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**INVOLVING SERVICE USERS IN THE ASSESSMENT OF THE
PERFORMANCE OF PRE-REGISTRATION STUDENT MIDWIVES
– AN INTERPRETIVE STUDY OF THE PERCEPTIONS OF KEY
STAKEHOLDERS**

GWENDOLEN BRADSHAW

**A thesis submitted to the University of Huddersfield
in partial fulfilment of the requirements for
the degree of Doctor of Education**

January 2003

CONTENTS

ABSTRACT i

LIST OF TABLES ii

LIST OF FIGURES ii

LIST OF HISTOGRAMS iii

LIST OF APPENDICES..... vi

ACKNOWLEDGEMENTS..... vii

GLOSSARY viii

CHAPTER 1 – INTRODUCTION..... 1

 The professional context for the study..... 1

 Changing perspectives of midwifery practice and education 2

 The intentions of the study 7

 The structure of the study 7

 Organisation of the thesis 9

CHAPTER 2 – THE REVIEW OF THE LITERATURE 10

 The nature of knowledge within the midwifery curriculum 10

 Learning in the context of the midwifery curriculum..... 12

 Assessment as part of learning 21

 The process of assessment..... 31

 Midwifery practice and the concept of competence 36

 Evidence and its role in the assessment process..... 44

 Mentors and their contribution 47

 Performance, achievement and fitness for purpose 48

 Student involvement in the learning and assessment process 51

 Existing evidence of consumer involvement in assessment..... 59

 Conclusion 61

CHAPTER 3 - THE STUDY DESIGN AND METHODOLOGY 64

 Approaches to the study – an overview 64

 The positivist and interpretivist approaches 64

 Validity and reliability - some challenges 69

 Ethical issues 70

 Phase 1 73

 Data collection..... 77

 Data Collection Phase 2..... 83

 Data Analysis..... 85

Limitations of the Study	93
Conclusion	94
CHAPTER 4 - PHASE 1 FINDINGS.....	96
The midwife-woman, student-woman relationship	97
Listening to women	102
Power and the therapeutic relationship between the student midwife and women ...	103
Students' knowledge of theory and practice	105
How students learn and gain confidence	108
Developing students' ability to reflect.....	111
Student feedback and the role of women.....	114
The development of professional attitudes	125
The development of clinical skills.....	128
The place of honesty.....	130
Assessment and the use of multiple perspectives	132
Handling competing expectations.....	139
Selecting women as assessors.....	140
Preparing women for an assessment role.....	143
Providing better quality care.....	144
Conclusion	147
CHAPTER 5 - PHASE 2 FINDINGS.....	148
Findings from the textual data	148
Student-Women relationships and their influence on practice	149
Feedback and the learning process	151
Ascertaining levels of competence and the issue of validity	156
The overall principle of women's involvement in student assessment	158
Survey Findings – Summary Statistics	162
Conclusion	166
CHAPTER 6 - DISCUSSION OF THE FINDINGS	167
The midwife-woman, student-woman relationship	167
Listening to women and valuing their contribution.....	170
Power and the therapeutic relationship between the student midwife and women ...	171
The need to minimise vulnerability and empower women.....	172
The nature of knowledge within the midwifery curriculum	173
Learning in the context of the midwifery curriculum.....	176
Assessment as part of learning	178
Developing strategic learners.....	180
Autonomy and life long learning	183
Validity and the assessment process.....	184
Assessment and the use of multiple sources – adding women's perspectives.....	185
Reflection.....	187
Feedback from women and the achievement of competence	190
Feedback in relation to psychomotor skills	193

Professional attitudes and values	194
The place of honesty and competing expectations	196
Providing better quality care.....	197
The ability of women to be involved in the assessment process	199
The selection and preparation of women.....	200
Choice for women.....	202
Conclusion.....	203
CHAPTER 7 CONCLUSIONS, RECOMMENDATIONS AND PROPOSALS FOR FURTHER RESEARCH AND CURRICULUM DEVELOPMENT.....	204
Involving women in student assessment – inputs, processes and outcomes of the study	204
NHS policy and the service user as a consumer	207
Experiential learning theory and the assessment of student midwives.....	211
A partnership approach to care	215
The quality of care and the evolving nature of competence	216
Recommendations for further research.....	218
Recommendations for curriculum change to permit women’s formal participation in the assessment of student midwives	220
Postscript	225
REFERENCES	227
APPENDICES	253
Appendix 1 - Midwives Rules.....	253
Appendix 2 - Midwifery Competencies.....	255
Appendix 3 - Questionnaire - Section 7 Personal Information.....	265
Appendix 4 - Interview Schedule	267
Appendix 5 - Questionnaire.....	271
Appendix 6 – Histograms	279

ABSTRACT

This study investigates the perceptions of key stakeholders in midwifery education concerning the involvement of service users in student assessment. It identifies the key stakeholders in specific interest groups, as expert professional and expert lay people, parents, student midwives, qualified midwives who mentor students in clinical practice and the heads of midwifery education in University Departments. The work starts from the premise that assessment is an underestimated means of enhancing students' learning and the development of competence to practise as a registered midwife.

The inquiry opens by examining the professional context in which maternity services are provided. It identifies the relationships that midwives form with the women and their families for whom they care.

These considerations are followed by an interrogation of the literature that reveals a rich variety of interlocking concepts that are apposite considerations in terms of the assessment of student midwives and the involvement of women in it. This firmly links the problem to previous research and provides a sound rationale for the conduct of the study.

Interpretivism is advanced as a suitable philosophical framework for the prosecution of the study that offers a methodological rationale for a pragmatic, mixed methods investigation. The study design presents a *raison d'être* for a phased approach to the work and data are accrued variously from qualitative and quantitative sources.

Although the focus of the work concerned the role of users of maternity services in student assessment and found considerable support for their involvement, what emerged has wider consequences for teaching and learning, the overall student experience and also for women as health service consumers.

Having examined the principle dynamics that influence student learning in clinical placements, the study concludes that there is a superficial disharmony between learning and assessment yet it claims the two are mutually complimentary. The inclusion of women in teaching and learning is seen as a potent means to add an extra element to the definition of competence and to add to the authenticity of its assessment.

LIST OF TABLES

		Page
Table 1	Questionnaire Section 1 – Fitness for Practice	162
Table 2	Questionnaire Section 2 – Partnership Approach	163
Table 3	Questionnaire Section 3 – Autonomy in the Learning Process	163
Table 4	Questionnaire Section 4 – Feedback to Students	164
Table 5	Questionnaire Section 5 – Validity of the Assessment Process	164
Table 6	Questionnaire Section 6 – Feasibility	165
Table 7	Questionnaire Section 7 – Personal Information	266

LIST OF FIGURES

		Page
Figure 1	Structure of the study	8
Figure 2	Literature review themes	10
Figure 3	Structural dimensions underlying the process of experiential learning	14
Figure 4	The Johari Window	25
Figure 5	Model of the key processes needed for successful learning	28
Figure 6	A Model of Competence in Midwifery	42
Figure 7	Data analysis A Summary	86
Figure 8	Template analysis of Phase 1 – a synopsis	96
Figure 9	Template analysis of Phase 2 – a synopsis	148
Figure 10	Schematic Representation of inputs, processes and outcomes of the study	205
Figure 11	Recommendations for further enquiry	219

LIST OF HISTOGRAMS

Section 1 Fitness for practice

	Page
Histogram 1 Worth and not worth learning (Question 1)	279
Histogram 2 Focused Feedback (Question 2)	279
Histogram 3 Women friendly care (Question 3)	280
Histogram 4 Art of caring (Question 4)	280
Histogram 5 Doing the job (Question 5)	281
Histogram 6 Women’s influence on care (Question 6)	281

Section 2 Partnership approach

Histogram 7 Partnerships (Question 7)	282
Histogram 8 Client centred care (Question 8)	282
Histogram 9 Women’s interest in students (Question 9)	283
Histogram 10 Learning from women (Question 10)	283
Histogram 11 Empowering women (Question 11)	284
Histogram 12 Quality of care (Question 12)	284

Section 3 Autonomy in the learning process

Histogram 13 Weaknesses and strengths (Question 13)	285
Histogram 14 Motivation to learn (Question 14)	285
Histogram 15 Feedback and learning (Question 15)	286
Histogram 16 Reflection (Question 16)	286

Section 4 Feedback to students

Histogram 17 Theory practice gap (Question 17)	287
Histogram 18 Feedback – clinical skills (Question 18)	287
Histogram 19 Feedback – knowledge base (Question 19)	288
Histogram 20 Feedback – values (Question 20)	288
Histogram 21 Feedback – attitudes (Question 21)	289

Section 5 Validity of the assessment process

Histogram 22 Validity (Question 22)	289
Histogram 23 Expectations and bias (Question 23)	290
Histogram 24 Perception of care (Question 24)	290
Histogram 25 Course Management Team (Question 25)	291

Section 6 Feasibility

Histogram 26 Preparation for women (Question 26)	291
Histogram 27 Summative (Question 27)	292
Histogram 28 Formative (Question 28)	292
Histogram 29 Student involvement (Question 29)	293
Histogram 30 Women as a learning resource (Question 30)	293
Histogram 31 Involve all women (Question 31)	294
Histogram 32 Choice for women to make a contribution (Question 32)	294
Histogram 33 Feedback – format and choice for women (Question 33)	295

Section 7 Personal Information

Histogram 34 Years qualified as a midwife (Question 34)	265
Histogram 35 Years as a midwifery lecturer (Question 35)	265
Histogram 36 Years as an approved midwife lecturer (Question 36)	266

LIST OF APPENDICES

	Page
Appendix 1 Midwives Rules	253
Appendix 2 NMC Midwifery Competencies	255
Appendix 3 Approved Midwife Teachers – Professional Details	265
Appendix 4 Interview Schedule	267
Appendix 5 Questionnaire	271
Appendix 6 Histograms	279

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GLOSSARY

ANTENATAL CARE	The care of women during pregnancy by doctors and midwives to predict and detect obstetric complications that might occur in the mother or the unborn child. Comprehensive advice is also offered on matters relevant to pregnancy and birth during this period of care.
APPROVED MIDWIFE TEACHER	The Approved Midwife Teacher is appointed by the English National Board and is responsible for overseeing the quality of all midwifery programmes of education and training at their respective Higher Education Institutions.
CONFIDENCE	Women whose pregnancies are managed by experienced student
CASE LOAD	midwives under the indirect supervision of her mentor.
CONSUMER	A discerning user of the maternity services who has considered and understood the options and who exercises choice in the nature of her maternity care.
DEPARTMENT OF HEALTH	The Department of Health of Her Majesty's Government.
ENGLISH NATIONAL BOARD	The English National Board for Nursing, Midwifery and Health Visiting was the regulator of midwifery education in England until 1 April 2002.
HIGHER EDUCATION INSTITUTION	Universities and Colleges that provide Pre-registration Midwifery programmes.
INTRAPARTUM	The period of time denoting the duration of labour.
MATERNITY SERVICE LIAISON COMMITTEE	Maternity Service Liaison Committees are set up by each Health Authority. Membership includes representatives from professional groups involved in maternity services and lay representatives. Their aim is to make possible and sustain the co-ordination of services between the various professional groups involved in maternity care and especially between community based primary care and acute hospital trusts where most babies are born.
MENTOR	The term mentor is used to denote the role of the clinically based registered midwife who supports learning, supervises and assesses students in the practice setting.

MULTIGRAVIDA	A women who is pregnant and has previously had at least one other pregnancy.
NATIONAL CHILDBIRTH TRUST	The National Childbirth Trust is a charitable organisation that acts as a pressure group for the improvement of maternity services.
NATIONAL HEALTH SERVICE	The National Health Service is the state financed system of health care in the United Kingdom.
NURSING & MIDWIFERY COUNCIL	The Nursing and Midwifery Council is the overall statutory body governing nursing midwifery and health visiting. It came into being in April 2002 in succession to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
POST NATAL	A period of time denoting the weeks and months following childbirth.
PRIMIGRAVIDA	A woman who is pregnant for the first time.
SERVICE USER	The standard term used in NHS policy documents to denote a woman who accesses maternity services.
THIRD TRIMESTER	The final three months of a pregnancy.
UNITED KINGDOM CENTRAL COUNCIL	The United Kingdom Central Council for Nursing, Midwifery and Health Visiting was the overall statutory body governing nursing midwifery and health visiting prior to April 2002.
WOMAN/WOMEN	The term commonly used within maternity services to define both individuals and also collectively, all of those using health services that are provided by midwives during pregnancy, labour and the postnatal period.

CHAPTER 1 – INTRODUCTION

The professional context for the study

This study concerns the enhancement of learning through assessment in pre-registration midwifery education. The work originated from the premise that the single most effective way of enhancing learning is by ensuring that the assessment process is motivating and productive (Holroyd, 2000). It was further stimulated by the policy of the then statutory regulator of midwifery education, the English National Board (ENB), through the pronouncement in its document 'Learning from Each Other', that service users were to be involved at every juncture in the planning and delivery of its courses (ENB, 1996). The study therefore, is an evaluation of the feasibility of an aspect of this education policy concerning user involvement that compliments the larger Government agenda for their greater empowerment (DOH, 2002a; DOH, 2002b)

There is a legal requirement in Britain for all student midwives to demonstrate clinical competence as a mark of their fitness to enter the profession safely and be eligible to register as a practising midwife. How this professional competence is assessed is a central concern of the study (Worth-Butler et al, 1996). Before considering the assessment of midwifery students in detail, it is worthwhile summarising some current perspectives on both midwifery practice and midwifery education. The professional relationships midwives have with the women for whom they care forms the fundamental starting point. Students require the necessary skills to negotiate these relationships to prepare them to be registered as competent, autonomous practitioners. The potential for the women who are users of maternity services to make a contribution to the development

of these skills is explored through an analysis of the learning process with a particular emphasis on the part they might usefully play in student assessment.

Changing perspectives of midwifery practice and education

The uniqueness of midwifery and the place of the consumer

Considerable rhetorical and anecdotal evidence exists claiming that midwives are unique and that they occupy a caring role that is very different from that of nurses and doctors. This argument has always been sustained on the basis that historically, midwives adopted a more holistic and less reductionist approach to care than other health professionals and have placed a particular emphasis on well-being rather than illness (Bennett and Brown, 1999). Recent times however, have seen a sea change in the practice of health care. Some quite fundamental philosophical developments have occurred. These concern the new political and policy emphasis on patient involvement and consumerism and the cultural changes that make this traditional explanation about the inimitability of midwifery difficult to uphold (DOH, 1999; DOH, 2000a; DOH, 2000b; DOH, 2002a; DOH, 2002b). In the wake of these changes there seems a need to reconsider the evidence and explore the concept of midwifery again. Conversely however, a recent convincing doctoral study provides evidence to sustain the claim that the unique status for midwives is indeed defensible (Wilkins, 2000). This work argues that the distinctiveness of midwifery resides in the midwife-woman relationship. ¹So the debate continues.

¹ Whilst the aim of the study was to explore the case for greater involvement of women in the determination of student competence, fathers of new babies were included in an aspect of the work because of their increasing involvement in the process of care during pregnancy and childbirth. In effect fathers are secondary clients of the midwife and there is a statutory requirement for midwives to consider them within a plan of care.

Conventional definitions of professionalism and their associated masculine perspectives emphasise the promotion of rational, objective and formal knowledge and place the health professional in a privileged position of power (Wilkins, 2000). Indeed, there is a long history of authoritarianism within general health care professional circles both in practice and educational settings and it is interesting to consider from where this power emanated (Gear, 1990; Milligan, 1998). On the one hand it could be argued that it derived from a transparent and sound scientific professional basis, whilst on the other hand, some argue that it arose as a result of the mystique associated with professional knowledge and skills (Ellis, 1988). Midwives generally however, do not subscribe to a view that places them in a position of superiority to the women for whom they care and this difference alone sets them apart from other health professionals at an ontological level (Oakley, 1992; Bluff and Holloway, 1994; Wilkins, 2000). What is also apparent is that women who have resisted professional power and pursued more control over their care and achieved it, fare better psychologically in their experience of maternity services (Hutton and Shepherd, 1995; Frazer, 1999).

There have been many studies concerning professional/patient relationships and power. In recognition of the difficulties professional relationships may pose, the UKCC produced guidelines for practitioners (UKCC, 1999a). Whilst it is undeniable that associations between midwives and women are mediated to some extent through the authority midwives undoubtedly possess, a model of care that incorporates mutual participation is generally regarded as the most appropriate (Bluff and Holloway, 1994; Newburn, 1995). Midwives are not unaware of the inequalities between themselves and women and seek to

alleviate powerlessness, ignorance and dependence. This view of professional practice has an unambiguous relevance to the preparation of student midwives and their relationships with those in their care (Szasz and Hollender, 1956; Heron, 1988; Wang, 1995; NMC, 2002). Mutuality is a complex matter and midwives attempt to create an alliance with women on equal terms. Midwives have a more expert but general knowledge of a pregnancy and its management and women have a personal experience of it because only they know their own feelings, social circumstances, habits, attitudes to risk, values and preferences. Both types of knowledge are needed to manage a pregnancy successfully with the open recognition that women can be experts too. Accepting that element of personal knowledge allows women to share responsibility for their care and to be offered rational, practical choices that remove the expectation of passivity. Blatant consumerism in its generally accepted sense is not an option but an appreciation that the midwife does not always know best provides a recipe for the coalition that is needed. Whilst characterised by empathy, the affiliation between midwives and women includes elements of friendship, partnership and teamwork. One recent study about the notion of mutuality confirms that midwives are set apart because of the particular type of collaboration they have with women. This reinforces the view that they are equals with different expertise and implies the sharing of power by midwives rather than the occupation of a privileged position (Hunt and Symonds, 1995; Lawson, 1995; Donley, 1997; Leap, 2000). It constitutes a non hierarchical association based on trust and mutual respect for each others skills and a coalition that is valued by both parties (Gooch, 1989; Page, 1993; UKCC, 1999a; Sandall et al, 2000). The interactive nature of such a relationship has been said to possess,

a potential for both parties to learn from each other (Leap, 2000:3).

This potential for reciprocal learning between professionals and service users has also been demonstrated by Blasco et al (1999) who produced evidence of mutual learning in a paediatric context as a result of parents participating in medical student training.

At a paradigm level, midwives do not exclusively promote rational, objective and formal knowledge. Their roles also openly acknowledge the significance of experience, its associated tacit knowledge as well as degrees of subjectivity and emotion. To this end the humanistic components of knowledge need to be emphasised within the midwifery curriculum.

The value of this midwife-woman affiliation is being strengthened as more research-based evidence becomes available concerning shared information, shared decision making, shared responsibilities and shared evaluation (Kirkham, 2000). Producing midwives who are capable of sustaining the exclusivity of midwifery as identified thus far, presents substantial challenges to those in the field of midwifery education. How the student-woman relationship is developed and nurtured is fundamental therefore, to the development of this partnership approach. How students interact with women as they learn, provides a strong rationale for its investigation. This suggests that the more traditional approaches to learning and assessment need to be challenged if collaborative relationships are to be a reality for the student midwife and are not merely something they begin to develop once they are qualified and are practising (Hendry et al, 1999). Introducing changes in the curriculum to emphasise alliances with women is not without its difficulties, especially in relation to student assessment. Despite the general

acceptance of egalitarianism within the profession, there is a need to relinquish control within the assessment process by those who hold it (Szasz and Hollender, 1956; Griffith, 1987; Milligan, 1997; Hall and Holloway, 1998; Beresford et al, 2000; Neary, 2000). Traditionally the power base within student assessment was with the lecturers and mentors whose prerogative it has been to make judgements about students (Wolf, 1979; Bedford et al, 1993; Longworth and Davies, 1996). Yet because assessment is an integral part of the learning process, the contribution that women may make to the assessment of student midwives has been arguably underestimated and they have not always been afforded the recognition they deserve. It has to be accepted that little is known about the willingness of women to take responsibility in assessment activities. Their involvement should certainly not be a burden to them so presumably the skill will reside in identifying those women who wish to participate and those who do not? (Cain, 1997).

The consumer of health care as a citizen

It is generally acknowledged that women are indispensable to the training and education of student midwives as is the case for service user involvement in the training and education of most other health care professionals (Wykurz, 1999). Yet in a sense women are often treated as though they were a 'teaching aid', thus limiting their potentially valuable contribution. The concept of citizenship is an interesting one in the context of this study regarding the enhanced role women might play in the education of student midwives. Seeing women as 'citizens' rather than 'subjects' would change their status and further support the partnership relationships that have been identified. In the context of this study, this places women and their families at the 'hub' of the maternity services

‘wheel’ with midwives and student midwives representing its spokes. Citizenship also conjures up thoughts of rights, recognition and the responsibilities of women and this introduces an additional necessity to guard against the risk of exploiting women within the educational context.

The intentions of the study

The study is set within the context of changing perspectives of midwifery practice and midwifery education that is emphasising increased user involvement. Given the diverse and complex aspects of student assessment, the aim of the work was to explore the case for greater involvement of women in the determination of student competence, through the perceptions of key stakeholders. The key stakeholders are regarded as the following:

- a) Key expert professionals and key lay informants
- b) Parents
- c) Student midwives
- d) Those midwives who act as mentors to student midwives
- e) All ENB Approved Midwife Teachers

The structure of the study

The study was conducted in two principal phases as follows:

Phase 1 comprised semi-structured interviews with key informants with a vested interest in getting better midwifery services for women. Focus group interviews with separate groups of student midwives, mentors and parents of newly born babies followed this.

Phase 2 consisted of the design and administration of a self-response questionnaire to all ENB Approved Midwife Teachers, excluding the researcher. The structure of the study is depicted in Figure 1 below.

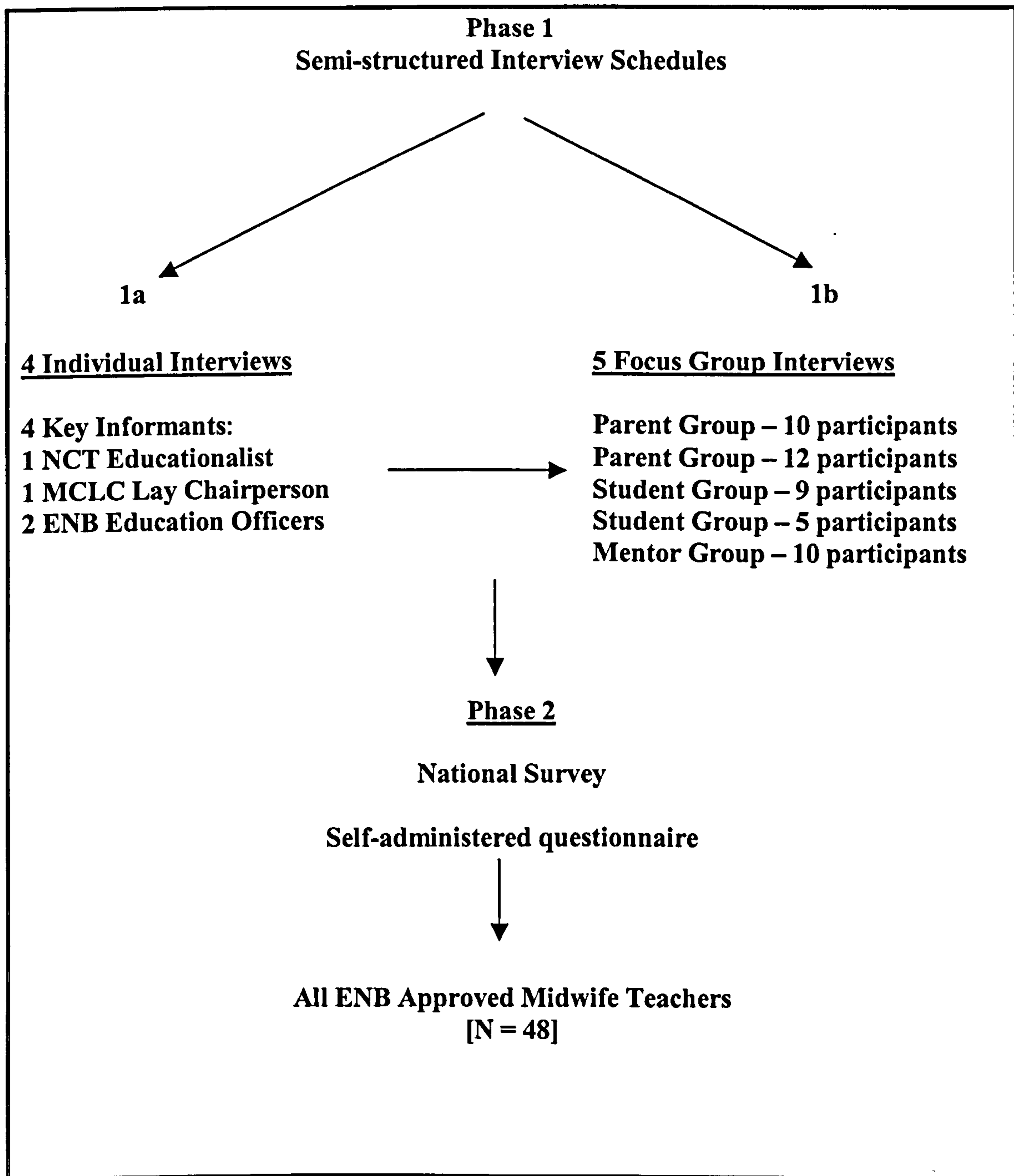


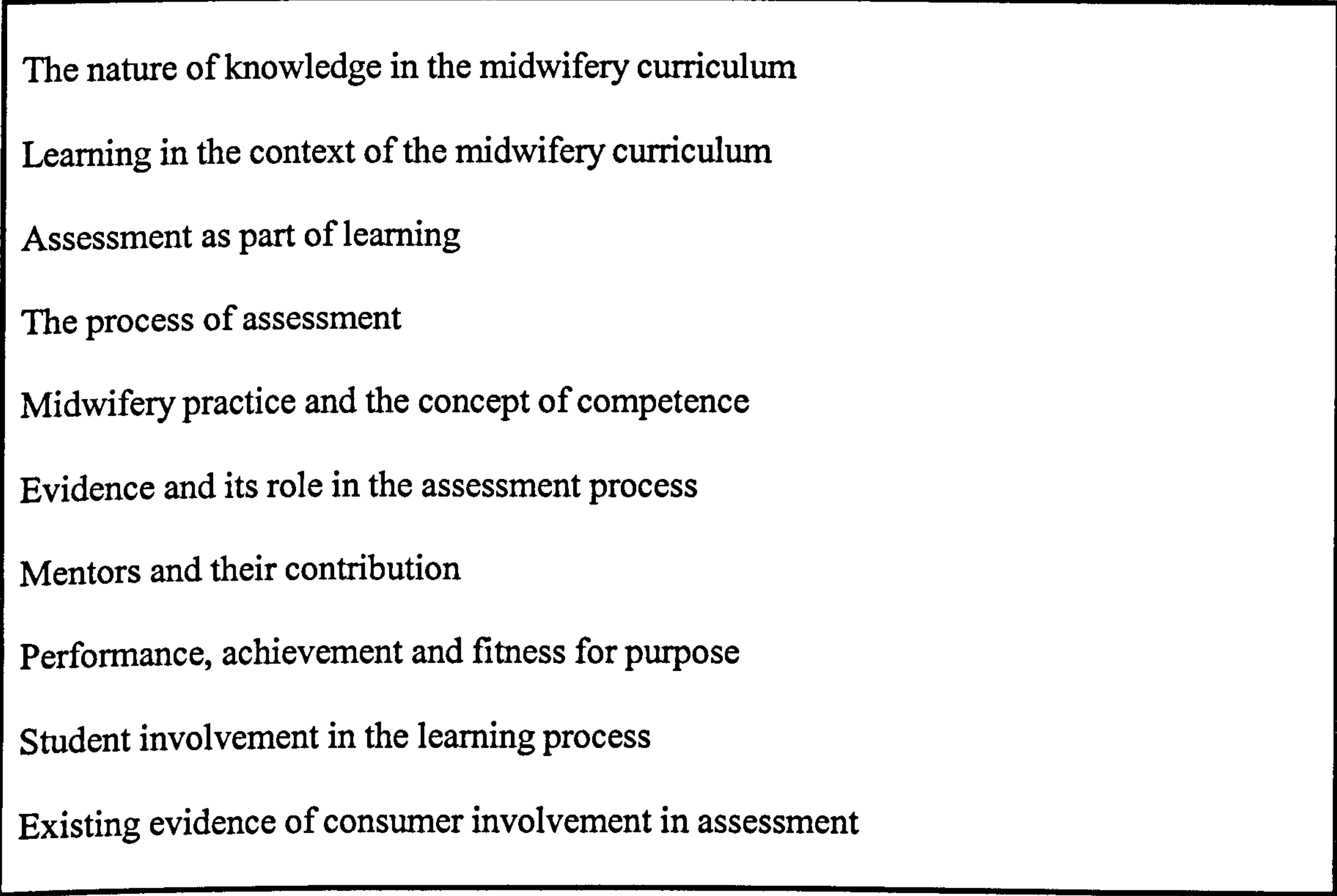
Figure 1 Structure of the study

Organisation of the thesis

The remainder of this thesis is organised as follows. Chapter 2 presents a review of the literature in relation to the theoretical underpinnings for the work. Chapter 3 explores methodological issues and provides a rationale for the approaches adopted. Chapter 4 captures Phase 1 of the study with a presentation of the findings from individual and focus group interviews. This is followed by a presentation of the findings from Phase 2 in chapter 5. An overview of the findings and discussion is presented in chapter 6. Emerging issues for further research and recommendations are delineated in chapter 7.

CHAPTER 2 – THE REVIEW OF THE LITERATURE

This chapter will interrogate the literature that forms the justification for the study. Of necessity, the review is selective in addressing a range of concepts that underpin the preparation of midwives. Reference is also made to the literature on nursing because it shares many challenges that are transferable to midwifery. Several relevant themes emerge from the literature. These are not mutually exclusive and do overlap but for practical purposes they can be categorised as follows:



- The nature of knowledge in the midwifery curriculum
- Learning in the context of the midwifery curriculum
- Assessment as part of learning
- The process of assessment
- Midwifery practice and the concept of competence
- Evidence and its role in the assessment process
- Mentors and their contribution
- Performance, achievement and fitness for purpose
- Student involvement in the learning process
- Existing evidence of consumer involvement in assessment

Figure 2 Literature review themes

The nature of knowledge within the midwifery curriculum

There are a number of ways of describing or defining the nature of knowledge that are dependent upon its purpose (Taylor, 2000a). From the perspective of the caring

professions and of midwifery, these purposes have been succinctly summarised by Carper (1978) as empirical or scientific knowledge, aesthetic knowledge capturing the art of caring, knowledge of self and ethical knowledge. Given that midwifery is an applied field of study and practice, the relationship between these different aspects of knowledge is a very interesting and important one (Jinks, 1994; Radnor and Shaw, 1995; Riding and Rayner, 1998; Rosie, 2000).

Originally, during the early 20th century, scientific knowledge was the organising paradigm within the midwifery curriculum. In recent times humanistic knowledge has assumed greater importance with a corresponding increase in the significance of the clinical placement within the curriculum (Jarvis and Gibson, 1997). This has created much debate about the development of the professionally skilled, knowledgeable doer (ENB and OU, 2001). This view is not new and it has been long regarded that any skill is,

as much an art of doing as it is an art of knowing (Polanyi, 1962:54).

It can be argued that knowledge, as defined within the vocational curriculum and succinctly articulated by Carper (1978), can be seen to exist on a continuum. This continuum possesses many components of procedural knowledge concerning skill development at one end and many components of easily articulated propositional or empirical knowledge at the other (Gonczi, 1999; Jones, 1999). This has serious implications for midwifery that has adopted the stance of not taking a dichotomous approach to these different types of knowledge. Its chosen allegiance allows knowledge that underpins performance to exist at various points on the continuum dependent upon

the context within which the student finds herself. Clearly a great deal of midwifery theory has an empirical basis. But the profession's approach to knowledge recognises that learning in the clinical environment does not occur by osmosis. Rather students should acquire the necessary procedural and propositional knowledge through a deliberate approach that encourages them to reflect on their experiences and identify what and how they have learned (Benner, 1984; Boud, 2001a; Stephenson, 2001).

Learning in the context of the midwifery curriculum

Educational theories

Teaching, learning and assessment are patently value laden. So there is a need for a rationale and for a coherence of any theories that are applied to teaching, learning and assessment contained within a curriculum (Cumming and Maxwell, 1999). Theories relating to the ways in which adults learn have been much debated. The initial presentation of pedagogy and andragogy as polar opposites by Knowles (1984) helped to stimulate this debate (Darbyshire 1993; Milligan, 1997). More recent developments that place andragogy within the wider conceptual framework of pedagogy are seen as a more constructive means of gaining an understanding of the subject (Savicevic 1991; Knowles, 1984; Knowles et al, 1998; Neary, 2000). It has been suggested, given that there is no exact science or theory of adult learning, that approaches can be placed on a spectrum ranging from behaviourism to humanism (Brockbank and McGill, 1998). In keeping with the philosophy of midwifery care espoused in *Changing Childbirth* (DOH, 1993), a humanistic approach to the education of student midwives seems appropriate. The humanistic, experiential perspective of learning provides a very useful framework for the

facilitation of learning within a midwifery practice setting, given the focus on the student's current experiences and the importance placed by the DOH on good quality practice placements (DOH, 2000a; ENB and DOH, 2001a). It has been argued that experiential learning captures the essence of many existing theories of learning and provides a practical framework (Beard and Wilson, 2002). The student gains understanding and knowledge through experiences and the level of knowledge and the degree of understanding develops as these have their impact on learning (Kolb, 1984; Quinn, 1995). Learning in this context is seen as,

the process whereby knowledge is created through the transformation of experience (Kolb, 1984 :38).

