition figures indicate the majority of women have a desire to breastfeed but do not continue to exclusively do so for six months, as recommended by WHO (2003).

Dyson et al (2010) evaluated breastfeeding promotion and concluded that three key elements were needed – a combination of public health policy, good clinical support and local interventions. Hannula et al's (2008) systematic review also advocated a similar range of measures and both authors note the importance of the Baby Friendly Initiative (UNICEF, 2012). The contribution of health professionals, peers and partners of breastfeeding women to the experience and success of breastfeeding has been noted (Alexander et al, 2003; Chapman et al, 2010).

This study set out to better understand the views of three key breastfeeding stakeholders: women, partners and midwives. Specifically, it set out to understand to what extent, if at all, the views of the three groups differ, and how much importance the key stakeholders place on different elements of the breastfeeding experience. The purpose of this was to help inform intervention design. The influences on breastfeeding are manifold and must be clearly comprehended if designing an intervention intended to increase breastfeeding rates (Forster and McLachlan, 2010). A modified approach to breastfeeding policy that recognises the significance and complexities of the woman's social and emotional perspective and is truly individualised has been tested by Stockdale et al (2008) and a similar approach is proposed as an alternative to current breastfeeding policy which does not address the complexity of the issue (Hoddinott et al, 2012).

Method

Study design

The key to successful public health promotion lies in effective targeting of interventions to encourage people to change their behaviour (Noar and Zimmerman, 2005). This is not possible without a clear understanding of how people are motivated to behave in a certain way. Concept mapping is a mixed method that uses structured focus group activities, enabling ideas to be brainstormed, organised and rated (Kane and Trochim, 2007). The relationships between ideas

are then explored using sophisticated multivariate statistical analysis (Trochim and Kane, 2005). Finally, information can be formed into maps, which can be used to plan actions or interventions (Kane and Trochim, 2007). This participatory method has been demonstrated to be suited to public health research questions, as it can facilitate understanding by giving greater context to the issues under discussion, and the perceptions of and level of concordance between key stakeholders can be gauged effectively (Burke et al, 2005; Risisky et al, 2008).

Focus group interviews were used for this study as a means of eliciting empirical data, which can help researchers gain a deeper understanding of experiences. This is useful within the health promotion context of breastfeeding duration, as this is concerned with changing behaviour, and qualitative research enables an empathetic understanding of human behaviour which, can help to identify opportunities for change (Green and Thorogood, 2009). Use of quantitative analysis helps to reduce bias, which can be a criticism of purely qualitative methods. Ultimately, the concept maps can increase awareness of the issues relating to the question and give an indication of how to proceed in planning interventions (Kane and Trochim, 2007).

There are five stages within the concept mapping process (Kane and Trochim, 2007): generating the ideas (brainstorming); ideas synthesis (reducing and editing the statements); structuring the statements (prioritising and clustering); concept mapping analysis (data entry and analysis); interpreting the maps. Participants can be involved in stages one to three of this process. However, in this case, the researchers felt that participants were making a considerable time commitment to stages one and three and, therefore, the researchers completed stage two. For a full list of the statements generated, see Table 1.

Recruitment of participants

The authors set out to recruit three groups of 10 participants through advertising in the local press, but ended up with seven midwives, seven women and five partners. Full ethical approval was gained from Norfolk Research Ethics Committee. All of the women and partners taking part had one child aged under a year. Although the intention was to recruit participants with a range of breastfeeding experience, the authors relied on volunteers and found that those with a less positive experience were less willing to be involved. Five of the women had breastfed exclusively for three months or more and two had breastfed for less than two weeks after birth (the partners' experience reflecting that of the women). The midwives worked in a number of settings, some in community, others on the postnatal ward and one in a specialist midwife role. No demographics, other than breastfeeding duration and place of work, were collected from participants due to the small numbers of participants.

Generating the ideas: brainstorming

Each focus group was asked to brainstorm using the statement 'The decision to stop exclusive breastfeeding before six months is influenced by…' Researchers facilitated the groups with minimal contribution, with the option to provide evidence-based prompts if the flow of the conversation slowed, however, this proved unnecessary.

Each group ran for two 45-minute sessions, with a 15-minute coffee break in between. During the first session, participants were encouraged to contribute to the discussion, and all points were noted on flip-chart paper and displayed around the room so that participants had the chance throughout the session and during the break to reflect on what had been discussed. Following the break, they were invited to expand on or clarify any points that had been made or contribute any new points. At the end of the day, the researchers summarised the main points and invited any further clarification or comments. The researchers were available at the end of each session so that participants could engage in conversation or disclose anything else they did not want to raise in the group (Bloor et al, 2001).

Ideas synthesis: reducing and editing the statements

Following the focus groups, the researchers organised the data into statements using the flip-chart notes and audio tapes of the groups to ensure proper understanding. Initially, 311 statements were produced across the three groups, at which point the researchers removed any duplicate statements or those which were felt to represent the same theme. A total of 95 statements were agreed upon by both authors as a final list, close to the maximum of 100 that could be dealt with by the concept mapping software.

Structuring the statements: prioritising and clustering

The same participants were invited to take part in a one-day drop-in session to complete the prioritising and clustering task a few weeks after the focus groups. Written instructions were provided on how to complete the tasks and the researchers were available to provide guidance. Each participant organised an identical set of statements and they carried out this task with no collaboration with other participants.

The prioritising task involved taking the full set of 95 statements and organising them into five groups; group one indicating those the individual thought less important, through to group five, most important. Participants were asked to ensure that the groups of statements were similar in size. Following this, participants completed the clustering task, whereby they organised the statements into groups according to theme and gave each group a title. There was no limit to the number of 'clusters' a participant could choose to make. Participants recorded the statement numbers for both tasks on proformas, which were then used for the data input. This proved to be a lengthy task, particularly for the parents of young babies, and individuals needed more guidance with this activity than the researchers had anticipated.

Concept mapping analysis: data entry and analysis

The data from the proformas were input into the Ariadne software. The software generated mean preferences for each individual stakeholder group, and produced concept maps to demonstrate the relationship between statements.

Table 1. List of statements generated from the focus groups

Painful breasts or nipples	Partners being excluded if the woman is breastfeeding
Partner is unhappy that the woman is in pain	How supportive the partner is when breastfeeding in public
Baby not able to breastfeed	How understanding the partner is about the woman's time being taken up
Feeling that milk is slow to come in	Women returning to work
A traumatic or difficult birth	Not having enough money to allow longer off work
Wanting to go home quickly after birth	Starting to feed expressed breastmilk by bottle
Being discharged too soon after birth	Finding that expressing breastmilk is time-consuming
It being hard to understand how babies behave when breastfeeding	How confident and comfortable you are at hand expressing
Not feeling like you know what you are doing	Mother feeling depressed
Not being taught how to position and latch the baby properly	Believing that formula milk is the same or better than breastmilk
Not recognising signs that the baby is not latching and feeding well	Concern that the baby is losing weight
Lack of skin-to-skin contact at birth	People making comments about the baby's weight
Feeling that breastfeeding does not get off to a good start	Too much focus on weighing babies
Wondering whether the baby is getting enough breastmilk	The baby being unwell
Partner's concern that the baby is not getting enough food	Amount of support given by health visitors
Not being able to measure how much the baby drinks	Health professionals not helping women feel confident with breastfeeding
Believing the baby will sleep for longer if he/she is given formula milk	Wanting to get back to normal life
Being woken at night to feed, which is too much hard work	Wanting the baby to be in a routine
Feeling exhausted	Fear of baby not taking the bottle may encourage bottle use sooner
Feeling that a baby that sleeps for long periods is a 'good' baby	People's disapproval of breastfeeding in public
The baby beginning to show interest in solid food	Needing to be so discreet in public when breastfeeding
Family and friends giving lots of different advice	Women feeling stressed when needing to breastfeed in public
Trying the next idea before giving the previous idea time to work	Lack of good breastfeeding facilities in public places
Health professionals giving lots of different advice	Embarrassment at breastfeeding in public
Lack of advice on practical things like how fathers can help	The woman's mother's attitude to/experience of breastfeeding
Partners wanting to 'fix' the problem	The woman's friends' attitude to/experience of breastfeeding
Being unsure about the advice given by health professionals	Lack of support from family members
Too much information being as confusing as insufficient information	Not being around other women who breastfeed
Topping up with formula	Hearing about other people's negative breastfeeding experiences
Midwives not observing women's breastfeeds enough	Being put off by overly pro-breastfeeding health professionals
Lots of support in the early days, which then reduces	Too much pressure 'setting you up to fail'
Getting good advice about managing sore nipples	Too little support given by health professionals in hospital
Midwife/health visitors' willingness to recommend using nipple shields	Lack of dedicated breastfeeding area/education on the postnatal ward
Timely intervention from health professionals when support is needed	Too little support given by midwives at home
General advice being given that may not suit everybody	Pressure on time preventing midwives offering more breastfeeding support
Being discharged too soon by the community midwife	Some health professionals not being committed to breastfeeding
Breastfeeding being so time-consuming	Whether women see the same midwife for help with breastfeeding
Breastfeeding being very demanding and constant	Lack of promotion of resources by midwives and health visitors
Breastfeeding meaning the responsibility for feeding is not equal	Lack of media campaigns to promote breastfeeding
Finding that breastfeeding doesn't 'come naturally'	Lack of availability of breastfeeding resources in the community
Not knowing what to expect	Lack of antenatal education about breastfeeding
Lack of commitment to breastfeeding	Concern that breastfeeding can alter the physical appearance of breasts
The fact that it is stressful	The sexual aspect of breasts – feeling strange about a baby suckling
Unpredictability of when or where the baby may want to feed	Breastfeeding feeling lonely
Difficulty breastfeeding having a negative impact on bonding	Fear of how breastfeeding affects physical relationship with partner
Partners wanting to help by sharing feeding	Poor culture of breastfeeding in the UK
Partner's need to sleep to function at work, so disruptive nights are difficult	Powerful marketing from formula milk companies
Partner's practical approach conflicts with the woman's instinct to nurture	

The Ariadne software produces a map with a horizontal and a vertical axis, on which a point for each numbered statement is placed, according to the co-ordinates generated by the software, the proximity of the points giving an indication of a relationship between statements. The closer together two statements are, the more often those statements will have been placed in the same cluster by participants. The positioning of the statements allows the researcher to identify common themes related to statements in close proximity, and from this to label the axes to represent the breadth of the theme across the statements. This is a subjective process based on immersion in the data, similar to other methods of qualitative research, and can involve participants (Burke et al, 2005) or researchers only (Netherlands National Centre for Mental Health and Talcott, 1995). In this case, the researchers conducted this element rather than asking participants to take part in another lengthy exercise. The researchers identified four distinct themes to represent the range of statements. On the Y axis 'shared experience' through to 'personal experience', and on the X axis 'professional expectation and knowledge' through to 'public expectation and knowledge'.

The researcher selects the 'form clusters' option available within the programme or software package, whereby statements that have been similarly prioritised by participants are grouped together. The researcher assigns a label to each cluster to represent the nature of the statements contained within it.

Interpreting the maps: findings

If participants have frequently placed two statements in the same pile during clustering, these statements appear close together on the map. If participants had rarely placed two statements in the same pile, then they would not be close together, and may even be in different clusters. This means that a cluster of statements shows that the participants made an association between them, and their proximity to each other gives an indication of the strength of that association. This makes it possible to identify a label to describe the group of related statements, which can justifiably be seen as a key theme for that group of participants.

At the point of cluster labels for the 'all participant' analysis, the cluster map becomes closer to achieving a visual representation of the theme under discussion, with the most prominent themes being identified alongside how participants have grouped statements together and where these clusters sit on a continuum, from professional through to public expectation and knowledge and shared through to personal experience. The final step is to consider the mean preference score (the average score for all the statements within that cluster) for each individual cluster, and for the 'all participant'.

The cluster with the highest mean preference score (such as including the statements rated most highly by participants) is cluster one: 'the physicality and unpredictability of breastfeeding'. Least significant for participants overall is cluster six: 'lack of available breastfeeding resources in the community'. Cluster four is rated second most highly across all participants during the clustering and sorting exercise. It is of interest to note the consensus of the contribution of lack of skin-to-skin contact at birth as a factor in early attrition. In view of the fact that this is an important breastfeeding standard, it raises concerns about practice soon after birth.

Subgroup analysis

One main aim was to compare the different subgroups to identify whether there is any disparity between groups that may offer further insight into this complex phenomenon.

The concept map for the midwives-only group generated eight clusters. For the women and partners, six clusters were generated per map. The mean preferences across all groups are shown in Table 2. The skin-to-skin statement is within the cluster on early experiences in the women's subgroup. Comparisons between the ratings for each set of subgroup clusters are discussed below.

Discussion

Midwives' perspectives

Within the midwives' concept map, the cluster rated most highly was cluster four: 'not recognising poor latch and feeding'. Midwives' training in breastfeeding, under the UNICEF Baby Friendly Initiative, focuses strongly on the importance of good positioning and attachment, and the potential complications that can arise from poor technique (UNICEF, 2012). Therefore, it is to be expected that midwives would rate this highly, having possibly witnessed women ceasing to breastfeed due to problems caused by poor technique.

The midwives rated statements related to the importance of the health professional in third place, which reflects the level of influence they feel they have on breastfeeding outcomes. Other studies have noted that midwives can be key contributors to women's breastfeeding experience and are responsible for the positive promotion of breastfeeding to women at all times during their professional involvement (Swanson and Power, 2005). The findings of this study indicate a sense of responsibility felt by the participating midwives. It is suggested that interventions that can influence a mother's attitude and social support may help increase intention to breastfeed, as well as sustained long-term breastfeeding (Bai et al, 2010). The powerful influence of the health professional is acknowledged and it is recognised that there is the potential for this influence to be negative or positive (Bai et al, 2009). Negative attitudes of health professionals towards breastfeeding can be damaging and it has been suggested that there is a need to address this issue to improve breastfeeding support (Ekstrom et al, 2005).

The midwife's experience of breastfeeding support has its own complexities, and midwives cited their frustrations and negative emotions when providing breastfeeding support and working within policy recommendations, expressing disappointment at working with breastfeeding mothers who have not behaved as expected. They also note the impact of negative peer responses, but consider that there is potential for great satisfaction to be achieved through positive relationships with the mothers (Furber and Thomson, 2008).

Table 2. Mean preferences across groups

	Cluster label	Mean	Statements in cluster
Midwives			
Cluster 1	Emotional and physical demands	3.17 (4)	38
Cluster 2	Shared responsibilities with partner	2.89 (6)	10
Cluster 3	Role of health professional	3.18 (3)	24
Cluster 4	Not recognising poor latch and feeding	4.00 (1)	1
Cluster 5	Culture of breastfeeding	3.16 (5)	7
Cluster 6	Lack of practical resources	1.86 (8)	2
Cluster 7	Concern about attitude of others	2.74 (7)	12
Cluster 8	Baby being unwell	3.29 (2)	1
Women			
Cluster 1	Unexpected demanding nature of breastfeeding	3.58 (1)	22
Cluster 2	External influences	2.32 (6)	24
Cluster 3	Early experiences	3.40 (2)	6
Cluster 4	Role of health professional	3.38 (3)	26
Cluster 5	Bottle-feeding as a solution	2.54 (5)	8
Cluster 6	Physicality of breastfeeding	2.95 (4)	9
Partners			
Cluster 1	Influence of early experiences	3.85 (1)	19
Cluster 2	Partners' needs	3.13 (2)	9
Cluster 3	Lack of early support	3.10 (=3)	2
Cluster 4	Taking back control	3.10 (=3)	22
Cluster 5	Role of health professional	2.34 (6)	24
Cluster 6	External influences	2.93 (5)	19

Again, this supports the midwives' view of the significance of their role. However, in contrast to the studies mentioned above, the midwives rated clusters six and seven lowest, indicating that they did not collectively feel that practical resources or the attitudes of others played such a significant role in the issue.

Grassley and Nelms (2008) refer to 'the breastfeeding conversation' that takes place between health professionals, mothers and their newborns, and acknowledge that there is the potential for supportive and non-supportive behaviours. The authors describe breastfeeding support as a conversation between three participants where breastfeeding is facilitated and maternal confidence heightened by all three having an understanding of the 'text' (a feed at the breast), and this forms a breastfeeding partnership. The importance of their role in this partnership was clearly evident among the midwives in this study.

Women's perspectives

Of highest importance in the women's concept map was cluster one: the 'unexpected demanding nature of breastfeeding', followed by the influence of experiences in the early days (cluster three). This was different to the midwives, who rated the physical and emotional demands statements fourth (midwives cluster one). Evidence about breastfeeding experiences indicates that it is a complex phenomenon that can be physically and psychosocially challenging, and can be far removed from the 'natural' early breastfeeding experience described in the pro-breastfeeding public health rhetoric (Thomson and Dykes, 2011; Burns et al, 2010; Lamontagne et al, 2008). A level of disconnect between women and the natural process of breastfeeding has also been described (Scott and Mostyn, 2003), as well as a desire to have some separation from the baby (Win et al, 2006). Concerns around the focus on baby weight gain can also increase pressure to cease breastfeeding and can compound women's common, but often inaccurate, perception of an inadequate milk supply (Schanler et al, 2006; Cooke et al, 2003; Dykes, 2002), in spite of the fact that regular weighing of newborns during the early neonatal period has been shown to have no negative impact on breastfeeding. It is recognised, however, that regular weighing must be combined with effective breastfeeding support to optimise neonatal wellbeing (McKie et al, 2006). The demanding early experience documented by these other authors was also felt by the women participants in this study.

Like the midwives, women did not appear to feel that external societal influences were overly significant, with cluster two rated lowest. In their statements, women referred to the views of family and wider society, but did not discuss peer influence. This is in contrast to the findings of other studies which discuss social influences, including embarrassment around breastfeeding in public and returning to work (Wambach et al, 2005; Hauck, 2004).

Overall, the women's collective response appears to reflect a more individual take on the experience of breastfeeding and its demands on them personally, although perhaps leaning more towards the emotional demands than the physical, as statements to do with the physicality of breastfeeding were rated fourth (cluster six). However, previous work has found that the experience of sore nipples is a major influence on the discontinuation of breastfeeding (Ahluwalia et al, 2005).

Studies have also examined maternal characteristics that may have an influence on breastfeeding. Relationships have been identified between age, smoking, employment/income status and level of educational achievement, and duration of breastfeeding, breastfeeding intention and attendance at support groups (Baxter et al, 2009; Bosnjak et al, 2009). A notion of 'confident commitment' is also described as a necessary characteristic of a breastfeeding mother to enable them to continue breastfeeding, despite a

lack of support and numerous challenges faced (Avery et al, 2009). This supports the idea of breastfeeding being a highly individualised phenomenon, which is in line with the findings of the women's concept map.

Partners' perspectives

The highest rated cluster in the partners' concept map was the influence of early experiences, which was also reflected in the women's responses. Five of the women had breastfed beyond three months so this would appear to reflect the importance of early experiences in enabling them to continue. However, the partners also generated a completely new cluster with a strong theme around their needs, which they rated second most highly. These statements were given lower priority in the other two subgroups so, therefore, sat in other clusters rather than forming one of their own.

Interestingly, the women did not 'strongly' rate statements to do with the partner's needs, in spite of the fact that the impact of partner support on breastfeeding success has been documented (Pisacane et al, 2005). Even within a group of fathers with a mostly negative perception of the constraints of breastfeeding, it was recognised that there was a clear role for partners in supporting the breastfeeding women and that this could positively impact on breastfeeding duration (Pontes et al, 2009). One study found an association between a 'good relationship' between the couple and an increase in paternal breastfeeding support (Falceto et al, 2004). There is clearly some evidence that strongly suggests the importance of the partner's role, therefore, it is interesting that the authors' groups of women and partners appeared to differ on this matter. The findings suggest that the partner's influence is less strong than suggested in the literature. However, it is recognised that, to add weight to this, it would be necessary to further explore the views of women who had stopped breastfeeding earlier. It is clear that there is both a role for fathers or partners to play in breastfeeding, and a need to consider this in targeting campaigns and interventions.

In common with the other subgroups, partners placed less importance on the influence of external factors (cluster five). Campaigns to promote breastfeeding have not just been aimed at women. One paper describes a corporate scheme where males were targeted in the workplace to try and influence breastfeeding and this was found to be a viable scheme (Cohen et al, 2002). It has been suggested that the role of the father and their involvement in breastfeeding campaigns should be acknowledged (Earle, 2000).

However, least important of all, partners felt, was the role of the health professional, mirroring the views of the women, and again raising a question around how much influence the professional has (cluster six). Previous studies have discussed the positive impact professional support has on women's early experience of breastfeeding (Barclay et al, 2012), and how crucial it is that the professional understands the culture and the multiple influences on breastfeeding to be able to provide support (Bailey et al, 2004; Bai et al, 2009).

Conclusion

The findings from this study perhaps suggest that we need to reconsider what the biggest factors of influence are in a woman's decision to cease breastfeeding. Many of the findings concur with existing breastfeeding literature. However, there were some unexpected findings. The lack of importance felt by women and partners on the influence of the health professional and society, and the fact that the partners rated all the statements relating to their needs highly enough to create a separate cluster for these. The fact that women did not create a separate cluster for partners' needs indicates that women are perhaps less influenced by their partners, midwives and society than we think. If measures were achieved to help with a positive early breastfeeding experience that focused on intrinsic motivators and the emotional impact of breastfeeding, this might make the biggest difference to women.

The researchers found some limitations to the Ariadne software used for concept mapping in this instance, as it did not facilitate the level of statistical analysis hoped. This could be improved in further studies by the use of either Q methodology or another software package (Watts and Stenner, 2012). The small sample size also meant that the study was too small to be able to do more than speculate, and more conclusive findings would have to include a bigger sample with a wider range of experiences, particularly greater representation from women who stopped breastfeeding within the early days.

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An evaluation of the professional status of Italian midwives

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The author would like to thanks Giovanna Vicarelli, professor of economic sociology at the Polytechnic University of Marche Region, for her support and advice, and the Italian and UK midwives and medical staff interviewed for this research.

Abstract

Aim. To critically evaluate the professional status of Italian midwifery and to gain a deeper understanding of midwives' professional autonomy.

Methods. Data were collected using a mixed method approach including participant observation, ethnographic interviews and in-depth interviews. The sample was a medium-sized maternity unit in which the practice of eight midwives was observed, followed by six in-depth interviews with obstetricians. A further eight in-depth interviews with midwives practising in hospital, community, birth centre, education and independently were also undertaken. Ethical approval and access to participants was granted from the hospital where the study was conducted.

Findings. Italian midwives appear to be working in a medically dominated system. Differences in autonomy between community and independent midwives were observed. However, the former seem to be subjected to hierarchical and functional medical dominance, while the latter appear to face a dominance that is cultural. Midwives in both settings suffer frustration and disaffection. Italian midwifery is currently a semi-profession.

Conclusion. The lack of professional autonomy, the absence of a professional identity, as well as the level of fragmentation within the professional category, seem to limit the possibility of Italian midwifery becoming an independent profession. There are many differences between the role of the midwife in Italy compared to England.

Key words: Italian midwifery, professional autonomy, medical dominance, qualitative analysis, evidence-based midwifery

Introduction

Outside the sociological field, the term 'occupation' is usually used as a synonymous term for 'profession. From a sociological point of view, the two terms are distinct and usage is different. In particular, an occupation must meet certain standards and conditions in order to obtain a professional status. Even if there is not a universally accepted definition, a profession is a *'high-status, knowledge-based occupation characterised by abstract, specialised knowledge, autonomy, authority over clients and subordinate occupational groups and a certain degree of altruism'* (Hodson and Sullivan, 2008: 258). A professional is a person who is qualified and legally entitled to pursue a profession (Hughes, 1965). While some of them are well-established professions, like medicine and law, others are regarded as semi-professions (Etzioni, 1970) due to the lack of power and autonomy and responsibility for their decision-making, as well as a lack of prestige (McBride and Schostak, 1995).