Knowledge in this sense is not perceived as something that is transmitted to and memorised by learners. Knowing becomes a transforming process whereby the students are stimulated to inquire and generate knowledge and gain a personal understanding either directly from their own experiences, or by placing themselves within the experience of others. In the context of this study, this includes quite legitimately, those for whom they care (Melamed, 1987). Leading thinkers including Dewey, Lewin and Piaget in their respective theories, all adopt a similar approach to the learning process in that they all value experience and see it as an integral part of that process (Brockbank and McGill, 1998; Torrance and Pryor, 1998; Heron, 1999; Neary, 2000). A very helpful model representing the various stages in the use of experience as a means of learning has also been proposed by Kolb (1984) and outlined in Figure 3 below.

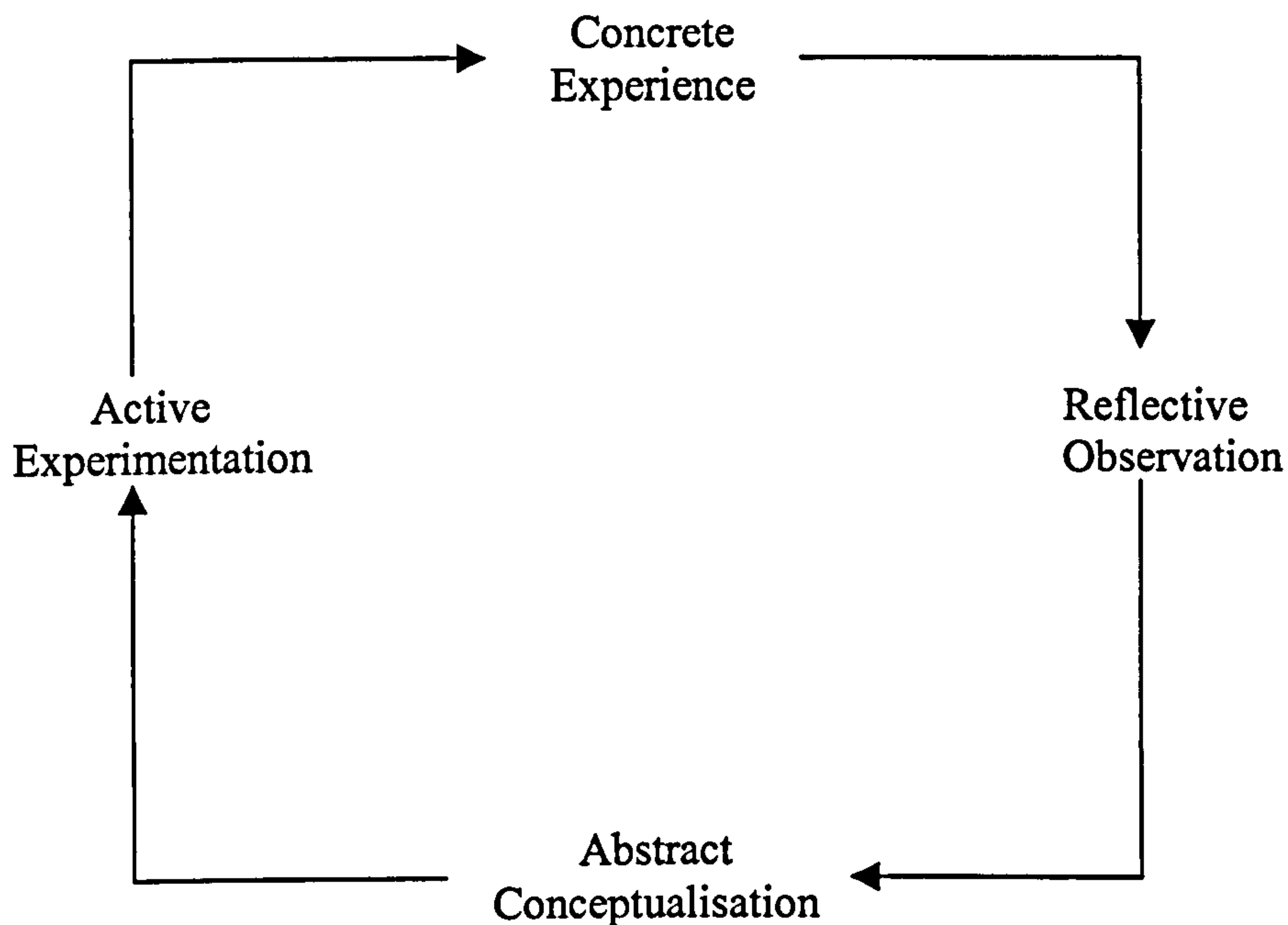


Figure 3 Structural dimensions underlying the process of experiential learning (Kolb, 1984:42).

Generating knowledge and understanding in this way does not enjoy unanimous support due to its perceived lack of rigour. It is however, gaining in credence as theories in relation to work-based learning which incorporate broader social and psychological dynamics and complexities are developed and tested (Greenwood, 1993; Torrance and Pryor, 1998; NHSE, 1998; Hager, 1999). Rogers (1996:107) believes that,

There is a growing consensus that experience forms the basis of all learning.

The challenge for midwifery remains one of producing caring, questioning and critical thinking practitioners who can utilise tacit, procedural and propositional knowledge.

Learning from clinical experience

Both past and present experience can have a positive as well as a negative influence on adult learners and affect their levels of confidence (Stephenson and Weil, 1992; Hanson, 1996; Neary, 2000). So there must be an explicit strategy within the curriculum to ensure that experience does lead to learning because no assumptions can be made that it will take place automatically (Benner, 1984; Postle, 1993; Bewley, 1995; NMC, 2002). Given the complex nature of midwifery practice and the types of experiences in which students will be involved in or exposed to, there are varying opportunities for learning in the psychomotor, cognitive and affective domains. It is important therefore, to be aware of emotions and feelings generated through past experiences which may be mis-educative and block learning. Emotional awareness as a concept is receiving greater attention. Boud and Miller (1996:17) believe that,

The affective experience of learners is probably the most powerful determinant of learning.

Indeed Goleman (1996) drawing on the work of Salovey and Mayer (1990) provides a classification of emotional intelligence. He identified five main domains; knowing ones emotions, managing emotions, motivating oneself, recognising emotions in others and handling relationships.

Because students edit, deny or are blind to aspects of clinical experience, there is always the potential to restrict the learning that occurs (Postle, 1993; Neary, 2000). Learning strategies within the curriculum therefore, should take account of emotional intelligence

and address such impediments by providing students with opportunities to identify and deal with them in a trusting and safe learning environment.

Practical experience can become, through an interpretative or reflexive process, a form of personal knowledge for students (Usher, 1993). Yet despite the use of this interpretative process, learning from experience can be less spontaneous than it may often be portrayed to be, hence the need to have a formal strategy within the curriculum to facilitate this potentially very valuable source of learning (Usher, 1993).

Reflection

The contribution that reflection can make to learning has been extensively researched (Argyris and Schon, 1974; Kolb and Fry, 1975; Schon, 1983; Boud et al, 1985; Kemmis, 1985; Gibbs, 1988; Atkins and Murphy, 1993; Ixer, 1999; Johns, 2000). There are also many definitions of reflection to be found at the technical, practical and emancipatory level. For the purposes of its use within the clinical component of a pre-registration midwifery programme it can be defined as follows,

Reflection leads to interpretation for description and explanation of human interaction in social existence. (Taylor, 2000a:4).

Whilst it is not the intention here to explore theories in relation to reflection in any great detail, a brief conceptual analysis is worthwhile concerning the part it has to play in the midwifery curriculum. It is generally agreed that the ability to reflect *on* and *in* practice leads to effective learning *from* practice (Rosie, 2000; NMC, 2002). Indeed it could be argued that without reflection, learning potential can be missed, with experiences simply remaining as memories (Pearson and Smith, 1985; Chambers, 1999; Neary, 2000).

Following an intensive and rigorous review of pre-registration midwifery education it was concluded that,

reflection on and in practice offers midwives a useful, if not the best, source of meaningful knowledge (Frazer et al 1998:25).

Not all are so enamoured with the use of reflection however and some would argue that it has gained in prominence through its use, almost as a panacea to mop up the difficulties that competency based education poses (Edwards and Knight, 1995). Others question its fundamental appropriateness for the profession of nursing arguing that nurses do not have sufficient time to reflect and should be guided by various systems, processes and protocols in the decisions and subsequent actions they take (Ixer, 1999). This view is transferable to midwifery and Ixer (1999) goes on to emphasise that Schon's original work in relation to reflection concerned architects whose day to day job differs considerably from nurses and midwives whose occupational demands do not automatically allocate protected time for reflection.

Student midwives however, are becoming more familiar with reflection as the development of reflective capabilities features in most pre-registration courses for health care students who are being encouraged to learn from their day to day experiences through the use of reflection (Rowan and Steele, 1995; Johns, 2000; ENB and DOH, 2001a; NMC, 2002). This enables students to identify not only what they know but also how they learn (Thorpe, 2000). Reflection therefore, is seen as an important characteristic of a higher education where midwifery is now located. Despite Ixer's pessimistic view, reflection is considered by many to be integral to the role of the

practising nurse and midwife and therefore warrants serious consideration (Bradshaw, 1989; Purdy, 1997; Brockbank and McGill, 1998). By embedding reflection within the curriculum as a means of learning, the pre-registration programme can be tailored to the individual student experience as well as meeting the requirements of the professional body (Dewar and Walker, 1999). It has been argued that the process of reflection on practice,

validates personal experience as the foundation for learning (Dewar and Walker, 1999:1465).

Reflection is linked inextricably to practice and the notion of taking a more responsible approach to the standard of care delivery by learning from previous experience and its associated feedback, lead to the application of that learning in new future circumstances (Dewing, 1990; Rust, 2002). As with all clinical learning, reflection on practice cannot be taken for granted. Just because students understand the concept it does not necessarily mean that they can automatically engage in what is a complex endeavour (Brockbank and McGill, 1998). Care must be taken to ensure that the process is managed because there is the danger that it is capable of inducing a destructive cycle of self-criticism leading to self-doubt (Brookfield, 1986; Atkins and Murphy, 1993; Studdy et al, 1994; Quinn, 1998; Stefani, 1998; NMC, 2002). Even when presented in a constructive way, student midwives can still find the process threatening as they critically re-assess their knowledge, values and feelings and are exposed to uncertainty and doubt. It has been argued therefore, that adequate student support should be available as the focus on clinical learning becomes translated into a sustained change in practice (Kemmis 1985; Hanson, 1996).

Reflection in the midwifery curriculum is thus seen as a very structured, context specific activity and there are many models of reflection providing logical reflective cycles available to students (Gibbs, 1988; Heywood, 2000; Johns, 2000). These approaches to learning are in direct contrast to the much criticised focus on abstract learning with which many students are familiar (Kolb, 1984; Thorpe, 2000). Reflection can be emancipating. Custom and practice and taken for granted assumptions that act as constraints to learning can be revealed and challenged through its use (Taylor, 2000a). It is therefore, important to encourage students actively to,

develop the capacity to keep an eye on themselves, and to engage in critical dialogue with themselves in all they think and do (Barnett 1992: 198).

Reflection within the midwifery curriculum is intended to develop practitioners who are not only more self aware but whose practice is informed by a number of different perspectives not least of which, is that of the client (Sadala, 1999). Mezirow (1981) developed a theory of perspective transformation. He viewed what are referred to as 'meaning perspectives' as central to adult learning whereby adults make sense of the present based on their previous experiences. He defined meaning perspective as,

the structure of cultural assumptions within which new experience is assimilated to - and transformed by - one's past experience. It is a personal paradigm for understanding ourselves and our relationships (Merzirow 1981:4).

Through this explanation, the student can be encouraged through the use of reflection, to get closer to the women's perspectives and to relate to them in more meaningful ways for

example, by examining how values and culture influence interactions and care delivery (Usher, 1993; Moon, 1999; Sadala, 1999).

Boud and Griffin (1987) devised a schema for students to follow which enables them to reflect firstly on the experience as objectively as possible, then to concentrate on the feelings that the experience evoked. The experience is then re-evaluated enabling students to connect their existing knowledge and attitudes, based on previous experience, with the ideas and feelings they have identified. Students can then consider any implications associated with these. The new perceptions generated as a result of this process can then be integrated with existing learning and tested in new situations. Once an effective practice is identified it can be adopted. Whilst this is a schema that is ostensibly for students to use, Kemmis (1985) is also of the opinion that there should be a facilitator involved in the management of the reflective process. There are many examples of how the facilitation of student learning is achieved at present through the involvement of mentors and lecturers (Frazer et al, 1998). However the contribution women could make to student reflection has possibilities that remain un-illuminated.

Ultimately it can be argued that students' independence is enhanced through the use of reflection. Through its conscious application they are encouraged to become more self-aware, develop their critical analysis skills and increase their understanding by adopting a deeper approach to learning (Miller et al, 1994). The arguments of the protagonists for reflective practice can be summarised as follows as a,

need for a close knowledge of the difference between one's current performance and the achievements which are required if progress is to be made (Powell 1985:41).

Assessment as part of learning

It is worth considering at this point the importance of the words of Boud (1995:35)

There is probably more bad practice of significant issues in the area of assessment than in any other aspect of higher education.

There is a need to ensure that assessment practices are justified on the basis of the research evidence available in relation to the impact assessment might have on student learning (Rust, 2002). The assessment process has gained prominence in the eyes of the Quality Assurance Agency (QAA). It is not unusual to see points being lost in subject reviews as a result of poor assessment practices (Rust, 2002). Within its code of practice regarding assessment the QAA clearly requires the appropriate assessment of all learning outcomes (QAA, 2001). Indeed the Higher Education Funding Council for England (HEFCE) has placed assessment at the top of its generic priority areas with an emphasis on the matching of modes of assessment with learning outcomes (HEFCE, 2001). Biggs (1999a), perhaps in anticipation of this shift in emphasis, suggested a change in approach to curriculum development. He suggested a systematic approach whereby firstly the learning outcomes are agreed, secondly effective modes of assessment are identified and finally that the most appropriate learning opportunities should be made available to students in order to equip them to engage in the assessment process.

Feedback

Feedback is a term first coined by Norbert Weiner in 1948 and is a concept derived from electrical engineering. It was introduced by Kurt Lewin to the social sciences to demonstrate how its consistent application could be utilised to generate valid information within the learning process. The qualities and components of the idea have been much debated in the literature with overwhelming support for feedback that is prioritised, timely, constructive and most importantly, interesting to the students (Brown et al, 1995; Potterton and Parsons, 1996; Khan et al, 1997; Bujack et al, 1991; Frazer et al 1998; Miller et al, 1998; Hendry et al, 1999; Neary, 2000; ENB and OU, 2001; QAA, 2001). Jacobs (1974) provides a pertinent observation on the concept and is of the view that feedback has two major properties. These are firstly, the information on which the recipient will contemplate in order to improve performance and secondly, the encouragement that can be derived from feedback and its consequences for energising students' motivation.

It can be argued that to be a competent and effective midwifery practitioner there needs to be an emphasis on information gathering in addition to decision making and action (Kolb, 1984; Black and Harden, 1986; Woodburn and Sutcliffe, 1996). Information in the form of feedback on all aspects of performance and the knowledge underpinning it is seen as an important part of the learning process of relevance to the focus of this study. Student feedback can therefore be defined as,

verbal and non verbal responses from others to a unit of behaviour provided as close in time to the behaviour as possible and capable of being perceived and utilised by the individual initiating the behaviour (Bruner, 1970:158).

Students can be influenced by non-verbal cues and encouraged to reflect on these as well as on the verbal feedback both to promote critical self-awareness and also to refine their skills of discernment in the context of the work place (Rowntree, 1987; Knapper and Cropley, 2000; Boud, 2001a). Feedback is particularly central to the effective implementation of experiential models of learning that emphasise the here and now. Within these models, experience is interpreted through information gathering that is directed at evaluating the strengths and weaknesses of students' performance and the implications of these for future actions that might improve practice (Kolb, 1984).

Providing feedback to students is capable of being a difficult and personally threatening process. Because the effects of receiving negative feedback can be potentially detrimental to students, care must therefore be taken to minimise such harmful consequences (Jones, 1999). Research indicates that there may be benefits to be gained through creative feedback exercises for students to prepare them to engage actively with and to get the most out of learning from feedback they might subsequently receive (Rust, 2002). Students value user-friendly feedback that is delivered sensitively and gives focused, personalised information about achievement and provides them with some direction in relation to their future learning (Boud et al, 1985; Brookfield, 1986; Preston-Whyte et al, 1998; Stefani, 1998; McDowell and Sambell, 1999). It is also argued that when students request feedback on particular aspects of their practice it increases the level of student

autonomy and boosts their personal responsibility for their learning (Kelly and Wykurz, 1998).

Hanson (1996) argues that adult learners value feedback on their performance particularly when entering a new field of study where they lack a yardstick for measuring their performance. Feedback of a formative nature can thus prove to be non-threatening and can assist in learning where it is used in a prospective, 'feed-forward' manner that assists students in the identification of their own strengths and weaknesses and becomes an integral part of the process of self development (Torrance and Pryor, 1998; Yorke, 1998).

Past experiences and how these have been processed and perceived by the student make a significant contribution to future actions. The attitude to learning adopted by students when engaging in clinical practice plays an important part in the way in which the experience will be interpreted by them (Boud et al, 1985). Introducing feedback from women could have a significant effect on students' attitudes when engaging in clinical practice and may help them to gain new insights into their own performance. The students' repertoire of behaviour could thus be expanded to appropriate more closely to women's perspectives.

Various conceptual tools exist that provide a theoretical rationale for the involvement of women in student feedback. An often quoted and apposite example is the Johari window below.

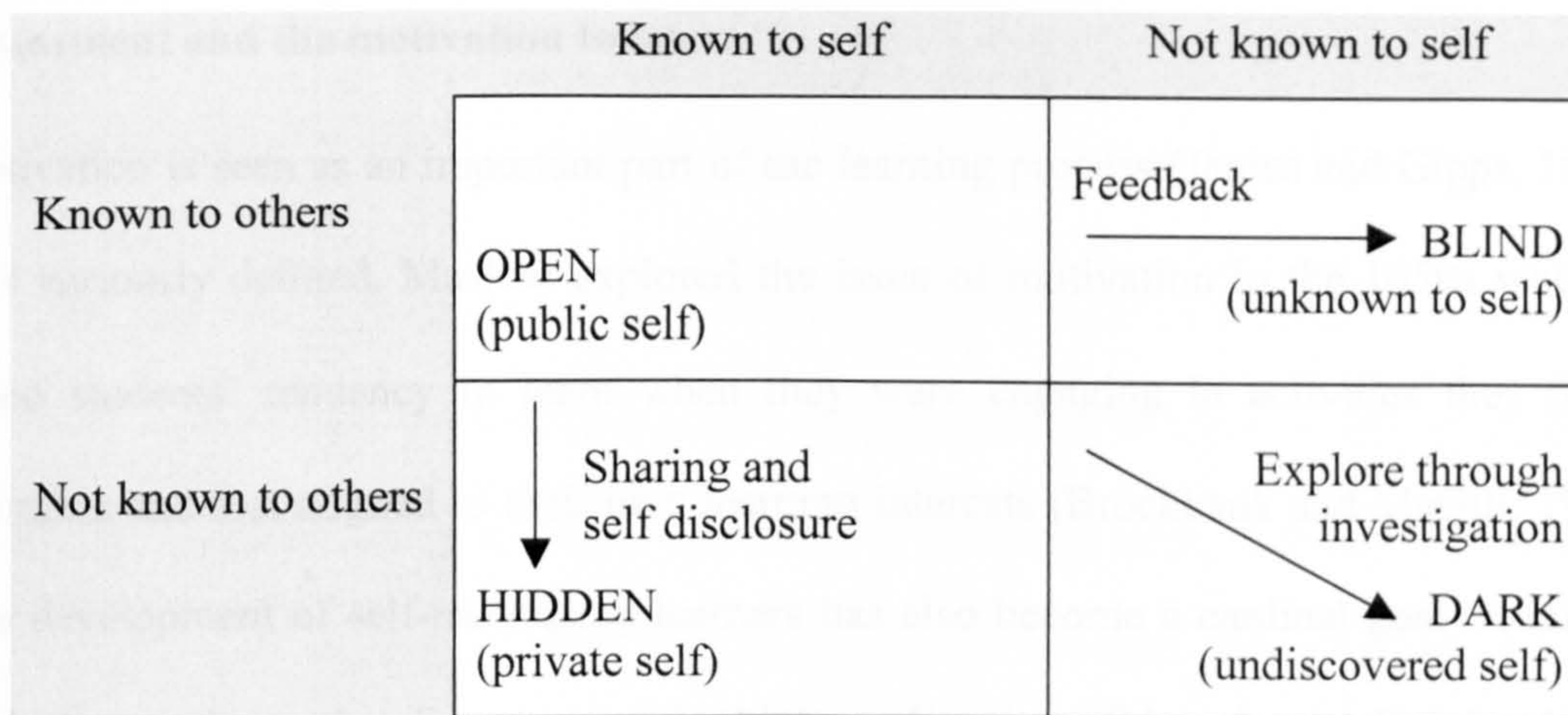


Figure 4 The Johari Window (adapted from Luft, 1969 cited in ENB and OU, 2001).

This provides a useful framework to demonstrate to students the part women could play through the provision of feedback in helping them to gain enhanced self-awareness of what Johari terms the ‘unknown to self’ (ENB and OU, 2001). This model also identifies what it calls a ‘blind domain’ through which women could provide students with information that is known by them and not by the students and possibly not by the mentors.

An issue of importance to this study is the willingness of women to provide feedback. There is evidence that women may be reluctant to provide it when they have had negative experiences during their care (Reid and Garcia, 1989; Green et al, 1998). This clearly limits their contribution if it is the case. But more recent research suggests that women will provide feedback about negative experiences in an attempt to be helpful (Bluff and Holloway, 1994; Frazer, 1999).

Assessment and the motivation to learn

Motivation is seen as an important part of the learning process (James and Gipps, 1998). It is variously defined. Maslow explored the issue of motivation in the 1950s when he noted students' tendency to learn when they were engaging in activities they found desirable and that aligned to their own learning interests (Brockbank and McGill, 1998). The development of self-motivating learners has also become a cardinal goal within the student experience that forms part of a higher education (Edwards and Knight, 1995). Maslow's initial recognition of the association between perceived relevance and student motivation is a recurrent theme within the literature as exemplified by the following,

motivational benefits accrue when students can perceive the relevance of learning and assessment activities (Cumming and Maxwell, 1999 :177).

The importance of assessment in student motivation is also crucial. Evidence suggests that when the relevance of an assessment activity is not evident to the student, the assessment process can be very de-motivating and have a negative effect on learning (Gibbs, 1992; Torrance and Pryor, 1998; Rust, 2002). In consequence the inherent interest in the assessment activity which students adopt relate closely to its perceived importance. The more meaningful an assessment activity is, the greater its benefits (Cotton, 1995a; McDowell, 1996; McDowell and Sambell, 1999). Indeed opinion suggests that this is one of the main functions of the assessment process and that effective learning can only be achieved if students are motivated by the various assessment activities within a curriculum (Gibbs, 1992; Potterton and Parsons, 1996; Smith and

Levin, 1996). It is therefore important at the curriculum development stage to give due consideration to the likely motivational potential of the chosen assessment strategy.

The literature repeatedly draws attention to the interactive and mutually complementary nature of feedback and motivation in which feedback following an assessment activity in relation to students' strengths and weaknesses, encourages them to reflect on their own performance (Miller et al, 1998). This scope for student reflection provides an opportunity to enhance their capacity to learn and improve (Darling-Hammond and Ancess, 1996). This has been aptly described as 'competence motivation' whereby students' future performance is improved as they take stock of achievements to date and seek to continue to build upon them (White, 1959). There is a self-perpetuating aspect of motivation and this has been called 'functional autonomy'. It concerns the way in which motivation is established and becomes sustained through a subjective sense of achievement (Allport, 1963). Students who are fuelled in this way and are proud of their achievements, tend to engage in sustained study and develop their learning strategies (Miller et al, 1998). These motivational attributes are desirable in any student midwife and because students' behaviour is closely linked to their motives, their approach to any learning situation is important (Boud et al, 1985).

Rice (1995) is also convinced that motivation is central to successful learning and has produced a simple model, which depicts the key processes involved in Figure 5 below.

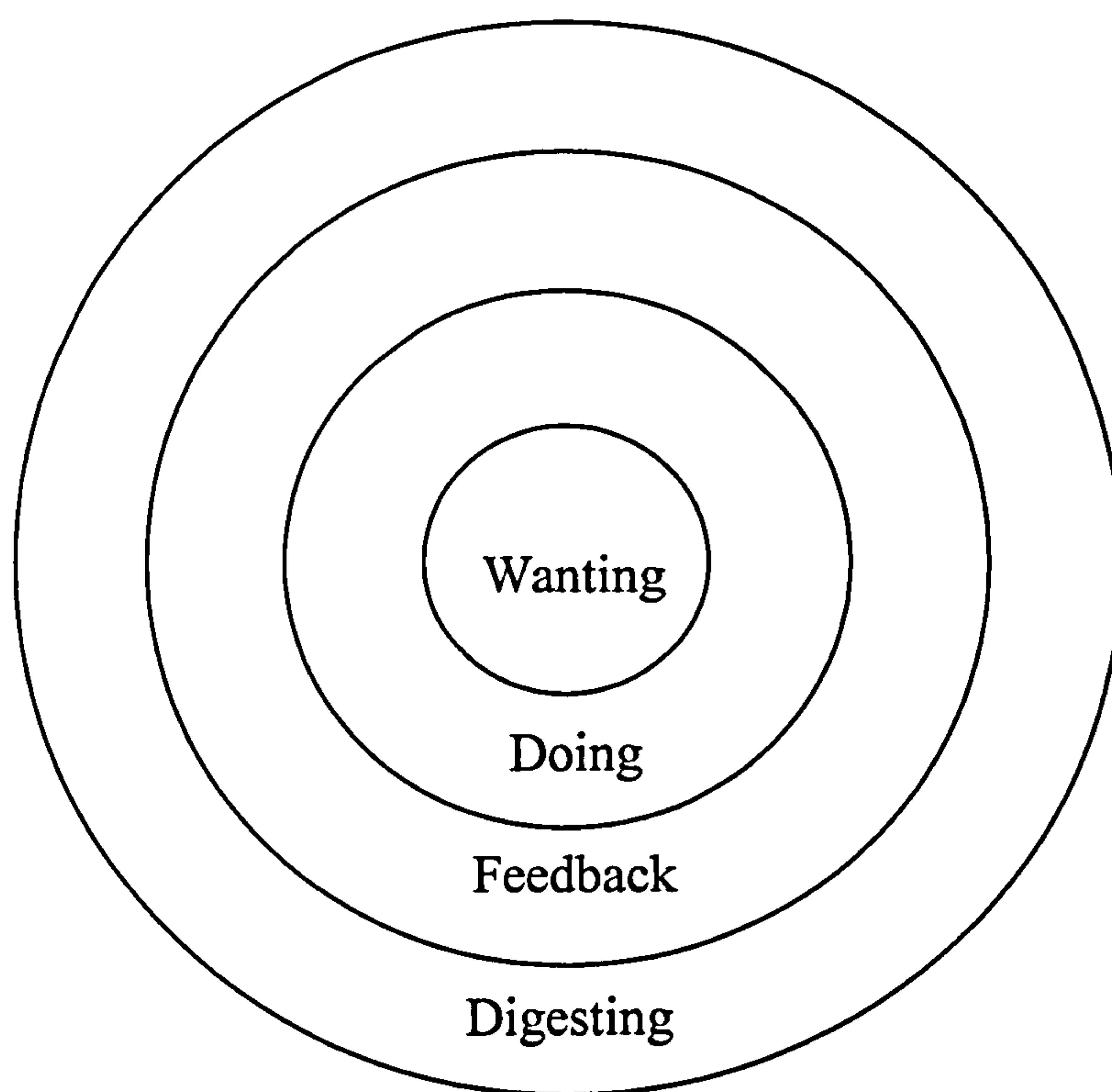


Figure 5 Model of the key processes needed for successful learning (Rice, 1995:62)

Whilst he admits there is overlap between his categories he suggests that learning results from firstly wanting to learn something, doing it and then receiving feedback that can be digested. This model incorporates assessment in that judgements are made about the students' learning and are made explicit in the form of feedback. Rice also confirms the importance of relevance to the positive reinforcement of the student.

Understanding and assessment

Understanding is fundamental to the mastery of transferable skills in professional practice fields of study. Student midwives therefore, require a broad level of understanding in order to be able to perform effectively in a range of settings (Debling and Hallmark, 1990). It is argued that to generate understanding, the curriculum should be student-

focused with an emphasis on processes as well as outcomes (Biggs, 1999b). This implies that what the students actively do to achieve understanding is as important as the contribution made by the lecturer.

Understanding is socially constructed and is therefore, gained through interaction. Assessment can contribute significantly to understanding because it can be constructed to be a highly interactive process (Broadfoot, 1996). Whilst the idea of viewing assessment as a means of advancing understanding is accepted, some argue that certain, perhaps more traditional approaches to assessment actually hinder students' ability to develop understanding (Gordon and Bonilla-Bowman, 1996). The importance of understanding from a number of different positions and contexts in which they might be applied, is seen as relevant when students are seeking to master transferable skills. Because many of the traditional approaches to assessment are decontextualised and to a certain extent merely symbolic of student performance, they are not seen as conducive to the development of understanding (Gordon and Bonilla-Bowman, 1996). The link between many forms of assessment such as examinations, written assignments, poster and seminar presentations and the students actual level of competence in the work setting is not directly clear. The potential therefore, of the assessment strategy within a curriculum to enhance understanding can be limited if real life interaction is not a feature of it. This thinking in relation to clinical practice is advanced by Johns (2000) who suggests that student interaction with the client that is reflexive is essential to gaining an understanding of the clients' needs and expectations. Within Higher Education in general however, there continues to be an artificial divide between knowing and doing that has been a feature of

academic tradition and is an inherited part of educational thinking in the western world (Gonczi, 1999). This divide can result in tensions within the assessment strategies in professional courses such as midwifery. An assessment strategy is necessary that places an emphasis on competent performance in a clinical context and is part of an education designed to render students safe to practise. At the same time there is an equally important need to examine students' knowledge base for the profession into which they are being socialised and inducted (Edwards and Knight, 1995). Managing practice assessment and theoretical assessment produces tensions for students. So within the pre-registration midwifery curriculum there is clearly a need to have an assessment strategy that is student-focused and promotes understanding on a variety of dimensions in order to foster in students the development of transferable contextualised skills.

The assessment of attitudes and values

The assessment of attitudes and values is notoriously difficult to achieve yet it is recognised that these professional attributes are very important (Bedford et al, 1993; Eraut, 1993; Hager et al, 1994). This challenge to assessment practices has sometimes been avoided with the emphasis being placed on knowledge and skills. Limiting the assessment of practice in this way has the potential to deny students the opportunity to learn from their experience and develop the requisite professional attitudes and values (Bedford et al, 1993; Boud et al, 1993; Bradshaw, 1997). Not only does the student midwife need to develop a professional attitude towards those in her care but also the appropriate attitudes for critical thinking. These include intellectual humility and the courage to contemplate change based on sound evidence, integrity, perseverance and

empathy (Miller et al, 1998; Taylor, 2000a). Hager et al (1994) conclude that the most reliable way of assessing attitudes and values is in the context of practice over a sustained period of time. This requires the use of multiple sources of evidence including self-reports and evidence from prior achievements as well as the direct observation of the mentor. Making the assessment of attitudes and values more explicit can also inculcate in students the need for a strong commitment to the code of professional conduct (Eraut, 1993). Involving women and considering their views on care could support the students' acquisition of professional values and nurture their empathic skills (Nias, 1993; ENB, 1996).

The process of assessment

Subjectivity in the assessment process

Assessment of clinical competence includes judgements and inferences made on the basis of samples of available evidence that may take the format of artefacts or observable behaviours (Patterson, 1996; Holroyd, 2000). Subjectivity will always exist in the assessment process in varying degrees. But the assessment of clinical competence is especially susceptible to and can be significantly influenced by subjective factors because of its multifaceted nature (Hepworth 1989; Coates and Chambers, 1992; Brown et al, 1995; Rogers, 1996; Filer and Pollard, 2000; Holroyd, 2000). This observation is particularly reinforced by the findings of a major study that was commissioned by the ENB (Bedford et al 1993). Assessment decisions can on occasions, be overly influenced by subjective variables such as feelings, personalities and the individual discretion given to mentors (Woodburn and Sutcliffe, 1996; Jarvis and Gibson, 1997; Bennett, 1999). An

antidote to the inevitable intrusion of subjectivity lies in the careful selection of the information that is used to judge students' performance. Data needs to be selected from varied sources to offset bias that might occur from solitary subjective opinions. Women's views could be incorporated into this range of assessable data and be utilised to make judgements regarding competence. This could contribute towards minimising the distortion associated with current methods of clinical assessment because it is known that the presence of mentors observing students inhibits their performance. Furthermore judgements made by mentors whilst observing students are especially vulnerable to personal whim (While, 1991; Bedford et al, 1993; O'Neill and McCall, 1996; Chapman, 1999; Taylor, 2000b).