Focusing on the main results of an empirical study, this paper aims to investigate this issue. It is divided into two sections. The first is a theoretical section in which a brief history of Italian midwifery is presented in order to explain the changes in its professional status over time. The midwives' work settings are also described in this part, as it seems useful to explore the existence of a relationship between workplaces and professional status. After describing the methodological approach used for the study, in the second part of the paper the main results of an empirical research are presented and discussed. The discussion compares the main differences between English and Italian midwives and the paper concludes that Italian midwifery is a semi-profession.

Background

Up to the medicalisation of pregnancy and birth in the 1950s and 1960s, Italian midwives had professional autonomy in their clinical practice. Working in a community setting, namely at patients' homes, they had respect from the community they served and the population had a high level of confidence in their ability (Lanzardo, 1985). Due to the centralisation of birth into hierarchically organised hospitals, at the turn of the 1950s and 1960s, their autonomy was reduced: they moved into hospital employment where they provided care in wards and departments under medical supervision, experiencing medical dominance (Freidson, 2002a). Due to the dominant hospital setting, the medicalisation of childbirth was stressed and it started to be viewed as a medical issue by Italian women.

Working in hospitals under medical supervision, midwives *'manifest the classic responses of an oppressed group... internalising the powerful values of medicine'* (Kirkham and Stapleton, 2000: 466). The control exercised over pregnancies and labour by gynaecologists destroyed the individual relationship established over time between women and their midwives (Page, 2003), who never had the opportunity to re-establish this personal relationship. As a result, the midwifery 'model of care' has progressively changed into a medical model of care. With the introduction of the Italian NHS (INHS) in 1978, which deeply changed the existing health structure, Italian midwives experienced the reduction of their autonomy and their social function changed. At the point in which over 90% of births took place in hospital, midwives partially lost their social recognition, while the medical profession furthered its dominant position.

Recent changes

When the process of the managerialisation of the INHS took place in the early 1990s, Italian midwives became involved in a process of professionalisation. Both these processes introduced some relevant changes for midwives, so as to increase their professional skills and knowledge (Spina, 2009), replacing a task-oriented logic with a responsibility-oriented view. In 1994, an academic course of study in midwifery was introduced and midwives' professional profile was re-defined and regulated by a specific law (Ministerial Decree n. 740/1994). This recognised the role of midwives in providing maternity services, defining their set of competencies and responsibilities.

In 1999, when a new health reform started, midwives, together with other non-medical health occupations, formally lost their 'auxiliary status'. Recognising and defining them as professions, their job description was abolished by law (n. 42/1999) and their autonomy and responsibility were increased. One year later, a new law gave them the opportunity to hold managerial roles and, since 2006, they have been able to perform the function of team co-ordinator (l. 43/2006). The same law called for the transformation of their professional association into a royal college. A new education system was also introduced and, currently, there is an academic course of study in midwifery, even though it takes place within medical schools and is run by physicians.

However, few changes have occurred in the workplaces. A new pattern of practice was introduced for hospital midwives who have to perform different tasks, which are less manual and more bureaucratic than in the past, losing some of the traits that have identified their professional profile over centuries. This resulted both in the limitation of midwives' competencies and in the legitimation of the medicalisation of childbirth.

Workplaces

Italian midwives can be employed in healthcare institutions, mainly within the INHS, or in the private sector as independent practitioners.

Hospital midwives provide care in wards, typically in obstetrical-gynaecological departments, or in public community centres called 'consultori familiari' (CF), usually working standard shifts. On one hand, the shift system favours the reconciliation of work and private life (first of all family responsibilities), on the other, it does not allow continuity of care from the beginning of labour to the end of the birth. Some midwives work in obstetrical/gynaecology wards performing nursing functions, while others provide care during labour and birth. The lack of a job rotation system ensures neither the maintenance of skills for midwives, nor the opportunity to have a completely professional experience. This can cause both the disaffection of midwives and fragmentation among members of the professional group.

Midwives who work in CF have to promote, protect and maintain health, with respect to the events of the sexual-reproductive sphere related to the life cycle. However, few women turn to CF when they find out they are pregnant in Italy. The majority of them turn to a gynaecologist, usually an independent gynaecologist. Therefore, midwives who work in CF usually provide care for women who do not have sufficient economic means to pay for a private service, as well as for individuals who call for a midwife's advice and support.

Midwives who work as independent practitioners are approximately 2% of the total in Italy (Raccanelli, 2013) They may work in community settings, typically, at women's homes, or in birth centres (there are only four in Italy). Working outside the INHS, independent midwives believe that they have to provide continuity of care for women through pregnancy, birth and during first motherhood. A pregnant woman who is supported by an independent midwife is usually actively involved in the decision-making process, therefore, a very close and supportive relationship may develop between the two women.

Method

An empirical study was conducted during the period 2005 to 2008 within a PhD programme in economic sociology. The study was divided into two phases. In the first phase, a participant observation was conducted in order to gain a deep understanding about midwifery. The ethnography was conducted over a four-month period (from July to October 2006) in a specialised maternity unit in a mid-sized city located in the centre of Italy. A team composed of eight midwives was observed.

At the end of the observation period, ethnographic interviews were carried out with midwives in order to complement and expand the project's data collection via participant observation, with the aim of gaining deeper insights into midwives' perceptions about their work and profession. Since gynaecologists are always involved in labour (even in case of normal confinement), six in-depth interviews were conducted with them, in order to identify their belief system regarding midwives' work and profession.

The second phase of the research aimed to explore the point of view of those midwives who practise elsewhere, in order to grasp a different perspective. Therefore, eight in-depth interviews were carried out with privileged witnesses who have different roles within the profession (including independent midwives, midwives who play a formal role in their professional associations and midwives who teach at university). In order to evaluate how different places of birth can affect the midwives' way of working, a birth centre run by independent midwives was also visited.

Discussion of findings

Observation of midwifery practice in the hospital setting

The ward was composed of 13 rooms (29 beds) where women with different physical and emotional conditions were hospitalised:

- Women with diseases of the reproductive system who had undergone (or were due to undergo) surgery
- Women experiencing a high-risk pregnancy
- Women who have given birth waiting to be discharged.

This leads to a paradox that is based on two arguments.

The first refers to the incongruity between the high level of specialisation of the hospital and its inadequate spaces. This suggests that pregnant women are regarded as patients, their status is medicalised and the social dimension of childbirth is neglected.

The second issue is based on the idea that the needs of the organisation and those of professionals significantly outweigh the individual interests of users.

The absence of places reserved for normal labour and birth emerges from the observation: there were no areas which were specifically devoted to low-risk pregnancies, where both labour and birth could be experienced as quite natural.

The role of the hospital midwife

Midwives who provide care in the delivery area perform a wide set of functions, including bureaucratic work. The provision of these tasks can be seen as a necessary step towards the process of professionalisation, because it implies the assumption of new responsibilities. However, it has created considerable discontent and frustration among midwives, since their attention is distracted from supportive activities towards bureaucratic work.

Hospital midwives support 'unknown' women during labour and birth, seeking medical advice before each takes place (even in case of natural confinement). Obstetrical and gynaecological staff are usually present during delivery, handling the situation, therefore reducing the midwives' control over the process.

Midwives report the difficulty of creating close and supportive relationships with pregnant women, based on trust and respect. They complained that the women they meet are in the final stage of their pregnancy, thus limiting the possibility to develop a relationship of trust over time. This results in an increase of disaffection and frustration for midwives, decreasing their social visibility. Childbearing women often arrive in hospital unaware that a midwife will attend their birth, therefore, the midwife must be able to break down the women's resistance and mistrust. This capability is not always understood and valued by physicians, or by patients who sometimes call for medical advice. Therefore, in many cases, women regard them as professionals who do not possess the necessary skills to attend the birth.

In conclusion, hospital midwives seem to have become accustomed to this way of thinking, understanding that a well-established culture cannot be uprooted by laws. Therefore, it will be necessary to wait for a generational change in medicine as well as in midwifery so that a new culture can emerge.

Three ideal types of midwives and interpersonal relationships

Even if they form a cohesive group, hospital midwives seem to have different points of view about their role, adopting a different way of working and different job behaviours. Each midwife can adopt a different professional approach, categorised into three broad types:

- Naturalistic midwives: those in this category believe in physiology, regarding childbirth as a natural process. They respect the physiology of normal birth and try to create a supportive relationship with women (Odent, 1989). They challenge the prevailing medical and medicalised views and resist any unnecessary operative interventions
- Moderately interventionist midwives: recognise that childbirth is a natural process and have a cautious perspective. Their desire to reduce women's physical pain prevails over their need to give them emotional support
- Medicalised midwives: they play an important role in sustaining the medicalisation of labour and birth, even if they are a minority. They adopt a medical view and speed up the birthing process.

Due to their approach, medicalised midwives face fewer problems in their relationships with physicians than their colleagues, enjoying both a highly-respected position and informal protection within the hospital.

On the other hand, 'naturalistic' and sometimes 'moderately interventionist' midwives are medically dominated: they feel frustrated and disaffected with their work, because they feel subservient to medical staff. Believing in their autonomous role, they would like to handle normal confinement, therefore, the relationship with gynaecologists is usually complicated and conflict can occur at any time, even in the delivery room.

Some midwives accept and legitimate the medical point of view: they recognise that an autonomous role cannot be played within hospitals, which are seen as places for 'cure' and not for care. Other midwives refuse this approach, arguing that, since the majority of births take place in hospitals, they should have the chance to play an autonomous role, even within health structures.

These differences between midwives' points of view suggest that the occupational group is internally divided and characterised by weak cohesion among members. Therefore, this can limit the possibility of achieving a process of professional mobility for midwives.

The relationships among midwives

Working relationships among midwives themselves are based on esteem and mutual respect. Differing personal opinions do not limit the development of collaborative relationships. The quality of their relationship is also due to the fact that they do not work in teams, but usually as individuals.

Conflict between colleagues does not emerge during participant observation. The interview data demonstrated that none of the midwives feel part of a professional community; they do not have a collective identity; they seem devoid of any sense of belonging to a group. The small size of a professional group can limit its strength, however, this explanation is not sufficiently relevant to explain why individual pride does not became a collective and systemic pride. They do not believe in the possibility of a structural change, as that is not deemed achievable because of the lobbyist power of other health professions and, in particular, the physicians. Secondly, they do not have confidence in the organisations appointed to protect their interests.

Inter-professional relationships

Formal interaction only takes place between midwives and

obstetricians. Therefore, their relationships are limited to brief interactions. The fragmentation between the professions is evident when observing the different groupings during tea breaks at the canteen, situation midwives are on one side of the room, and obstetricians on the other.

The only occasions in which they come into contact are during birth, in the delivery room, and during morning rounds. In the labour room their interaction appears to be negligible, as the midwife can usually work autonomously. The possibility of meeting in the midwives' office is also limited because obstetricians only go there because of the physical proximity to the delivery room.

Medical staff interviews

Feeling sure that hospital midwives already play an autonomous role, all the gynaecologists interviewed claimed to be in favour of major autonomy for midwives, provided they assume all clinical responsibilities. Responsibility is the crux of the problem. Faced with increasing medical malpractice complaints and litigations, physicians tend to adopt a defensive approach, both centralising the work process and supervising the workforce. Even if some gynaecologists say that the childbearing process is a natural issue, they tend to have a very different point of view from those of the midwives, which are sometimes considered quite dangerous:

"Some midwives are obsessively devoted to natural birth and sometimes they tend to dangerously deny the problem, to minimise it. This is a dangerous perspective; it means not recognising that something can rapidly change. Some midwives are convinced that nature will take its course. Yes, of course. But nature is also bad" (Obst/Fem/Hosp/01).

Five out of six respondents said these different approaches can lead to tensions between the gynaecologist and the midwife and one stated that no discussion should take place:

"The midwife has to shut up if the gynaecologist is in the delivery room during birth… She has to do what I say considering that the responsibility is mine. If I'm not there, she can do what she wants" (Obst/Fem/Hosp/02).