Throughout the last decade a search for more valid and reliable assessment mechanisms has been underway. There is a consensus that assessment should go beyond the technical and formulaic and it was thought that the introduction of the continuous assessment of students would result in a more accurate process but this has not been realised (Nicol et al, 1996; Holroyd, 2000). A growing trend towards student involvement has resulted in greater self and peer assessment that is also believed to heighten credibility (Somers-Smith and Race, 1997). The introduction of the objective structured clinical examination (OSCE) is a further attempt to enhance validity but this too is not without subjectivity (Nicol and Freeth, 1998). A tripartite approach incorporating contributions from assessors, lecturers and students that is responsive to multiple sources of evidence is another innovation. But this too is reported to have fallen short of the sophistication that it intended to achieve (McAleer and Hamill, 1997).

A sense of fairness to students in the assessment process

Due to the ethical dimension of assessment, it is generally accepted that one of the essential components of any assessment strategy is that of fairness to students (Bedford et al, 1993; Milligan, 1998). Yet trenchant criticisms of the assessment process in professional courses have included a lack of justice in instances where a dissonance exists between what is expected to be assessed and what actually is assessed (Girod, 1993; Woodburn and Sutcliffe, 1996; Gonczi, 1999). Accepting that assessment is an inexact science and bearing in mind the current emphasis on accountability in relation to professional assessment, efforts arguably need to be redoubled to ensure the process is equitable for all students (Brown et al, 1995; Holroyd, 2000). Assessment must naturally be designed within the context of the aims and learning outcomes of the curriculum. But from the student perspective, an assessment is only considered fair if it accurately allows them to demonstrate what they know and can do in relation to these aims and outcomes as these relate to practice (Smith and Levin, 1996; McDowell and Sambell, 1999).

Formative and summative assessment

Formative and summative assessment have been differentiated as follows,

when the chef tastes the sauce it is formative assessment but when the customer tastes, it is summative (Biggs, 1999b:143).

The term formative assessment was introduced by Scriven in the 1960s (Boud, 1995). The interest in this type of assessment led to an emphasis on how attitudes, skills and knowledge were formed. This serves to supplement the assessment of final learning outcomes, which form the primary focus of summative assessment (Bedford et al, 1993).

Formative assessment provides opportunities to explore learning processes and its adoption has led to a methodological shift from quantitative to qualitative and interpretative approaches to assessment (Bedford et al, 1993). The focus of formative assessment therefore, relates to students' developmental needs and it has been argued that if the formative element of assessment is to enable students to learn, then it must be pre-eminent within the assessment strategy (Walton and Reeves, 1999). Not only are students likely to benefit from formative assessment but the lecturers derive advantages from formative assessment because through it, they have the opportunity to evaluate the effectiveness of the teaching and learning strategies within the curriculum (Jarvis and Gibson, 1997; Miller et al, 1998).

An interesting aspect of formative assessment is its use within work-based learning programmes where it is seen as vital to successful learning. In terms of the midwifery curriculum, the challenge lies in the development of sustainable approaches to formative assessment that enable students to develop their skills and realise their potential within the context of the clinical setting (Rowntree, 1987; Boud, 2001b). Proponents of formative assessment place immense value on it within the learning process believing that actually understanding how one is developing is, *the life-blood of learning* (Rowntree, 1987 :24).

Formative assessment is resonant with the overall philosophy of life long learning. Its emphasis is on process as well as outcome and hence, it requires students to be fully engaged with it if it is to be successful (Torrance and Pryor, 1998). Assisting students to take more control of and maximise their learning in clinical practice through the use of

formative assessment has other attractions because with it brings a shift in emphasis from teaching to learning. The 'feed forward', developmental concept associated with formative assessment is directed at both current and future learning that can be tailored to student need in the context of care delivery rather than on teaching per se (Torrance, 1995).

As with any course that leads to a professional qualification, there is the need for an observable final and summative judgement to be made about the students' level of competence in relation to pre-defined standards (Rowntree, 1987; Bedford et al, 1993). Formative assessment has the potential to make an important contribution to this final outcome by enabling the student to identify learning and produce evidence that can be difficult to capture through summative assessment (Broadfoot, 1995). There are also those who advocate that the level of student involvement associated with formative assessment should follow through cumulatively to add to the summative assessment process (Jarvis and Gibson, 1997). Within the midwifery curriculum it has been suggested that formative assessment could be utilised in the learning of component parts of a particular competence with a view to making a subsequent summative assessment in relation to the overall holistic performance of the student (Worth-Butler et al, 1996).

Supporters of formative assessment are largely unchallenged in their claim that it assists learning (Torrance and Pryor, 1998). Yet despite any intuitive appeal it may hold, there is by no means a consensus view about its associated benefits. But with the purpose of this study in mind, it is necessary to be aware of the potentially negative consequences

associated with this type of assessment and it is important to bear in mind the potential for generating apprehension for students through its use.

Midwifery practice and the concept of competence

The delivery of women centred, holistic midwifery care is an intricate activity (Frazer et al, 1998). In consequence, any definition or model of competence inevitably has to embrace the challenge posed by the complexity of holism that is captured in the philosophical, psychological, professional and sociological bases that underpin the delivery of care (Newble, 1979; Edwards and Knight, 1995; Hager and Gonczi, 1996; Jones, 1999). A search of the literature reveals that in general terms, competence means different things to different people. There are even those who argue that because competence is concerned with perceived skills, it cannot actually be measured (While, 1994). For its adherents however, one generally recognised definition states that competence is,

the ability to perform the activities within an occupation or function to the standards expected in employment (Debling and Hallmark, 1990:9).

Central to competence based education is the need to express and define educational outcomes that are explicit and transparent. Attempts to translate these principles to midwifery practice have proved difficult to operationalise (Frazer et al, 1998). Problems arise particularly concerning the humanistic aspect of midwifery where the explicit definition of learning outcomes have been described as the 'Achilles heel' of competence based education (Chapman, 1999). Although learning outcomes for pre-registration midwifery programmes have existed for some time, these have been constructed in very

broad terms that elude the specificity needed to assess competence (UKCC, 1998, See Appendix 1). More recently, a new definition of the competencies required for registration as a midwife have been published by the (NMC, 2002, See Appendix 2). These provide a more substantial account of the knowledge, skills and attitudes to be achieved by student midwives. Although considered an improvement by some, these definitions of competency still do not result in a desirable degree of comprehensive meaning and clarity. The introduction of benchmarking statements is seen as another attempt to introduce more precision (QAA, 2001). The overall problem of competence measurement has been recently summarised as follows,

Despite a 40-year history of researching and developing an instrument for the measurement of clinical competence in nursing, there are none that are universally accepted for this purpose (Robb et al, 2002:293)

Despite the attempt to be more exact in the definition of competence, critics would argue that this results in an atomised approach to learning that reduces performance to a multitude of tasks and does not do justice to the intricacies of practice and its assessment (Milligan, 1998; Gonczi, 1999). In reality the observable becomes paramount and the more subtle aspects of care, such as its humanistic features, continue to prove difficult to encapsulate within assessments (Gonczi, 1999).

Such elemental approaches to the definition of assessment of competence have been described as primitive behaviourism and have served to bring competence based learning into disrepute (Gonczi, 1999). It must be acknowledged therefore, that any definition or model of competence in relation to midwifery practice is a construct that is unlikely to

represent all aspects of care (Wolf, 1989). Midwifery practice undoubtedly incorporates discrete tasks that can be accommodated by a reductionist, behaviourist approach to competence. But many of these discrete individual tasks are part of a holistic scheme of care requiring the midwife to draw on most, if not on some occasions, all of the characteristics that represent competence. Midwives often need to demonstrate several competencies at any one time. For example at a booking interview, whilst eliciting information about a woman's previous reproductive history, the midwife is also simultaneously building a relationship with the woman. This integrated holistic approach to competence that combines knowledge, attitudes, dispositions, values and skills is needed if competence is to be captured as experienced in the real world where emerging practitioners can develop in the context of the employment environment (Mansfield, 1989; While, 1994; Worth-Butler et al, 1995; Milligan, 1998; Gonczi, 1999).

This significance of the work place context cannot be overlooked when considering the impact of clinical reasoning and professional judgement because it can be argued that there are many ways of dealing with a clinical issue competently (Ilott and Allen, 1997). To this end the ENB and more recently the DOH advocated a close link between HEI based courses and professional practice (ENB, 1995; DOH, 1999; ENB and DOH, 2001a). It is apparent then, that whilst there is a necessity to measure competence, the temptation to over simplify midwifery practice and diminish its integrity by adopting a very reductionist, task orientated approach needs to be resisted (Frazer et al, 1998). Perhaps it has to be accepted that in defining competence, complete exactitude and

transparency will never be achieved because of the unquantifiable aspects of professional performance (Wolf, 1989).

Despite all the challenges competence throws up due to its epistemological, ethical and political dimensions it is still an attractive construct because of its direct ties to the practical realities of the work place (Cumming and Maxwell, 1999). It is because of this relationship to reality that some would argue that competence is an evolving construct that is certain to change over time as the context of practice changes and practitioners challenge accepted ways of behaving (Gonczi, 1999). It can be argued that the whole idea of competence is actually constrained by such things as time, human resources, finances and even local custom that further complicate the debate (Heywood, 2000). Midwifery practice by its very nature is unpredictable. In keeping with the emphasis on the real and changing world, competence has also been defined as,

the possession and development of sufficient skills, knowledge, appropriate attitudes and experience for successful performance in life roles (Evans 1987:5).

This definition values experience and fits with the theories of experiential learning and the call for student midwives to learn from their personal experiences of clinical practice (DOH, 2000a; DOH, 2000b; Heywood, 2000; ENB, 2001; ENB and DOH, 2001a; NMC, 2002). It is contended that the actual process of caring can provide them with opportunities to identify their own learning needs and attain the levels of competence required to safeguard the general public. It is important to realise therefore, that

competence is never guaranteed and it does not exist in a fixed state (Bedford et al, 1993).

It has been suggested that,

Performance standards at the work place are not absolute they are established, maintained and improved through negotiation coupled with professional pragmatism (Bennett, 1999:287).

For these reasons some are of the view that quality judgements about competence should incorporate a contribution from those on the receiving end of care who are perhaps best positioned to assess whether or not their personal needs were met (McDowell and Sambell, 1999). After all, what may meet the needs of one woman may not suit another. On this premise the congruence between learning and being competent could arguably be enhanced by involving women (Worth-Butler et al, 1995; Frazer and Murphy, 1996; Neary, 2000). It has been claimed that those receiving care can act as an *informal scientist* in evaluating the service that has been provided within a system of negotiated care where women are more than passive recipients (Ellis, 1988:50). This type of feedback could augment the criterion referenced approach to making judgements about student performance that at present rely heavily on observation by a mentor. Obviously this idea would require a great deal of examination because the actual process of gaining competence is an imperative that is far from straight forward and needs no complications adding to it (Milligan, 1998). Yet women's feedback could capture some of the more subtle attributes that constitute competence because in midwifery this does not just mean intelligent and safe psychomotor performance but the delivery of highly personalised, tailor made care. Indeed it has been argued that,

Patient assessment may be a very effective and efficient way of maintaining regular checks on clinical competence (Furnham, 1988:103).

A conceptual overview of competence has been described in terms of five broad features. These are said to be motives, traits, self-concept, knowledge and skills (Spencer and Spencer, 1993). Within this model, characteristics such as knowledge and skills that underpin competence are potentially visible and lend themselves to criterion based judgements. Motives and traits however are difficult to observe yet they influence actions that equate with performance on the job. Capturing these motives and traits that lie at the core of an individual students' personality and the cultivation of them to achieve standards that are acceptable in employment, is an unresolved challenge for competence based education (Spencer and Spencer, 1993).

A further model of competence for midwifery that provides some orderliness and that expresses the centrality of women in the competence debate has been developed by Frazer et al (1998). This model embraces the professional, friendly, individualised approach to care in a way that resists trivialising practice by reducing it to a series of tasks. Midwifery competence within it is represented in a three dimensional way as depicted below.

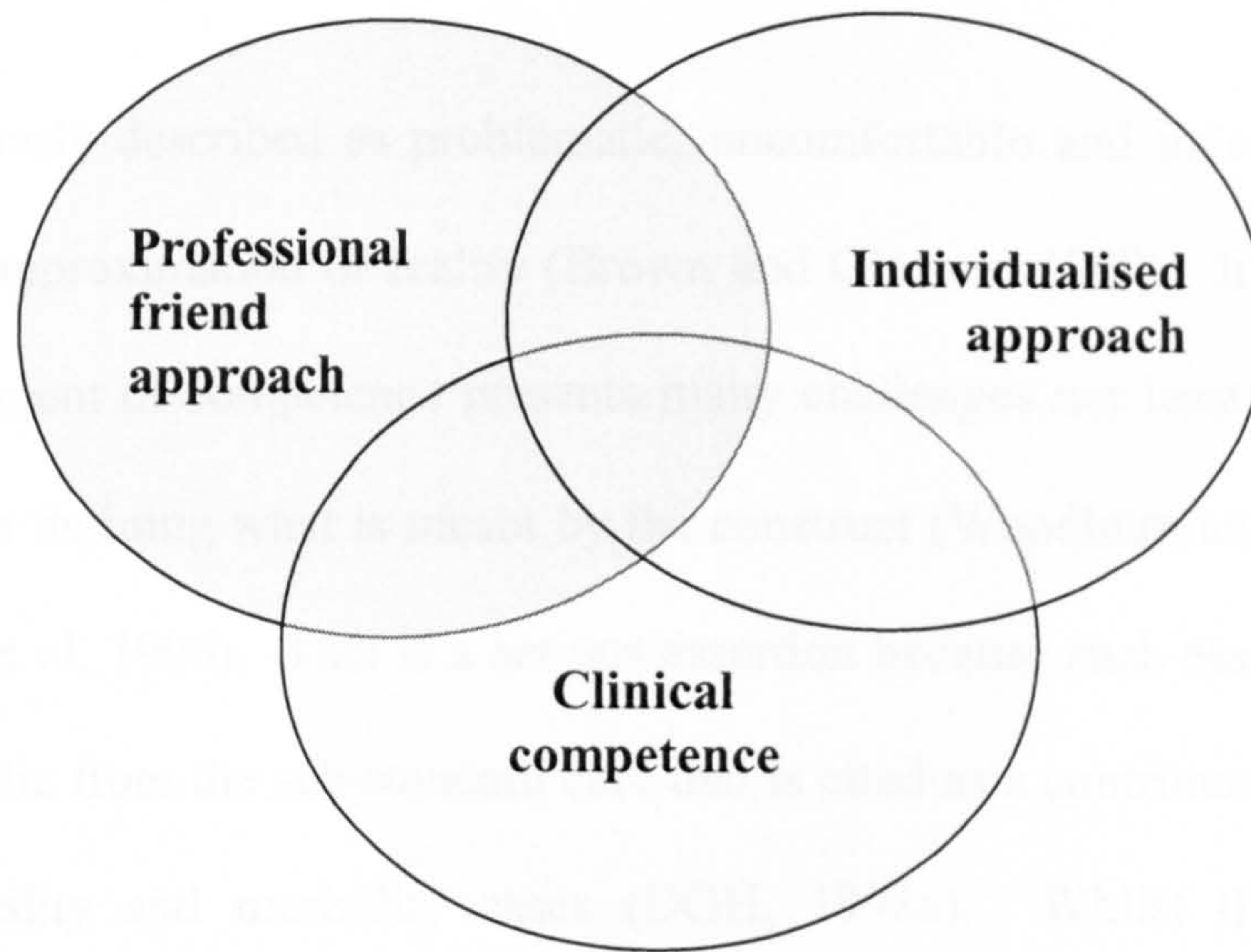


Figure 6 A Model of Competence in Midwifery (Frazer et al 1998:35)

It has been argued that a competence based curriculum is assessment led and driven (Winter and Maisch, 1996). This position arises because of the emphasis that is quite rightly placed upon learning outcomes and their measurement. However it must be kept in mind that the assessment strategies used within curricula will be dependent upon how competence is conceived and defined and as a consequence these strategies have been found to vary considerably (Hager et al, 1994; Worth-Butler et al, 1996).

The assessment of clinical competence - some challenges

Assessment of clinical competence has been a contentious theme in the literature for many decades as educationalists have sought to achieve greater veracity within the assessment process (Giot, 1993). The assessment of clinical competence has evolved over the years. Historically it consisted of simulated classroom assessments. Since the 1970s, the introduction of ward based continuous assessment involving clients has been adopted in an attempt to seek greater authenticity (Clifford, 1994; Nicol and Freeth, 1998). Yet throughout this time it has been noted that the assessment of clinical practice

has been variously described as problematic, uncomfortable and indeed, often nothing more than an approximation of reality (Brown and Glasner, 1999). It is acknowledged that the assessment of competence presents many challenges not least of all because of the difficulty in defining what is meant by the construct (Woodburn and Sutcliffe, 1996; Worth-Butler et al, 1996). This is a serious assertion because such assessments serve to protect the public from the sub-standard care that is cited as a contributory cause in many maternal mortality and morbidity cases (DOH, 1998a). Whilst the assessment of knowledge and understanding are important dimensions of competence it is their application in terms of professional effectiveness that is a crucial determinant of professional registration (NMC, 2002). The shift away from emphasising the assessment of knowledge at the expense of effective performance, that is the synthesis of cognitive, affective and psychomotor skills, is a timely one. Given the serious state of affairs concerning the definition and assessment of clinical competence, the current contribution made by users of the maternity services and the feasibility of including them in the assessment process as a means to enhancing learning is of interest. This interest is entirely resonant with the policy of the former UKCC that published its unequivocal commitment to public involvement in the preparation of qualified midwives (UKCC, 2000). The new NMC has issued no policy to contradict this established position.

Whilst students may avoid poor teaching they are not in a position to escape poor assessment processes (Knight, 1995). It therefore behoves educationalists to develop sound assessment strategies. Ideally, assessment should be an integral part of teaching and learning (Heron, 1988; Ramsden, 1992; Holroyd, 2000). Indeed this perspective is

embraced by the Quality Assurance Agency that has a requirement that the contribution assessment makes to student learning be evaluated during subject reviews (QAA, 1997). Its view is also consistent with the needs of a more consumer-orientated student population, the language of competence and skills and the aspirations of modern HEIs that are keen to promote excellence and increase their niche in the student market. It has been suggested that these forces will,

combine to provide the revolutionary context in which assessment will be viewed as inextricably linked to learning in higher education of the 21st. century.
(Glasner 1999:27).

If an emphasis is placed on the learning enhancement aspect of the assessment process it can prove to be both motivating and productive for the students. By providing them with appropriate and constructive feedback of a formative and summative nature regarding their progress, a deep rather than a superficial approach to learning may be encouraged (Mc Dowell, 1996; Holroyd, 2000).

Evidence and its role in the assessment process

To test thoroughly a person's professional competence it is necessary to evaluate a range of evidence. In consequence a multi-perspective, multi-method approach that is conducted longitudinally is necessary to achieve a comprehensive overview of performance that will not be achieved by a parsimonious, once off approach to assessment (While, 1991; Hager et al, 1994; Worth-Butler et al, 1996; UKCC, 1998; Gonczi, 1999). Expectations of competence are socially as well as technically defined and will therefore, vary from person to person. This would certainly be an important

consideration if women were to be involved routinely in the assessment of midwifery students. Over the years service users have indeed been involved in defining the working roles of midwives through an expression of their own expectations of maternity services. This inevitably has contributed to the definition of competence and also to the improvement of the quality of services. (DOH, 1993).

Interestingly, Cotton (1995a) is of the view that every skill embraces three types of knowledge that underpin performance. These includes knowing *that*, knowing *how* and knowing *what* ought to be done. From the perspective of student midwives, knowing what ought to be done must involve listening to women to allow an understanding of their personal expectations and this is becoming a feature of pre-registration programmes (Wolf, 1989; Bluff and Holloway, 1994; Twinn, 1995; Richens, 1999; ENB, 2001). So there is an arguable logic that is supported by the literature for going a step further and obtaining evidence of how students' performance matches and compares with the women's expectations of their care. This additional evidence could add to the credibility of the assessment process. There is support in the literature, albeit it with varying degrees of enthusiasm, that this type of evidence should be given a high priority (Jessup, 1990; Eraut, 1993; Bennett, 1999; Blasco et al, 1999; Wykurz, 1999). It has been argued that an approach that incorporates women's views would contribute to a further shift from the heavy reliance on assessing knowledge to one concerned with the assessment of evidence of effective performance (Debling, 1989). Significant and influential models exist that will enable mutually shared understandings and shared perceptions of performance to be realised by students and women (Falchikov, 1986; Patterson, 1996).

Triangulation of evidence in the assessment process

Research concerning observed behaviour is of particular relevance in this study through its recognition that when mentors observe and make judgements about students, it will inevitably affect and alter their performance (Rowntree, 1987). With this in mind the use of alternative, perhaps less intrusive, sources of feedback for students on their performance in clinical practice could assist their learning. Yet limiting the sources providing feedback to students has the potential for relevant information and perhaps more accurate feedback to be lost (Tennant, 1997). It has been suggested that through the adoption of a triangulation of the evidence used in assessment, subjectivity and distortion can be reduced by offering students several interpretations of their performance (Harris and Bell, 1990; Walklin, 1991; Cumming and Maxwell, 1999). Whilst it is common to find this approach to the assessment of midwifery theory and practice, sources can be limited.

Although the triangulation of evidence can expose differences of opinion, it has the potential to stimulate debate and help both students and practitioners to question practices and help in the identification of students' learning needs (Bedford et al, 1993). Given the multifaceted nature of professional practice it could be argued that a simplistic task focused means of assessing practice is not appropriate (Tuxworth, 1989). The students' level of criticality could thus be improved through the use of these multiple sources of feedback on performance in which women could be contributors (Taylor et al, 1999),

Mentors and their contribution

Students of midwifery are allocated a mentor in each of their clinical placements. The increasing complexity associated with the assessment of clinical practice has resulted in changes to the role of the mentor in recent years (ENB and DOH, 2001b). The current requirement for students to provide portfolio evidence about their clinical competence has made a significant contribution to this change (Taylor et al, 1999). It can be seen from the evidence that the operational aspects of the relationship between student and mentor are not without threats to the reliability and validity of student assessment that are illustrated in several ways.

A recent study found that students deliberate about what theory they will apply to practice when being assessed by their mentors. They also take great trouble to make appropriate choices about what evidence they will include in the portfolio to impress their mentors (ENB and OU, 2001). This evidence suggests that their attitude to care might well be tailored to please the mentor rather than focusing on the preferences of the women for whom they are caring. Furthermore, although the ENB clearly identified the qualifications required by a mentor and how they are to be prepared for their role, too many assumptions are perhaps made about their abilities and the degree to which inter-rater reliability exists between them (Somers-Smith and Race, 1997; Frazer et al, 1998; Ashworth et al, 1999; Jones, 1999). A constructive way forward may be to accept that complex competencies are almost impossible to describe as transparent, unambiguous, specific learning outcomes and that the richness associated with competent midwifery practice is difficult to portray (Jones, 1999). This provides a further rationale for women

playing a part in assessment and contributing to the student experience in relation to some of the caring aspects of practice that are difficult if not impossible to observe and equally difficult to demonstrate in a portfolio of evidence.

Performance, achievement and fitness for purpose

It has been argued that a key aim in training for any job is the enrichment of performance (Wallace, 1999). It has been demonstrated that there are apparent links between individual and organisational performance so that developing individuals has an improving influence on services generally (UKCC, 1999b; UKCC, 2001a). This macro approach to organisational development requires an assessment strategy that is forward looking and enables students to take ownership of their achievements, to have an understanding of their level of competence and most importantly, to be aware of learning opportunities that are available within NHS organisations. (Gonczi, 1999; Torrance and Pryor, 1998). The design of any curriculum requires selectivity (Tarrant, 2000). Midwifery curricula have become highly selective in terms of their responsiveness to the demands of NHS employer organisations. Employer organisations are interested in overall performance and their recruitment decisions are based in part on the work experience students have had (Gibbs, 1991). To this end a curriculum that emphasises overall performance rather than the development of individual skills has been advocated (Tuxworth, 1989; While, 1994). Within this process, students are supported in the collection of employment focused evidence relating directly to their performance, which they reportedly find to be both practically useful and to be motivating (Jessup, 1990; Gonczi, 1999).

Historically, midwifery curricula have focused on fitness for practise. This concerned outcomes that gave assurances that the qualifying midwife was safe to practice. Employer pressure has introduced new demands that students now be fit for purpose and can meet a broader spectrum of work place demands (UKCC, 1999b; UKCC, 2001a). Being fit for purpose has at least two dimensions. There is that aspect concerning fitness to do the job that is the purpose of pre-registration midwifery programmes. But there is the additional and more enduring requirement for the practitioner to make up to date professional judgements based on changing evidence that reveals their personal capacity to perform in changing circumstances. This latter feature of fitness for purpose is pivotal to the development of autonomous accountable practitioners (Day et al, 1998). Certain potentially immeasurable qualities are associated with autonomous practitioners that have been described as follows:

courage, risk-taking, intuition, sharing acceptance of personal responsibility, flexibility, initiative, self-confidence and values (Stephenson, 2001:88).

The literature contains strong evidence that the development of practitioners who are fit for purpose is problematic and may lead to excessively high expectations of newly qualified midwives (Rushforth and Ireland, 1997; Kapborg and Fishbein, 1998). This brings with it certain ethical tensions. The aims of vocational curricula usually encourage a broad liberal education alongside those things needed to do a job of work. Narrowing the focus to that which employers see to be relevant runs the risk of neglecting to develop intellectual breadth within the individual student (Tarrant, 2000). With this in mind decisions about assessment are important if they too are to capture the broader concept of the intellectual development of students within the curriculum and avoid a purely task

orientated assessment strategy (Edwards and Knight, 1995). The ENB has provided a useful framework as part of its insistence that course content corresponds closely with professional practice and this incorporates employment related materials (Boud, 1995; ENB, 2001). But from the perspective of the student, while there is a need to ensure that assessment is closely linked to professional activity and the realities of the job, a similar emphasis on what is personally important is also required (While, 1994; ENB, 1996; Cumming and Maxwell, 1999; ENB and OU, 2001). For midwifery, this requires close collaboration between higher education and NHS stakeholders in curriculum design and delivery to achieve contemporary relevance and also to create a learning experience that is consonant with the pace of change in maternity services and the context in which these are delivered. This state of flux brings with it a requirement to ensure that there is a greater congruence between work and learning because it is argued that, *work demands learning* (Barnett, 1999:40).

This view is also supported by Bujack et al (1991) who recognised the challenges of preparing a practitioner for contemporary practice as well as for a long professional career. Amongst these challenges is the significance of,

Cultures, languages, lifestyle and religions....not only from the majority white population but also within and between minority ethnic groups (Vydelingum, 2000:100)

For these reasons the development and assessment of many of these employment related qualities that rely heavily on interaction with others could perhaps take place in clinical practice with the greater involvement of women (Curzon, 1985; Stephenson, 2001).

Student involvement in the learning and assessment process

Assessment and the empowerment of students

Academics struggled in the 1980s and early 1990s to introduce innovative approaches to assessment that would result in student empowerment. This new paradigm raised expectations on behalf of students. The suggestion that student valourisation should become a norm within a higher education experience met originally with mixed reactions (Wright, 1992; Stefani, 1998). The empowerment movement proposed a shift in power that was seen as contentious and was perceived as threatening to the reliability and validity of assessment. What it achieved was an alteration in focus on the place of the learning process within assessment strategies themselves. These became recognised as legitimate vehicles for increasing students' autonomy through their increased involvement in the assessment procedures (Gibbs, 1995). Such approaches to student empowerment therefore, were intended to be both enabling and to nurture creativity.

Developing strategic learners

A consequence of empowering students is that they continue to play a more active role in their own education with an emphasis on the process of learner managed learning as a mechanism for the development of autonomous practice (Rogers, 1983; Raichura, 1987; Cotton, 1995b; Stephenson, 1992; Stephenson, 1998a; Neary, 2000). It is argued that students should be strategic learners with an ability to think for themselves, to have a good understanding of how to evaluate their own performance, to acquire, integrate and apply knowledge and to use knowledge to achieve identified learning needs (Dux, 1989; Broadfoot, 1996; James and Gipps, 1998; Riding and Rayner, 1998). Developing

strategic learners involves amongst other things, an inclusive and collaborative approach to assessment and with this comes the devolution of some control in relation to the assessment process with students seen as valid stakeholders with an agreed level of responsibility (Boud 1988; Harrison, 1996; Somers-Smith and Race, 1997; McDowell and Sambell, 1999). There are those who disagree and believe that the involvement of the student detracts from the perceived objectivity of the assessment process (McDowell and Sambell, 1999). The protagonists believe however, that strategic learners will know what they *should do* when they do not know *what to do*, something requiring,

resilience, resourcefulness, reflectivity and responsibility (Heywood, 2000:388).

This approach to learning enables students to improve their standard of performance and to develop a personal working definition of excellence (Gordon and Bonilla-Bowman, 1996). For student midwives this enhanced level of personal involvement in the assessment process has the potential to make a contribution to a new professionalism that embraces collegiality and enhances their partnership with women (Holroyd, 2000). Midwives are required to respond to the Government's consumer oriented modernisation agenda that will increase the need to develop their knowledge and skills (DOH, 1999). Creating a strategic approach to learning in them will enable them to have a career long responsiveness and adaptability to such changes.

Autonomy in the learning process

There is no consensus as to what autonomy actually means within the context of midwifery education and this is reflected in the diversity of descriptions it has received (Candy, 1987). Although there are these differences in interpretation there is agreement

that the development of autonomous learners is an important goal (Butcher, 1998; Stefani, 1998; Neary, 2000). Autonomous learning gained prominence in the literature in the 1970s with the conceptual confusion that it provoked being attributed in part to a lack of clarity between teaching and learning (Candy, 1987). It was recognised that there needed to be a differentiation between autonomous learning as a method, and autonomous learning as a goal because the former does not automatically lead to the latter (Candy, 1987). There is also a need to consider how assessment strategies contribute to autonomous learning given that it is well recognised that traditional modes of assessment can actually be quite disempowering and run counter to this overall objective (Edwards and Knight, 1995). Bearing these issues in mind a further exploration of the concept revealed some very pertinent points for consideration.

Autonomy is not an absolute concept, it is primarily an individual quality which emanates from an inner motivation and commitment. It exists in degrees and is closely aligned to attitudes and most importantly, it can be developed. It enables the student to exercise some form of control in relation to their actions. Within a curriculum that aims to produce autonomous learners and autonomous practitioners there must be a deliberate and enabling approach to the development of this quality (Hanson, 1996; McNair, 1996; Foster, 1998). Within the context of adult education, autonomous learning and knowledge of self are closely aligned (Stephenson, 1998b). From the perspective of the midwifery student therefore, autonomous learning represents two processes consisting of both growth at a personal level as well as growth at a professional level. The tensions

which these two processes can produce have been recognised (Bradshaw, 1989; Cook, 1999). Nevertheless it can be argued that,

learning will increase autonomy most if it recognises and builds on the individuals' sense of self (McNair, 1996:238).

Learning is a personal activity and the way in which students learn is claimed by some to be as important as what they learn (Stephenson, 1992). It is clear then, that in order to be an autonomous learner and indeed eventually an autonomous practitioner, students must be instrumental in their own achievements (Sherman, 1985; UKCC, 1992; Patterson, 1996). On the journey to autonomous learning the transfer from a state of dependence to one of independence occurs and Stephenson (1993) has identified this as a cycle of legitimisation. Following an in-depth study he found that independent study students progressed through three coterminous stages. Firstly there was the acceptance of themselves as persons (*I am*). Secondly they accepted the right they had as students to take some control over their own studies (*I can*) and thirdly a sense of confidence that their achievements have been as a direct result of their studies (*I have*). As a consequence each time they enter this cycle, their confidence in relation to their ability to manage their learning is legitimised on the basis of the evidence from their previous achievement.

To be successful there needs to be a shared commitment to autonomous learning at an institutional level as well as at the level of the individual (Candy, 1988; Higgs, 1988; Dewar and Walker, 1999; Stephenson, 2001). In the case of student midwives this commitment must be experienced equally across the curriculum with no differentiation being made at either a clinical or theoretical level. This plainly has implications for

clinical learning. Grant (2002) suggests that changes in practice are more readily achieved if a needs assessment involving the student is undertaken and informs the educational programme. Although her conclusions are directed at continuing professional development the principle is equally applicable to pre-registration programmes.

Confidence and clinical practice

The issue of self confidence and confident performance in clinical practice has been debated for some time. This is not surprising because it is contended that the level of staff confidence can have a direct impact on the quality of care that they deliver (While, 1994). It has also been demonstrated that health care workers' abilities to make clinical judgements can be impaired if they are either over or under-confident (Heywood, 2000). A certain level of self-confidence is therefore central to the concept of competence (Stephenson, 1992).