Three of the six interviewees thought the gynaecologist and the midwife should solve problems by using conflict resolution, such as talking together rather than 'declaring war'. However, three thought the final decision has to be taken by the gynaecologist. Only one interviewee felt that the presence of the gynaecologist was necessary in the delivery room. Four other doctors thought that the midwife is able to attend a physiological birth by herself. One female gynaecologist said that the presence of the doctor is unnecessary during birth, in general, but is required in a hospital:

"A pregnant woman who chooses to give birth in a hospital wants medical advice, otherwise she would give birth at home. It's a matter of expectations" (Obst/Fem/Hosp/01).

Reflecting on medical dominance, two respondents agree that it is exerted within the hospital. One said:

"Medical dominance is exerted by physicians. This is because we deal with physiology and pathology at the same time without any distinction between them. We call it defensive medicine... this is not correct, but it has become the key word nowadays. But it's logical. Dominance exists here because the gynaecologist takes responsibility for mistakes. Therefore, medical dominance arises from this fact. It does not come from the fact that physicians want to have the last word. They must have the last word; they go on trial otherwise. It's a matter of wrongly shared responsibility" (Obst/Fem/Hosp/03).

Three respondents said no dominance exists. One was unaware of the literature about medical dominance, but said:

"I do not think it is present here. I think that midwives can do whatever they want until they call me for advice. When they call me, they have to do what I say. However, independently from their responsibilities, the gynaecologist is not on an equal footing with the midwife. Each profession has its own role to play. It is like in the army. The captain is above the soldiers and the general is above the captain. There is a hierarchy. There must be a hierarchy. If I have a problem here that I can't solve, I have to call the health director. Even he may not be able to solve it, but I can't avoid calling him because he is responsible for the organisation" (Obst/Mal/Hosp/02).

Interviews demonstrated that both the medical approach and medical behaviour can limit the acquisition of professional autonomy for midwives, reducing their possibility to perform their functions and ultimately impacting on professionalisation.

The independent midwives' perspective

The independent midwives interviewed have chosen to practise in the private sector, in order to avoid both the limitations and the excess of bureaucracy that characterise the public sector, mainly hospitals, where some of them have worked in the past. Practising in their own offices or at patients' homes, they seem to prefer the instability and the insecurity of the private labour market to the stability granted by the public sector.

The choice to work in the private sector usually stems from the wish to perform an activity that is seen as 'different', giving them the opportunity to develop a complete set of skills, which are required to handle different situations as well as criticism. Their move to the private sector is not justified by economic reasons, nor by a lack of confidence in the INHS. Many of them, in fact, express deep regret at the lack of public services offering pregnant women an alternative to hospital and not giving professionals the opportunity to work according to the epistemological principles of their own disciplines.

Independent midwives strongly believe in women's power and have a natural and physiological perspective towards pregnancy and childbirth; they feel sure that, in low-risk pregnancies, women are competent to have a safe birth. They refuse any unnecessary operative interventions, believing that natural confinement is essential for the creation of a good mother-child relationship.

Therefore, their work is based on the respect of women's needs, wishes and expectations. They consider the childbearing process as one of the most special experiences in a woman's life; therefore, they let *"the woman's body speak"*, as an interviewee says, giving them both physical

and emotional support. If any problem occurs, they promptly ask for medical advice. Women who decide to be attended by independent midwives usually have a similar point of view regarding pregnancy and childbirth, so they are ready to take the risk. Independent midwives are usually less worried than their hospital colleagues about complaints or legal actions taken by patients.

The main difference that emerges between independent and INHS midwives is related to cultural approach.

"We see birth as a social event [...] because a learning process during birth can take place as well as a change in the primary relationship (between the mother and her baby) which is reflected outwardly in terms of trust in the world" (Ind/Mid/Fem/01).

"Birth should be seen as the cornerstone of a society, as the beginning of life, the imprinting for future social, family and emotional relationships" (Ind/Mid/Fem/02).

"There's a lack of respect for birth, for women, for children and for people. It is an issue that goes beyond the professional behaviour. This is the cultural meaning usually attributed to giving birth to a child: quickly, healthily, no matter how the child comes out and then back home" (Ind/Mid/Fem/03).

As the interviews show, independent midwives do not follow established routines; some procedures do exist, but they are loosely organised, not universally applied by midwives because they are the results of an empirical process.

A very different way of thinking about their profession exists between independent midwives and those who work in hospitals. As Kirkham and Stapleton (2000: 469) observe: *'The difference in trust and in sources of support may be because these midwives have opted out of the NHS and its culture of midwifery, or it may be that their very different models of midwifery practice increased both the need and the opportunity to develop appropriate support networks.'*

The difference is so great that two professional profiles can be imagined. An interviewee said of hospital colleagues:

"I see them as another profession. We have two very different points of view... They see us as crazy people; they think we take on too much responsibility" (Ind/Mid/Fem/02).

The gap between them is evident both on the theoretical and the practical level:

"Only if a midwife does what the doctors want, is she recognised as a good midwife. Therefore, also those who do not agree with the medical opinion, usually have to adapt to it in order to obtain recognition and consideration" (Ind/Mid/Fem/04).

This reveals the cultural subordination that midwifery as a group are experiencing.

The possibility that independent midwives have to practise outside the INHS gives them more discretion, but does not grant complete autonomy. This is culturally threatened by the inability to challenge the dominant medical models. The process of obtaining content by physicians is not attributable solely to the medical profession. If, on one side, it has usurped maternity care from the jurisdiction of midwifery, on the other, midwives have not been able to challenge this process for several reasons. Midwifery is dominated by females and many would say that this determines the profession's status as semi-profession (Witz, 1992). Gender can limit female perspectives of development, especially if one takes into account the male connotation of the medical profession, which continues to hold a strong power.

Another issue, linked to the midwifery profession's gender composition, concerns the patriarchal culture of Italy. This culture could have influenced the structuring of social and professional roles. In particular, it is said that this culture has strongly affected the development of social institutions, reproducing logics and work patterns devised for men only, even within increasingly 'feminised' places, such as hospitals.

Midwives found it difficult to capture the true essence of social change. In order to professionalise themselves, for example, they have always tried to conform to other professions (mainly physicians), instead of focusing on their own peculiarities. Seeking emancipation through a process of imitation, rather than through the strengthening of their capabilities, means that midwifery values could be rejected and work contents modified.

Looking at the question of professional representation, a stronger sense of belonging can be seen among independent midwives; a strong desire to identify with shared values. The interviewees complained not only about the lack of dissemination of certain principles and values (those of midwifery), and the subsequent failure of the sedimentation of a culture, but also about the fact that there is no agreement regarding the recognition and the validity of these values, even among members of the same professional category.

The interviews allow the observation of strong intra-professional fragmentation, bringing to light a completely different way of interpreting the profession between hospital midwives and independent practitioners.

Professionalisation

Both in Italy and England, midwives have to be registered with the professional body in order to practise. Italian midwives have to be registered with the Provincial College of Midwives, which is a professional organisation representing the professional group and keeping the professional register. English midwives have to be registered with the NMC, whereas the RCM is both the trade union and the professional organisation run by midwives for midwives that aims to promote and advance the profession. Even if registration with the latter organisation is not compulsory, the RCM represents the majority of practising midwives. Beyond organisational differences, it is important to point out the different model of professionalism prevailing.

In the Italian model, the State limits self-regulation of professions and the structural weakness of professional associations tends to consolidate over time. This weakness appears to be due to the prevailing market and economic logic, as well as the effect of bureaucratic 'dirigisme' (Giannini, 2003). This leads to questions about the usefulness of professional associations, which can be seen as corporative bodies unable to limit political action and market pressures. These forces, by contrast, tend to alter the values and ideals of service to the community that professions serve, which attempt to comply with the logic of 'dirigisme' and

mass consumption, without being able to restore the prior dynamics and structure, as Freidson suggests (2002a; 2002b).

The Italian model appears to be characterised by professional associations, which acquire the configuration of 'clans': groups that use a model of governance, based on a blend of familistic logic and well-established lobbies (Vicarelli, 2005). Looking at the midwifery profession, it can be observed that there is low participation in the activities of the association in Italy: midwives seem to distrust their professional organisation, which is considered as a self-referring subject, unable to lobby on its own.

By contrast, the Anglo-Saxon model of professionalism is based on the power of the professional associations that are able to regulate and control the market. The robustness of this model of professionalism, that considers professional associations as a heritage to be protected, is to be found in the secular roots of royal institutes in the social context. These organisations guarantee the competencies of their members by requiring some obligations of them.

Professional groups operate with relative freedom on the market and are able to obtain monopoly on their activities, thanks to the legitimation of the State. This allows them to maintain a high degree of professional autonomy as well as to exercise forms of control on working conditions (Vicarelli, 2005). This is proven by the strong adherence to representative bodies, mainly due to their ability to provide services and benefits in order to protect and enhance the profession. The RCM enjoys the consensus of its members, keeping control over maternity policies. According to this view, UK midwifery can be considered a powerful subject, that is able to influence health governance and the maternity services, when compared to Italian midwifery. The consolidation of these different models of professionalism over time has not only affected the dynamics of intra- and inter-professional interaction, but also the organisational structure and supply system of maternity services.

Conclusion

Should Italian midwifery be considered a profession? It is difficult to answer this question. National history, as well as social, cultural and institutional dynamics, seem to suggest a negative answer. The lack of professional autonomy, the absence of a professional identity, as well as the level of fragmentation within the professional category, seem to limit the possibility of becoming a profession in the true meaning of the word (Carr-Saunders and Wilson, 1933). The process of midwives' social mobility (Sarfatti Larson, 1977) is limited by the fact that they are still too divided in their perceptions of professional and organisational identity; they do not have a professional perspective nor a strategic view. Furthermore, the spread of a medicalised mindset among users, as well as increasing medical dominance, can affect their chance to play an autonomous role. They are not yet able to challenge medical power-holders.

What should Italian midwives do to increase their status? Italian midwives should find, within their own professional consciousness, the motivations to counteract. They should put their professional project into practice in order to mark their boundaries, excluding physicians from their occupational field (Odent, 2008). They should then socialise their model of care as the correct alternative to the medicalised one, strengthening their characteristics, rather than trying to resemble physicians. Until then, they are probably destined to remain a semi-profession (Etzioni, 1970).

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A qualitative evaluation of a preceptorship programme to support newly qualified midwives

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The authors would like to thank the midwives who participated in this study, the peer reviewers for their comments on the first draft of this paper and practice development midwife Jeanette Carter.

Abstract

Background. Contemporary UK midwifery practice has its own particular pressures upon – and requirements of – newly qualified practitioners. The NMC recommends that the focus of pre-registration programmes of midwifery must be on the skills and attitudes needed to support and promote normal birth (NMC, 2007). In relation to the skills of caring for women at high risk of complications, the NMC states that *'skills required for taking on the role of lead carer for women with complex medical and/or obstetric needs is developmental, and competence is to be achieved after initial registration'* (NMC, 2009: 19). It is therefore likely that the midwife, at the point of qualification, will not be fully conversant with the range of skills associated with the care of women with complex needs, and some structured programme is required (DH, 2008).

Aim. A midwifery programme of preceptorship was implemented in 2004 in one NHS foundation trust in north-west England and a structured evaluation was undertaken, starting in June 2009, to identify strengths and weaknesses to further develop the programme.

Method. Focus groups and interviews were used to collect data from one cohort of six newly qualified midwives (NQMs), six preceptors and four midwifery managers over an 18-month period from June 2009 to December 2010. Data were collected on participants' perceptions of strengths and weaknesses in the programme with regard to curriculum content, support and professional development. Data were analysed using thematic analysis. Three overarching themes were identified from the data: developing competence and confidence, support, and organisational constraints. The head of midwifery gave permission for the study to be conducted and the proposal received ethical approval from the university ethics committee.

Results. The structured preceptorship programme was viewed as helpful in developing the NQM's confidence and competence. The relationships built up during this time were considered to be valuable and mutually beneficial. Organisational constraints at times made achieving the aims of the programme more difficult and necessitated a flexible, individualised approach.

Implications. The evaluation supports the evidence for implementation of a personalised, structured, and equitable approach to UK midwifery preceptorship, accompanied by further research on its effects on the care of women and retention of staff.