It has been concluded from a substantial study that the confidence to practise midwifery is an important attribute and should therefore, be addressed by those delivering pre-registration programmes (Frazer et al, 1998). It is a recognised phenomenon that students' ability to learn is influenced by their confidence (Entwistle, 1988). It is argued however, that some midwives still lack the expected degree of confidence in clinical situations at the point of registration (Kapborg and Fischbein, 1998). Confidence in the ability to practise midwifery is the difference between knowing how to provide care and having the capacity to provide that care effectively. This confidence could be developed if students were allowed to have a greater degree of autonomy in the learning process, in particular if they were encouraged not only to reflect on the care that they as individuals

have provided but if they were also able to account for their learning achievements (Stephenson, 1992). A multifactorial approach to confidence has been identified (Stephenson, 2001). This includes, the specialist knowledge, communication and practical skills needed to perform and also a degree of insight and self-awareness particularly in relation to issues concerning personal values as well as those held by others. In the context of this study this has a particular significance for the values held by women in relation to their care.

Assessment and its relevance to life long learning

Life long learning is now a further salient goal of Higher Education (Dearing, 1997; Fryer, 1997; Stefani, 1998; NMC, 2002). Despite the clear intentions there is an element of cynicism in the literature with the goal being seen as nothing more than the oratory of Higher Education (Rust, 2002). Yet life long learning is not such a novel idea as some may think. References to it can be found in ancient writings although, its more recent resurgence can be found in the early days after the second world war (Knapper and Cropley, 2000). The impact of life long learning was articulated most cogently as the move from learning how to be taught to learning how to learn (Knowles, 1975).

This transformation in culture and the shifting emphasis from teaching to learning has been described as an ideological one which, although coming packaged in many different formats, results in more student control and autonomy (Candy, 1987). It has added to the prominence and momentum given to the concept of life long learning coming from employers. They are emphasising the demand for graduates who have acquired life long learning skills as opposed to graduates who are mainly subject specialists. This

intensifies the need for core intellectual skills to receive new impetus within the student experience. Life long learning became incorporated into national educational policy over a decade ago which began to emphasise its value to students in gaining employment in what was, and continues to be, a rapidly changing, turbulent and competitive working environment (Training Agency, 1989; UKCC, 2001b). Within the rhetoric of the NHS, life long learning skills not only equip practitioners to realise their potential but also to help them to shape, improve and modernise service delivery (DOH, 2001).

How life long learning is achieved in Higher Education very much depends on the individual student's capacity to self-assess. Rust (2002:146) believes that there is a, *significant lag in the connection between changes in teaching methods and changes in assessment.*

The development of this capacity is pivotal to the development of life long learning skills and it is argued that there is,

a link between clearly understood assessment criteria and ... the capacity to self-assess (Stefani, 1998 :345).

Once self assessment is mastered, the student is equipped to work and problem solve not just in the familiar but also in new and changing situations. Students thus develop the ability constantly to improve their own performance and that of others a talent much in demand in today's NHS work place. (Bujack et al, 1991; Milligan, 1998). The perpetual change being experienced by NHS employees demands continuous learning that dictates

the need for life long learning to become what has been described as *a pedagogical ethic* (Knapper and Cropley, 2000 :14).

Students need to be able to utilise a variety of learning strategies effectively to translate their work experiences into a superstructure for learning (Edwards and Knight, 1995; Dewar and Walker, 1999; Knapper and Cropley, 2000). To achieve this, the acquisition of life long learning skills and an enquiring approach to practice have become curriculum outcomes (ENB, 1995; DOH, 2001). Life long learners do not learn simply by chance because they set out with the deliberate intention of learning. This needs to be organised skilfully if it is to occur in the pre-registration midwifery curriculum. A well thought-out approach is required where learning needs identified from new experiences or events are met. The individual student must also be able to articulate clearly not only what has been learned but also how this happened. These therefore are the hallmarks of life long learning (Benner, 1984; Knapper and Cropley, 2000; Boud, 2001b).

There are those who are not convinced that Higher Education is necessarily succeeding in making life long learning the pedagogical ethic that has been claimed for it (Heywood, 2000; Knapper and Cropley, 2000). In terms of professional education however, the regulatory and the statutory body have been emphatic. The ENB in their last guidelines for pre-registration midwifery education and in conjunction with the UKCC, emphasised the centrality of this requirement as a learning outcome and the NMC continue to be emphatic (UKCC, 1999b; Phillips et al, 2000; NMC, 2002). This is particularly relevant given the constant government policy initiatives that impact directly upon care delivery

and have associated implications for practitioners (DOH, 1998a; DOH, 1998b and DOH, 1998c; DOH, 1998d).

Existing evidence of consumer involvement in assessment

Involvement of patients in medical education is an attempt to create new learning relationships between medical students and their patients (Kelly and Wykurz, 1998; Sayer et al, 2002). Studies where patients were involved in both teaching and assessment conducted by Hendry et al (1999) were able to demonstrate,

statistically significant gains in students' knowledge ... their confidence ... and their attitudes ... and highly significant gains in competence (Hendry et al, 1999:675).

Indeed it is interesting to note in Hendry's study he found that patients' ability to teach the medical students was, *at least equal to the Consultant Rheumatologists* (Hendry et al, 1999:676). Although these studies were modest in their scope with one involving just forty two medical students, they do provide substance for interesting debate and possibly, *vindicate the call for a more patient-centred approach to teaching* (Stacy and Spencer, 1999:694).

Further empirical evidence from medical education demonstrates that those who are on the receiving end of care do indeed 'teach' care givers but are, *not usually aware of doing so* (Stacy and Spencer, 1999:693).

However when asked, even in the absence of briefing or preparation, some patients cared for by medical students,

saw themselves as having specific contributions to make to medical students education and training (Stacy and Spencer, 1999:693).

Patients' ability to participate in student education and training with little in the way of preparation has also been found by Blasco et al (1999).

Clients have also participated actively in Health Visitor education since the 1960s. Twinn (1995) found that not only did some clients welcome the opportunity for involvement but they could clearly identify factors that they considered to be essential to competent practice. As the student/client, student/assessor relationships vary considerably in Health Visitor education it is contended that the inclusion of the client perspective adds a valuable dimension (Ramos, 1992). Further evidence of effective patient involvement in teaching can be found in the field of dementia studies (Skog et al, 2000).

Users of midwifery services are not a homogenous group but student midwives are required to provide individualised care to a consistent standard for them (Henderson, 1994; Lofmark et al, 1999). It has been argued that the inclusion of recipients in the assessment process contributes to improved standards by enabling students to learn from those in their care (Collington, 1998). The Bart's Nursing Objective Structured Clinical Examination provides an example of this. It allows assessors to incorporate simulated patients' feedback regarding student performance within the assessment process. Whilst not entirely in the authentic world of practice, it does demonstrate a genuine attempt to involve the patient in the process of assessment. (Nicol and Freeth, 1998)

Conclusion

This review of the literature has revealed a rich variety of interlocking concepts that are apposite considerations in terms of the assessment of student midwives and the involvement of women in it. This firmly anchors the problem to previous research through what is meant to be a thorough exploration of the subject matter surrounding the various facets of the topic. The review has attempted to achieve breadth and depth and has incorporated major sources from the education literature as well as those that are midwifery specific. It has aimed to be systematic and to describe accurately trends and assumptions and to provide an appraisal of these. It is contended that this literature review has unambiguous implications for the intended study and provides a sound rationale for its conduct.

The main findings of the literature can be broadly summarised into five major categories as follows:

1. Processes and explanations for learning from practice.
2. The roles of the various participants involved in teaching and learning.
3. The assessment process.
4. The roles and potential roles of those involved in the assessment process.
5. The professional ethos of midwifery.

The literature review established that clinical experience and learning can be regarded as different concepts. Yet for the student midwife, the two overlap. Although some

experience offers little in the way of learning. On other occasions experience makes high intellectual demands upon the student. The challenge for all involved in teaching, learning and assessment therefore is to bring about the confluence between clinical experience and learning

These five factors that comprise the above summary of the literature review were to become the determinants of the study design. Although their eclectic nature supported a seemingly concise research question, the lack of previous enquiries in the particular subject required a purposeful study design with mixed data collection methods. A modified interpretivist approach provided a feasible solution.

The aim of the work was to explore the case for greater involvement of women in the determination of student competence, through the perceptions of key stakeholders. Given the uncharted nature of the topic and the exploratory characteristics of this research question, a method was required that led to the selection of the key stakeholders with differing personal interest in the processes of student learning and assessment yet sufficient commonality of concern to make an applicable contribution.

The key stakeholders were regarded as the following:

Key expert professionals and key lay informants – provided expertise derived from the responsible statutory body and lay pressure group sources that differs but is mutually complementary.

Parents – are end users of the service and have a subjective interest in the quality of the personal care they receive.

Student midwives – have a vested interest in learning from practice and in being successful in their clinical assessments.

Those midwives who act as mentors to student midwives – have a professional responsibility to coach and guide students and to assess students and confirm their abilities to practice safely.

All ENB Approved Midwife Teachers – have a statutory responsibility for curriculum development and the statutory oversight of a student's fitness to practice as a Registered Midwife.

The following chapter will address in greater detail the study design and methodology that were adopted in the prosecution of the subsequent investigation.

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CHAPTER 3 - THE STUDY DESIGN AND METHODOLOGY

Approaches to the study – an overview

Researchers have to choose between a variety of research strategies and the initial choice may not be easy. Approaches consist not only of procedures of sampling, data collection and analysis but they are based also on particular assumptions about the world and the nature of knowledge that sometimes reflect conflicting and competing views about reality. Two main sets of assumptions underlie approaches to research. These are the positivist and the interpretivist paradigms (Lincoln and Guba, 1985; Bryman, 1988; Scott, 1996). There are possible commonalities as well as the potential for conflict and tension between the two. For the purposes of this work an examination was undertaken to determine how each approach differs in the spectrum of methods it employs, perceives research problems and the type of data each yields, with the intention of selecting what was most appropriate for the exploration of the research focus.

The positivist and interpretivist approaches

Positivism is an approach to science based on a belief in universal laws and an insistence on detachment, objectivity and neutrality (Thompson, 1995). Positivists follow the natural science approach by testing theories and hypotheses. Comte (1798-1857), the French philosopher, introduced the term positivism and suggested that the emerging social sciences should adopt natural science, nomothetic research methods. These were quantitative in nature and thus influenced social science throughout the nineteenth and the first half of the twentieth centuries. Positivist researchers begin with certain assumptions about human behaviour. In consequence they search for patterns and regularities within it

and believe that universal laws and rules or law-like generalities exist for human action (Hitchcock and Hughes, 1995). The fundamental stance of positivist researchers is that people can be studied as individual entities. Positivists are committed to numerical measurement, statistical analysis and the search for cause and effect and objective knowledge (Duffy, 1985). These researchers control the theoretical framework, the sampling frames and the structure of the research they undertake (Brannen, 1992; Maykut and Morehouse, 1994; Holloway, 1997).

The interpretivists' view can be linked to Weber's concept of 'Verstehen' which emphasises understanding something in its context (Blaikie, 1993). In this paradigm human experience is studied holistically and is not believed to be free from time, location or from the mind and experience of the research participants (Sherman and Rodman, 1988; Denzin and Lincoln, 1994; Holloway and Wheeler, 1996). Through interpretivism, research participants are seen as actively construing, constructing and subsequently interpreting not only their own actions but also that of those with whom they interact (Blaikie, 1993; Denzin and Lincoln, 1994). Interpretivist researchers place a similar emphasis upon understanding human experience as researchers from the positivist paradigm place upon explanation, prediction and control. The interpretivist approach is not completely precise because of the belief that human beings do not always act logically or predictably. On a philosophical level therefore, a fundamental difference exists between the two camps regarding the assumptions concerning human nature. In the extreme interpretation positivists are proponents of determinism that portrays human beings as responding mechanically to their environment. Interpretivists on the other hand

subscribe to voluntarism in which human beings are seen as initiators of their own actions (Leininger, 1985; Lincoln and Guba, 1985; Denzin and Lincoln, 1994). There is a distinctive interest in the processes that leads to the establishment of meaning. How meaning is generated through negotiation and how it is subsequently sustained in a day to day context specific way is central (Denzin and Lincoln, 1994). Interpretivists turn to their human participants for guidance, control and direction whilst also acknowledging and indeed celebrating, that they are not divorced from the phenomenon under study and realise that their own values and interests become part of the research process and subsequently the results (Smith, 1983; Porter, 1993; Holloway, 1997; Denscombe, 2002). Traditional positivist notions of objectivity and neutrality therefore, are impossible to achieve in interpretivist research. It has been argued that the researcher using these interpretations,

celebrates the permanence and priority of the real world of the first-person, subjective experience. (Denzin and Lincoln, 1994:119).

These assumptions mean that interpretivist research is not wedded to a particular methodological orthodoxy. Rather it operates on the principle of methodological appropriateness where decisions are made concerning the reasonableness of fit that particular methods have in relation to the questions being asked and the resources available to the researcher (Patton, 1990; Crotty, 1998; Denscombe, 2002). Interpretivists maintain that a focus on methods per se can detract from the principle intention of social research, namely that of getting to grips with complex, situation-specific meanings (Polit et al, 2001; Erickson, 1990). Smith (1989a) refers to this style of enquiry as the middle ground of methodology whereby the use of different methods is part of an error

elimination strategy. This view finds support from a number of researchers (Firestone, 1990; Patton, 1990; LeCompt et al, 1993). It gives way to a mixed method approach and results in a certain blurring of the boundaries between the art of interpretation, the social scientific and the literary account (Geertz, 1980). It enables the researcher to capture what have been described as,

non-contradictory descriptive and explanatory claims about any phenomenon
(Hammersley, 1989:135).

This stance has been informed by philosophical pragmatism, a pluralistic ideological framework, the need to be situationally responsive and the belief that when trying to come to an understanding of human behaviour, there is only interpretation (Denzin, 1989a). There are those who resist this pragmatic approach but subscribe to it perhaps at a methodological level but not at a paradigm level (Brewer and Hunter, 1989; Denzin and Lincoln, 1994). Another important feature of interpretivist claims to knowledge is the realisation that they are a mixture of facts and values. From the interpretivist perspective there cannot be fact without values. An interpretivist approach to inquiry can accommodate a range of values without necessarily advocating any particular one. This was an important aspect of this study given that different values result in different facts. Gathering data from a range of people associated with maternity services and midwifery education with potentially very different value systems needed to be recognised and explicitly incorporated into the study design (Smith 1989b; Cluett and Bluff, 2000; Donovan, 2000). In contrast to the positivist paradigm, the theoretical framework is not always predetermined but can be derived directly from the data. It is apparent therefore that assumptions of an ontological kind concerning the essence of social phenomena

differ between positivist and interpretivist approaches. Assumptions of an epistemological nature also differ regarding the basis of knowledge and how it can be acquired and communicated (Usher, 1996). Some are of the view that this apparent polarisation of the two paradigms does not produce a useful debate but rather results in misleading conclusions and claims of a distillation of what is 'good' and 'bad' in each (Hammersley, 1993). In an attempt to inject some balance into the debate Bryman (1988) and Silverman (1993) suggest that neither paradigm is superior to the other and stress that the approach should depend on the intentions and goals of the researcher. It is the case that both positivist and the interpretivist approaches may even use the same data collection method. The case for rejecting too rigid a distinction has been made and such dichotomous thinking is being challenged as being unhelpful (Jackson, 1989).

This study adopts a modified interpretivist approach that allows for a purposeful design of data collection methods. An additional justification for the choices made in the conduct of the work can be summarised as follows:

I want to emphasise that there is no cookbook for doing qualitative research. The appropriate answer to almost any question about the use of qualitative methods is "it depends" (Maxwell, 1996:63).

and,

research is a messy and untidy business which rarely conforms to the models set down in methodology textbooks (Brannen, 1992:3).

Validity and reliability - some challenges

Interpretivists' claims to knowledge are understandably contestable and it has been suggested therefore, that judgements about interpretive accounts should be made in a pragmatic way given the commitment within this research style to methodological appropriateness and the usefulness of the findings rather than to methodological orthodoxy (Patton, 1990; Denzin and Lincoln, 1994). Terms such as validity and reliability are no longer perceived as appropriate in an interpretivist research context. They represent an awkward fit when seeking to establish the trustworthiness of data (Seale, 1999). There are helpful alternatives that can be employed to make a quality judgement about a piece of interpretivist investigation. Four such concepts are worthy of attention in relation to this study namely, credibility, transferability, dependability and confirmability. To a certain extent they all depend upon the rigour of the study and the integrity of the reader (Coyne, 1997).

Seale (1999) suggests that the notion of internal validity be replaced by the notion of credibility when evaluating the integrity of interpretivist work. This concerns how the reader will be convinced of the 'truth value' of the findings. Methodological rigour can be demonstrated within interpretivist research through a detailed 'audit trail' where researchers describe the methods adopted and the problems they encountered (Sandelowski, 1993). It is in this way they open their work to public scrutiny and critical examination (Holloway, 1997). Secondly Seale encourages the reader to consider the transferability of the findings. It can be argued that the interpretivist researcher can,

seldom specify with precise detail the universe to which he wishes to generalise (Denzin, 1971:175).

This is simply because the total population may be unknown to the researcher. It can be argued therefore, that readers of this kind of research are in a position to formulate a conclusion about the persuasiveness of the findings and the reasonableness of generalisation or transferability from a particular study by comparing it to their own circumstances (Porter, 1996). The adequacy of the proof and the degree of confidence that can be assigned by readers will depend to a certain extent upon the level of description that the study gives (Becker, 1978). Thirdly Seale replaces the notion of reliability by drawing attention to the dependability of the findings and this concerns their consistency and the chances of obtaining similar results if the study were repeated. Finally he points to the concept of objectivity. This encourages the readers to think in terms of confirmability whereby they can be assured that the findings have been determined solely by the research participants and are not a product of researcher bias.

Ethical issues

Throughout the study, from the identification of its purpose to the reporting stage, ethical dilemmas were anticipated, identified and confronted as a means of strengthening the integrity of the work (Blaikie, 1993; Kvale, 1996). A very comprehensive definition of the concepts, and ethical issues in social research that captures them from multiple perspectives including those of research participants, the researcher and the project itself has been proposed by Barnes (1979). He was concerned with moral standards and the

various decisions that have to be made throughout the research process and was of the view that these ethical decisions,

arise when we try to decide between one course of action and another not in terms of expediency or efficiency but by reference to standards of what is morally right or wrong (Barnes, 1979:16).

Ethical judgements within research are a permanent challenge and it is suggested that the only way to avoid violating ethical principles is to refrain from engaging in research in the first place (Barnes, 1979). The purpose of this study was considered morally legitimate on the basis of the literature review and a deontological approach to ethical matters was observed throughout its conduct. Certain principles were respected at the design stage. For example informed consent was obtained from all participants and they were given guarantees of confidentiality and anonymity (Dane, 1990). Steps to ensure anonymity required that key informants were not identified individually in any subsequent coding framework. Focus group participants were identified collectively to most accurately capture their contributions that were difficult to differentiate thus avoiding misattribution within each group. Gaining informed consent is not straightforward and potential participants may for whatever reason, feel obliged to participate. In seeking to minimise coercion to join the study a third party was used wherever possible to make an initial approach to the participants and seek their willingness to join the study prior to their formal consent to contribute being obtained (Dewar and Walker, 1999). The Director of Midwifery Education and Practice approached the ENB Officers. The Approved Midwife Teacher at the Higher Educational Institution was involved when seeking access to recruit students. Procedures that were in place for gaining access to

mentors and women and their partners at the NHS Trusts were also followed assiduously. The women and the partners were also approached initially for expressions of interest by the Midwifery Sister conducting the parentcraft class reunion from where they were recruited.

Whilst it is possible to make specific ethical decisions at the design stage it was also necessary to take cognisance of the possibility of having to make hasty ethical decisions during the conduct of the research itself and to be prepared for this. Interview inquiry is a moral enterprise that is capable throwing up ethical concerns in terms of the interview style of the investigator, power within the interview relationship and the very nature of disclosure by participants that can be difficult to anticipate in advance (Mason, 1996). In consideration of these potential consequences of interview interactions the researcher offered the respondents an opportunity for debriefing following the interviews. The literature suggests that this can alleviate uncertainties on all sides (Bowling, 1997).

Ethical considerations also permeate the analysis of the data that must result in,

Knowledge which is as secured and as verified as possible.

(Kvale, 1996:111).

This necessitates absolute probity in the reporting of findings and requires the discussion to be supported fully by the data and the conclusions should also demonstrate an honourable reflection of what the study has found. To this end all participants apart from the parents were offered verbatim copies of interview transcripts for verification. An

assurance was given to all participants that all tape recordings of interviews would be erased when the study was completed.

Phase 1

The study population and sampling

The work set out to provide illuminating descriptions of the perspectives of various stakeholders in the outcomes of pre-registration midwifery programmes that may or may not be generalisable (Schofield, 1993). Realistically there is a need to be pragmatic yet principled in determining a sampling approach that ensures economy of size and an overall feasibility (Coyne, 1997). It is accepted that the interpretivist approach has been criticised for generating impressionistic and non-verifiable findings often due to small sample sizes (Miles and Huberman, 1984). The counter claim however, is that this form of enquiry generates high levels of relevance. A non-probability, purposive sampling approach was adopted in the initial phase of the work. The appropriateness of the purposive sample in interpretive research has a profound effect upon the ultimate quality of the research (Coyne, 1997).

Phase 1a - Individual interviews with key informants with an interest in improving midwifery care

Four expert representatives from those with an interest in the improvement of maternity services were considered to be an apt population to include in the research. A leading member from the National Childbirth Trust (NCT) and a lay Chairperson of a Maternity Services Liaison Committee (MSLC) were recruited to be part of this expert sample. Because the ENB had national responsibility for promoting the involvement of service

users in the assessment process, nominations were requested from the Director of Midwifery Education and Practice at the Board and as a consequence, two of its midwifery officers agreed to participate in the study. The two midwifery officers were interviewed in their respective offices whilst the lay chairperson of the MSLC was interviewed in the researcher's office. The member of the NCT was interviewed in her home at her request.

Phase 1b - Focus group interviews the student, mentor and parent participants

The Phase 1 sample included two groups of women and their partners (N=10) and (N=12), two groups of experienced student midwives (N=9) and (N=5) and one group of mentors (N=10).

The women and their partners formed the first two focus groups. Each group interview was held following a parentcraft class reunion. Having gained consent from the NHS Trust to proceed, all parents were consulted directly by the Midwifery Sister who ran the classes in advance of the reunion meeting to explain the purpose of the focus group interview and to seek volunteers. All parents in both gatherings agreed to participate. As a consequence of having met approximately six times prior to the birth of their babies the parents knew each other. They were familiar with the setting and refreshments were available. The Midwifery Sister who conducted the reunion meeting assisted by tending to any of the babies who required attention during the interviews. None of the parents were known to the researcher although the Midwifery Sister was. Both groups were drawn from a ward that is characterised by Victorian terraced housing in various states of repair. Its residents include working class young white families along with a high

proportion of extended Asian families. The participants reflected this mixture and were all English speaking.

These were followed by two midwifery student focus group interviews. The students were either in their penultimate year or final year of study. The interviews were conducted in a discussion room in the Higher Education Institution that the students were attending. A total of twenty eight students were contacted by letter that was distributed by the AMT for the Institution informing them of the study and the purpose of the focus group interview. Fourteen volunteered to participate. The researcher knew none of the students.

Having received permission from their respective employers at two NHS Trusts, a selection of thirty mentors were contacted by letter seeking their willingness to participate in the study. The mentors were selected from both trusts to ensure that there would be representation from the range of clinical settings where students were placed. Ten mentors meeting the above criteria made themselves available for interview. Others were interested in participating but met with difficulties in terms of diary and shift commitments. The Trusts differed in that one was located in a city where forty percent of the women accessing its maternity services were from its ethnic minority population. The second Trust was in a rural setting servicing a smaller though ethnically mixed population. This final focus group was held in a classroom specially arranged for the interview in the researcher's HEI that was familiar to the mentors. Arrangements were made for parking and refreshments were made available. The researcher knew all of the mentors although not all mentors were known to each other.

Phase 2

Population and sampling

A self-response questionnaire was designed using the findings that emanated from the literature, the data analysis from the individual and focus group interviews in Phase 1 and the personal familiarity with the culture of midwifery education of the investigator (Steckler et al, 1992). This tool was administered to all ENB Approved Midwife Teachers seeking their opinions in relation to the emerging themes. The Director of Midwifery Education and Practice at the ENB provided names and contact addresses. The total number of Approved Midwife Teachers excluding the researcher was small (N = 48). In an attempt to maximise the response rate a second mail shot followed the first some three weeks later. A letter explaining its purpose accompanied the questionnaire and the value of the respondent's views was emphasised within it. This elicited 40 responses that equated to an 83% response rate. Professional information regarding the AMTs was collected. This provides details in relation to the number of years they were qualified as a midwife, the number of years they spent as midwife teachers and the number of years they had been in the role of AMT (See Appendix 3).

Data collection

Phase 1a and 1b - The individual and focus group interview as a method of data collection

The interview procedure

A crucial aspect of the interview as an instrument is the means by which the data will be captured. Of the options available the researcher decided to tape record each interview with both the individual key informants and the focus group participants.

The sole exception to this was the first parent focus group. The researcher sensed that this group although uncomplaining, was inhibited by the tape recorder and became much more comfortable when it was removed. It was acknowledged that the retrospective process of attempting to remember all that had been said and then writing up the record following the interview would create a vulnerability to error and thereby cause distortion of the data. It was decided therefore, to seek a compromise and to record the responses manually through field notes that summarised the salient observations.

Designing the interview schedule – some considerations

Structured and unstructured questions

The semi-structured interview schedule that was used required the research participants to think, deliberate and provide specific information during the conduct of the interview (See Appendix 4). A decision was taken to use the same schedule with both the key informants and with each of the focus groups. Plainly each constituency had different interests and so as a consequence, the points in the schedule were not followed slavishly in the same order on each occasion that it was administered. Rather, they were presented

in the order of their assumed interest and importance to the respective groups as the interview progressed. It was recognised that this would be reflected in the data and the results but the assumption was made that the core questions had relevance to all participants. The respondents were able to express themselves at some length yet there was sufficient structure to prevent aimless rambling (Rubin and Rubin, 1995). This approach allowed the researcher to seek clarification, to probe and to introduce follow up questions thereby enriching the findings and enhancing the credibility of the data that resulted (Ackroyd and Hughes, 1992). It seemed reasonable to suppose that the context, format and sequencing of questions, together with the response categories would be helpful to the respondents without intentionally biasing their answers (Oppenheim, 1992).

Question content and format

The importance of an appropriate focus and content for all the questions was recognised and addressed. Given that each question is considered a proxy for an actual measure, it was presumed that,

each question has a job to do and that job is the measurement of a particular variable. (Oppenheim, 1992:144).

As a result, the themes that emerged from the literature, the personal experience of the investigator and the focus of the study combined to dictate the content of each question. A distinction between seeking to ascertain what people knew, what they thought and felt and what they did was made in constructing the interview schedule. This resulted in questions concerning facts, beliefs, attitudes and behaviour. To secure an accurate understanding of the questions on behalf of the participants, care was taken with their

actual wording to add to the volume of the exchange of information each might produce (Jones, 1985; Holstein and Gubrium, 1997). The socio-linguistic aspect of interactions thus informed the question design and this reflected the different individuals and groups that were to be involved.

Probably the most widely debated issue in the design of a question and how it is to be answered concerns its open-ended or closed-endedness (Jones, 1985). Open-ended questions have an obvious advantage in that they put a minimum of restraint on respondent's answers and on their freedom of expression. This format was mainly used in this exploratory study in seeking the opinions and attitudes of respondents in relation to the overall concerns of the study. It was also felt that this format would help to establish rapport and encourage co-operation during the interview itself (Mishler, 1986; Cohen et al, 2000). This approach is in keeping with the view that the skilled interviewer using a good interview question should not just contribute thematically to knowledge production but should function dynamically in order to promote good interview interaction (Kvale, 1996; May, 2001).

Main questions created a scaffold for the interviews and this was important to ensure that these covered the overall subject of enquiry and that the questions had logical consistency. Probing questions were included deliberately. They were designed to elicit three main functions namely to signify the level of detail the interviewer was seeking to extract, to establish that the interviewee was paying attention and lastly to encourage the interviewee to reach a conclusion to the answer that was being provided (Rubin and Rubin, 1995). This type of question was of particular relevance to both the parent and

student focus group interviews. Follow up questions were used to pursue the overall theme to its logical conclusion to thus secure the depth of response that is supposedly the hallmark of effective interviewing in qualitative research (Cohen et al, 2000).

The pilot study of the interview schedule

A number of tactics were employed at the pilot stage in order to refine the interview tool. Firstly a small number of experienced educators and senior service colleagues in the field of midwifery were asked to comment on the questions. This resulted in some amendments to the schedule. These were followed by a mock interview with a senior midwifery lecturer who was asked to repeat the questions in her own words to help further refine their linguistic style (Jones, 1985). Opportunities were given to this colleague to ask questions of the researcher in order to clarify issues or simply to seek confirmation regarding the meaning and relevance of the questions (Massarik, 1981).

The interviews with the key informants

Four key informants were interviewed individually. The following guiding principles were born in mind during these four important interviews, each of which lasted a duration of about one hour.

The interview process with these significant individuals, was recognised to be a multifarious activity requiring considerable skill if was to succeed. There was confidence in the appropriateness of the method in relation to the overall research topic and in its resonance with the aims of the study as well as with the epistemological orientation of the work. There was a similar faith in the design of the actual interview schedule that

stemmed from careful piloting. The exercise attempted nevertheless, to avoid complacency. The face to face interview is one of the most tried and tested methods of investigation. Yet despite its power in the acquisition of relevant research information, it was recognised that it is not without its problems and can be one of the most ill used devices (Cohen et al, 2000; Robson, 2002). Care was taken to ensure sufficient standardisation in relation to what was asked but to also make profitable use of the flexibility of the technique to explore the stance of the respective interviewees. Awareness was also maintained during the conduct of the interviews that bias could occur through the personal influence of the interviewer. This can produce errors and misunderstandings in the subsequent data. In its broadest sense therefore, the interviews with the key informants were regarded as a near normal everyday chat about the issues.

Focus group interviews

As with the individual interviews that have been described above, the use of focus group interviews was considered congruent with the overall philosophy that underpins the study.

A simplistic rationale for their use has been provided as follows:

group discussion can help individuals to develop a perspective which transcends their individual context (Barbour and Kitzinger, 1999:19).

The focus group interview was also seen as a useful tool to engage the various participants with the subject in which they all expressed a vested interest. The aim was to elucidate the participants' perceptions and also to capture attitudes and feelings (Morgan, 1988). Thought had been given at the sampling stage about whether the participants were known to each other because it was felt that the degree of familiarity would result in the

participants being more comfortable in one another's company for the purposes of the interview. (Krueger, 1994; Vaughn et al, 1996). The composition of the various groups was considered with a view to achieving a sufficient level of typicality and also a degree of diversity (Kuzel 1992). The membership of all the focus groups did have a sufficient level of homogeneity and compatibility to give confidence that debate was likely and each individual would feel able to contribute to it. The groups varied in size but were similarly kept to manageable numbers with the intention of securing full participation. The sessions attempted to generate a relaxed and permissive atmosphere that offered security and aimed to minimise inhibitions and so encourage spontaneity and disclosure that would mimic the social nature of everyday conversations (Krueger, 1998). The milieu that was created thus allowed for the expression of multiple points of view yet also involved the researcher as an integral part of the process.

As previously, the interview schedule was amenable to sufficient adaptation in the order in which its questions were raised to provide an adequate degree of organisation for the sessions yet to also, give participants sufficient freedom to express personal opinion within the discussions (Barbour and Kitzinger, 1999). Clearly the priority of the different clusters of questions altered according to the different groups of participants. In addition the language used was also varied to accommodate the comprehension of the particular participants. This interactive, synergistic nature of the focus group interviews proved vital to generate the necessary relevant data (Morgan, 1988; Proctor and Renfrew, 2000).

Data Collection Phase 2

The self-completion questionnaire

The major challenge in designing a self-completion questionnaire is the translation of the research objectives into specific questions (Frankfort-Nachmias and Nachmias, 1996).

It is suggested that,

as a general rule the kind of information sought and the means of its acquisition will determine the choice of response mode. (Cohen and Manion, 1994:285).

The questionnaire was designed to elicit information in an ordinal, textual and numerical format from the AMTs about six themes concerning the involvement of women in the teaching and learning aspects of the Pre-registration Midwifery Curriculum (See Appendix 5). These themes like those of the previous interview schedule emerged from the literature review and from an analysis of the data collected in Phase 1 of the study and from personal knowledge of the culture of midwifery education.

It is recognised that questionnaire and interview techniques have similarities but also important differences. The questionnaire that was used aimed to demonstrate clarity, specificity, precision and a lack of ambiguity (Jones, 1985; Fowler, 1995). Apparent epistemological differences between the self-completion questionnaire and interview methods were also considered during the design process. Whilst acknowledging the extremes of precision associated with survey research that can exist, the instrument was not designed to produce an absolutely impartial version of the verifiable truth from the AMTs. Although it had closed ended items that sought measurable and objective

information, its intention was also to seek detail concerning the respondents' subjective opinions and beliefs through the open ended comments that were invited in each section (Gordon, 1987).

The closed ended items enabled respondents to rank order their attitudinal response in terms of levels of agreement in relation to specified topics. Double barrelled questions with the use of words like 'and' and 'or' were avoided to minimise confusion and to maximise the validity and reliability of the data (Frankfort-Nachmias and Nachmias, 1996).

It is recognised that rank order ordinal scales provide a set of closed-ended questions, while attempting to permit the respondent to express a range of opinion, rely on subjective interpretations and as such, cannot be assumed to have absolute meaning (DePoy and Giltin, 1998). These do nevertheless, provide a relative measure in relation to the question. The use of closed-ended questions also had advantages because these can be more efficient than the open-ended variety in terms of their ease of completion. Effortless completion is an important determinant of the response rate but this had to be weighed against the tendency of closed ended questions to evoke superficial responses. By contrast, open-ended questions require more commitment and the motivation to complete them on the behalf of the respondents and 35 of them took this trouble. This guarded against some limitations in meaning associated with closed-ended questions. A number of open ended questions were also justifiable because the AMT population were all articulate, were well able to express themselves and would knowingly enjoy doing so (Fink, 1995). It was intended to give them a chance to think through their responses and

that seemed a reasonable consideration for those whose opinions were not totally crystallised.

The pilot study of self-completion questionnaire

A pilot study involving four midwifery lecturers was conducted for the purposes of pre-testing the questionnaire and was an integral and crucial part of the design of Phase 2 of the study (Youngman, 1978). The piloting included a review of the comprehensiveness of the covering letter and its ability to convey to each potential respondent the value of their contribution to the overall study. Personal knowledge of the population suggested this would also be pertinent to the eventual response rate. The exercise also tested the comprehensibility of the instructions to respondents and most importantly, the intelligibility of the questions themselves (Rees, 1995; May, 2001).

Data Analysis

Phase 1 Interview transcripts from the individual interviews and focus groups

Phase 2 Textual data from the self-completion questionnaires

Qualitative data from both phases of the study were analysed using the same techniques although each is reported separately in the accounts of the respective phases of the study. The transcripts from the individual and focus group interviews were analysed at the end of Phase 1 and were utilised to inform Phase 2. Textual data from Phase 2 was analysed when all the completed questionnaires had been received. The approach to the analysis of qualitative data is quite a flexible one that is by no means standardised with researchers making sense of their data in different ways. It is agreed however, that there are a number of appropriate methods with common features (Tesch, 1990; Kvale, 1996). Given that

the aim of this research is to persuade, the means of analysing the data sought to present the most logically argued, clearly articulated and plausible account of the findings that was possible. Being explicit about the style of analysis that was used intended to achieve this aim.

To this end a systematic, sequential procedure to interrogate the textual data was initiated that can be depicted as follows:

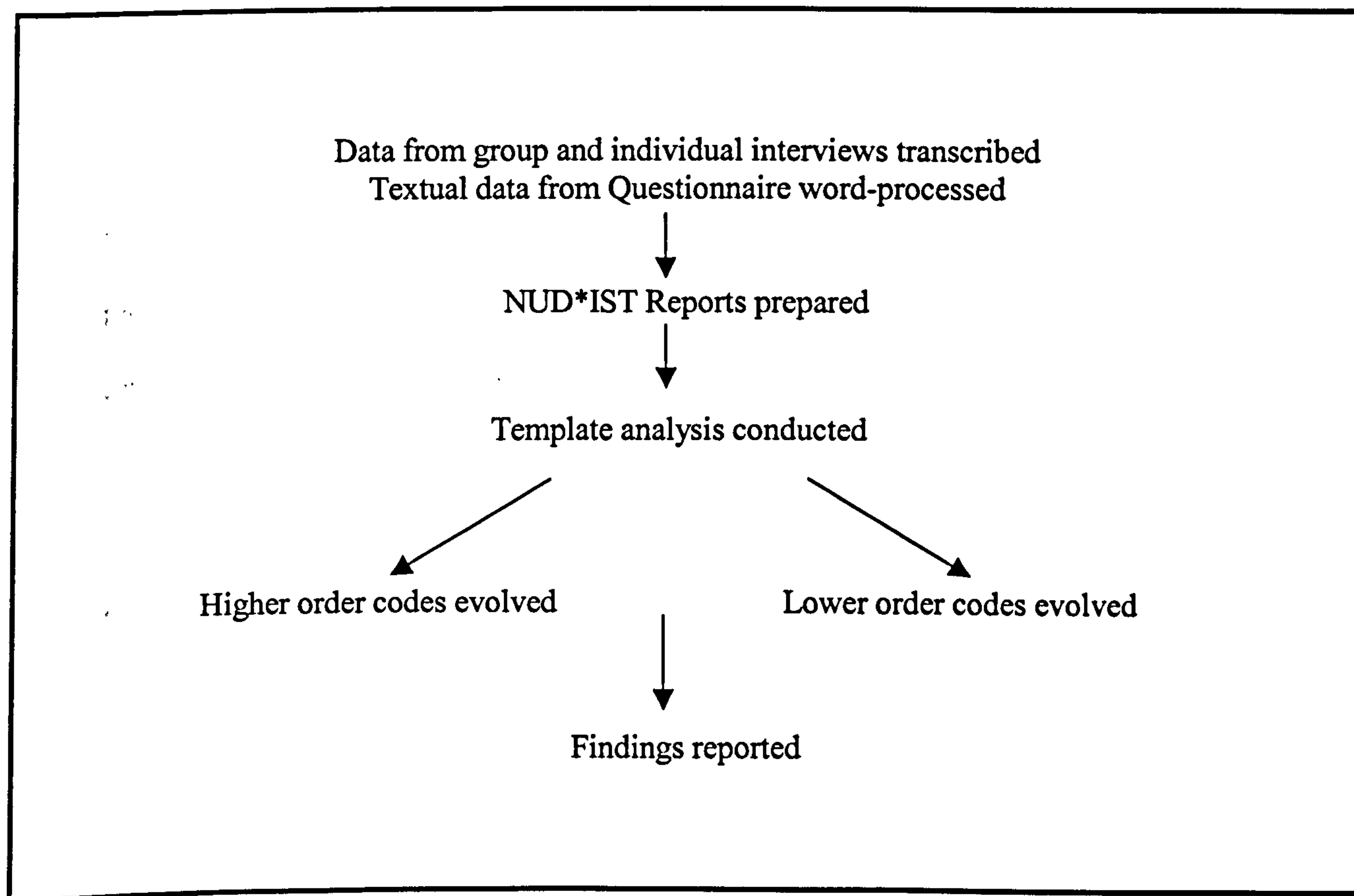


Figure 7 Data Analysis - A Summary

Data management

The textual data from both phases of the study was managed initially through the use of the computer software package NUD*IST (Non-numerical, Unstructured Data Indexing, Searching and Theorising). The advantages and disadvantages of the using NUD*IST for this purpose were considered. From a fundamental epistemological perspective, interpretive researchers have associated the use of computers with the positivist paradigm. The notion that computers could assist with the handling of qualitative data has therefore been resisted in part due to *fear that the computer rather than the researcher controls the research process*. (Pateman, 1998:80).

Computer software programmes that support the management of textual data have proliferated in recent years as they have become more user friendly although, their limitations are worthy of acknowledgement. The reluctance on behalf of researchers to utilise them has thus receded (Dey, 1993; Pateman, 1998). The inability of computer software to control the research process is being acknowledged increasingly by interpretivist researchers. It is contended that no matter what software programme is used it will,

not affect your conceptual results more profoundly than your word processor influences the character of your writing. (Tesch, 1990:305).

The decision was made to use a limited rather than a full use the facilities of the package. Its use was confined to making the data manageable rather than using its more extensive analytical capabilities. Whilst software programmes support data analysis they are certainly not a substitute for the competence and the intellectual clarity required of the

researcher using the programme (Coffey and Atkinson, 1996). The encounter with this technology immediately created trust that large quantities of narrative text would be handled more competently and more effectively by this means rather than by the use of more traditional manual techniques.

The difficulties associated with “knowing” qualitative data is attributable directly to both its density and its volume and can result in short cuts in its analysis (Pateman, 1998). It is not unknown for researchers to illustrate findings with convincing yet opportunistic samples that are found conveniently in the text that are in fact biased and lead to unwarranted conclusions (Miles and Huberman, 1994). The use of NUD*IST helped to redress this possible tendency effectively without being overly reductionist (Reid, 1992).

The tape recordings of the individual and the focus group interviews had been transcribed and the qualitative data from one focus group with parents who were not recorded and the AMTs who had provided qualitative comments were word-processed verbatim to create text that was the nearest equivalent to a transcript. All the textual material was then imported individually from each transcript into NUD*IST and a NUD*IST report was created for each one that identified each line of each transcript by a number. Each individual transcript from the key informants was assigned a colour code and those from the focus groups were similarly identified as the parent, student midwife, mentor and AMT sample.

Data analysis using the Template Analysis technique

Many qualitative researchers look for themes in a rather non-specific fashion whereas others set out with a quite distinct plan that is wedded to a particular approach to the task. Content analysis and grounded theory have been described as being on the opposite ends of a spectrum in this regard (King, 1998). Content analysis uses codes to define the thematic content of qualitative research that are discrete and are largely predetermined. Conversely, grounded theory begins from a point where no codes are defined. The middle way between these two extremes is provided by template analysis and this seemed to provide an appropriate fit with the qualitative data that this study set out to collect (King, 1998). A process was employed that was not overly mechanistic but was both methodical and comprehensive and corresponded with the “intellectual craftsmanship” concept associated with qualitative analysis (Cohen et al, 2000). Whilst the process of analysis was concerned with the unravelling of the data the ultimate goal was,

the emergence of a larger, consolidated picture (Tesch, 1990:97).

Template analysis, thematic coding and codebook analysis are all terms used interchangeably to describe an approach to the analysis of qualitative data (Crabtree and Miller, 1992). This approach to analysis is evolutionary and so affords a degree of flexibility in the scrutiny of textual data that allows the researcher to explore it and present the findings with varying degrees of specificity.

Although the individual transcript reports formed the basis for this examination it was decided to conflate the reports for the key informants for the purposes of the analysis to preserve their anonymity. Similar treatment was given to the reports of both the focus

groups for the parents because of the strong similarity of both samples. The reports on the transcripts of the student midwives were also considered together because of the uniform characteristics of both groups.

The initial template used was a combination of the topics from the semi-structured interview schedule and the themes that headed the six sections of the questionnaire. These had also derived from the academic literature as well as from the researcher's professional experience. They were collapsed into a number of predefined codes to chart the course of the analysis without making pre-conceived assumptions. Examples of the codes used included, 'relationships', 'power', 'feedback' and 'learning'. This provided the initial template.

The research then concentrated on working systematically through all the NU*DIST Reports to identify pieces of text that corresponded to the themes identified in the initial template that were then marked with an appropriate code. Throughout this process, additional themes were identified and existing ones were modified as the textual data was read and interpreted to fill in the gaps between the initial template and the new salient topics that emerged from the data. Eventually a final analytical template materialised that represented the themes found in the data that were most germane to the focus of the research. This point was reached when there was no data left un-coded that was of significance to the study.

A degree of selectivity was applied in reporting because not every theme emerging was of relevance and not everything about each theme could be presented. In an attempt to be transparent, consideration was given to whether or not excluded themes had any particular

bearing on the findings of the study. When the template reached its final form it was possible to present the broad representation of the data to the reader by not only defining the general umbrella higher order codes but also including the more detailed, subtle lower order codes. For example, the higher order code 'Midwife-woman, student-woman relationship' gave way to the following lower order codes:

Listening to women; Power; Therapeutic relationships.

This process of template analysis of the qualitative data gave way to the thematic presentation of the findings of the study that follows in chapter 4 of the thesis for the Phase 1 data and chapter 5 for the Phase 2 textual data.

Phase 2 Statistical analysis of quantitative data

Although it is recognised that some interpretivist researchers would not attempt to present statistical data in relation to themes, there are those who find comparisons of frequencies helpful (King, 1998). Analytical considerations were relevant from the origins of the questionnaire design (Youngman, 1978; Silverman, 1993). Consequently it was necessary to identify which category of data each response mode would provide. The analysis of the findings was plainly dependent upon the different categories of measurement that were obtained (Hicks, 1996). The questionnaire was designed to produce textual, ordinal and numerical data. This permitted descriptive and summary statistical analysis to be undertaken and presented (Hicks, 1996). Coding has been defined as the translation of question responses into specific categories for the purpose of analysis (Cohen et al, 2000). This level of detail at the design stage contributed to the

data reduction process in preparation for the analysis. The Statistical Package for the Social Sciences (SPSS) was used for preparing and executing the computerised data analysis. All questions were pre coded using a Likert scale as follows:-

1 = Agree strongly

2 = Agree

3 = Neither agree nor disagree

4 = Disagree

5 = Disagree strongly

The process of transferring data to the software programme provided an excellent opportunity to check for missing, unusual or unexpected values (Bowers, 1996).

Descriptive statistics are concerned with the presentation, organisation and summarisation of data. These permitted concentration on features of the data in question that were of interest. Descriptive statistics are commonly presented in terms of the most typical scores, for example average scores and measures of dispersion that present data in terms of the variations that were found (Hicks, 1996). The choice of measures depended upon which aspect of average the researcher wished to portray and also upon the type of data. For the purposes of the study the inter quartile range associated with the responses for each question was calculated and presented in Chapter 5. A summary of the statistical analysis was also produced providing the minimum, first quartile, median, third quartile and maximum value from each question (Bryman and Cramer, 1999).

Limitations of the Study

A number of potential limitations to the study were identified at its design stage against which every safeguard was taken. These can be enumerated as follows:

1. The participants in the study knew fully what it was about before they entered and all were volunteers. It could be anticipated that they might be positive about its intentions.
2. The researcher was an insider with inside knowledge and an appreciation of and sensitivity to the culture of midwifery and midwifery education. While that could be a helpful factor, having status might influence certain participants to say what they thought the researcher wanted them to hear. Professional loyalty from the professional members of the study groups might also encourage them to show their organisations as progressive and to portray them in a good light.
3. Interviewer enthusiasm could bias the instrument design and the conduct of the interviews.
4. The trustworthiness of the coding of the qualitative data and the limited use of statistical testing of the quantitative data could lessen the impact of the findings.
5. Very little is known of the willingness of women to participate in student assessment. Offering them involvement should not be a burden. Their preferences and sensitivities might be excessively biased.

Conclusion

Interpretivists pursue teleological explanations of individuals' subjective experiences and in so doing grapple with the tensions that exist in research between subjectivity and objectivity and between engagement and objectification. Because of their belief in the uniqueness of human inquiry and the emphasis on establishing contextualised meaning, research methods can be seen to take a back seat. Rather than giving methods per se prominence, they seek to harmonise the method with the purpose of the enquiry. Interpretivism therefore, requires the inquirer to be at ease with the blurring of the boundaries between the art and science of interpretation (Denzin and Lincoln, 1994). Whilst some subscribe to the view that paradigms are irreconcilable, interpretivists are content with pragmatism both at a paradigm and at a methodological level on the basis of securing the information that they need.

Interpretivism is believed to provide a suitable philosophical framework for the study and to provide a methodological rationale for the use of mixed methods with the researcher as the primary gather of data and the interpreter of it. In addition, the associated emergent study design provides a *raison d'être* for the phased approach for the work. Finally the commitment to a 'best fit' from a methodological perspective rather than a unquestioning adherence to methodological orthodoxy as a means of judging the quality of the design had some fascination. This rather pragmatic philosophical and methodological approach has been gaining momentum as inquirers search for the improvement of the robustness of their investigations and ultimately the credibility of them (Bryman, 1988; Firestone, 1990; Pitman and Maxwell, 1992; Denzin and Lincoln, 1994; Denscombe, 2002).

This chapter has attempted to demonstrate that the overall design and methods proposed for the study address the focus of the enquiry. It has articulated procedures that are seen to engage with the research topic. This occurs through a conceptual account providing grounds for the framework for the study, the selection of its participants, the safeguard of their rights, the creation of the research instruments, data collection procedures and an explanation of how trustworthiness was be achieved during the data analysis.

Chapters 4 that follows will provide details of the findings from Phase 1 of the Study. Chapter 5 will subsequently provide details of the analysis of both the textual and statistical data from Phase 2.

CHAPTER 4 - PHASE 1 FINDINGS

The findings in this chapter are reported in accordance with the template analysis that is described in the previous chapter. The themes it recounts emerged from the data collected at individual interviews with key informants and the focus group interviews with the parent groups, student groups and the mentors. Not all participants expressed a view in relation to all the themes reported and certain themes were of more relevance to particular groups. The following figure identifies all higher order codes (emboldened) that appeared in the data and a number of the lower order codes that warrant individual reporting.

The midwife–woman, student-woman relationship

- Listening to women
- Power and the therapeutic relationship between the student midwife and women

Students' knowledge of theory and practice

How students learn and gain confidence

- Developing the student's ability to reflect

Student feedback and the role of women

- The development of professional attitudes
- The development of clinical skills
- The place of honesty
- Assessment and the use of multiple perspectives
 - Handling competing expectations
 - Selecting women as assessors
 - Preparing women for an assessment role

Providing better quality care

Figure 8 Template analysis of Phase 1 – a synopsis

The midwife-woman, student-woman relationship

Key informants

All key informants discussed the therapeutic nature of the relationships women had with their midwives and the discomfort that could be felt by women if their relationship with the midwife was not positive. The potential for students to enjoy a relationship with those in their care that is based on equality and trust was seen to be important. It was acknowledged that the skills needed to engage in such relationships, particularly when these have to be built rapidly, ought to be developed during the pre-registration period. One participant felt it important that students had an opportunity to discuss relationships with women to establish,

“ground rules”

and

“set precedents for their relationship [with women] and how it works”.

There was a clearly articulated need amongst the key informants for students to gain,

“confidence in relating to people”.

Changes in culture in recent years concerning the midwife-woman relationship were noted with one saying that she found,

“a big difference now from when I started midwifery. Women just used to sit down and be done unto”.

Nevertheless, despite these changes this key informant was of the view that,

"we still do to people".

She was of the opinion that this power imbalance in professional relationships ought to be challenged. Another key informant felt that involving women in the assessment process was a constructive way of developing the student-woman relationship and was of the view that it is difficult to achieve true partnership relationships,

"until practical steps like this are taken"

by involving women in this way she thought,

"would empower the women ... they would feel much more part of the whole process of their care and also of the student's education".

Some of the less tangible aspects of care such as empathy were identified as key to the midwife-woman relationship. One key informant referred to the evidence available relating to professional relationships stating that if,

"you look at the research, those are the things which make the massive difference to all sorts of aspects of care right down to how likely she is to breastfeed, how much pain relief she needs, whether she is more likely to get postnatal depression. All these things are affected by her experience of birth and particularly how well supported she is and that's a major role of the midwife".

Additional benefits related to the general use of the NHS were also identified. One key informant thought that by strengthening the relationships women had with midwives this could,

"change their attitude or change their relationship with health professionals for a very long time to come which would probably be no bad thing"

Parents

The parents gave an account of a variety of experiences in terms of relationships with both midwifery students and qualified midwives. There was a consensus view that relationships were very important and that the degree of confidence one had in a relationship had a direct impact on how care was negotiated. There were several accounts of needing,

"a go between"

or,

"some one that you feel that's on your side perhaps".

One parent thought that during their course of studies the students'

"bedside manner could be worked on"

This was discussed and an example drawn from their personal experience, again relating to the confidence of student midwives in a relationship and it was suggested that,

"not everybody is confident in talking to people and that they might not be comfortable dealing with people who are half dressed all the time".

One partner described how the relationship his wife had with the midwife made a difference,

"the midwife who was with my wife for that, those few hours, made a hell of a difference, she calmed her down and I certainly saw the difference in her, cos I

was waiting in the room and I was running back and forth from the house, so I didn't know what was going on either. But I think she put my wife at ease, it took that added pressure off myself as well, so it [the relationship] does make a difference".

Students

Discussions in both student groups revealed that they were conscious of the relationships they had with women in their care. They felt a need to address relationship issues at their initial meeting with women. They welcomed an open approach, with mentors declaring from the outset that,

"we're honest, this is a student midwife and she's learning".

Both student groups valued the time they spent alone with women. In the absence of their mentor they enjoyed,

"having a bit of a heart to heart" [with women] and getting into "big discussions"

about issues and being with women particularly in support of breastfeeding.

They spoke of the change in the dynamics of the relationships that they had with women due to the presence of the mentor with one student reporting that,

"I act differently if she's there than if she's not there"

another saying that,

"as soon as the midwife goes out of the room you just change completely"

Mentors

The need for student midwives to learn to establish and to develop relationships with women was discussed. The “one to one” relationships midwives have with women, particularly during the intrapartum period was highlighted by this group. One mentor felt that,

“if you build that partnership over a period of time, you get a relationship going”.

This was picked up by another who identified the need for students on occasions to be able to,

“very quickly build up a rapport”.

The presence of the mentor and its impact in the student-woman relationship was also discussed by several of the mentors. One mentor posed the question,

“how many times are they [the students] intimidated because we’re there?”.

It was agreed that there can be a tendency for the woman to relate to the qualified midwife and not the student during a consultation. One mentor confessed that as they were not always accompanied by a student and that they often responded by,

“taking over”

having to subsequently apologise to the student and allow the student to build her own relationship with the women. There was a general agreement that the student, particularly towards the end of the course, was probably more relaxed with the women if the mentor was not present.

The mentors also recognised that by having women play a more significant formal role within the relationship with students that not only could the dynamics be enhanced but that the students and the mentors themselves might develop greater insight regarding their professional care. One mentor summarised this as follows,

"It might help as well, when you've got a conflict between a mentor and a student, because obviously there's personality clashes, and if you have, and the mentor is thinking, 'well, I don't like her and I don't think she's very good'. But that's influenced because she just doesn't like this student, not because of her practice, which can happen. It can happen, can't it. You know, everybody can't like everybody. But then if the woman, the women are saying, she's fine, she's giving me good feedback, I understand what she's saying, she's explaining everything'. Then it might set alarm bells going in the mentor and think, you know, put that aside, that's just a personality clash but she's [the student] OK".

Listening to women

Key Informants

A key informant, recognising that maternity units were getting bigger and more anonymous, posed the question,

"Are we listening to the patient ... and are we building that into our systems? ... and the answer is probably no".

They also felt that in terms of developing relationships listening was again seen as key,

"being listened to is the beginning of developing trust".

However the assessment of listening skills was thought to be problematic,

“active listening is a skill and something that is difficult for the external observer to assess. I mean it is not impossible but it would be very valuable to have women’s direct feedback”.

Students

The students were aware of the importance of listening to women. However they had also experienced the realities of traditional approaches to care which had the potential for allowing poor custom and practice to perpetuate,

“we’re training to be better midwives to bring a better future into the profession and the only way we can do that is to listen to what women are telling us rather than ignoring them and carrying on doing things,.... well I’ve always done it that way, to do things in a better way for them [the women]”.

Mentors

The mentors agreed that being listened to and heard was valued by the women. However in reality,

“women have always complained that they’re not listened to”.

Power and the therapeutic relationship between the student midwife and women

Key informants

The key informants held a unanimous view that involving women more directly in the students’ learning experience would necessitate a shift in the balance of power. It was noted that the midwives who acted as mentors for the students would have to rethink their relationships with both women and students to accommodate any change in assessment practices that involved women. Participants agreed that women’s views should be heard,

"it immediately is making that a powerful voice".

One reported that women can feel that they are,

"in a vulnerable position and that they feel that the power base is not with them".

It was agreed that involving women would set a good precedent in the shift of power.

One thought this would represent,

"a huge shift for those women as well as for everybody else who is involved in the care of that woman and would probably need a lot of nurturing".

Indeed this "shift" was described as a "leap" by one.

The key informants also considered that the students' performance might have an improved focus through client involvement in assessment. There was potential for the proposed changes to involve women in assessment to,

"put the woman at the centre of where the students are focusing their attention, and very naturally that focus of attention is not going to be the woman that they are caring for when they know that they are being assessed, if she is not assessing them"

Students

The students also recognised the need for a shift in the balance of power that would have to occur if women are to be involved in assessment. They felt that women would need to be encouraged to provide what they felt would be valuable feedback. It was recognised that there was almost the need to give women, "permission" to comment on the care they had received and to encourage them to be critical. This potential shift of power was seen

as positive in so much as women who were reluctant to have students involved in their care, might feel more inclined to do so if they were able to engage actively with the student and become more involved in the whole process.

Mentors

The mentor group discussed the issue of power, recognising the changes which would need to take place if women were to be more participative. There was a general recognition that the roles of mentor, students and women would alter. One commented that,

“for years we’ve been harking on about women centred care, we have, haven’t we?, and this is the first time they’ll really get the message that, you know, somebody is relinquishing a bit of control”.

Another said that implementing the change would be like,

“giving them [women] that power to be able to comment on care”.

The mentors felt strongly that the proposed changes should not result in women feeling that their care could be compromised if they either declined to participate or if they provided negative feedback on students’ performance.

Students’ knowledge of theory and practice

Key informants

Views on how women could help student midwives to improve their knowledge base were mixed. One key informant drawing on her experience said,

"I find that women certainly feedback to me that they feel that some midwives aren't competent in certain areas, knowledge areas for example, some midwives are very up to date on research based evidence and some are not and some women need to be encouraged to raise these issues with midwives and others are very assertive".

Another was of the view that,

"people very often underestimate the level of knowledge that a woman has about her own pregnancy".

In terms of access to and being in receipt of knowledge another noted that,

"more and more people are accessing the internet"

as more information is made available particularly in relation to performance in a range of aspects of service delivery in the NHS.

The contribution currently being made by women who are knowledgeable in relation to a medical condition they might have and its impact on their pregnancy is illustrated as follows,

"If she has a particular condition ... she will be telling her obstetrician about the implications for her and yes she is certainly capable of telling her midwife".

and,

"you would get knowledge from a perspective that we are not getting it from at the moment, they could question things like procedures".

One key informant responded to the notion of involving women by saying,

"I don't believe they could make ... that useful a contribution because they don't know what knowledge that student should have".

But when explored in more depth she too was able to draw from experience in terms of women with medical conditions. She cited a woman who had sickle cell disease and said that ,

"She knew a lot more than the physicians that were treating her when she went into crisis ... so you know in those sorts of circumstances I think that they should rely on the woman a lot because they do know often more about what is happening to them".

Students

The students found the application of theory to practice difficult on occasions. Certain curriculum content,

"don't seem too fitting with what we're doing on the placements so you can't sort of act on what you've learnt theoretically".

Some theoretical aspects of the course were studied simply because,

"you just have to learn it because you have to pass this particular stage".

and,

"sometimes you just can't make a connection, its really hard sometimes to understand why you're doing certain things and what benefit it would be to your practice".

How students learn and gain confidence

Key informants

How students learn and develop was explored by each expert participant. It was argued that students needed to be able to identify their learning needs. Once identified the student required the ability to,

“go off and pursue them individually”.

One felt that the assessment process was crucial to learning,

“getting feedback is possibly the only way in which they are going to change”.

Indeed receiving feedback from women was seen as potentially,

“part of what influences what the students learn”.

Another noted that,

“I don’t think that women altogether realise just how valuable they are in the [learning] process”.

The key informants were of the opinion that the issue of confidence was important. It was recognised that midwives need to be able to relate to those in their care with confidence.

“involving women in the assessment would be a really good training ground for building up their confidence with women”.

Parents

Although parents varied in their willingness to have students involved in their care they felt that their interactions with students could contribute to student learning. The best way of learning was agreed as getting,

“hands on experience”.

Encouraging women to ask students questions was thought to stimulate learning. It was recognised that,

“the student might not actually be able to answer everything, but they learn from you asking them”.

The parents recognised that learning in this way can be difficult for students. One cited an example when the student received negative feedback from the mentor in relation to the care that she had provided and she ,

“was very upset and she did apologise”.

But the overwhelming feeling was that,

“They’ve got to learn”.

Students

Involving women in the learning process was considered by the students as appropriate.

They were of the view that,

“you learn from the whole [clinical] environment, anyway, it seems logical that you should involve the women in that learning process”.

One student expressed this by saying that involving women in asking them to provide feedback

“would serve as a much better tool for self development than what we’ve got”.

The students in both focus groups recognised the relevance of the mode of assessment in terms of their ability to learn,

“it depends on the assessment you’re given whether you can actually tell where you’re going”.

In terms of confidence it was felt that,

“A very little thing usually boosts your morale, things you don’t know you’re saying to them [the women] or the way you came across to them or the way you make them feel calm and they say it back to you and the midwife doesn’t realise what you’ve done, she [the woman] perceives it differently”.

Mentors

The mentors felt that by involving women the students’ ability to learn would be enhanced. The students could,

“learn from, you know, what they are telling us, and then bring it on board with a view of, you know improving care to them”.

They also were of the view that supporting the student in learning from women could have the effect of boosting their confidence.

However the mentors were also conscious of the fact that negative feedback could,

“be quite a knock for their [the students’] confidence”.

Developing students' ability to reflect

Key Informants

Promoting a reflective approach to learning was supported by all the key informants. Students needed to develop the skills to be able to evaluate their care and to do so not solely from their own perspective. Involving women in the reflective cycle was perceived as a beneficial dimension of learning. One informant said,

"It is fine for the student midwife to reflect on her case studies and so on and what she has learnt from it, but, she will get so much more if the Mother is also reflecting and feeding back".

Being able to incorporate the woman's perspective was thought to result,

"in better outcomes for the Mother".

This was because of a shared view that the reflective cycle should effect change, in essence success would depend upon,

"how she picks up and works with what they have said and how she changes her practice as a result of what they have said".

Or identifying that certain situations were atypical and,

"the student may decide that actually her practice doesn't need to be changed em ... and that is just as useful a learning outcome".

Again from a practical perspective a number of approaches to the inclusion of women were proposed. Most consisted of a cyclical series of activities. Firstly it seemed important that students reflect on their own performance prior to receiving feedback.

Secondly having gained the women's perspective it was considered useful for the student to identify any dissonance of views. Thirdly the mentor has a significant role in the summation of the process.

Parents

The concept of reflection was introduced by the parents spontaneously. Their personal perspective suggested that in order to provide students with feedback in relation to some aspects of care, particularly during the intrapartum period, there was a need for them to have an opportunity to reflect themselves,

"you're not sure what happened until it's all happened and afterwards you can reflect".

This was agreed as a helpful suggestion enabling parents to think through what aspects of care they might wish to raise with the student.

Students

The students were familiar with the concept of reflection and obviously used it as a means of improving their practice. Involving the woman in the reflective process seemed a natural progression to them. The students reiterated many of the views of the other participants. Reflecting on the care given prior to eliciting feedback from the woman was one approach,

"So if you did a little bit of a self-assessment initially and you reflected on the care that you gave to the woman and then you went to them and said 'now this is how I feel I've done and I'd really value what you think'".

another thought was that,

“if it [the feedback] was verbal and there wasn’t any kind of documentation, if it was like that, you could incorporate it into your own reflection on your practice as well. We keep journals and write about our experiences on the wards and keep up to date with that maybe you could incorporate it into that”.

The students discussed the possibility of getting immediate and therefore spontaneous one-off opportunities for receiving feedback from the women to,

“do some reflection on”.

Another suggestion was to meet with women some time after they had been discharged from maternity services at a venue of the woman’s choice to allow a more detailed approach to be adopted by the woman.

They also thought about the practicalities in terms of planning, in particular the issue of time management. Ring-fencing time to engage with women in this way would need to be secured.

Mentors

The mentors were familiar with students compiling a portfolio of evidence from clinical practice. They suggested that students could demonstrate how they had reflected on and responded to the proposed feedback from women and demonstrate their learning in relation to the specific learning outcomes of the course,

“when she is [the student] providing her evidence ... put that in as her evidence, she may critique how she felt and say ... well actually from my feedback ... so it’d be really good evidence”.

Student feedback and the role of women

Key informants

The concept of feedback in general within the context of the NHS was discussed. There was a generally held view that as a result of the Patients Charter and the complaints procedure in particular, a sense of negativity had grown in relation to the receiving of feedback from service users. It was suggested that this was because via the complaints procedure,

“midwives become used to the only user feedback they get being negative”.

It was suggested that the introduction of a feedback system that was not associated with any form of complaint or litigation process and which encouraged both positive and negative feedback, could begin to break down what was described as,

“barriers to the whole idea of feedback”.

A number of issues relating specifically to student feedback were identified. These included, when and how often the feedback should be given, whether it should be verbal or written or both, its status, what choices should be available to women and students, preparation for giving and receiving feedback, the nature of the feedback itself and general issues of equity. Discussions revealed that there was a commonly held view that giving women an opportunity to express their thoughts and feelings about the care they had received was of value not just to students and their mentors but also to women. Requesting feedback from women could,

“centre the care as it should be on the mother and her supporter or supporters”.

The women's ability to provide feedback to students was discussed and some stereotypical assumptions surfaced and were explored further. This was highlighted by one of the key informants saying,

"I am not quite sure that I feel confident that all women could or would be able [pause] ... I think possibly I have been a bit judgmental here ... and I am falling into the trap that I think a lot of people might fall into of thinking that some aren't bright enough to do it ... and I think that probably is wrong, because I would think that they are bright enough to say how they feel and how this person is caring for them".