Key words: Preceptorship, newly qualified midwives, support, development, transition, evidence-based midwifery

Background

The first year after registration is known to be a particularly stressful one for new practitioners as they learn to cope with the complex demands of clinical practice (Robinson and Griffiths, 2009; Oermann and Garvin, 2002; Charnley, 1999). Preceptorship programmes aim to bridge the gap between learner and accountable practitioner, with the aim of ensuring safe care, as well as to reduce the rate of attrition of newly qualified practitioners. It has been defined as *'a period of structured transition for the newly qualified practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours, and to continue on their journey of life-long learning'* (DH, 2010: 11).

In recognition of the fact that what happens to newly qualified practitioners is 'pivotal' (DH, 2010: 3), the Department of Health (DH) laid out a 'Preceptorship Framework' which noted that the NMC was considering the introduction of a period of mandatory preceptorship (DH, 2010: 11). Although high on the policy agenda (Robinson and Griffiths, 2009), the delivery of programmes of preceptorship remains a local responsibility and is variable, both in terms of timing and content. For example, some trusts simply require rotational experience, while others require rotation, study and competence sign-off. In Scotland a national development programme, Flying Start NHS, has been introduced to support the transition of all newly qualified midwives, nurses and allied health professionals (Roxburgh et al, 2010).

There was little research into preceptorship in midwifery in the UK until the large qualitative study (n=62) of newly qualified midwives' (NQMs) experiences (Hughes and Fraser, 2011). This study, tellingly entitled 'SINK or SWIM', found that most new midwives found the transition from student to midwife quite difficult (Hughes and Fraser, 2011). The study found that NQMs valued the role of a practice development midwife with specific responsibility for preceptorship and felt that their named preceptors would benefit from a programme of preparation. The authors recommended that further research into the role of the practice development midwife be conducted, and concluded that a personalised, rather than standardised, programme is necessary because of differing skills and abilities of the NQMs on qualification.

A 12- to 18-month midwifery programme of preceptorship was implemented in 2004 in one NHS foundation trust in north-west England by one of the authors (JM) who was

a lecturer practitioner working alongside the practice development midwife in the trust. As part of the programme, all NQMs were rostered to rotation of experience in community, antenatal care, labour ward and post-natal care. The NQMs were each assigned a preceptor who would be responsible for supporting them to progress and achieve specific competencies in each area. The NQMs were allocated to work with their preceptors at least two shifts per week and also had the clinical shift leader to approach for support and guidance. As practising midwives, they had a supervisor of midwives and access to the 'supervisor on call' contact numbers. The programme lead (JM) visited the clinical area on an ad hoc basis and the NQMs were provided with her contact telephone number. The competencies and skills to be achieved had been identified during the development of the programme in consultation with the senior midwifery leads in the unit, as well as experienced and NQMs. Skills study days and mandatory training were incorporated into the programme, which included theory, reflection and simulation. From June 2009 to December 2010, the programme was evaluated by the first author JM, as part of a masters in midwifery, with supervision from the second author (SD).

Design

The overall design was practice development evaluation, consisting of individual interviews and focus groups with a longitudinal element. A cohort of six NQMs was invited and agreed to participate. Four managers and six preceptors also agreed to participate. One focus group with four midwifery managers was held after a unit meeting prior to the induction day held for the NQMs. The six NQMs participated in the first focus group during their induction study day. Two subsequent focus groups with the NQMs were conducted during planned study sessions halfway through the programme, and one near the end. A focus group with six preceptors was held near completion of the programme. Focus groups were chosen as they are 'particularly naturalistic' when members know each other, and offer a safe environment that aims to minimise the potential power imbalance between researcher and participants (Anderson, 2011). This was an important consideration, as the evaluation was undertaken by the programme lead (JM). JM acted as focus group moderator, negotiating ground rules, posing questions and suggesting areas for exploration. The groups were held in the maternity unit in rooms booked for the study days. Flip charts were used to record the discussions. After each session, contemporaneous notes were written to fill in any gaps on the flip chart and clarify any comments. Participants' comments were discussed with them for verification to minimise the possibility of misinterpretation or misunderstanding. The length of the focus groups and interviews varied from 30 minutes to an hour.

Three individual interviews were also held with each NQM based upon an evaluation questionnaire with eight open-ended questions. These interviews were held during the skills practice elements of the study days. A separate room was available and the NQMs were invited in for interview at opportune moments. The benefits of using the evaluation questionnaire included gaining information related to specific questions and allowing *'conversational opportunities as they arose'*, in order to explore matters more fully (Fulcher and Scott, 2007: 87). Individual interviews provided an opportunity for participants to express their views in a confidential environment. The NQMs were also sent the same evaluation questionnaire by email at the end of the programme and invited to fill in the questionnaire electronically and leave it in a pre-arranged place if there were issues they wished to raise anonymously. A pilot was conducted with two NQMs from a previous cohort to authenticate the questions, as recommended by Bowling (1997).

Advice was sought from the local research and development committee and as the study broadly fitted the criteria for service evaluation (NPSA, 2009), full NHS ethical approval was not considered necessary. Ethical principles were followed throughout the evaluation in that written consent was gained from participants, and confidentiality was maintained. Data were stored in a locked cabinet and destroyed at the end of the study. Details of the trust counselling service were provided on the evaluation information sheet.

Findings and discussion

Analysis of the data was thematic: the qualitative data from the focus groups and evaluation interviews/forms were coded and then organised into themes by both authors separately. The themes were reviewed by both authors and organised into three overarching themes: developing competence and confidence, support, and organisational constraints.

Developing competence and confidence

At the first interview, all the NQMs discussed awareness of deficits in their skills:

"*I know I can do the midwifery stuff... it's the cannulation and the epidurals that scare me... I've never done them before and when it's so busy, I don't want to hinder the team*" (NQM 2, first interview).

By the second interview, the participants expressed satisfaction that they were clear about what was expected:

"*I knew what I had to achieve and I was clear as to how to do it*" (NQM 1, second interview).

"*The competencies were achievable and relevant... yes we had to learn the obstetric stuff, the cannulas and the theatre techniques... but even then the midwifery bit was highlighted... communication etcetera*" (NQM 2, second focus group).

Concerns were similarly voiced by managers and preceptors, regarding the ability of NQMs to undertake skills related to the care of women with complex needs. Managers in the focus group at the start of the programme expressed concerns regarding NQMs' ability to prioritise during busy clinical shifts, based on prior experiences of clinical incidents and complaints. Both managers and preceptors expressed appreciation at the structured approach to skills acquisition embodied in the programme:

"It felt structured – like we could evidence they were competent... if we needed to... – not just the clinical skills – the organisation, understanding the escalation policy" (manager).

"I knew if I had that lot signed off, she could do it" (preceptor).

Both NQMs and preceptors said they felt that the practice-based education and support facilitated the development of skills and decision-making expertise effectively. The opportunity to learn 'in the real world' with time for reflection appeared to help NQMs gain a deeper understanding of the theory relating to clinical experiences (Walton et al, 2005) and develop competence in decision-making:

"Being a midwife means making quick judgements... you should have seen her (NQM) care for the eclamptic lady and send the student to direct the team... no hesitation... she said after the 'shaking mannequin simulation it was easy" (preceptor).

The value of skills simulation, formal teaching and reflection in learning new skills and in the consolidation of prior knowledge was further highlighted by the NQMs:

"*The skills study days allowed me to practise in a comfortable environment and enabled me to ask questions without feeling daft"* (NQM 5, third interview).

"Study days in a supportive environment make such a difference when learning new skills" (NQM 3, second focus group).

"I knew it already, but now I know I knew it and I know it even better" (NQM 4, third focus group).

There were some negative comments regarding the skills programme, as the cohort of NQMs could not all be allocated to the clinical area specifically matching the content of the study days. Two NQMs expressed dissatisfaction and said that they felt that it prevented consolidation of their learning.

The NQMs reported that the opportunity for reflection within the programme, in addition to the formal onsite teaching sessions and simulations, was valuable.

In the second focus group, the NQMs indicated that the degree of confidence they had in their preceptors affected their own self-confidence as practitioners. To enable the NQM to become a confident, competent practitioner, the preceptor needed to have the requisite skills and abilities. One NQM expressed dissatisfaction with her preceptor:

"You want to do it right and she (preceptor) wants to take a short cut" (NQM 4, second interview).

"She (preceptor) was very friendly and supportive, but her practice wasn't evidence based (perineal suturing), so how was I going to learn?" (NQM 4, second interview).

Two NQMs expressed fears that they might be criticised or undermined by colleagues if they were unable to perform particular skills. They expressed concerns that if they were unable to perform specific tasks, it would make it hard for them to 'fit in' in some of the clinical areas, especially during busy shifts. One NQM discussed feeling undermined and bullied by a senior midwife. This related to an experience when she was asked to administer prostaglandin gel vaginally to induce labour. She had never done this in initial midwifery education and did not feel confident in carrying out and interpreting vaginal examinations. She discussed this with the senior midwife on duty who responded in a way which made her feel humiliated:

"She said: 'I don't know how you newly qualifieds can call yourselves midwives'– and she said it in such a harsh, derogatory way" (NQM 6, second interview).

This incident had a significant impact on the NQM. She stated in her final interview that it resulted in her having a stress-related period of sickness and considering leaving midwifery. At this interview she said that she could not ask this midwife for advice or support and she felt that this was holding back her development in that clinical area:

"I just hope every day that we are not working together... it's only when she is there… but she is there a lot" (NQM 6, third interview).

The issue of bullying and harassment was raised also in the manager focus group. They expressed concerns that bullying behaviour on the part of certain midwives might impact on sickness and retention of NQMs, as well as career progression and development. This incident was the only specific example of bullying behaviour to arise in this study, but the long-term effect on the NQM was significant:

"I doubted myself for a long time... Even now I'm a jabbering wreck when she is on shift... even though it's a long time ago... you don't forget" (NQM 6, third interview).

The other NQM who had expressed initial fears regarding 'fitting in' said in her final interview that she felt the support she had received had helped her to develop confidence to manage conflict at work.

The NQMs in their initial interviews also expressed fear about the potential of causing harm and the possibility of litigation. The fear appeared to reduce and change, although not disappear, as they progressed through the programme and gained experience:

"It's their lives in my hands... it's too scary... I will be in court after my first shift... Well, I won't, but it's at the back of my mind… what if I hurt someone – I have to live with it" (NQM 4, first interview).

"I still worry, but all midwives do, don't they? I have the knowledge and experience and I am confident to ask for help... if it does go wrong I will still feel bad but I will know I have done all I could" (NQM 4, third interview).

Support

Two of the NQMs identified ongoing learning needs and expressed a wish to remain in a particular clinical area for longer, so this was arranged. One preceptor expressed satisfaction with this individualised approach:

"*You just knew she hadn't quite got it... and it was good that the clinical leads listened and sorted it that she could stay or come back later... then you didn't feel pressured that they couldn't be signed off*" (preceptor 4).

NQMs and preceptors alike suggested that when there was a good relationship, there were reciprocal benefits.

"However bad the day was... you could have a laugh with her (preceptor)... make the best of it" (NQM 5, third interview).

"She (NQM) was a joy to work with... she taught me so

much about current research... I think it was meant to be the other way round" (preceptor 6).

Learners also expressed appreciation of their peers during the transition process:

"At least we were all in it together... it was good to feel safe in the group at the start although we didn't need each other quite so much as we progressed" (NQM 5, third focus group).

The opportunity for group reflections supported the NQMs' transition. Group reflections demonstrated socialisation into the culture of the NHS trust, learning and adopting new skills, and moulding to the organisation's identity by complying with its requirements (Bosanquet, 2002).

One of the NQMs stated that she valued the support and teaching from the obstetric staff with clinical skills development. This was echoed by the other participants.

NQMs and preceptors suggested that support and challenges received had helped them to develop personal coping strategies, in addition to acquiring clinical and decision-making skills and consolidating prior learning:

"*I have been given time and patience – I've been recognised and appreciated… I'm not a 'baby' midwife any more... I'm all grown up and I can hold my own and advocate for me as well as women"* (NQM 4, third interview).

"She used to drive me mad... but she has grown... she was always convinced she had got things wrong, now she comes with positive reflections... it was worth it" (preceptor).