The whole issue of women's ability to make valid judgements was picked up again and couched in terms of equity when another participant said that she would,

"not want the individual women to be treated differently".

Constructive feedback was seen as a very useful vehicle for effecting change and improving care at a personal as well as at an organisational level. Unless the students obtained feedback from women it was felt that it would be very difficult for them,

"to appreciate what it is like for the woman that they are caring for".

Another participant commented that,

"you can never know whether you are doing what you think you are doing unless you get some feedback".

There was a general open mindedness regarding the format the feedback should take. But there was agreement that without a structured approach, opportunities for women to give feedback were problematic. Over the course of the interviews a variety of approaches

emerged including the notion of affording women opportunities to give immediate feedback and also giving them time to reflect on their care prior to providing feedback. The key informants emphasised the need to have a strategy in place that would harvest the most valuable information for the students.

Another important aspect of the process was the actions taken by the students in response to the feedback they had received. One informant highlighted the importance of the way in which the student,

“picks up and works with what they [women] have said and how she changes her practice as a result of what they have said”.

Receiving feedback was also recognised as potentially a,

“threatening thing”,

There is the possibility for the feedback to be given in an insensitive way was raised and the need for the process to be facilitated was advocated,

“it is really important for them [women] not to destroy the student in the process”.

There was a view that it was,

“good to get a nice balance ... to celebrate what's good in addition to receiving negative feedback in order to grow and develop”.

In gaining a balance it was suggested that it might be helpful to involve partners in the feedback process as,

“their needs and expectations can be very different from the mothers”.

It was considered to be beneficial to involve the students themselves in the design of any tool to be employed to reap feedback and that there should also be an opportunity for them, as part of the process, to identify particular aspects of care for which they would personally welcome feedback. In addition to the format the feedback would take the nature of it was also discussed. One key informant said that women could provide feedback in relation to,

“feelings, either physical feelings of how that skill was experienced by her in terms of ... ‘that hurt’ ... or ... ‘that felt invasive’ or emotionally ... how that experience was and I suppose neither of those things the mentor, although she might be able to observe that that hurt, equally she might not because the woman who is having a vaginal examination that is painful may well not express that. So I suppose at both those levels it is not necessarily something that an external person could observe”.

Receiving feedback was also seen as contributing to building and developing relationships.

In considering assessment and feedback from the students’ perspective, it was thought that,

“midwives are only going on what they see, how they get on with the woman in very global terms, where as this would be able to give them precise feedback [from individual women] so that they would really be able to evaluate their practices and see how they came across which is obviously very different from their [students’] perception in some cases”.

It was also felt by the key informants that it was important not to blank out "subtle feedback" such as body language but to reflect on the care provided and the feedback received in relation to it. The anxiety associated with feedback needed to be taken into consideration and minimised. It was suggested that this could be assisted if all concerned understood the process fully and were willing participants. This generated further discussion about the preparation that might be necessary for the students, women and mentors.

Parents

Introducing the possibility of providing student midwives with feedback was received positively by parents. The perception was that current arrangements did not make giving feedback easy with the onus placed upon the parents,

"we'd have had to ... actively had to look where to go".

Whereas being invited to give feedback was viewed as, *"an opportunity to express yourself"* and, *"its an avenue to go down isn't it"*.

The parents were of the view that the nature of the feedback given to students would be very much dependent upon the relationship they had with the student,

"I think it depends on the relationships really, how confident you were".

Overall confidence in giving feedback was also thought to be influenced by experience of maternity services and therefore women may feel more inclined to do so in second or subsequent pregnancies.

Providing negative feedback was perceived as difficult with one parent saying that,

“negative feedback is a complaint isn’t it?”.

Receiving negative feedback on the other hand was seen as key to students’ development,

“they’ve got to, they have got to learn”,

whilst another said that,

“sometimes negative feedback is good because you think, well, I can go away and look at that”.

How students were performing over time was discussed,

“if somebody’s getting bad feedback time after time after time, you should want to know surely”.

Conversely it was agreed that if the student,

“was superb all the time, you’d want to know about that and give ‘em a pat on the back for that wouldn’t you”.

How the feedback could be given was also discussed. The parents held a variety of views. Whilst there was a unanimous perception that they would like to and felt able to provide feedback the difficulty lay with the provision of negative feedback. One parent felt that,

“obviously you’d have to give it directly back to the person involved”

But thoughts on how this could be achieved by those not keen on a direct approach ranged from the use of an intermediary, to the feedback from the parents being used in the classroom by lecturers,

“even if you used it as an example in teaching later, by saying ... even if it was a demonstration, role play”.

In relation to the timing of feedback the parents thought that there were advantages associated with the provision of immediate feedback. It was felt that as a result there could be an immediate response to poor standards of care,

“if there’s anything going slightly wrong, it could be corrected straight away”.

Students

The students discussed the existing mechanisms for receiving feedback and its quality. This included their academic as well as their clinical performance. Although there were examples of helpful feedback being provided by mentors, some students questioned the quality of the feedback indicating that it did not always facilitate learning as the feedback consisted of grades rather than narrative in relation to specific skills. Feedback in relation to academic work was usually provided in more detail with guidance for improvement. It was felt that this level of detail would perhaps be helpful in relation to clinical performance. The students’ perception was that they did not often receive praise from their mentors. There was a general feeling that the feedback they received focused predominately on their weaknesses,

“its all very negative, there’s not many positive comments, its all negative, what you are doing wrong, what you should be doing”.

The students welcomed, the idea of women providing them with feedback albeit with some reservations particularly in relation to negative feedback,

"I think it would be more positive to have the feedback from the woman about how you really are rather than from an assessor".

The woman's perspective was of value to the students as one described,

"Well it's more to do with the future of midwifery practice and if women are saying to us 'I like the way you did that', you're going to take that on for future practice when you're a professional. A mother could say 'your attitude towards me was brilliant' or 'the way you spoke to me then when I was really upset was great', or 'the way you calmed me down was brilliant', or something like that. The midwife doesn't realise what you've done, she [the woman] perceives it differently".

Another student was concerned that,

"you could pick up bad habits, not habits but theories of practices that the women don't like and then you'll go on and take them through practice; if you do get feedback from the woman's point of view you can take that on board".

The students discussed the role they could play if women were to be involved in providing feedback. They felt that they would have to actively engage in the process to influence the quality in terms of balance in the feedback received,

"There's a difference I think, probably if you just went and said to a woman, 'can you give me feedback on how it was with you'? that would probably lead to, more likely be positive. Whereas if you actually said to her 'now I want to know what things you think I could improve on', the way you actually ask her could encourage her".

Students were keen that women were enabled to provide negative feedback and by adopting the above direct approach they felt that,

“yes you’re giving her permission in a way to be ... [pause] critical, you’re letting her know you feel comfortable and its all right with me if you do [give negative feedback]”.

Another student thought in order to encourage women to provide both negative as well as positive feedback that they could,

“do some reflection on how you think it went and then ask the woman for feedback in terms of ‘I don’t think I did so well here, I felt I did well in this part of your care”.

The students also regarded the relationship they had with women as an important factor.

They were keen to,

“build up that relationship where you can get more in-depth feedback”.

The students voiced little concern regarding women’s ability to provide feedback.

In order to assist with the process the students felt that if women were told that,

“it isn’t an opportunity to complain about the food but it is an opportunity to tell us how we are as carers, I think they’d get it”.

Mentors

There was again a consensus view that involving women in the learning process was valuable for the students, the midwives themselves and indeed the women. An assessment process whereby women were encouraged to give feedback was seen as an

opportunity to understand the woman's perspective on the care she received and not to learn about it second hand,

"tell us , tell me direct ... and then we can deal with it".

The mentors gave examples of how on occasions women commented on the abilities of students in their absence and were able to comment on aspects of performance. They reported that women also differentiated between the practices of individual midwives. One mentor experienced this when a woman compared care she had previously received from a midwife with the care that the mentor in question was currently providing,

"she can compare and she was saying it to me"

A number of other issues were discussed and debated. They felt that the willingness of women to provide constructive criticism would need to be facilitated because it was acknowledged that there was the potential for women to provide,

"positive feedback rather than negative".

Here again the relationship the student had with the woman was seen a crucial. The willingness to provide negative feedback would they felt increase over time,

"If you build that partnership over a period of time, you get a relationship going, more open, and then you'll probably get more accurate feedback".

To gain a balance in the feedback, particularly during the intrapartum period, it was suggested that involving partners would be an additional helpful dimension,

“When people are in labour we should consider the birthing partner as well. It should be a dual assessment, because your ... perception can be confused when you are in labour, and the actual birth partner could be really valuable then”.

It was agreed that feedback can be a sensitive issue and the mentors recognised the need therefore for students to,

“approach it professionally, and take it on to improve”.

Whilst recognising the need for students to receive negative as well as positive feedback the mentors were aware of the potential vulnerability of the students. They felt that they could be proactive through the process acting for students as,

“advocates, protecting them from open hostility”.

They were conscious of the fact that negative feedback could,

“be quite a knock for their confidence”.

The mentors were also keen that the women should also feel at ease when giving feedback in that their care should not be compromised in any way as a result of unfavourable feedback or indeed declining to be involved. The absence of feedback was also discussed by the mentors one of whom said,

“if you’re doing something badly, theoretically you carry on doing it for years, don’t you”.

This view was reinforced with another mentor saying that,

“it’d be useful to get feedback, not just for the students but for us that have been qualified for years, its like, quite nice to get feedback from them [the women], because its rare that we get feedback from anybody”.

One mentor said that,

“we’ve always learnt from students and its taking it further, we’re going to learn from, recognise our patients and learn from them”.

The development of professional attitudes

In general the participants thought that one’s attitude was not always apparent to an external observer and as a consequence this added to the difficulties experienced in bringing about changes in attitudes that may be appropriate.

Key informants

Adopting a professional attitude was seen as an important factor that should be addressed within the pre-registration course. In the context of midwifery care one respondent felt strongly that attitudes had to be sensitive to the woman being cared for,

“Its learning to be appropriate to the individual isn’t it; their [the student] attitude may not be acceptable to the woman being treated”.

All key informants discussed the potential role of the woman in assisting the students in the acquisition of appropriate professional attitudes and the following quotes are illustrative of these views.

“Women are probably the best people to tell you how the attitude of this student affected them as an individual”.

and,

“you need to know from the Mothers’ point of view how she is perceiving this student”.

and,

“its not necessarily something that an external observer could perceive”

and that attitude was,

“one of the most important things that a woman can feedback on”.

By including the Mothers perspective the potential to engage in discussions with students about their attitudes may be prompted and may, *“actually help to change attitudes”.*

Parents

The parents spoke about good and bad experiences in terms of the attitude of their carer. They recognised the possibility of a production line approach to care,

“oh its just another [birth] ... oh, I’ve seen ten of these”.

Midwives were seen as professionals and as such the parents expected them to adopt a professional attitude that respected their individuality,

“I think every birth should be special [to the midwife], you know, everyone’s different, isn’t it?”

Students

The students were committed to developing professional attitudes towards the women and their families. Concepts such as dignity, privacy, personal space, and preferences were

explored by the students. They were enthusiasts about the idea of receiving feedback from women in relation to their disposition and professionalism. They felt that women were best positioned to do this,

“That’s probably what they’d be best at I think, sort of telling you how you came across to them, whether you were considerate and all those sorts of things”.

and,

“that’s one of the things they’re most expert at isn’t it, just how they got on with you and what your manner was like”.

And,

“they might say ‘you seemed really nervous or worried all the time’ then you could sort of concentrate on that”

and,

“are you treating them as an individual rather than ‘ooh I have to learn on you’ that sort of thing”

Mentors

Professional attitudes were also seen by mentors as central to the provision of high standards of care. Many of the problems that arose in practice were felt to be attributable to ‘attitude’. Within the first minute of the focus group interview the issue of appropriate attitudes was introduced by the participants. The possibility of involving women when teaching their student midwives about attitudes, although appealing, did pose some problems. Some felt that women may be reluctant,

“to say, well, her attitude’s not very good”.

The possibility of women identifying poor attitudes was thought to be valuable and would need to be explored. However the mentors generally thought that women would

“pick up a lot on attitude”.

The importance of professional attitudes was highlighted by the mentors with one commenting that,

“somewhere along the line it’s gone wrong, because this is why we get complaints about attitudes and most complaints are about attitude”.

The suggestion that attitudes could continue to be addressed following qualification was introduced by one mentor and found general agreement with the others,

“Supervisors are going to know that they are doing it [receiving feedback from women regarding professional attitudes] in their training and they are going to say, you know, if there is a problem, they are going to say ‘well look back to your training, you know, did you get feedback, did you have any problems? Is this creeping back?’”

The development of clinical skills

Direct feedback from the woman in relation to skills was cited as vital to student development. These ranged from the more intrusive procedures involved in midwifery care to issues of an emotional nature. They also included the care provided to the newborn.

Key informants

One key informant said,

“I suppose the feedback that a woman can provide at a practical level is feelings either physical feelings of how that skill was experienced by her or emotionally, how that experience was”.

It was suggested that in gathering this feedback ultimately it may,

“inform the training at a practical level”.

Further support for this included,

“you get an opportunity to find out how it feels for a woman, how to do it without causing pain”

because experiences of pain and emotion are,

“not necessarily something that an external person could observe”.

“unless you are on the receiving end of somebody’s treatment then it is not something you can assess I don’t think”

“Well obviously they would be able to give feedback on how comfortable it was or not which anybody else is only judging for that women. So the mother can give direct evidence of those things which involve her comfort and her pain levels and obviously there is a big area there”.

Students

The students were also interested in both the physical and emotional impact of the care they provided for women. In relation to physical examinations one said,

“so she should give you feedback because she’s not just something that you’re putting your hands on, she’s experiencing it at the same time”.

As regards the type of skill they felt that,

“the kind of focus of the assessment could change while you’re training. You are involving women but it would change what they were actually assessing you on. Like with our assessment anyway we’re not assessed at the beginning like we’re assessed at the end of the course so maybe at the beginning you could get more feedback about your actual hands on care because when you are new to a ward that is what you want to do”.

Mentors

It was also suggested by the mentors that there may be a difference in relation to the skills the junior students received feedback on as opposed to the experienced students. There was a suggestion that,

“they just get feedback maybe about certain physical skills that they have initially rather than communication”.

and,

“Hopefully, refine you know, their physical examinations etc., and then concentrate on the more complex components or professional competencies i.e. interpersonal skills”.

The place of honesty

The importance of honesty in how women might respond to the care provided by students was of importance to some participants.

Key informants

The issue of honesty and the status of feedback were seen to be linked. This is illustrated by one of the key informants,

“I feel that possibly if the mothers thought it was going to be part of a summative assessment of that student they would be much more cautious about what they said and it might not be as honest because they would want, the majority would want her to do well”.

Accepting that perhaps some women may be more open and honest than others, gaining an overall picture of the individual student's performance could be obtained. One key informant suggested that differing degrees of honesty and frankness would cancel themselves out because in knowing,

“how a particular student is performing across the spectrum we will get a balance”.

Students

The students were concerned about but interested in receiving feedback in relation to their weaknesses in order to learn. However they wondered if women were,

“going to be able to put her true feelings across?”

And,

“it could be very hard for them [mothers] to give you an honest answer and say well actually I thought you did that really badly or something like that. How often are we going to get a woman who actually blatantly comes out with what she thinks?”

The students felt that women may be more honest if they did not give negative feedback directly to them. In order to address this issue they suggested choices for women so that they felt comfortable about providing negative feedback,

“a different way, other than to just give feedback to you [the student] maybe they’d be more honest”.

“couldn’t they say what they felt to your mentor?”

Assessment and the use of multiple perspectives

Key informants

Several aspects concerning assessment were explored with each key informant. They regarded the involvement of women as an innovative approach to learning. National policy in relation to maternity services was also noted as consistent with this level of service user involvement. However operational aspects together with such issues as, ability to read and write, language and cultural differences, quality of care, choice and reward were raised. The challenge presented to those responsible for the assessment of competence in the clinical area was noted, and it was suggested that the challenges occurred in part,

“because its very individual and I think that’s where you come into the problem of assessing competencies and why probably external observation has been used”.

During one interview it was noted that the assessment of performance in practice was the subject of comprehensive deliberations in Higher Education yet,

“within that context I have not seen any procedures or policies or statements on asking women how she perceived that particular skill em ... I think that it is ideal to do that”.

A number of different ways of incorporating women's evidence in the assessment process were suggested, *“so that we might inform the training at the practical level”.*

It was agreed that the evidence in whatever format should make a contribution to the summative assessment of the student. To do otherwise was suggested as nothing more than tokenism. One key informant said that she thought,

“it is good to have formative assessment from the women and that they won't feel inhibited in giving feedback appropriately because they may be very inhibited if they feel 'I might be failing this person by saying that hurt' ... but I think if you don't make it part of the summative assessment then it just undermines everything”.

She felt that the women's contribution, *“should count towards the degree”.*

A staged approach to the incorporation of both formative and summative contributions was suggested with the early stages of the course representing an opportunity for,

“formative development and then perhaps as she becomes mature as a student midwife then we could look at some summative assessment”.

Given the standing of the proposed feedback from women it was agreed that they would require some guidance and support in order to make a contribution that was perceived by all as, *“conducive, and helpful and fair”.*

But,

“how do we do it?... that’s the tricky one in a way isn’t it? I mean I suppose you have probably got to go back to the basic procedures of how we assess a skill”.

A range of suggestions at an operational level were explored and these included,

“a facilitated session where the student received direct feedback but the mentor or the link lecturer would facilitate the session”.

Another was the use of a, *“questionnaire or form”*.

But this then raised the issue in relation to reading, writing and language for some women on the one hand and women who would, *“be able to assess students very articulately”*.

on the other. Capitalising on any tripartite arrangements in place for the assessment of student midwives was another approach with a,

“testimony from the woman available when you have the tripartite meeting”.

A degree of continuity rather than a snapshot approach was suggested by involving women,

“that would see the students over a period of time ... so I think what I am talking myself out of is for a one off assessment.”

Students

Students welcomed the idea of feedback from multiple sources. They recognised that different perspectives and expertise existed,

“I think the art of caring should be taken from a woman’s point of view but the practice and theory side of things should be taken from your mentor”.

To enable a triangulated approach that involved women to be implemented the students were content with women engaging directly with them. However if they found that uncomfortable particularly if the feedback was negative then they were happy for women to engage with the mentor.

“if they’re going to find it hard doing it to your face, maybe they could do it to your mentor”.

The students were not exclusively focused on, *“just being here for the degree”*.

In addition to gaining a degree the students were committed to developing as, *“women friendly practitioners”*.

Although they did admit that they did focus on things that were to be assessed at the expense of aspects of the course that were not to be assessed,

“the attentions shifted about which area you’re going to concentrate on”.

They admitted that the attention often tended to be on theory rather than on practice. Given their philosophical approach to their studentship they agreed that women’s involvement in the assessment process should constitute both a formative and a summative component. They said that in the time they spent alone talking with women and discussing care they began to realise that, *“women do assess midwives”*.

They also found that,

“women often want to say a lot but they think ‘oh well I’ve got my baby”.

With this history in mind students felt that women would benefit from some form of preparation prior to being involved in their own assessment,

“I think you need to be very careful because if women are just ticking boxes and just going through it I think they would need some understanding that that goes towards my future, not only to the future care but it’s my future that I’ve worked hard for”.

In terms of capturing evidence in relation to performance and being in a position to demonstrate competence the students felt that their ability on occasions,

“doesn’t get passed on to the university so they don’t know that you’re good at this and good at that”.

The students welcomed the thought of being actively involved in the process with the possibility of opportunities to seek personal feedback from women as well as using a standardised tool. One having had experience of maternity service users providing feedback about the effectiveness of the epidural service suggested the use of a

“Likert scale”.

The advantage associated with this approach was the opportunity to capture the poor and the good aspects of performance in a fairly user friendly way. The development of various skills was discussed by the students. There were a number of examples of how women could participate in their assessment. Again these included physical examinations and assessments, communication skills, interpersonal skills, breastfeeding support and interestingly, emotional and social support and care.

Mentors

The mentors also raised the concept of triangulation. In their discussions about women actively participating in providing students with feedback they reflected on what often currently happened,

“we just ask, seek their permission [for the student to be involved in the care], the assessor looks on the student performing and the woman is always the silent one... where as this one [the proposal to involve women] is like a triangle”.

The mentors suggested that the inclusion of women in the assessment process would add to its authenticity. Again however there were important issues to be addressed in order to avoid amongst other things,

“assessment overload”.

They favoured a deeply embedded approach where the involvement of women became culturally accepted and as such it was suggested that in terms of the student experience it occurred,

“from the very beginning”.

Some of the mentors agreed that the assessment should take both a summative as well as a formative format. Again a staged approach was suggested with summative assessments occurring towards the end of the course. Those who thought that the woman's contribution should be restricted to a formative assessment only did so for a few reasons. Firstly, they felt that the,

“woman does not see the whole picture”,

secondly, the woman may not,

“be quite as objective as what she should be”

and thirdly, the midwife would make the summative assessment on the basis that the woman's input was,

“taken into account rather than them having that responsibility”.

Regardless of the status of the feedback the mentors agreed that there were time management implications but that,

“you can arrange to give them extra time”.

Opportunities for students to care for women over a period of time ensuring a degree of continuity was thought possible,

“our students already follow women through from booking”.

Parents

There were differing interpretations of continuity. The parents suggested that continuity consisted of,

“seeing somebody you know on a regular basis, say, your named midwife for the day.”

This was reflected in the parents report of their own experiences,

“I had a student midwife through my pregnancy and she was lovely”.

Handling competing expectations

Key informants

Students can find themselves in difficult situations when attempting to provide woman centred care and also meeting the expectations of the mentor. The observation of one of the key informants illustrates this,

“Its important that she is getting the right kind of feedback from the woman as well as doing the things that will suit whoever it is that is assessing her or supervising her”.

“it can be very difficult to operate, as the belief is right, when there are particular staff on duty who expect particular patterns of care. So this [involving women] could be quite a liberating thing not just for the students but also important for the supervisors”.

Students

The students also identified with these tensions recognising that women and mentors may have,

“completely different views of how I was in practice”.

When asked how they felt about the different view points and their relevance for their practice, the general response can be reflected as follows,

“when you’re in practice I think it’s the woman’s views, in the University its the mentors view... they’ve got to pass the placement overall, for you to then go on to the next year, its not the women who pass you at the moment”.

Mentors

Despite attempts to promote the authentic assessment of clinical practice the mentors felt that assessment tends to influence behaviour because,

“people are going to be on their best behaviour aren’t they, and that’s the nature of assessment isn’t it”.

The mentors identified a potential problem if their views were contrary to those of the women,

“if you’ve got this lady saying ‘oh, she’s superb’, and ‘she’s lovely’ because they might have just clicked and yet you’re saying her practice is not up to scratch. It could cause a lot of problems”.

Selecting women as assessors

A serious issue concerned the inclusion criteria for selecting women who might be involved in the assessment of students.

Key informants

Involving a range of women was also illustrated by a key informant who felt that primigravid and multigravid women should be included, the rationale being that the experience of women,

“is very different”

and by only involving multigravid women for example then there was the potential to,

“skew the feedback that you got”.

Students

The students felt that it was important to involve women who would be able to make constructive yet honest contributions. By inviting the women to provide feedback they recognised the possibility that,

“you’re more likely to pick people you’ve got on with, you are though aren’t you? You’re not going to pick somebody you haven’t got on with”.

Mentors

The mentors were also sensitive to the need to take cognisance of the fact that,

“if they take a dislike to somebody, just for whatever reason, it could have quite an important effect”.

However they were of a view that the students needed to receive feedback from a range of women,

“its got to be equitable, hasn’t it, you can’t just ‘oh well, we’re just going to ask those women or certain mums”,

and,

“you’ve got to be sensitive to the student, ... there’s got to be some selection, I know its unequal, it is, but you know, you’ve got to try and make it so that she’s going to get some constructive feedback”,

and,

“you want somebody that’s going to ... be objective ... and not going to confuse the poor student”.

On the other hand some felt that there should be no deliberate selection made on behalf of the mentor. Getting the right balance for the student was thought to be important yet there was the need to involve women who did not adopt a sanitised approach. It was accepted that there was the need to involve,

“women that are going to complain [in general about the services] you’ve got to teach the students how to cope with these women”.

Attempts to protect the student so to speak had the potential when trying to,

“make it a good experience for the student without necessarily realising it, subconsciously you could be picking people who you know ... are really going to give positive feedback”.

Choosing the women to be involved in the assessment process needed some thought in the light of the issues identified during the discussions. It was suggested that ,

“maybe it is a joint decision between the student [and the mentor]’.

The mentors also suggested that women being involved should be known to them and therefore would be in the third trimester of pregnancy. Continuity was also an issue and they felt that they were well positioned to choose,

“somebody at about thirty odd weeks, somebody who you’re going to see very frequently, you’re going to know them anyway, you’re going to know whether they’re going to agree to it and probably you can have a discussion with them about it”.

Preparing women for an assessment role

Key informants

The key informants all agreed that the women would require some preparation and the format it would take was explored. The central issue was that women should understand the importance of their feedback and how it would be used. This is illustrated by one who said that women require,

“I think generally em... the most preparation that they [women] need is just basically an explanation of their value and their role within the process and that in itself will facilitate the women being able to deal with the role and do it well”.

Another felt that,

“it would help if it was a standard routine and something that they found out about when they booked”.

This argued another could set the scene for their training,

“shouldn’t it be the philosophy of their education from the beginning?”

Mentors

The mentors also felt that women would require some form of preparation because,

“the woman’s got to feel confident that she can do it”.

Providing better quality care

Key informants

There were thought to be a number of advantages associated with the proposal to involve women in the assessment of students in terms of delivering enhanced individualised care.

The general tenure of each interview resonated with one particular quote in relation to the involvement of women in the assessment process,

“it is sort of shocking that it doesn’t happen em ... because ... there is no other way of assessing quality of care because the quality of care is what the woman has experienced. So if no one is actually asking them what experience they are having then what is being assessed?”.

Any approach to assessment that did not directly involve the woman was seen by another key informant as,

“judging for that woman”.

One key informant noted that,

“as opposed to a guideline that was written ... they would look at the individual and provide that individual with the appropriate care because they had taken the time out to find out what that individual wanted and needs’.

To focus on the woman in this way meant that one key informant felt that unless students were receiving feedback from women,

“throughout their training how are they going to learn to tailor care to individuals because they are not going to know otherwise how individuals experience the care”.

Quality of care was discussed by all participants and in particular how women perceive quality. Indeed quality was seen to be a very topical and current issue by the key informants one of whom said,

“there is so much talk at the moment about quality of care and women centred approaches”.

This is illustrated by another who said that,

“a lot of clinical things are intrusive, aren’t they, for the mother and it helps the mother a great deal if she not only knows what’s going on and why, but also feels that her feelings about them are valued and so the midwife who asks her whether this is comfortable or not and tries to make it as comfortable as possible for the mother is going to be really valued by the woman”.

The strength of feeling on behalf of the key informants in relation to this issue is reflected in the following illustration.

“It seems inconceivable that anybody else can assess the quality of care that a woman has received, because nobody else has received it. It just seems crazy not to use her experience as the main assessment for quality”.

Although there was an emphasis on standards and quality of care one key informant felt that approaches to quality improvement were limited because the woman was not involved in its determination,

“I think it comes back to deciding on what makes up quality care and I think that one of the key parts of quality care is how they were cared for, because that is a therapeutic and emotional need rather than a physical need and it is seen as a luxury”.

Students

This issue was picked up by the students who recognised that,

“if they say its right for them it doesn’t mean its right for every one ... because it’s different for every woman”.

As far as quality was concerned the students felt it was important to be assessed in the provision of holistic care,

“ because the little things that you do for women and how you look at that woman holistically is actually assessed because all of your skills come into it just looking after that woman and meeting little needs that aren’t midwifery procedures but they are very important in the care situation”.

Mentors

The mentors also recognised that they had a role in supporting students when there was a need to respond differently in what was perceived to be a known and familiar situation because,

“you will meet women who ... in all walks of life you will meet people who are different”.

Differentiating between general complaints about maternity services and students performance was seen as another advantage in terms of enhancing care. Once a complaint had been voiced women could be,

“headed in the appropriate direction so that the two don’t become tangled up”.

The mentors felt that any patterns in relation to issues that women raise regarding students could be identified and this could have the potential to,

“influence practice, so they’d be probably doing us [mentors] good as well”.

and,

“There may be a knock on effect, you might learn something and think, well I’ve done something for years and I didn’t realise how annoying or whatever it is, it may actually influence our practice as well, which would be quite good really”.

Conclusion

This chapter has reported in detail on the findings from the individual and focus group interview data. Chapter 5 will similarly give an account of the results that emerged from the survey of the Approved Midwife Teachers.

CHAPTER 5 - PHASE 2 FINDINGS

The findings from the questionnaire yielded both textual and numerical data. Although the principle objective of this aspect of the study was to gather quantitative data, its probity is magnified by the conscientious approach that the AMTs adopted in their responses to the less structured dimensions of the instrument. These are reported according to a respondent number that was allocated to each individual who provided textual data. The approach to the analysis of the data is discussed in chapter 3.

Findings from the textual data

The textual data was subjected to template analysis and the quantitative data yielded descriptive and summary statistics. The template analysis yielded the following higher order (emboldened) and lower order codes.

Student-Women relationships and their influence on practice

- The need to reduce vulnerability and empower women
- Listening to and valuing women's contribution

Feedback and the learning process

- Feedback-some challenges
- Format of the feedback
- Choice for women

Ascertaining levels of competence and the issue of validity

The overall principle of women's involvement in student assessment

- The ability of women to be involved in the assessment process
- Preparation for involvement

Figure 9 Template analysis of Phase 2 – a synopsis

The AMTs provided data from their perspective as those charged with responsibility for the overall quality of pre-registration midwifery programmes for their respective educational institutions. Whilst there was overwhelming support for the involvement of women a number of themes emerged that captured the advantages, disadvantages and challenges it represents. Both the clinical context and the policy context within which students study and learn and the part women might play in that were seen as very important. They felt,

Students have to work within the culture of the maternity services, which, at present is very influenced by women's expectations (R34)

Given the current emphasis by the Government on users' and carers' views I believe this initiative to be innovative, I support it in principle. (R14)

Student-Women relationships and their influence on practice

It was envisaged by the respondents that the contribution made by women had the potential to affect relationships with students both positively and adversely. If the emphasis was focused upon the judgemental aspects of assessment one respondent thought that,

Knowing that women are 'assessing' them could interfere with the rapport/relationship between student and women. (R7)

On the contrary, another felt that if the emphasis was placed upon the developmental aspect of assessment then,

Women's involvement in learning ...has the potential to be extremely helpful ...to the [student-woman] relationship. (R5)

There was overwhelming support for the opportunity for students to concentrate on a partnership approach to their practice. The benefits are illustrated by the following,

I feel it [partnership] is vital. Partnership working can empower women and listening to women can I believe improve practice and individualised care.
(R28)

This emphasis upon learning and improved practice was thought by one respondent to have the potential to enhance students',

ability to create a rapport and partnership. (R21)

Another saw a partnership approach as beneficial to students in general,

We need to keep women 'on our side' in relation to their willingness to allow students to be involved in their care in the light of recent bad publicity about NHS provision. Involving women as partners could certainly help in this respect.
(R34)

The need to reduce vulnerability and empower women

The active participation of women was balanced by the need to ensure that women were true partners and not taken advantage of. The level of support and the degree of involvement experienced by the women would impact on any contribution to student learning made by them. Respondents felt the following,

Empowerment will depend on how the women are approached, who asks them to become involved and what role they are given. (R22)

This approach may be welcomed by some women but seen as threatening or an imposition by others. (R7)

If they are threatened by it or feel it is just 'another thing to fit in' then this could disempower them. (R21)

They may feel vulnerable and not give accurate feedback because of this. (R17)

One to one feedback I think needs to be sensitively handled. Managed both from the woman's perspective she could feel intimidated/anxious etc. (R3)

They [the women] need to be confident that criticism will not result in punishment to themselves and their baby. (R8)

Listening to and valuing women's contribution

The respondents felt strongly that student midwives should develop the appropriate listening skills to hear what women were telling them and to value their input. The following summarises the general view,

I believe women can and should be encouraged to provide feedback on care and this should be valued. (R20)

To ask directly, must ensure that the woman is not 'burdened' with yet another 'task' in her care but treated in a way that values her comments on the care given. (R20)

I have a great belief in feedback from the mother – if we listen, if we ask the questions, and if we want to really hear what is said. (R8)

Feedback and the learning process

The respondents held a strong impression that feedback from women had the potential to assist the student in the process of learning through the following comments,

What better feedback than from those directly involved in the care. (R34)

feedback about performance is a vital tool for learning. It increases self-awareness and thus the ability to reflect. Reflection without feedback from others can become very introspective – pure naval gazing!. (R28)

I think this [feedback from women] could potentially be a very rich source of feedback for students. (R33)

One respondent did present a possible student perspective in relation to feedback that is worthy of consideration stating,

Students do not always value or see this. (R13)

The respondents focused on the value of feedback in relation to differing aspects of student performance. These included physical, psychological, and social aspects of caring as follows,

Feedback could provide information of the emotional response of women to the particular approach/skill being applied. (R40)

The usefulness of information, perhaps on techniques e.g. abdominal palpation, too rough, too gentle etc. (R12)

Views may be biased but will relate to women's specific interests as opposed to those educators consider to be important. (R29)

Respondents' thoughts went beyond the contribution women could make in respect of student midwives believing,

Your questionnaire has really challenged me for I believe women should be involved in the process of feedback and assessment of all professionals. In many respects they are not overtly acknowledged or in many cases, properly valued. (R20)

All women should have the opportunity to provide feedback about all aspects of care not just student midwives so all providers can learn. (R7)

Feedback – some challenges

The respondents whilst providing an overwhelmingly positive welcome to the proposal also addressed some of the challenges it could present from the perspective of both women and students. Firstly the provision of negative feedback and objectivity prompted the following,

I think during care giving women are not likely to want to give negative feedback and the outcome may influence the objectivity of their assessment. (R23)

Many women may just keep quiet. (R27)

They may only be willing to feedback positive element. (R27)

Bearing this in mind another respondent did state that,

Women need to know that their feedback will have a powerful effect, and that they are not meant to just provide positive comments. (R8)

It was acknowledged that students do on occasions either directly or indirectly receive feedback from those for whom they care and that mentors do include this feedback from women in the judgements they make in relation to students' performance. However without a formal requirement to do so it was believed that gaining the women's perspective,

depends on the student's motivation to seek feedback about the care given . (R17)

The vulnerability of the student was also raised. As women's expectations may vary and personality clashes could impact upon the student so that the potential to enhance learning would in part,

be influenced by how well the students receive negative feedback from women.
(R38)

What do we do if a woman takes a dislike to a student? (R30)

Indeed another noted that,

human nature, with all its aspects of discrimination or interactive chemistry, could create a bias either way. (R21)

The concept of fairness for the students was commented upon as follows,

In this, you begin to see how much such involvement while inherently 'right' also gives rise to problems and practical difficulties in the application of fairness, validity and reliability of responses from women. (R20)

The challenge was picked up by another who asked,

How does one build this into a fair and reliable assessment process? However just because its difficult does not mean we should not do it. (R20)

In order to address the issue of fairness and equity one suggested that,

we all know how subjective assessment is, even with trained and experienced teachers. It is inevitable that any feedback from women will be biased and subjective. I'm not sure there should even be an attempt to suggest otherwise. I think that feedback from women as one part of the evidence students need to present is reasonable. (R7)

This is supported by another who suggests that students should in order to inject balance receive,

feedback from several women. (R3)

This problem of bias and the need to have meaningful feedback that could assist in the learning process could also be addressed in part by inviting,

the student to identify specific feedback to be included as evidence for their portfolio. (R33)

The concept of validity is an important one. Whilst women's views may be subjective one respondent referred to their inherent validity by virtue of the fact that they were offering their perspective. She stated,

the majority of judgements may be valid. (R10)

The format of the feedback

The format and context of the feedback was deemed to be important. Again equity and fairness could be addressed by using the most appropriate format. It was felt that,

A structured, semi-structured format for providing feedback may encourage balanced assessment. (R29)

Another observation was that receiving feedback,

may require some facilitation from educationalists. (R32)

Another suggestion was the use of a

grid like or Likert scale. (R12)

Regardless of the format it was felt that there should be,

a clear structure and process. (R25)

Choice for women

In keeping with Government policy, the philosophy of maternity services and the midwifery curriculum the respondents felt it as important to ensure that women could choose whether or not to participate. This was linked to a number of issues namely time, ability, confidence, family input and responsibility. Respondents believed,

Some women may not wish to be involved or may find it too much of a responsibility. (R21)

It would be very important for the women not to feel that they had to give feedback. (R33)

However one respondent thought that,

women should be encouraged to contribute. (R9)

Interestingly the option to extend the invitation to provide feedback to the partner was also raised.