Organisational constraints

The effects of perceived staff shortfalls on the NQMs' experience were highlighted in the interviews:

"They (managers) tell us we have enough staff... even with sickness and maternity leave... well something isn't working is it?" (preceptor 3).

The managers also expressed concerns about retention of senior staff available to support NQMs:

"It feels like the more we recruit, the more staff leave, we never catch up and the ratio of senior staff is decreasing, which just adds to the pressure" (manager).

The issue of specialising in a specific clinical area emerged in the NQM focus groups and interviews. One participant said she thought it was important to consolidate her midwifery knowledge and skills during a programme of preceptorship and expressed a desire to be able to specialise in a particular clinical area on completion of the programme. The rest of the group expressed agreement with this perspective.

Limitations

The main limitation is that the programme lead inevitably had a personal investment in the success of the programme; this is a potential source of bias. There was a power imbalance between the NQMs and the programme lead/researcher who was a longstanding member of the midwifery team and, although focus groups were used as a way of addressing this, it is still possible that issues did not surface because of this power differential, or because participants did not want to hurt the feelings of the programme lead. Being an 'insider researcher' can be advantageous in that there is a deep understanding of the issues faced by the participants, but this can make it more difficult to take an objective stance towards the data. Another limitation is that the focus group and interviews were all conducted somewhat opportunistically during the study days. This made completion of the evaluation possible, but meant that data were collected onsite when participants and researcher were enmeshed in the clinical situation, which must be recognised as having a possible impact on the evaluation. The evaluation is reliant on self-reports and it must always be remembered that perceptions are different from actual behaviour (Roxburgh et al, 2010). Finally, ongoing feedback from participants was acted upon at the time, so the evaluation was of an evolving programme responsive to individual needs. This could be a limitation of the study.

Discussion

This study aimed to evaluate the strengths and weaknesses of one particular programme of preceptorship, as perceived by a cohort of NQMs, their preceptors and managers. The themes identified are broadly similar to those of previous research, including Robinson and Griffiths (2009). Although no new issues have emerged from this study, it adds to existing evidence that a structured period of preceptorship is of benefit during the transition from student to practitioner.

All participants were highly focused on the issue of skills acquisition and development. This is possibly reflective of a culture where NQMs are expected to 'hit the ground running', and that 'fitting in' involves being perceived as able to perform specific tasks. 'Ticking off' the competencies appeared to be linked with the development of confidence. It is also possible that the peer/preceptor support (Ferguson and Day, 2007) and relationships with the managers and medical team that were fostered through skills acquisition were equally important in developing confidence.

The NQM who reported an episode of bullying found this experience greatly affected her ability to function at work. Transition is a particularly vulnerable time; Einarsen et al (1999) suggested that the damaging effects of such interaction will be particularly marked in newly qualified practitioners. The attitudes of midwives and the quality of relationships with learners are crucial in creating a positive working and learning environment (Andrews and Wallis, 1999). NQMs on this programme spoke of feeling confident to speak out and ask for help. It is likely that an organisational focus on the needs of newly qualified practitioners will bring patient safety benefits. Employees at all levels feeling able to speak out has been emphasised in key reports as an important aspect of a safe culture in maternity (O'Neill, 2008; RCOG, 2007) and most recently highlighted in the Francis Report (Mid Staffordshire NHS Foundation Trust Enquiry, 2013).

In relation to organisational constraints, when the content of study days did not match the NQMs' clinical allocation, the practice development midwife secured the support of an experienced midwife from each clinical area who was willing to work individually with the NQMs, when required. This role helped to mitigate against some of the organisational constraints. An individualised approach to preceptorship

needs was found to be valuable in the preceptorship study conducted by Hughes and Fraser (2011). These NQMs were scheduled to have a period of consolidation in each clinical area, but this was undermined by frequently having to move to another clinical area in response to service needs. The most common reason for this was sickness cover. Temporary rotation of the NQMs to meet service needs appeared to be especially frustrating when elements of structured study sessions (an integral element of the 'sign off' documentation) were missed. This was, to some extent, unavoidable due to service pressures.

The NHS is experiencing a period of unprecedented financial constraints which are impacting on the work of midwives. In a 2011 survey by the RCM, two-thirds of heads of midwifery said they did not have enough staff to cope with the workload (RCM, 2011). Concerns have been voiced as to how staff shortfalls result in a lack of supervision for learners (for example Currie and Richens, 2009). Birthrate Plus is a midwifery workforce planning tool which is utilised in most NHS trusts, including the one where this programme was provided. It is designed to assess the numbers of midwives required to match the standard of providing all women with a minimum of one-to-one care from a midwife during labour (Ball and Washbrook, 2010). Further research is necessary to establish the amount of midwifery time needed to support NQMs during the preceptorship period.

Conclusion

This evaluation found that the preceptorship programme aided NQMs to develop confidence and competence and to integrate well with the multidisciplinary team. Skills teaching and practice were seen as valuable by all groups and the results of learning were demonstrated in the clinical area.

In the small number of studies that have been conducted in the UK, it has been suggested that an individualised preceptorship programme for NQMs will have a positive effect on the NQMs' professional confidence, self-development and perception of support and these findings have been reaffirmed in this evaluation. The evidence supports the implementation of a personalised, structured, and equitable approach to midwifery preceptorship across the UK, accompanied by further research on its effects on the care of women and retention of staff.

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Encounters in the field, challenges and negotiations in midwifery research

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The author wishes to acknowledge and thank the women and midwives who contributed to this research and supervision team of Professor Pauline Pearson and Dr Joan Aarvold.

Abstract

Background. There is increased emphasis upon midwives undertaking research to enhance midwifery practice and develop midwifery theory. This research frequently occurs within the practice area by midwives who have a range of roles and responsibilities, which may impact upon research processes, particularly accessing and collecting research data.

Design. This paper provides a reflexive case study on research exploring midwives' assessment of maternal postnatal genital tract health. Reflective data were collected in a research diary.

Findings. For the midwife researcher, accessing the research field involves negotiating with gatekeepers and potential research participants to gain acceptance of a new role, that of researcher. This includes identifying where along the insider-outsider researcher continuum the gatekeepers and potential research participants perceive the researcher and making the researcher position explicit. This may reduce potential ethical concerns regarding participation and sharing research findings externally. The interview and observation process must be flexible, with rapport developed quickly to maximise a responsive researcher style and effective data collection. However, exaggerated intimacy can place the participants in a vulnerable position, therefore, it is important to utilise a balanced approach and employ reciprocal reflexivity to ensure an appropriate ethical research position and maximise trustworthiness of the research data.

Conclusion. A reflexive approach to data collection enables the novice researcher to learn from experience in the field.

Key words: Midwife, research, interview technique, observation technique, reflexivity, evidence-based midwifery

Introduction

Research activity is recognised as a principal ingredient to the potential success of future healthcare provision and services (Department of Health, 2010). As a result, there is increasing emphasis within contemporary health and educational arenas for practitioners to actively engage in practice-orientated research and innovation activity (Council of Deans, 2012; Department of Health, 2012; Midwifery 2020 Programme, 2010). Clark and Thompson (2013) highlight the need for health practitioner researchers to make greater inroads into influencing mainstream health, but acknowledge the increasing complexity faced by healthcare practitioner researchers who handle multiple roles.

Research undertaken by midwives concerning midwifery-related care and provision has increased significantly over the last 20 years, supported by dissemination in a range of influential national and international midwifery journals (Bryar and Sinclair, 2011; Steen and Roberts, 2011). As a preliminary overview of how midwifery research is currently reported, the following databases were searched for research studies undertaken by midwives that have been published in the last 25 years: CINAHL, Blackwell Synergy and ProQuest Hospital Collection and library catalogues. The content of a bibliographic database is sectioned under subject headings. One of the most commonly referred to is the medical subject heading system (MeSH) (Fink, 2010). Research design is a MeSH heading, its scope identified as: '*A plan for collecting and utilising data so that desired information can be obtained with sufficient precision or so that a hypothesis can be tested properly*' (National Library of Medicine, 2013). Boolean operators were used to expand or reduce data, for example midwifery 'and' research design and alternative terms, including research data collection, were also employed. As the hits returned from these terms were relatively small (74 and 12 respectively from CINAHL), a broader search term of midwifery and research was also used, producing 2400 results.

Many midwifery research articles use the majority of the available word count to focus upon the presentation and discussion of findings. There tends to be an overview of research design principles provided at the start of the text with less detail provided of the researchers' day-to-day experiences of data access and collection. Other examples of areas of focus for midwifery research articles include: identifying research priorities (Butler et al, 2009); discussing principles of research philosophy, methodology and methods (Yuill, 2012; Ledward, 2011; Way, 2011; Roberts, 2009) or highlighting means and implications of assessing the quality and rigour of research (Marchant, 2010; Walsh and Downe, 2006). Over the past 10 years, there has been some acknowledgment of researcher skills and processes within the midwifery literature, for example: Begley (2008); Downe (2012); Mander (1999); Mitchell (2011); Deery (2011); and Baird and Mitchell (2013). A smaller number of midwifery-focused articles solely concentrate upon the researcher experiences and lessons learnt during the research process, for example: Burns et al (2012); Hall (2009); Hunter (2007); McNeil and Nolan (2011); and Ryan et al (2011).

This paper will utilise a case study approach to explore some of the day-to-day challenges encountered when researching professional practice in a recent qualitative

midwifery study as part of a professional doctorate award (Larkin, 2013). During the planning and implementation of the research process, a number of issues arose that may have resonance for many researchers from professional backgrounds, particularly those who re-enter the professional practice arena with a different role, that of researcher. These include gaining access to the research field, negotiating new roles and awareness of gatekeepers. The implementation challenges of data collection involving interviews and observations will be critiqued, highlighting the need for flexibility and mutuality when undertaking research in the practice context. Discussion of the issues raised is integrated throughout the text and will start with an overview of the research from which these issues arose, highlighting the potential contribution of a reflexive case study on research practice.

The research context

In June 2012, the researcher successfully completed a professional doctorate in midwifery. The research explored the experiences and practice of midwives when assessing maternal postnatal genital tract health within a small maternity unit providing midwifery care to childbearing women, in both the hospital and community setting in the north east of England (Larkin, 2013). The methodology was constructionist grounded theory, which advocates a more flexible adaptation of grounded theory processes in which the researcher and participants develop and mutually construct a version of reality (Charmaz, 2006; Charmaz, 2003).

The constructionist/interpretative research paradigm considers that the meaning of social reality is constructed and interpreted by people through transactional interactions between thought processes, the external world and other people (Jaccard and Jacoby, 2010; Blaikie, 2007; Lincoln and Guba, 2000; Schwandt, 2000; Crotty, 1998). It reflects a multitude of perceptions of reality with the potential to facilitate the evolution of new insights via the fusion of these transactional engagements (Schwandt, 2000; Crotty, 1998). Such constructed meaning is specific and time and context bound. It intends to develop a mid-range theory which is grounded in the data, but may have some transferability (Jaccard and Jacoby, 2010). For example, if the researcher had interviewed a particular midwife on a different day, she may have shared different narratives of her practice, sourcing differing perceptions and leading the researcher to construct different concepts. Contextual and temporal relevance reflects the nature of constructionism in which reality is complex, dynamic, unique and obscure and, in turn, this also mirrors the dynamic nature of midwifery practice, in which many potential truths co-exist (Jaccard and Jacoby, 2010). However, the researcher must ensure quality principles are upheld to ensure the research process and conclusions are trustworthy.

Trustworthiness consists of credibility, dependability and transferability and is deemed to be an appropriate assessment tool for determining the quality of qualitative research (Graneheim and Lundman, 2004).

So that credibility and dependability can be established, the research process must be transparent. An integral aspect of such trustworthiness is reflexivity, an in-depth self-awareness of one's strengths, limitations and perspectives (Patton, 2002; Lincoln and Guba, 2000; Cowley and Billings, 1999). Reflexivity is intended to allow for the exploration of bias and assumptions, to enable them to be challenged and help safeguard against pre-conceptions entering the analysis, unless they are evident in the data (Robson, 2002). This reflexive activity was particularly salient for the doctorate study from which this paper originates.