The entire family, not just the women are recipients of midwifery care other members might therefore be able to contribute to the process. (R1)

What about the partner? (R33)

Ascertaining levels of competence and the issue of validity

Feedback from women regarding certain skills was thought to be appropriate and potentially of greater relevance to students than feedback from other sources including

mentors. Examples given included communication skills, certain clinical skills, attitude, values and interpersonal skills. Some reservations were also cited, particularly in relation to women's knowledge base and levels of competence and their assessment. These included the following,

It may be difficult for women to contribute to the assessment of some midwifery skills but professional attributes, interpersonal skills etc. would be easy for them to rate/ assess. (R18)

Women should certainly contribute to the assessment of communication and caring skills. (R28)

It is very hard to change attitudes and to teach how to! This could be another approach to help the development of the 'right' attitudes to midwifery practice and women. (R28)

I feel women are good at describing attitude – better than we are. (R30)

Other respondents agreed that feedback from women in relation to clinical competencies would assist students to reflect on practice but they were,

unsure how feasible or easy it is for women to assess the level of clinical competence. (R18)

Women are not well placed to determine competence. They know what they like and don't like- they do not usually have the background to determine competence. (R21)

Women tend to value interpersonal 'caring' approaches and be largely uninformed about the complexity of practice. (R40)

They certainly cannot judge the knowledge base unless they are better informed than the students. (R21)

The issue of validity was acknowledged and as with any form of assessment the need to address this was emphasised by some.

Thought needs to be given towards inclusion on academic credits in particular issues of reliability and validity. (R14)

A woman's assessment of a student midwife could not be allowed to over influence the overall assessment. (R34)

Students with good communication skills both verbal and non-verbal who interacts will receive a good report when practice skills remain poor. (R38)

I believe some women would find it difficult to be totally honest and this would be counter productive. (R4)

The overall principle of women's involvement in student assessment

The principle of involving women was supported however, challenges in relation to the assessment process were acknowledged and some helpful approaches were provided including,

The principle of involving women in the assessment process is I believe important. (R20)

We would need to be selective about the areas that women can assess. The assessment should contribute triangulation of evidence about student performances. (R18)

Inherently I believe women should be involved but what would you have them comment upon? Acceptability, comfort, approach, understanding are all

important aspects and women have the right to comment but how is this weighted in the assessment process and to what assessments would it apply. (R20)

Overall its an excellent idea, the logistics are the next problem. (R28)

It was suggested that the woman's assessment if it was to be summative could be limited to,

a small component. (R21)

It could be useful for the student to identify specific feedback to be included as evidence for their portfolio. (R33)

What is being assessed should be crystal clear to the student and assessor. (R12)

This may be useful early in the programme or combined with feedback from practitioners/lecturers. (R40)

Continuous assessment was raised by one respondent who noted the potential difficulty if students were

caring for women for short periods. (R14)

The ability of women to be involved in the assessment process

The ability of women to participate in the assessment process and provide students with useful feedback prompted many of the respondents to provide additional textual data. It was felt that not all women could or would wish to participate. The following quotes capture the reservations some of the respondents had,

many won't be able to or won't want to. (R7)

Women don't usually have the background to provide feedback which is anything other than emotive with regards to skills. (R21)

These concerns were not evident in the thinking of other respondents who adopted a more positive position and were of the view that whilst women did possess the ability to participate that their ability to constructively do so may vary considerably. Respondents also felt it important to address the issue of ensuring that those who were perhaps less able were in a position to provide feedback if they so wished stating,

Women can and do judge professionals and students alike. (R20)

Involvement and feedback from women will vary according to social class, education, motivation and attitude to pregnancy. (R26)

Such a lot depends on the client group, their level of knowledge, how they communicate and what their perceptions are of the student midwife. (R12)

How would the less articulate whose cognition is not so developed be utilised? (R32)

Feedback from them (those perceived to be less able) is important . (R34)

In addition to ability other challenges included,

Language ... culture ... reading skills ... understanding. (R7)

In recognition of the concerns articulated and in an attempt to minimise bias the notion of selecting women was proffered,

Selection of the women would need to be considered as is selecting role models from the midwifery profession as mentors. (R3)

Need to consider a selection process. (R19)

Preparation for involvement

The degree of preparation which the respondents thought women might need also varied and certain aspects of their involvement were highlighted in terms of their need for preparation as follows,

Women would need guidance on being constructive. (R30)

Women are broadly speaking (able to participate) but as in most cases, people need to be prepared. (R3)

How are women to be prepared if feedback is to be negative? (R5)

It would be unreasonable to expect women to be able to provide feedback without some preparation. However the preparation could be brief. (R7)

Formal preparation but not lengthy. Advice on constructive feedback for example. (R34)

Survey Findings – Summary Statistics

This section presents the statistical analysis of the survey of the total population of AMTs in England. SPSS was used to provide a descriptive analysis of each question and findings are represented diagrammatically by the use of histograms that can be seen in Appendices 3 and 6. As it is easier for the reader to make comparisons if the data is reduced, summary statistical analysis was also performed using SPSS to identify the minimum, first quartile, median, third quartile and maximum for each question. This provides an idea of how spread out the values are. The interquartile range was also calculated giving an indication of the spread of the central 50% of values. Sections one to six are presented below and section seven can be found in appendix 3

Table 1. Questionnaire Section 1-Fitness for Practice

Histogram	Minimum	1 st . Quartile	Median	3 rd . Quartile	Maximum	Inter- quartile Range
1. Worth and not worth learning	1	1.00	2.00	2.00	4	1
2. Focused feedback	1	1.00	2.00	2.00	4	1
3. Women friendly care	1	1.00	2.00	2.00	4	1
4. Art of caring	1	1.00	2.00	2.00	3	1
5. Doing the job	1	2.00	2.00	3.00	4	1
6. Women’s influence on care	1	2.00	2.00	3.00	4	1

Although the 3rd quartile indicates some ambivalence there was strong agreement that the involvement of women would enhance student midwives fitness for practice as indicated by the results of the 1st quartile, median and 3rd quartile data analysis. No respondent disagreed with this and the interquartile range indicates consistency amongst the AMTs as it was 1 in each case.

Table 2. Questionnaire Section 2-Partnership Approach

Histogram	Minimum	1 st . Quartile	Median	3 rd . Quartile	Maximum	Inter- quartile Range
7. Partnerships	1	2.00	2.00	3.00	4	1
8. Client centred care	1	2.00	2.00	2.75	4	.75
9. Women's interest in students	1	2.00	2.00	3.00	3	1
10. Learning from Women	1	1.00	1.00	2.00	2	1
11. Empowering women	1	2.00	3.00	3.00	5	1
12. Quality of Care	1	1.00	2.00	2.00	5	1

The median value for this section indicates once more that the AMTs generally approved of the involvement of women in preparing student midwives to adopt a partnership approach to care. There was support from the majority that this initiative would enhance the quality of care delivered. However there was some indecision regarding the empowerment of women through their involvement. The issue of empowerment together with the status of the partnerships students might have with women is discussed in chapter 6.

Table 3. Questionnaire Section 3-Autonomy in the Learning Process

Histogram	Minimum	1 st . Quartile	Median	3 rd . Quartile	Maximum	Inter- quartile Range
13. Weaknesses and strengths	1	2.00	2.00	2.00	5	0
14. Motivation to learn	1	2.00	2.00	3.00	4	1
15. Feedback and learning	1	1.00	1.00	2.00	2	1
16. Reflection	1	2.00	2.00	2.00	5	0

The majority of the AMTs felt that student autonomy in the learning process was not only desirable, but an aim of the curriculum in which women could play a part. The 3rd quartile and interquartile range indicate this. When interrogated further, the data revealed

that just over half of the respondents agreed that women's involvement would motivate students yet there was an obvious degree of uncertainty associated with this possibility.

Table 4. Questionnaire Section 4-Feedback to Students

Histogram	Minimum	1 st . Quartile	Median	3 rd . Quartile	Maximum	Inter- quartile Range
17. Theory practice gap	1	2.00	3.00	3.00	5	1
18. Feedback-clinical skills	1	2.00	2.00	3.00	4	1
19. Feedback-knowledge base	2	2.00	3.00	4.00	5	2
20. Feedback-values	1	2.00	2.00	3.00	5	1
21. Feedback-attitudes	1	2.00	2.00	2.00	4	0

This section explored feedback from women to student midwives in relation to specific aspects of their professional practice. When the data was interrogated in full it was established that the majority of AMTs supported feedback regarding professional attitudes, skills and values. Whilst there was ambivalence surrounding feedback regarding knowledge as indicated by the interquartile range, women's ability to help bridge the theory practice gap was received more positively.

Table 5. Questionnaire Section 5-Validity of the Assessment Process

Histogram	Minimum	1 st . Quartile	Median	3 rd . Quartile	Maximum	Inter- quartile Range
22. Validity	1	2.00	2.00	3.00	4	1
23. Expectations and bias	1	2.00	2.00	3.00	4	1
24. Perception of care	1	2.00	3.00	4.00	5	2
25. Course management team	1	1.00	1.50	2.00	3	1

The AMTs felt strongly that the course management team should oversee the involvement of women. When the data was analysed in full the majority agreed that validity would be enhanced. However the degree to which it would be possible for women to differentiate between the care provided by student midwives and maternity services generally was unclear. The interquartile range for this question was 2 indicating a range of differing opinions.

Table 6. Questionnaire Section 6-Feasibility

Histogram	Minimum	1 st . Quartile	Median	3 rd . Quartile	Maximum	Inter- quartile Range
26. Preparation for women	1	1.00	2.00	4.00	5	3
27. Summative	2	3.00	4.00	4.00	5	1
28. Formative	1	2.00	2.00	2.00	4	0
29. Student involvement	1	1.00	2.00	2.00	2	1
30. Women as a learning resource	1	1.00	1.00	2.00	2	1
31. Involve all women	1	1.00	2.00	2.00	4	1
32. Choice for women to contribute	1	1.00	2.00	2.00	3	1
33. Feedback – format and women's choice	1	2.00	2.00	3.00	5	1

It is clear to see from the summary statistics that all the AMTs agreed that women were a significant learning resource for student midwives. The general spread of opinion indicates that the AMTs felt that there should be an opportunity for all women to participate but that there should be choice for women both in their agreement to participate and in the format of the feedback they might give to student midwives. There was a wide range in opinions regarding the preparation of women for the role with an

interquartile range of 2 however, the majority agreed that women would require formal preparation.

Whilst the spread of opinion indicates that there was some agreement that women's contributions should inform summative judgements the general view was that they should not. The consensus lay in relation to formative judgements as indicated by the interquartile range result.

Conclusion

This chapter has catalogued the qualitative and quantitative findings from Phase 2 of the study. These will be discussed together with the findings from Phase 1 in chapter 6.

CHAPTER 6 - DISCUSSION OF THE FINDINGS

This chapter provides a commentary on, and an interpretation of, the various data that were accumulated in the course of the study and uses these to reflect on the literature that had been explored previously. The chapter attributes meaning to the more important findings by identifying both their theoretical and practical consequences. Although the focus of this work has concerned the role of women in student assessment, what emerged has wider consequences for teaching and learning, the overall student experience and also for women as NHS consumers. The data resulted in findings that are reported in the previous chapter and was categorised according to the following themes that will now be discussed.

The midwife-woman, student-woman relationship

The review of the literature provided a very clear picture of the professional relationship that midwives have with women as one based on respect, trust, partnership and mutuality (Newburn, 1995; Wang, 1995; Leap, 2000; Wilkins, 2000). Preparing student midwives to develop this approach to their professional alliances with women was explored with all participants. They all acknowledged the importance of the student-woman relationship throughout the learning experiences that student midwives undergo. Participants urged that the skills required to perpetuate the unique mutual affinity that midwives and women have a need to be developed during the course of the pre-registration education programme. Whilst this view was held by all of them to a degree, it was especially emphasised within the qualitative data. Here the participants highlighted the impact of

the midwife-woman relationship on the experience of the woman and the clinical outcomes of her care.

Parents in particular relied very much on a good relationship with their midwife in order to negotiate their care. The development in students of the appropriate skills to maintain the type of rapport that is required were seen as challenging, given the complexities of providing comprehensive physical and psycho-social care. Involving women in the student assessment process was cited by one key informant as a very necessary, practical and positive step in the provision of a personalised, holistic service to women.

This was endorsed by most of the AMTs who largely supported the proposed change to involve women in the assessment process and consequently in student learning. Yet the proposal was rejected by five of the sample who saw this as potentially detrimental to the establishment of student-women relationships (see histogram 7, page 282). In the light of this evidence therefore, it seems axiomatic that any barriers to the nurturing of professional alliances with women be addressed at the curriculum development stage. Recently the medical profession emphasised the importance of the ability of medical practitioners to establish effective relationships with patients and have adopted a competency based curriculum approach to achieving this (Mayor, 2002). A teaching and assessment strategy that does not place the woman at the centre of teaching and learning has the potential to relegate the importance of partnerships in midwifery care. Involving women in the assessment process arguably has the capacity to influence power relationships positively. It is of interest that when AMTs were asked if the involvement of women in student assessment would assist 'women friendly' relationships there was

overwhelming support that the influence would be positive (see histogram 3, page 280).

When however, the sample was asked more directly about the possible effects on 'partnership', they were more equivocal and seemingly suspicious about the shift in power that women might acquire if they were to become co-assessors.

These findings concerning power relationships within the assessment process raise an additional question about the students' relationships with their mentor, given the power that mentors have. This is an issue that students touched upon when they described the way in which they develop professional partnerships with women for whom they care. Noteworthy from their responses was the great sense of satisfaction that they derive from the time they spend with women whilst not being supervised directly by their mentor. On these occasions, they obtained great satisfaction from the spontaneous dialogue they had with women. These findings raised questions about the ways in which students develop interpersonal skills and the tacit assumption that the acquisition of these is part of a planned learning experience. This also raises questions about the student-mentor relationship, the nature of which contains assumptions that are seemingly ill understood.

The mentors acknowledged similarly that the necessary emphasis within the pre-registration programme upon building relationships with women was not always explicit within the curriculum or not always implemented when it did exist. They admitted that despite the presence of a student during consultations with women, mentors tended to dominate proceedings. They recognised nevertheless, the benefits in terms of interpersonal skills not just for students but also advantages for themselves that the feedback from women would provide.

Listening to women and valuing their contribution

The themes of respect and due regard for women were further developed by the participants who drew particular attention to the importance of listening to women. A key informant believed that the increasing rationalisation within the NHS was resulting in fewer, larger maternity units. It was believed that this reconfiguration has resulted in the disappearance of 'friendly' smaller units with their replacement by larger more impersonal organisations. The mentors also pointed out that whilst the smaller units did not necessarily guarantee that women's views would be heard and considered by their carers, the degree of anonymity had increased within these newer services. The key informants were similarly sceptical about current formal systems that are intended to listen to service users as consumers (DOH, 2002b).

The AMTs also recognised the need for the development of listening skills but they emphasised that the willingness to hear must be accompanied by responsive action if the quality of partnerships are to be enhanced. In a similar vein, the students were convinced that listening to women represented an important staff development opportunity for themselves and for the midwifery profession.

Assessing listening skills was agreed generally to be problematic. Yet it was also thought that seeking women's views on the students' ability to listen to them had value. One key informant remarked that women underestimate the worth of the contribution they make to the development of students' communication skills. This theme was picked up by one of the AMTs who felt that not only did women underestimate their role but that clinicians and teachers also neglected to acknowledge its importance. Again this

resonates with findings in the literature from similar studies in relation to the education of medical students (Kelly, 1998). The data from this study confirm that listening to women who use maternity services was viewed by all participants as fundamental to proper partnerships in care. This also concurs strongly with the associated midwifery literature (Wang, 1995; Leap, 2000; Wilkins, 2000).

Listening to, hearing and taking action will be explored further when considering how women might influence students midwives ability to reflect upon their practice and learn from it.

Power and the therapeutic relationship between the student midwife and women

The review of the literature considered the issue of power within therapeutic relationships. Whilst it was recognised that all relationships are mediated to some extent through power, the model advocated as most appropriate for the midwife-woman relationship was one of mutual participation whereby midwives resist some of the more traditional controlling relationships that they have had with women (Lawson, 1995; Donley, 1997; Leap, 2000; Wilkins, 2000). Consequently midwives have begun to address these inequalities and seek to alleviate powerlessness, ignorance and dependence. Involving women more directly in the student' learning experience adds a dimension that alters the distribution of power within the triadic relationships between mentors, women and students. Women's fuller participation also has implications for midwifery lecturers and their power base that is associated specifically with the assessment of students.

The participants all recognised that any shift of power to involve women in student assessment is of sufficient magnitude to have fundamental implications. These concern a shift in both the curriculum philosophy and also for the philosophy of care adopted by maternity units. Both of these would need reconsideration in order to generate the genuine involvement of women in such a revolutionary venture.

The need to minimise vulnerability and empower women

The participants were keen to ensure that women who became partners in student assessment were not misused simply for the benefit of student midwives. The UKCC guidance on this is very clear emphasising that women using maternity services should not be exploited (UKCC, 1999a). There was a widespread emphasis on the need for joint ownership of care with women being approached in a non-threatening way and afforded the appropriate level of support if they wished to participate. The AMTs generally agreed that the involvement of women in the assessment process would provide them with a vehicle to actually influence practice (see histogram 6, page 281). There was also evidence from the parents and the AMTs to suggest that women would enjoy the role and take an interest in student midwives (see histogram 9, page 283).

The student midwives were keen to receive both complimentary and critical feedback to maximise their learning. They expressed several ideas as to how they personally could enable women to provide this. Yet the mentors and key informants were mindful that women might be reluctant to be critical and would need reassurance that their care would not be compromised as a consequence of negative remarks they might make about students. The parents also talked about how they might feel if the feedback they wanted

to give was uncomplimentary. It was evident that they saw the distinct benefit of doing so but it was also clear that they might feel somewhat vulnerable and believed this sort of information would require sensitive handling. Both the parents and the students saw a significant role for the mentor if parental opinion on students' performance was to become a norm. They believed that the mentor could act as a useful conduit to transmit any necessary negative messages from parents to the students. Whether or not such a level of engagement in the assessment of students would result in a sense of empowerment for women is debatable. Whilst almost half of the AMTs agreed with this sentiment, a similar number were undecided the reason for this is unknown (see histogram 11, page, 284). However deliberations in relation to partnerships suggested a degree of support for the empowerment of women.

The nature of knowledge within the midwifery curriculum

The review of the literature had revealed the approach the midwifery profession takes towards its underpinning knowledge. Whilst it is widely accepted that there are discrete types of knowledge that have been succinctly captured by Carper (1978), midwifery remains very much an applied field of theory and practice. Midwives acknowledge the necessary empirical knowledge underpinning their practice. But they also draw significantly upon humanistic knowledge, knowledge of self and ethical knowledge, all of which are necessary to engage in competent clinical practice. Empirical knowledge is highly valued within the Higher Education sector and it has a tendency to dominate the curriculum in applied fields of study to the detriment of other forms of knowledge concerning skill development. The exploration and debate regarding discipline specific

knowledge has had implications for the development of the curriculum, notably through the more recent emphasis on the potential for planned learning in the clinical environment (Jarvis and Gibson, 1997). This has the tendency to redress the balance between empirical knowledge and humanistic knowledge. This debate continues and a tension exists between these forms of knowledge, their integration within the curriculum and their application in practice.

This study reinforces this position in that key informants, students and AMTs favour a philosophical approach to practice that places women on equal terms with midwives and recognises the importance of the knowledge that women bring (Wilkins, 2000). Although there were mixed views, there was general support for equality based on a combination of the women's personal knowledge and experience of pregnancy and childbirth along with the technical and professional knowledge that midwives bring to bear on the management of pregnancy (see histogram 18 and 19, pages 287 and 288). One key informant was impressed by the judgements made by women regarding the knowledge base of the midwives they encountered. Women who have a wealth of information, sometimes gleaned from the Internet and together with their personal experience, are in a position to make balanced, evidence based judgements about the levels of clinical competence of the midwifery practitioners providing their care. In addition, it was suggested by another key informant that women whose pregnancy was complicated by a superimposed medical disorder might also have an important part to play. These women can act as a particular resource for students regarding their condition by bringing their own personal experience and sometimes, empirical knowledge to any discussions they have with student midwives.

The students signalled the problems they sometimes have with the tension that exists between theory and practice in the midwifery curriculum and this concern is also reflected in the literature (Frazer et al, 1998). They claimed difficulty in making sense of some of the material covered in their lectures in terms of their one to one caring relationships with women. The AMTs felt that student feedback from women might better assist the effective synthesis of theory and practice. Only three disagreed that this was the case although half were indecisive again the reason for this is not evident (see histogram 17, page 287). When asked directly about women being a resource for the acquisition of clinical skills by students, the AMTs were much more decisive and supportive of the women's role in this (see histogram 18, page 287). When questioned about women acting as a means to the development of empirical knowledge, opinion was divided almost equally. In the interview setting the participants were given the opportunity to explore a similar question about empirical knowledge and this shed further light on the issue. One key informant initially rejected the idea that women had any part to play in the development of students' empirical knowledge but following reflection and further discussion, concluded that they could be a resource that she had never really considered.

The challenge remains to produce midwives who are caring, critical thinking and questioning practitioners who can call upon the continuum of knowledge available to them from empirical and humanistic sources. This data emphasises the importance of knowledge within the midwife woman relationship. It brings out the symbiotic relationship that might be better generated between students and women to optimise learning in the clinical setting.

Learning in the context of the midwifery curriculum

There has been much debate relating to the way in which adults learn (Neary, 2000). In the context of this study and indeed the context of midwifery care espoused in *Changing Childbirth*, experiential learning theories and their associated humanistic approach to the teaching and learning that are employed generally, seem to be appropriate (DOH, 1993; Brockband and McGill, 1998). Experiential learning theories provide a very useful vehicle for learning from clinical experience. Their application affords the student midwife the opportunity to gain understanding and knowledge and to achieve competence through personal experience. Most importantly, and of direct relevance to this study, is the view that the experience need not be confined to the personal experiences of the student midwife but that she can learn by placing herself within the experience of others (Melamed, 1987). In the clinical setting student midwives often share experiences and learn from one another, as well as from their mentors. Providing students with a formal means to explore the women's expositions on the care provided by them is however, under-utilised within the curriculum and was much valued by the AMTs (see histogram 2, page 279). This is perhaps indicative of the limited interpretation by curriculum planners of the theory underlying experiential learning and the possible tendency to believe that such learning occurs more spontaneously than it does in real workplace settings (Kolb, 1984; Usher, 1993). In addition, the perceived lack of general rigour associated with work-based learning may have contributed to the reluctance to exploit formally the potential for learning from clinical experience in its broadest sense (Torrance and Pryor, 1998; Hager, 1999). The use of a strategic approach to clinical learning was explored with all participants. A key informant argued that student midwives should be actively

involved and responsible for identifying and meeting their own personal and professional learning needs. This process was discussed and it was concluded that the involvement of women as part of a planned learning strategy would have a positive influence upon the clinical learning objectives that students pursue.

Experiential learning, though perhaps not fully understood in terms of its underlying theory, found sympathy with the parents. They felt that they could give both direction to the students in terms of their learning needs and that they could also stimulate the students' appetite for enquiry. There was overwhelming support on behalf of the AMTs in recognition of the resource women could be in the assistance of student learning (see histograms 10 and 30, pages 283 and 293). Interestingly, the parents raised the issue of the sensitivities and difficulties associated with experiential learning. They recognised the emotional implications for the student. This is very much in keeping with the literature where impediments to student learning can exist for example due to dissatisfaction and unhappiness that has been generated by previous unfulfilling experiences (Postle, 1993; Neary, 2000).

The students sensed a certain degree of logic in involving women in the learning process and in keeping with the theory associated with experiential learning, they recognised and were eager to make the most of their learning opportunities within their clinical experiences. Their approach to learning took account of the many options that are available from the whole multidisciplinary team, all of whom they felt had a part to play. Broadening the approach to include women was seen by students as an additional means of assessing their own progress and identifying their personal developmental needs.

Mentors added a note of caution and were especially conscious of the sensitivities associated with experiential learning and the detrimental effect on students that disappointing feedback about their performance might have. The AMTs were supportive of the notion of involving the course management team in overseeing the process and acting in the students' best interests (see histogram 25, page 291).

Assessment as part of learning

It has been suggested that one of the main functions of assessment is to promote effective learning (Potterton and Parsons, 1996; Smith and Levin, 1996). To this end the assessment and provision of information in the form of feedback in relation to all aspects of performance is seen as an important part of the learning process (Kolb, 1984; Woodburn and Sutcliffe, 1996). This concept was explored with all participants. The AMTs all emphasised the need for feedback (see histogram 15, page 286), and in general there was agreement that women could play important roles in student assessment. The significance for participants however, was not solely on particular judgements women might make but rather on their more overall involvement in student learning. There was a mixed reaction as to whether or not the contribution made by women should be formative, summative or both.

This issue was discussed with all key informants who voiced a strong view that whilst they were not against the involvement of women in formative assessment activities, the women's contribution should also be included in summative judgements about students. They were of the view that to do otherwise would undermine the women's role in terms of the partnership relationship status they held. This contrasted significantly with the

AMTs who almost unanimously expressed a view that women should contribute solely to formative assessment (see histogram 28, page 292). There was however, some minimal support from the AMTs for a contribution of a summative nature (see histogram 27, page 292).

These mixed views on when and where women might be best involved in assessment was also reflected in both the student and the mentor data. The emphasis for these groups was different from that of the AMTs in that most were in favour of women making a summative contribution. The students and mentors welcomed feedback from the women of a formative nature and they suggested that this should perhaps take place towards the beginning of the educational programme with a greater summative contribution at the latter end. Both groups felt it important that the women were involved from the beginning of the student's clinical experience, a view also expressed by some of the key informants. The rationale for these participants was that the inclusion of women should be presented to the students as a normal experience.

In terms of student learning, the parents were of the view that the qualified midwives would want to know how women thought the students were performing. Parents were generally happy to make a contribution to the assessment process, given its implications for learning. This was felt strongly by one who saw the opportunity to detect poor performance at an early stage and thus to provide the students with an opportunity to rectify any deficiencies and to learn from them.

The students welcomed women's participation in their assessment process because they thought it might introduce an additional sense of balance to the feedback they already

receive. Their perception was that mentors often emphasised weaknesses following an assessment of performance. By contrast, they thought that women would perhaps emphasise their strengths. In terms of learning, the students thought this reinforcement of good practice would be beneficial although they did re-emphasise the point that they would also welcome parents' assessments that were critical of their performance.

It is important to also consider the fairness of the assessment process in relation to each student, particularly given the current emphasis on accountability in relation to professional assessment (Holroyd, 2000). The students expressed a degree of frustration at not always being able to demonstrate to their mentors what they knew or could do in relation to their course learning outcomes which was perceived by them as unfair (Smith and Levin, 1996; McDowell and Sambell, 1999). The mentors commented favourably on the implications for fairness of involving women in assessments. They believed this afforded the opportunity for students to receive comments from the woman's standpoint. Mentors felt that this would add a perspective to the information given to students that might suitably complement that which they themselves provide. Indeed, mentors also recognised the scope to add value to their own professional development as a consequence of inviting women to engage actively in the assessment of student midwives believing that a covert source of information is available that might be better exploited.

Developing strategic learners

The student midwives claimed to take an active role in their education and to enjoy a degree of self managed learning. They did not however, perceive a direct link between the process of learner-managed learning and their own development as autonomous

practitioners that is described in the literature (Stephenson, 1992; Stephenson, 1998; Neary, 2000). There is a close link between autonomous practice and the main characteristic of strategic learners, that of knowing what they should do when they do not know what to do. This requires the students to take responsibility for understanding how to evaluate their own performance (Riding and Rayner, 1998). It was evident from the student data that their role in evaluating their own performance is minimal in terms of the existing assessment systems. Data from students suggested that they did not have ownership within assessment to give them the necessary level of responsibility in relation to the assessment of their own performance to enable them to develop as strategic learners. Whilst the level of reflection associated with strategic learners was evident amongst the students, the resilience, resourcefulness and responsibility in relation to assessment described in the literature were under emphasised and underdeveloped in their programme (Heywood, 2000).

The students welcomed the idea of taking a greater level of responsibility for their own learning and this was supported by the AMTs who provided overwhelming support for greater involvement of students in evaluating their own practice and identifying their personal strengths and weaknesses (see histogram 13, page 285). There was further endorsement from the AMTs for an enhanced level of student participation in assessment generally and all the sample agreed that students should have some choice in determining in what aspects of performance they were to be assessed (see histogram 29, page 293). The key informants also supported students having more responsibility for the assessment of their own competence through the involvement of women. All of these views were

consistent with the literature that envisages students playing a more active role in acquiring, integrating and applying knowledge, particularly in relation to their own learning needs (Broadfoot, 1996; James and Gipps, 1998; Riding and Rayner, 1998).

Giving students more responsibility and a distinct role in their own learning has the capacity to add fresh energy to their motivation. The importance of assessment within any plan to heighten their inclusion is also crucial to their own interests to succeed, given the de-motivating and detrimental effect some modes of assessment can produce (Torrance and Pryor, 1998). The maxim that the more relevant an assessment activity is, the more the student will learn was pursued with the participants (Cotton, 1995a; McDowell and Sambell, 1999). An overwhelming majority of AMTs believed that students would be more inspired to learn through the direct association of women in their assessment (see histogram 14, page 285). This reflects the general mood amongst the participants that this new dimension would be stimulating, would give impetus and thus be a strong driving force for students.