Trafford and Leshem (2008: 38) suggest 'doctorateness' consists of a coherent synergy between research process and research technique to facilitate a meaningful contribution to knowledge generation. Professional doctorates are intended to align doctorate level research and study with knowledge development relevant to a particular professional field, such as midwifery (Lee, 2009). The doctorate journey is *'a constant learning and developmental experience'*, during which the novice researcher must demonstrate research skills in action, including the ability to negotiate and handle the complexities of real world research (Trafford and Leshem, 2008: 191). Burns et al (2012) highlights the importance of reflexivity to uncover the challenges of professional research. Reflexivity helps the researcher and others understand how the planning, implementation and interpretation of the research process has shaped the inquiry and findings (Charmaz, 2006). In addition, Munkejord (2009) suggests reflexivity should include emotional as well as cognitive elements to help the researcher understand the ongoing challenges and changes during the research process; involving both the researcher and the research participants; mutually learning and adapting though this process to enhance data collection and interpretation. Freshwater (2005) considers reflexivity is a characteristic of trustworthy research and calls for reflexive writing to be more visible in research reports.

To fulfil these quality expectations throughout the research thesis, the researcher made explicit how data had been constructed and acknowledged and questioned personal values and preconceptions throughout the process (Hall and Callery, 2001). As part of this process, the researcher used a reflexive diary acknowledging issues and concerns as they arose, which is an accepted method of enhancing the rigour of qualitative research (Silverman and Marvasti, 2008; Graneheim and Lundman, 2004). Koch and Harrington (1998) clarify that the reflexive account must be detailed and contextual and reflect the engagement of the researcher within the research process involving self-critique and self-appraisal. This paper utilises a reflexive approach, citing entries from the researcher's research diary as a case study exemplar. Anthony and Jack (2009) suggest case studies are a useful approach in health and social care, helping to explore a phenomenon in context and are aligned to the constructionist paradigm. The intention is to illuminate and provide particular detail to the theoretical understanding of real world practitioner research, rather than provide generalisations (Anthony and Jack, 2009; Baxter and Jack, 2008).

Discussion

Reflections from the field of clinical data collection

Following a successful ethics submission, clinical access for six months was granted and the researcher was provided with an identity badge. The initial timeframe had assumed the researcher could move from this stage to undertaking some initial data collection in just over a month. This would involve initial meetings with midwifery department leads and attending meetings with midwives in order to provide them with information about the research and generate some interest and potential participant recruitment.

The researcher had previously liaised with the practice area as a midwife link teacher and knew many of the staff, the practice environment and practices. The researcher assumed knowing staff and the environment of care would make access easier and that there would be no role conflict to deal with, what several authors call an insider researcher (Reed and Procter, 1995; Labaree, 2002; McNeill and Nolan, 2011).

The naivety of the novice researcher

However, staff failed to respond to emails and cancelled meetings. As an excerpt from the research diary notes, when attempting to identify opportunities to provide potential participants with information about the research, demonstrates:

"*Received email from community midwifery lead, who suggested none of the dates and time were convenient and reminding me that, for community midwives, lunchtime rarely exists (in my email I had suggested lunchtime might be a good time to catch people). I responded by saying perhaps it was best if we approached this the other way and if she could suggest a date and time, possibly when she was having a community midwifery team meeting, I would try and attend. Since then, I have had no communication. This has been a surprise – I had hoped my past relationships with the staff which (I thought) had been very positive, would help allay potential anxieties and resistance regarding the research. I do appreciate staff are busy and my research will be fairly low on their list of priorities, however, I'm wondering how it's been articulated to the lead midwives. Perhaps they feel their time is being devalued, perhaps they feel anxious regarding what the implications could mean for them, such as: am I 'spying' on their practice? It could of course just be simple work overload, or perhaps the community lead is on holiday and, therefore, not responding. It has left me feeling very anxious, as I know my research clock is ticking, particularly access to the trust*" (Larkin, 2010: 1-2; Activity March, personal research diary).

Negotiating new roles and relationships

The insider status of the researcher was more complex than anticipated. In some respects, the researcher was an insider – a midwife who does know, from past professional or personal interactions, many of the midwives at the research area. However, insiderness is transformed by the situation and decided by the research participants, not the researcher as had been assumed (Labaree, 2002). In this instance, it was an attempt to access the practice context with a different identity and role, that of the researcher, which made the researcher an outsider, an external agent, to the potential midwife participants. In addition, the researcher's background was education; the researcher did not wish to research their own practice, but the practice of others, or what Reed and Procter (1995) term a 'hybrid model' – a practitioner researching the practice of others. As such, the researcher was simultaneously an insider and an outsider, rather than one or the other. Other authors have also suggested for many researchers it is not an insider/outsider dichotomy, but rather a continuum with middle ground along which most researchers sit (Burns et al, 2012; Labaree, 2002).

Despite a background conferring some elements of insiderness, this did not provide automatic advantage or access to the research site or participants, as had been assumed when planning this study. Renegotiation of roles and relationships was required in order for acceptance and legitimisation by the research participants (Labaree, 2002). The researcher attended the practice area prior to the start of their working day, which involved getting to the practice area by 7.30am several times over a two-week period, sharing in the early morning drink before practice visits and activities began. It was almost as if the midwives took this as a sign of commitment, which is a finding similar to Burns et al (2012), who stated informal discussion over afternoon tea with potential midwife research participants helped to clarify commonality and the research intentions:

"*Discussed overview of the research proposal with community midwives and then, in the afternoon, the postnatal midwives. Both groups of staff were very interested, stating they felt it was a relevant area for investigation... Many midwives informally, verbally agreed that they would be willing to participate in the research... I am quite astounded at the warm reception I have had and the generosity of the midwives who, in reality, will be giving up meal break time to talk with me*" (Larkin, 2010: 2; Activity April, personal research diary).

However, for a midwife researcher, there are also advantages to being an outside-insider and renegotiating new roles within the practice context.

Some information is traditionally maintained among a cultural group, therefore, the researcher's position as a researcher needed to be explicit to ensure the appropriate ethical stance, with the midwife participants aware of the intentions to construct a theory from the data, which would be shared with others, including publication in professional literature. Kawulich (2005) highlights the potential ethical dilemmas of being treated as an insider but needing to share findings externally. In addition, familiarity between researcher and potential participants may impact upon ethical recruitment, as participants could feel coerced to participate when the researcher is involved in the area, via employment or other roles and responsibilities (McNeill and Nolan, 2011; Morse et al, 2008). Therefore, being an outside-insider conferred some benefits, familiarity facilitated trust with potential participants, but some distance enabled a new researcher identity to be negotiated and accepted by the research participants and avoided the staff feeling coerced to participate.

Developing a responsive interview style

Interviews began with initial opening questions regarding biographical facts, which were useful to relax both interviewee and researcher, and quite quickly a comfortable conversational style was developed.

When the conversation was steered in order to provoke narrative telling by asking for a typical event, the first midwife interviewee responded with:

"What sticks out is the ones where you pick out a problem" (midwife A: line 51)

There was no attempt to pull her back by insisting she remember a 'typical' practice example, as per the interview schedule, for two reasons. It was felt she had instantly highlighted a potential chink in the interview schedule, as she was correct – people do tend to be able to recollect the unusual more readily than the mundane. Hunter (2007), in her PhD study, found similar issues and highlighted that the focus on the dramatic can sometimes obscure the detail of everyday practice. In subsequent interviews, the desire for an everyday example was emphasised, by reinforcing the idea of describing a recent practice event, as suggested by Hunter (2007). However, when midwives did veer towards a critical example, one of the principles of narrative style interviews was recalled – to let the stories flow. This was adhered to and areas in the interview schedule were attended to in a different order, in the order that possibly made more sense to the midwife being interviewed.

"I think I'm a little better at trying to pull the interview back when it goes off course, but this is always a double-edged sword, as sometimes the conversation can meander but then end up somewhere interesting, relevant and unexpected. It's trying to let the thread run a little and then stepping in if it runs too far" (Larkin, 2010: 1; Activity July, personal research diary).

Some midwives appeared to give examples automatically, using a range of narratives from their practice. There was some repetition of issues, however, when people tell stories this is common, sometimes repetition can indicate areas that people think are particularly important. In addition, to interrupt might prevent the development of the narrative flow of the interview and there was a conscious effort not to do this (Kelly and Howie, 2007). Silverman (2006) states the interviewer must use a flexible style while remaining mindful of the research intentions to ensure the content is applicable.

Using a more responsive interview style, rather then adhering to a rigid interview pattern, is suggested to be more likely to facilitate *'the genuine views and feelings of respondents'* (Wimpenny and Gass, 2000: 1488).

A responsive interview style involves developing a rapport with the interviewee to facilitate open discussion. In the interviews, there was an effort to maintain appropriate non-verbal communication, such as eye contact, nodding, smiling and an open posture, to demonstrate attentive listening and interest to maintain the flow of narratives (Silverman, 2006). With verbal responses, there was an attempt to keep to general utterances to demonstrate listening, but to try not to interrupt the flow of the narrative or direct the narrative by indicating a preference to a particular response. Shah (2006) highlights how difficult this can be, to both demonstrate empathy, but not assume insight into the interviewee's perspective:

"When listening back to the recording, I noted a few practical considerations I need to think about and develop in future interviews. I do tend to say "right" and "yes", I intend them as just the everyday responses one uses in a conversation, meaning I am listening, however could they be misunderstood by some as confirming the content of what was said? [...] On reflection I felt I could have developed the narrative flow a little more, when the midwife was providing a general response, by asking if she could provide practice examples" (Larkin, 2010: 2; Activity May, personal research diary).

Hunter (2007), in her experiences of qualitative interviews with midwives, highlights how midwives use 'embodied knowledge' by talking with gestures or using set phrases to articulate assumed common knowledge. Learning from interview experiences, the researcher increasingly utilised interview techniques, including probing and confirmation strategies, such as paraphrasing and summarising, to ensure full comprehension of what was intended by the midwife rather than making assumptions from personal interpretation (Roulston, 2010; Silverman, 2006).

Interviewer: *"So if I'm picking that up right, I get the impression there that sometimes you use direct clinical observation, such as inspection of the perineum, to mould or influence the specifics of the advice, but also have an impact in relation to subsequent care planning and resource management in relation to when you next need to visit."*

Midwife D: *"Yeah. Plus also, by inspecting the perineum sometimes – and not very often – but one lady in particular, it wasn't actually her perineum, that was the problem. It was her haemorrhoids"* (interview transcript, midwife D: line 218-226).

These techniques also enhanced the depth of the exploration by providing detail and complexity. For example, probing, such as: 'that's interesting, can you tell me more?' (Charmaz, 2006). The researcher would, on occasions, ask a specific question, sometimes closed or open to probe when it was felt that there was a need for more information, or clarification to illuminate detail, intentions and significance of the comment (Silverman, 2006).

However, interviews are co-constructed and, therefore, issues can arise from the perceptions of the interviewee as the following excerpt from the research diary demonstrates:

"The second interview, I was much less nervous. However, my interviewee was more nervous on this occasion. The midwife had been a previous student of mine and I had not particularly seen or interacted with her since that time. During the interview process I felt she was a little anxious that she might somehow give the 'wrong' answers during the interview and perhaps was not as confident in her midwifery practice as the previous interviewee, a midwife with over 20 years' experience. I tried to reassure her that the intention was not to seek a right or wrong answer, but the diversity of practice. I felt there was an inequity in the power balance

between us that I found difficult to stabilise. Perhaps this was an overhang from the student and teacher days, which was fascinating for me, as I have never considered myself a particularly threatening or a power-focused teacher. However, these concepts can be inherent within the teacher role and, as such, it wasn't my perceptions that were important, it was those of my previous student who I was interviewing" (Larkin, 2010: 3; Activity May, personal research diary).

Overcoming perceptions of hierarchy to access mutuality

This raised the issues of power and hierarchy within the research interview and the impact it might have for the success of the data collection. This was a particular concern for this research, as the methodology was from the constructionist paradigm. As suggested by Mills et al (2006: 8), constructionist grounded theory must be based upon *'a position of mutuality between researcher and participant in the research process'*. This is required to facilitate the mutual co-construction of meaning and achieved through a reciprocal approach, ensuring a balance of power by avoidance of perceived hierarchy.

Nairn et al (2005) highlight how themes such as perceived power may impact upon recruitment and also participants' contribution to qualitative interviews. Where hierarchy is perceived, the ability to refuse inclusion may be difficult for the interviewee and they may feel compelled to express a particular perspective to win favour with the interviewer. In the second interview, the midwife had volunteered to participate during a presentation made regarding the research to a small group of midwives.

However, during the interview, there was awareness of a small number of responses which, it was felt, were expressed for the researcher's benefit, such as the source of knowledge being *"a good university education"* (interview transcript, midwife D: line 821). Silverman (2006: 137) warns the researcher against 'identity work' in which the interviewee presents a particular persona. This may be in response to the identity presented by the researcher, or the perception the interviewee had of the intentions of the research or researcher. The researcher was also conscious as her background was education, the midwife participants might believe a particular response was expected, perhaps involving their theoretical knowledge and may feel compelled to present that identity during the interview. To overcome such pre-conceptions, there was a drive to develop a rapport to form trust with the interviewee, acknowledging her anxieties regarding being interviewed and contributing to the research (Charmaz, 2006; Hunter, 2007).

Traditional interview approaches, based upon hierarchy and distance between the interviewer and interviewee have been perceived as promoting a power imbalance, which mutuality and rapport could overcome (Sinding and Aronson, 2003). However, Shah (2006: 211) warns of the dangers of 'overrapport', which can lead to the interviewer assuming insights into the interviewee's perceptions and also places the interviewee in a position of vulnerability, a concern shared by Ryan et al (2011). During attempts to be friendly, there is potential to create exaggerated intimacy, which can manipulate the interviewee into wishing to please and mirror the interviewer. This may occur during the interview, or around the interview, and involve re-affirming valued ideals and identities, in this instance regarding a 'good' midwife and 'good' midwifery practice (Sinding and Aronson, 2003). McCabe and Holmes (2009) liken the interview to the confessional, in which ideas of good and bad may be perpetuated, which is exacerbated by a society in which interview culture dominates and can objectify the interviewee (Denzin, 2001).

This highlights the need to ensure a balance between being the distant and enmeshed interviewer, to ensure narratives are constructed with interviewees and not about them. McCabe and Holmes (2009) suggest reciprocal reflexivity can help the researcher help the participant to explore their actions from new perspectives and therefore both the researcher and research participants may develop new insights into self and the research phenomena, a more emancipatory approach. This was attempted with the second interview, but the researcher was not sure how successful it was. However, if used reflexively, even these less effective interactions may be enlightening, by highlighting strengths and limitations not only in our researcher skills, but the tools, processes and contexts in use (Nairn et al, 2005). As more interviews were undertaken and interview skills were critiqued, technique progressed and reciprocal reflexivity was evident in several of the interactions. For example, during the third interview, as the midwife discussed her practice, she began to also question her actions. She said:

"Oh yeah, God. You're making me think! I'm sitting here thinking, 'How do I assess that?'" (midwife C: line 574).

Seeing when observing

The first few observations arranged were to be with a community midwife in the woman's home and, the night before, the researcher viewed her wardrobe, trying to decide what to wear. The decision was made to choose a smart-casual look, in an attempt to look as if an effort had been made, for the woman and midwife, but without appearing too smart, as if I felt the situation was formal and potentially reinforcing any perceptions of hierarchy or monitoring the process. Burns et al (2012) recount a similarly conscious effort to wear clothing which enabled them to fit in, but also to distinguish differences by avoidance of certain clothing, for example the colour worn by local practice managers, so as not to be perceived as a management spy.

During observational data collection there was an awareness of the need to quickly develop a rapport, to try and minimise the potential impact of presence upon the midwife and woman's interactions and, therefore, the data collection (Lambert et al, 2010). This included the researcher's presence impacting on the midwife who may assume what the intentions were and tailor the assessment with the women to provide the data she perceived was wanted (Labaree, 2002). Hunter (2007) suggested developing relationships and rapport is fundamental to accessing authentic data. Rapport takes time to develop and involves a range of interpersonal skills, including active

listening, respect and empathy (Kawulich, 2005). Hunter (2007: 79) identified how she '*chatted to the woman and her family, held the baby, played with other children, carried the midwife's bag and generally tried to seem warm and friendly and unthreatening*'. There was an attempt to emulate these activities and qualities by carrying equipment, trying to be useful and engaging in the social interactions. One of the advantages of having professional insider knowledge is having access to the shared understanding regarding cultural norms (Labaree, 2002). Therefore, the researcher was aware, as a woman and midwife, of the usual social pleasantries used during initial meetings with women following childbirth, which helped to create a more trusting environment:

"*The first observation I undertook on the community. I had a great day, but was almost so enthralled just to be back in the practice domain seeing the mother and baby that I was, at times, losing focus on what I was trying to particularly observe*" (Larkin, 2010: 1; Activity July, personal research diary).

A lack of focus during this observation did reduce receptiveness to the subtleties of the interaction, such as non-verbal cues and inferences, and subsequently impacted upon the quality of the data produced from this observation (Kawulich, 2005). There was an assumption that an insider position would be an advantage, however, it also had disadvantages. Labaree (2002) warns that insider insights may equate with false assumptions if a reflexive approach is not adopted. Hunter (2007: 78) suggests the midwife researcher must guard against drawing conclusions about what she observes or hears based upon insider knowledge of midwifery practice and '*treat the familiar as strange*'.

With the first observation, the researcher failed to achieve this intention. Due to nervousness, excitement and then being overwhelmed by a return to the practice domain, the researcher thought and observed like a midwife, rather than a researcher with midwifery insight. The researcher assumed understanding and tended to focus more on what action the researcher would undertake next if providing the assessment and care, rather than being sensitive to those cues and responses of the midwife and woman being observed. As suggested by Laberee (2002: 97). It was a case of going 'observationalist' and returning to the native midwife role. Being social was also found to be very difficult (due to being a guest in someone else's home), and it was hard to make meaningful notes without appearing to be monitoring the process:

"*With the second round of observations I undertook, I considered more where I positioned myself within the room. Initially close to the woman when gaining consent and making some pleasantries and then deliberately sitting slightly further away from the woman than the midwife, to try and keep out of eye line. I also took a small notepad and this, seating made it more comfortable to make some brief notes*' (Larkin, 2010: 1; Activity July, personal research diary).

There was an attempt to make chronologically sequenced, detailed notes, however, not every occurrence was noted. Wolfinger (2002) suggests there are two principal approaches to writing field notes: the 'salience hierarchy', in which those issues deemed relevant to the research focus are noted, or 'comprehensive note-taking', in which systematic and comprehensive notes are made of everything that occurred. The researcher's strategy incorporated some elements of both approaches. From a very practical perspective, it was not possible to physically note everything that was occurring within any given context and interaction and so, inevitably, some selection utilising prior professional knowledge of what may be associated with assessment of maternal genital tract wellbeing was inevitable and did occur. Tjora (2006: 433) agrees that researchers must use their tacit professional knowledge to provide a '*significance filter*' regarding what to particularly focus upon during observations and make notes about.

Such subjectivity is an integral aspect of qualitative research such as this. However, selectivity is subjective and, if wielded indiscriminately, it would introduce bias and affect the quality of the data collected and the conclusions drawn from the data, highlighting the need for a reflexive approach to try and minimise such an occurrence (Marshall et al, 2010; Corbin and Strauss, 2008).

Initially, brief notes were made on a small notepad during the observational process, so as not to detract the research participants and make them feel under scrutiny or miss any of the interaction while looking down and making notes. These were developed and expanded and noted on the observation scheduleas soon as was feasible after the event, adding detail from memory (Silverman and Marvasti, 2008; Charmaz, 2006):

"*It is still difficult when writing up overview field notes. I occasionally wonder did something actually happen or do I just think it should have e.g. with a phrase or advice*"(Larkin, 2010: 1; Activity July, personal research diary).

Kawulich (2005) suggests what the researcher recalls will reflect what is documented, what is noted and interpretations may be influenced by limited recall and the values, assumptions and biases of the researcher.

To help reduce this interpretative bias, copies of typed notes were provided to the midwifery participants, in order for them to check and confirm the accuracy, or '*respondent validation*' (Silverman, 2006: 291). The integration of these techniques and processes facilitated successful and trustworthy data collection.

Conclusion

The reality of undertaking research within the midwifery practice area brings rewards, including rich data, but also challenges which must be acknowledged. These day-to-day challenges include gaining access to the research field, gatekeepers and data collection methods. To negotiate these challenges, the midwife researcher must consider her place upon the insider-outsider continuum, be flexible during data collection and develop a rapport with research participants. This case study analysis has highlighted the significance of the researcher avoiding assumptions and adopting a reflexive approach during the research process.

A reflexive approach has minimised any potential bias and excessive subjectivity, while being open and acknowledging subjective influences. This position sits comfortably with the research methodology of constructionist grounded theory. In addition, by ensuring the research processes and techniques are explicit and by attending to quality principles, such as trustworthiness, the transferability of the research findings is enhanced. It was found that maintaining a research diary enabled the questioning of self values and pre-conceptions throughout the research process, which facilitated the development of research skills and abilities.

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Information for authors

Evidence Based Midwifery is published quarterly and aims to promote the dissemination, implementation and evaluation of midwifery evidence at local, national and international levels. Papers on qualitative research, quantitative research, philosophical research, action research, systematic reviews and meta-analyses of qualitative or quantitative data are welcome. Papers of no longer than 5000 words in length, including references, should be sent to: rob@midwives.co.uk in MS Word, and receipt will be acknowledged. Suitable papers are subject to double-blinded peer review of academic rigour, quality and relevance. Subject area and/or methodology experts provide structured critical reviews that are forwarded to authors with editorial comments. Expert opinion on matters such as statistical accuracy, professional relevance or legal ramifications may also be sought. Major changes are agreed with authors, but editors reserve the right to make modifications in accordance with house style and demands for space and layout. Authors should refer to further guidance (RCM, 2007; Sinclair and Ratnaike, 2007). Authorship must be attributed fully and fairly, along with funding sources, commercial affiliations and due acknowledgements. Papers that are not original or that have been submitted elsewhere cannot be considered. Authors transfer copyright of their paper to the RCM, effective on acceptance for publication and covering exclusive and unlimited rights to reproduce and distribute it in any form. Papers should be preceded by a structured abstract and key words. Figures and tables must be cited in the text, and authors must obtain approval for and credit reproduction or modification of others' material. Artwork on paper is submitted at the owner's risk and the publisher accepts no liability for loss or damage while in possession of the material. All work referred to in the manuscript should be fully cited using the Harvard system of referencing. All sources must be published or publicly accessible.

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News and resources

RCM Annual Conference

Top speakers have been confirmed for this year's RCM Annual Conference, which will take place at the Telford International Centre. Among those taking to the stage are the RCM's professor of midwifery Billie Hunter, and Dr Cate Bell of the University of Brighton. More than 1000 midwives and student midwives will attend to discuss topics and research. For more information, or to book tickets, visit: rcmconference.org.uk

Leadership scholarships

The 2013-14 leadership scholarships will close for applications on 18 September. The Florence Nightingale Foundation is offering scholarships to midwives and allied health professionals. The awards are aimed to develop skills and self-confidence to contribute positively to health care. Recipients will undertake a bespoke programme geared to their individual needs. For more information, visit: florence-nightingale-foundation.org.uk

Breastfeeding innovation

Applications are set to open for an annual grant of £10,000 to encourage take-up and duration of breastfeeding. The grant is funded through the partnership between the RCM and Philips Avent and midwives can apply from 19 September. It is open to all practising UK midwives who are RCM members and who wish to fund a new initiative to support breastfeeding. The scheme should focus on a defined population and have clear objectives and evaluation of outcomes. Further information will be published at: rcm.org.uk

Last chance to apply

There are just a few weeks left to apply for the Wellbeing of Women research grants. The grants, offered in collaboration with the RCM, include an entry-level scholarship, an international fellowship award – applications for both of which close on 13 September – and a research training fellowship, with applications closing on 6 September. For more information and to apply, visit: wellbeingofwomen.org.uk

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