It seems reasonable to assume that this level of inclusiveness and collaboration in relation to assessment between the student, mentor, woman and lecturer would also require some devolution of control and a greater collegiality. It would also need those who believe that the involvement of the student detracts from the perceived objectivity of the assessment process to be persuaded otherwise (McDowell and Sambell, 1999).

Autonomy and life long learning

Autonomous learners are enabled to exercise some form of control in relation to their actions without having the full range of qualities possessed by strategic learners. With the exception of parents, all the participants recognised the deliberate teaching and learning strategies within the curriculum to develop this quality but these did not necessarily always extend to the assessment strategy. The literature suggests that autonomy is not an absolute concept, rather it is primarily an individual quality that can be developed and is closely linked to motivation and commitment (Hanson, 1996; McNair, 1996; Foster, 1998). In the context of the assessment process there is obviously the need for students to be committed to and inspired by the modes of assessment they encounter. The students participating in the study did not always see the point of some assessments and therefore, lacked interest in them and were dubious of the personal and professional importance of these exercises.

There is evidence to suggest that, within the context of adult education, autonomous learning and knowledge of self are closely aligned (Stephenson, 1998). This is of particular relevance to student midwives who grapple with the tensions that can exist between growth at a personal level and growth at a professional level (Bradshaw, 1989). There was general support amongst the participants that learning in the clinical setting is very much a personal activity with students' experiences being varied and unpredictable. Clinical learning is dependent on a constellation of factors including previous experiences and very importantly, their sense of self and personal insightfulness into the consequences of their own actions.

The concept of autonomous learning is closely linked to that of life long learning. The key informants drew on their experience to identify innovative learning strategies associated with life long learning such as the confidence case loads student midwives hold towards the end of their training. There was however, no similar understanding especially amongst students in relation to innovation in assessment practices. It seemed students were often uncertain of the assessment criteria that had been set and were thus unable to judge their own performance against them. This is further evidence of their lack of involvement in both the learning and assessment process that emerges from the data. What is apparent is the need for a sustained commitment to autonomous learning that embraces the entire curriculum and has equal emphasis in both the classroom and the clinical setting (Dewar and Walker, 1999; Stephenson, 2001).

Validity and the assessment process

There is widespread recognition of the imprecise nature of the assessment of clinical practice (Bedford et al, 1993; Filer and Pollard, 2000; Holroyd, 2000). Prominent amongst the participants' concerns about this was the issue of subjectivity. The AMTs strongly supported the notion that the involvement of women in student assessment process could have a healthy influence on its validity (see histogram 22, page 289). They did however express a note of caution associated with this view that was also shared by the students and wished to guard against the women's judgement overly influencing the final outcome of their course. Despite the many measures that have been introduced to minimise subjectivity, none have had the desired effect and it seems safe to argue that assessment will always be prone to the personal whim of assessors (McAleer and Hamill,

1997; Somers-Smith and Race, 1997; Nicol and Freeth, 1998). Whilst there is greater scope for standardisation, norm referencing and a degree of objectivity in the assessment of theory, the assessment of performance in the work place continues to pose a problem. There is no guarantee that women's judgements would add to its validity. Whilst some AMTs indicated in their qualitative data that the involvement of women could result in yet more biased views that could compound the existing problems associated with the validity of assessment (see histogram 23, page 290), their general response indicated that they largely accepted that the inclusion of women's views would add to the integrity of assessment (see histogram 22, page 289). This finds support in the literature with Yorke (1998) suggesting that reliability is better understood in terms of consensus amongst assessors over time, because as far as capability is concerned, clinical experiences are unlikely to recur in exactly the same way.

The data overall show a reasonable and balanced concern for the possible beneficial influence women might have on the validity of assessment through their participation in it. These impressions were frequently qualified however, by the belief that through their inclusion, women's interests and needs would receive an additional impetus that could only be good for their partnership with midwives.

Assessment and the use of multiple sources – adding women's perspectives

The literature is unequivocal that judgements about student competence best come from a range of evidence over a period of time (Hager et al, 1994; Worth-Butler et al, 1996; UKCC 1998; Gonczi, 1999). Consequently it is not unusual to see a multi-perspective,

multi-method approach to assessment within midwifery curricula. This approach to assessment was discussed with all participants with the widespread recognition of the general challenges posed by student assessment.

The students who participated in the study had admitted previously that their behaviour towards women differed according to whether or not their mentor was observing them. This change in behaviour in similar circumstances was reported in the literature with students using considerable ingenuity in attempting to impress their mentors favourably (ENB and OU, 2001). The AMTs also recognised that the focus of an assessment influenced student behaviour (see histogram 1, page 279). They also supported the notion that behaviour could be changed in favour of the woman if they were involved in the assessment process (see histogram 8, page 282). Mentors likewise acknowledged the difficulties assessment often produced. They admitted that not all students were enthusiastic about their learning in clinical practice and that personality clashes between mentor and student could occur. These were cited as examples of how the robustness of the assessment process could be threatened. Mentors suggested that the extra dimension brought by women's views would generate further useful debate.

Given that expectations of student competence are socially as well as technically defined, the involvement of women could perhaps provide the students with greater balance between the two definitions with women emphasising the social dimension. One of the key informants commented on how remarkable it was that women had not been included in student assessment before, given the interest in multi-perspective assessment methods and of increasing consumer involvement in midwifery curricula. All participants agreed

that women receiving care could evaluate the 'softer' aspects of midwifery practice that are difficult to make transparent to an external third-party observer and are often ambiguous in terms of learning outcomes. The differing perspectives of midwives, lecturers, students and women all constitute an expertise that is rich in terms of the learning opportunities it provides and this was acknowledged particularly by the students.

In recent times women have had significant influence on the working role of midwives through their increased consumer involvement and have thus contributed to the definition of professional competence (Frazer et al, 1998). The key informants made the point that the non-involvement of women in any aspect of their care could result in midwives making erroneous judgements on their behalf and it was believed that this runs counter to the overall philosophy concerning mutuality in care.

It seems reasonable to contend from these data that by the inclusion of women in the multi-faceted assessment process, there is greater scope for shared understandings and jointly held perceptions of performance between women, mentors and students.

Reflection

A classic description of reflection 'on' and 'in' practice has been provided by and Argyris and Schon (1974) and is very closely aligned to the previously discussed concepts of strategic, autonomous and life long learning. The literature presents a variety of approaches to the development of reflective practice that appear in one form or another in all pre-registration midwifery curricula. These place an emphasis on human interactions that are closely aligned to the philosophy of care endorsed by both practitioners and

educationalists (Gibbs, 1988; Heywood, 2000; Johns, 2000). There was general agreement, although not a unanimously held view amongst the participants, that student engagement in a structured and facilitated reflective cycle could lead to effective learning from practice (Johns, 2000; Rosie, 2000). As a result, students were believed to articulate not only what they had learned but also to possess insights into how the learning had come about. This is generally regarded as a hallmark of the ability of life long learners (Knapper and Cropley, 2000; Thorpe, 2000; Boud, 2001b). The AMTs endorsed the implementation of reflection within the curriculum and the need for a managed approach to it (see histogram 16, page 286). In their qualitative comments they acknowledged the intricacies of the reflective process, arguing that students might understand reflection intellectually but that they do not necessarily engage in it spontaneously (Brockbank and McGill, 1998).

Students highlighted the intrusive aspects of reflection that exposes deficiencies in their knowledge and poses threats to their values and their feelings. They admitted to the instances when they had been made to feel uncertain and self-critical through its use (Stefani, 1998). This further supports the need for a formal, structured approach to the use of reflection as part of the learning strategy within the midwifery curriculum.

In the context of learning in the clinical setting, reflection has a particular potency for the learning opportunities it provides (Neary, 2000). The students had repeatedly provided evidence that they were keen to capitalise on the learning potential associated with their clinical placements and were familiar with the concept of reflection. They understood its use as part of the learning process and the development of reflective capabilities featured

in their own pre-registration programme. Students discussed two differing approaches to the inclusion of women in the reflective cycle in use within their curriculum. Firstly, on some occasions they would like the opportunity to reflect on and evaluate the care they have given prior to seeking women's opinions about it. This would enable them to identify any dissonance between their perceptions and those of women. This they believed would improve their self-awareness. Secondly at other times, they would value some spontaneity by receiving women's opinions immediately care has been given. They thought this could be incorporated with their own perceptions of what had occurred as they subsequently reflected on their actions.

Ultimately reflection is concerned with the translation of learning into sustained changes in clinical practice that benefits those receiving care (Hanson, 1996). The key informants and the mentors endorsed this. Both groups were of the view that there was a need to see a demonstrable change in practice as a direct result of the input women might make to the reflective cycle used by students. The mentors and also an AMT suggested that the students could draw attention to these changes by including a reflective account in their portfolio of evidence. These participants believed that this would allow the reflective cycle to be tailored to the individual student's experience and to authenticate the learning experiences in the clinical setting (Dewar and Walker, 1999).

Mezirow's (1981) theory of perspective transformation argues that the adult learner makes sense of present experience by its assimilation in the context of previous experiences. This results in an in-depth and rich understanding of self and of relationships with others. This combination of reflection and perspective transformation could assist

the student to get better approximation of the woman's perceptions and relate to them in a way that is closer to women's personal preferences. Without necessarily being aware of Mezirow's theory, the students demonstrated their commitment to fulfilling women's expectations and this was an aspiration supported by all the other participants.

Some of the critics of the appropriateness of reflection for the professions such as nursing and midwifery draw attention to its time consuming nature (Ixer, 1999). This was raised both by the students and the mentors who recognised that if it was to be of benefit then they would require its formal recognition in terms of timetabling. Despite the critics, both the literature and the participants provide a strong defence of the use of reflection in midwifery training and the under utilised contribution of women's experiences to the reflective cycle in the assessment of student learning.

Feedback from women and the achievement of competence

The magnitude of the challenge competence based education presents is succinctly captured by Robb et al (2002) who point to its relationship with what is expected by employers. In general terms the findings of this study confirm that the participants believe firmly that competence has clear links with the standards expected in employment. The key informants placed particular emphasis on the significance of competence in the work place although, they recognised that there is more than one way of dealing with most clinical issues competently (Ilott and Allen, 1997). The participants acknowledged nevertheless, that the term competence can be a semantic conundrum that is open to multiple interpretations. This is in part due to the intricate definitions associated with models of midwifery competence.

Whilst differences in definition exist, the conceptual overview of competence that is described by Spencer and Spencer (1993) provided a useful framework for discussion. The characteristics that they identified comprise motives, traits, self-concept, knowledge and skills all of which resonated to varying degrees with all the participants. Some expressed well-informed and confident views in relation to specific characteristics of competence. Midwifery clearly consists of discrete tasks to which the participants referred. Students are rightly required to achieve an acceptable level of technical competence and this was agreed upon by all participants, including the parents. The parents also agreed but added that students must also adopt an holistic, individualised approach to the care they provide for women. This expectation poses a problem in that there are those who have denigrated competence-based education because of its perceived reductionist and task orientated approach that is incapable of embracing holism (Gonczi, 1999; Phillips et al, 2000).

Despite the existing learning outcomes set by the UKCC in 2000 and adopted by the NMC, (NMC, 2002, See Appendix 2) the more subtle aspects of competence associated with the motives and traits remain elusive entities. But it is in relation to the assessment of these aspects of competence that most participants felt that women could make a unique contribution (see histogram 4, page 280). By contrast, fewer were of the view that certain characteristics such as knowledge and skills lent themselves more readily to measurement through criterion referenced judgements and observation. But all recognised that an integrated, holistic approach to midwifery practice is difficult to

articulate in terms of individual competences but nevertheless, they felt that this is a realistic albeit idealistic aim that is worth pursuing (Frazer et al, 1998).

Midwives practise in an evolving clinical context. There is thus the need to produce emerging practitioners who can cope with change and the turbulence encountered in clinical practice. In some circumstances women are not entirely satisfied with the service they receive whether this is justified or not. This raises issues of how feedback can be most effectively given to students. The mentors were concerned to ensure that the information from women that was given to students about their standard of performance was provided in a constructive manner. In reality however, the mentors accepted that on occasions student competence could be judged in a harsh way. This, they believed, would be an opportunity for students to explore with their mentor, issues relating to personal development through the careful handling of what could be perceived by them as hurtful feedback. The key informants endorsed this view. They wished also for a strategy to harvest the women's observations on student competence that was delivered in as helpful a way as possible. To this end they stressed the necessity for clarity of roles for all in relation to the feedback process and for the inclusion of only those women who were willing to participate. The students also wished to ensure the relevance of the feedback provided by women in relation to their level of competence. They especially saw the contribution of women as a means of receiving more detailed feedback than is conveyed solely in a grade that is given by their mentor. The students found the grading system was not always useful to them in terms of identifying the strengths and weaknesses of their competence.

The data conveys the overall impression that participants favour a competence-based approach to student assessment whilst acknowledging that a great deal of interactions between students and women are sufficiently ethereal to elude measurement in terms of individually isolated competencies.

Feedback in relation to psychomotor skills

Participants saw a generalised role for women in the provision of feedback regarding clinical skills at both cognitive, affective and psychomotor levels. Some AMTs who disagreed with this role did so on the basis that women would generally be insufficiently informed to make a valid judgement especially about the student's technical and psychomotor skills (see histogram 18, page 287). These participants did support the role in other respects. Feedback to students about the direct care they had given was considered to be of particular value in that it was information upon which the students could act that was not necessarily available to those such as mentors who usually observe the care being provided. All participants who were in agreement that women could provide useful feedback about a student's clinical performance provided a variety of practical examples. The students were of the view that this feedback could be prioritised with what they perceived as the more simple things providing a focus for women's participation during the early part of the course, with more sophisticated skills being considered later. They suggested for example that women's experience of physical examinations could be a priority at the commencement of the course with an incremental progression to include other skills such as interpersonal and counselling skills at a later

stage. This incremental approach to the involvement of women in the assessment of clinical skills also found support with the mentors.

The Johari window (ENB and OU, 2001) provides some explanation for the data that was collected (see page 25). This concept describes what it calls the 'blind domain' where students are unaware to a certain extent of the impact they are having on the women and their families. Feedback from women could result in a clearer understanding for students and a shift to the 'open domain' where there is a shared understanding between the student and those in their care. Although the mentor may have been able to provide the student with similar feedback, the Johari window also captures the occasions when information is not known to others, and in the context of this study this domain could represent the mentors. In this instance the student could find themselves in the 'dark domain'. It is at this point that the students could move from the 'dark domain' to the 'open domain' on the basis of feedback regarding clinical skills which could only be received from the woman and, as some participants suggested, the woman's partner.

Professional attitudes and values

The professional attributes of attitudes and values are deemed to be very important in midwifery education yet their evaluation and assessment are also notoriously difficult to capture (Bedford et al, 1993; Eraut, 1993; Hager et al, 1994). This was a view held by the participants who stated that attitudes and values are not always perceptible to an observer such as the student's mentor and that women may be best placed to make a contribution to their assessment and development. There was also the belief that women's individuality needed to be emphasised with students being sensitive to their personal

nuances. This was voiced in particular by the parents as one of their concerns and something that should be addressed within the pre-registration curriculum.

The involvement of women in judgements about attitudes and values that are held by students were seen by the participants as a necessary challenge and an important part of the student experience. The students were keen to develop these specific professional attributes through feedback from women and discussed the importance of their own performance in relation to such issues as women's dignity, privacy, personal space and individual sensitivities. Participants believed that the assessment of students' attitudes and values should be judged in the context of clinical practice and over a sustained period of time (Hager et al, 1994). In addition, there was support for a view that the intellectual humility and the courage required by students to confront themselves whilst being supported by the mentor, could be cultivated by the additional evidence women might contribute. Indeed one of the key informants saw women acting as a catalyst by providing the means by which mentors could address students' attitudes and values more explicitly than they currently do. This was accompanied by the expectation that seeking feedback of this nature as a student could become an important mechanism for developing self awareness and for initiating personal change over a professional lifetime.

The key informants suggested that there was a degree of arrogance amongst the curriculum planners that is associated with the teaching and development of professional attitudes and values if this was not directly linked to individual women and their preferences. They felt that certain stereotypical assumptions are made when courses are planned about people or groups of people that are not necessarily appropriate. The AMTs

were generally supportive of the women's ability to provide feedback in relation to students' attitudes and values although they were slightly more predisposed to feedback on students' attitudes (see histogram 20 and 21, pages 288 and 289).

This raises a curricular issue in that any teaching, learning and assessment strategy needs to be fully cognisant of the clinical context in which students experience the delivery of care and learn from it.

The place of honesty and competing expectations

The particular benefits associated with the involvement of women in terms of minimising distortion in the assessment process and thus improving its veracity and credibility were identified by the participants. They were concerned about the status and focus of the feedback from women and how these factors might influence its accuracy. Whilst the objectives of assessment are to obtain relevant, constructive and timely feedback for students, participants felt that there were occasions when the nature of feedback from women might militate against these intentions. (Jarvis and Gibson, 1997; Bennett, 1999).

The key informants for example raised honesty and frankness as an issue in relation to the earlier point about women's part in formative and summative judgements about students. They believed that women might be cautious about what they said and be less frank because of the possible permanent implications this might have for a student's subsequent professional career. They felt that degrees of honesty would vary naturally but that there would be a tendency to gain an overall consensus about students' performance if a variety of sources of evidence were used. The students were conscious of the need to encourage women not to disguise their experiences, in particular those that where they were inclined

to be less complimentary. They queried whether the mentor could act as an emissary to receive feedback that was critical, rather than, having to embarrass women by having them communicate it to students directly. The need for students to be aware of and responsive to current government policy regarding service users was a theme that ran through all the data in different guises. Responding to the expectations of those using maternity services raised by recent policy is something that has yet to be confronted fully in the midwifery curriculum (DOH, 1993; DOH, 1999; DOH, 2000).

This data confirms the nature and demands posed by women's expectations and there was a general conviction amongst participants that involving women more directly in the learning experience was also an innovative way of enabling students to begin to address consumerism.

Providing better quality care

It is difficult to contest one of the key aims of training for any job that is to improve individual performance continually (While, 1994; Wallace, 1999). In the context of this study, the key aim of midwifery training is to produce students whose performance matches the level required for professional registration. How the education and training processes address the quality of care provided for women permeated all the data. The task faced by those involved in training student midwives relates to the concepts of fitness for practice and fitness for purpose. Midwifery curricula have a strong tradition of producing practitioners who are fit for practice and who also have an appropriate level of confidence in their performance. The additional dimension of fitness for purpose requires newly qualified practitioners to have an ongoing appreciation of their personal capacity to

perform and have the skills to continue to practise competently in the context of changing evidence and circumstances. (Lawson, 1995; Day et al, 1998; UKCC, 1999b). It could be argued that the development of strategic learners, practising autonomously and continuing to engage with women by seeking their feedback about care, would result in an enduring attempt to enrich practice and provide better quality care. (Torrance and Pryor, 1998; Gonczi, 1999). There would appear to be considerable support for this claim amongst the AMTs (see histogram 12, page 284).

The current policy emphasis placed upon performance and the provision of quality care was reflected in the data. All participants discussed the role played by women in the determination of the quality of the care they received. There was a recognition amongst the participants that the quality of midwifery care cannot be properly judged without the involvement of the women (Proctor, 1998). Whilst participants believed that certain aspects of quality can be very adequately and most appropriately defined and judged by professionals, there were other aspects such as staff attitudes and empathy that require the inclusion of women to ensure comprehensive judgements are made.

The idea that quality also has multiple definitions was picked up by the students and mentors. They were keen therefore, to ensure that their focus was directed towards personally tailored care for women (Kelson, 1995). These participants felt that enabling students to gain a personal understanding of standards of excellence and the ability to develop these needs to be addressed within the pre-registration curriculum. In addition, the mentors were of the view that the possible inclusion of women in judgements about students would perhaps result in a clearer differentiation between general dissatisfaction

in relation to NHS maternity services per se and the quality of care provided by the individual student. This would add a new measure to the overall quality strategy within maternity services with more general dissatisfaction being addressed by the most appropriate party (Hoyle and John, 1995).

The mentors also identified the scope for their own personal development in relation to the quality of the care they themselves provided. Again this ripple effect is recognised in the literature where through the improvement of individual performance, a more general effect on service quality has been observed (UKCC, 1998).

The data concerning the provision of high quality care is of particular pertinence given the present high priority of the topic within NHS policy (DOH, 2002a).

The ability of women to be involved in the assessment process

There is evidence in the literature that demonstrates the successful involvement of patients in the education of medical students (Kelly and Wykurz, 1998; Hendry et al, 1999; Stacy and Spencer, 1999). The AMTs saw scope for a greater role in both teaching and assessment for women whom they believed were often participating in student education almost inadvertently and in consequence their contribution is frequently unrecognised. They felt that the importance lay in defining with clarity just what contribution women might realistically make. The parents were able to draw from personal experience of how they might have contributed had they been invited to do so. They welcomed a formal role but recognised that there would be aspects of their care on which they would not be qualified or able to make accurate judgements.

There was a general consensus within the data that women did have the ability to make reasoned judgements about the quality of their care with a strong consensus concerning their evaluation of physical care and of diagnostic examinations. But there were mixed views about their real ability to assist students with their knowledge base.

The selection and preparation of women

Users of maternity services are not a homogenous group but student midwives are required to provide individualised care to a consistent standard for them (Lofmark et al, 1999; NMC, 2002). Whilst this is a curricular issue in terms of students having opportunities to experience care delivery in a range of settings, it was re-emphasised by the mentors that some women could be challenging to students. Against this background, mentors indicated a preference for students to engage with and receive feedback from a variety of women with differing needs and expectations. The issue of how women might be selected to participate in student assessment was discussed from the points of view of both students and of women. There was a clear message from the key informants and the AMTs that women should not be deselected for any reason other than if they chose not to participate themselves (see histogram 31, page 294). This raised a number of points. The mentors identified their need to act as an advocate for students on occasions and make decisions about whether or not students should have involvement with particular women. This they saw as needing to be managed. A negotiated arrangement between the students, mentors and participating women was suggested by them. They felt that there might be an advantage in students getting to know these women at the antenatal stage and therefore, the notion of 'continuity of carer' was raised as a feasible factor to be

considered in the selection of women who might get to know and provide students with feedback over a sustained period of time.

The AMTs raised the additional challenges of language and literacy abilities amongst women, issues to be found in the recent literature that relates to the provision of care in the NHS (Vydelingum, 2000). The centrality of verbal communication to women's useful contribution was recognised but was not seen as a reason to preclude the overall initiative to involve them.

Students did not feel that women needed very much in the way of training in preparation for a role in assessment. This view coincides with experience elsewhere in medical student training (Blasco et al, 1999). The preparation that women might require for their involvement in student midwives training was discussed by the other participants. They agreed that a minimum level of briefing would be required for women to have a clear understanding of what was expected of them and the purpose their observations would serve to support student learning. There was little suggestion that more was required although, one key informant did indicate that women might need more formal training and might also need the opportunity to provide one another with peer support in their role. The AMTs did not express a strong view in relation to formal preparation for women. Just over half did support some form of preparation whilst the remainder either did not have a view or actually disagreed (see histogram 26, page 291).

These findings provide an overarching view that most women would be confident to participate if they were clear about their role and their contribution was appropriately facilitated and valued.

Choice for women

The partnership approach to care espoused by the midwifery profession and the concept of the consumer of health care as a participant rather than a passive recipient indicate that there should be free choice for women regarding their suggested involvement in student midwives' education and training (Leap, 2000; Wilkins, 2000). The participants raised issues of rights and respect in relation to this choice. The AMTs were mindful of equity for students and some of them were somewhat hesitant in agreeing to women having choice in relation to the format of the feedback (see histogram 33, page 295). There was general agreement that some women would choose to decline the offer to become involved and this was also the experience of Twinn (1995) in relation to the clients of health visitor students. There was an agreed view amongst the participants that any woman declining to participate should not be seen to be penalised in any way. There was a general spirit of inclusiveness favoured by the participants who were mindful not to be seen as acting in a coercive manner rather to provide a milieu that is characterised by encouragement. This they felt would foster a wish to participate. Women who simply needed that little extra by way of support should be reassured that it was available to them whilst making their decision whether or not to play a part. Participants saw choice being influenced by such factors as time, commitment, perceptions about ability, format of the feedback, confidence, associated responsibilities of the role, the concept of mutuality and the value placed upon women's contributions both by the students, mentors and lecturers. Various suggestions were made in respect of these factors. For example, it was suggested by the students that women might have choice in the format of the feedback in terms of whether it is verbal, written or both and that they should be given choice in terms of when

and to whom they give their views. It was generally thought to be helpful if women were provided with criteria that related to student learning to structure their judgements. To avoid this becoming mechanistic it should not exclude other additional observations that women might wish to make or even, comments from their partners and families. On the basis of this evidence, the participants did not underestimate the implications of recruiting women. They were convinced however, that women's inclusion should be a matter that has to be permeated throughout by the opportunity for them to exercise informed consent.

Conclusion

This chapter has sought to expand on the findings through a discussion of them in the light of the associated literature. It provides reassurance that the experience that women could bring to student learning through assessment is something that is relatively untapped but is worthy of further exploration that will occur in the concluding chapter.

CHAPTER 7 CONCLUSIONS, RECOMMENDATIONS AND PROPOSALS FOR FURTHER RESEARCH AND CURRICULUM DEVELOPMENT

The results of this study of the perspectives of the key stakeholders in midwifery education and training have clear implications for student learning and assessment and for women's greater participation in these. The outcomes of the work are in harmony with theories of experiential learning and furthermore, they coincide favourably with the policy intentions of the present Government to involve women as consumers of midwifery services. This concluding chapter will draw on the discussion of the findings to produce a schematic representation and an accompanying explanation that both summarises the contribution to knowledge that the study has achieved and will also locate it within a broader theoretical and policy context. As well as formulating conclusions, the chapter recommends actions for their implementation in the midwifery curriculum and makes proposals for further research.

Involving women in student assessment – inputs, processes and outcomes of the study

This study has implications for curriculum design, student learning and assessment and ultimately for the delivery of quality services to women. The schematic representation below aims to provide a succinct summary of the work by locating its inputs, processes and outcomes.

Inputs

Process

Outcomes

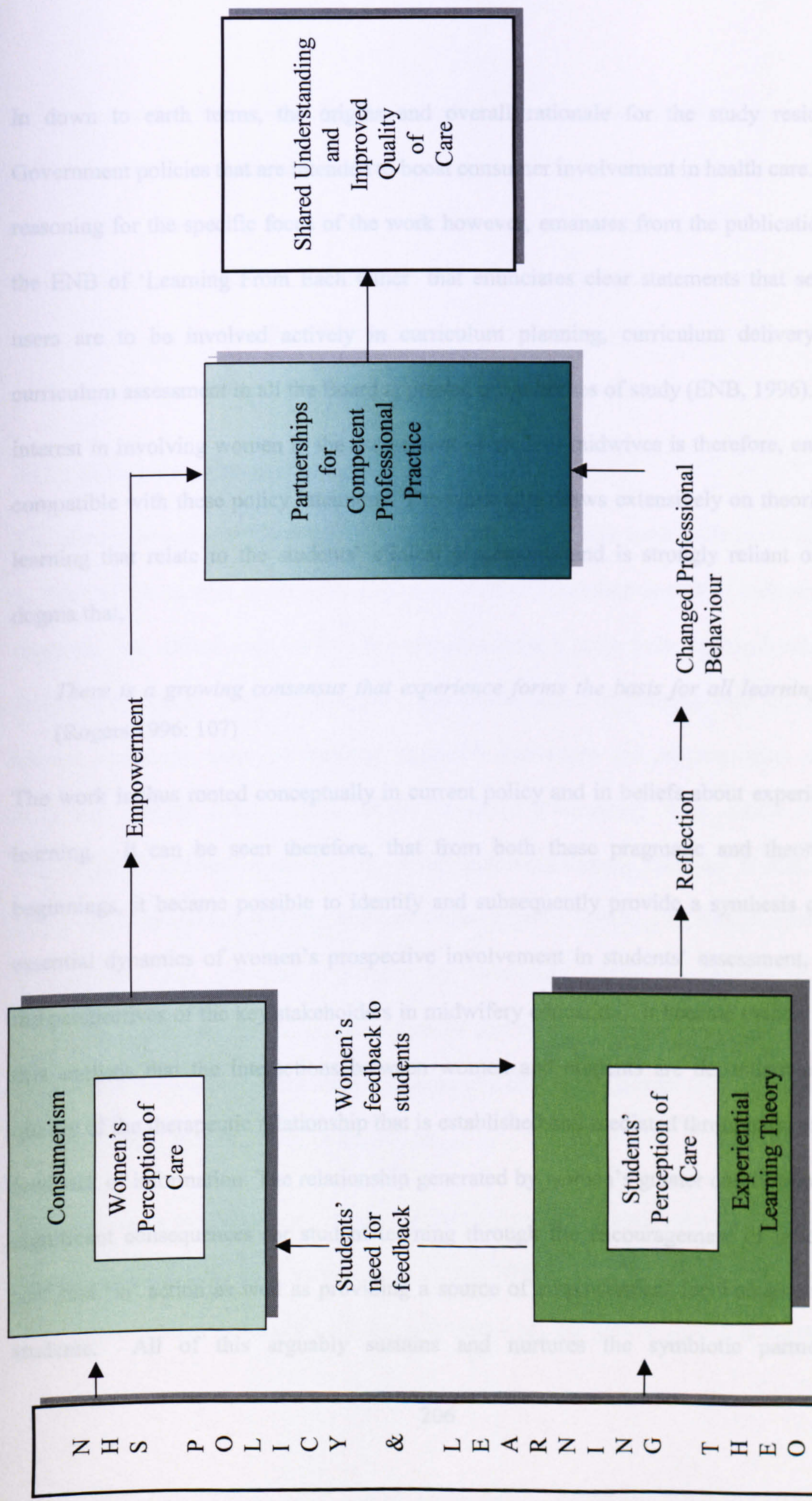


Figure 10 Schematic Representation of inputs, processes and outcomes of the study

In down to earth terms, the origins and overall rationale for the study reside in Government policies that are intended to boost consumer involvement in health care. The reasoning for the specific focus of the work however, emanates from the publication by the ENB of 'Learning From Each Other' that enunciates clear statements that service users are to be involved actively in curriculum planning, curriculum delivery and curriculum assessment in all the Board approved programmes of study (ENB, 1996). The interest in involving women in the assessment of student midwives is therefore, entirely compatible with these policy intentions. The work also draws extensively on theories of learning that relate to the students' clinical placements and is strongly reliant on the dogma that,

There is a growing consensus that experience forms the basis for all learning
(Rogers 1996: 107)

The work is thus rooted conceptually in current policy and in beliefs about experiential learning. It can be seen therefore, that from both these pragmatic and theoretical beginnings, it became possible to identify and subsequently provide a synthesis of the essential dynamics of women's prospective involvement in students' assessment, from the perspectives of the key stakeholders in midwifery education. It became evident from this analysis that the interactions between women and students are dependent on the quality of the therapeutic relationship that is established and mediated through the mutual feedback of information. The relationship generated by women's greater contribution has significant consequences for student learning through the encouragement of reflection 'on' and 'in' action as well as providing a source of empowerment for women and for students. All of this arguably sustains and nurtures the symbiotic partnership

arrangements that form the philosophical basis for present day midwifery care and this study adds illumination to present understandings about the reciprocity between midwives and women. The study identifies that the outcome of women's greater engagement within student assessment has important inferences for student competence and consequently for the quality of care that they are ultimately able to provide. These summary conclusions lead to the following subsequent observations.

NHS policy and the service user as a consumer

The idea of consumerism is not new to the NHS. Attempts have been made for some time to listen to the users of its services (Cox et al, 1993). The interpretation of consumerism however, has shifted over the last two decades from a collectivist approach whereby Community Health Councils allegedly represented broad community interests to the current seemingly more personalised approach that seeks the representation of the individual patient (DOH, 1998; DOH, 2002a). Endeavours now centre on the empowerment of users of services by actively involving them in decision-making at all levels of policy making, planning and care delivery (DOH, 2002a). Whereas the previous arrangements kept users at a distance by attempting mainly to respond to their observations, the new model embraces them as part of the NHS and provides a platform from which they can comment upon, influence and thus shape current and future services (Higgins, 1993; Blaxter, 1995; DOH, 2002a).

This is in direct contrast to the very passive role for patients associated with the historical interpretation of consumer involvement in the NHS. The introduction of this new government strategy is simply a starting point but what has proved elusive is the capture

of the representativeness of all consumers. This remains an inherent feature of current policy that is more emphatic than ever that the voice of the patient should be at the heart of the NHS (DOH, 2002a). These latest pronouncements express explicit intentions to increase patient choice and go so far as to assert that,

further steps will change the relationship between patients and services. Patients will be in the driving seat (DOH, 2002a: 24)

It can be seen therefore that this study makes a timely contribution to knowledge about an aspect of consumerism that is relatively unexplored.

In the context of the work, this new political attitude to consumerism has certainly produced a shift in the organisational culture of maternity services. Attempts are being made not solely to allay discontent with maternity services but genuinely to meet not only the needs, but also the expectations and wants of women. This movement has been described as making the 'invisible hospital' visible to the users and to juxtapose more closely, the world of the patient with that of the professional (Spiers, 1995). The dissonance between the professional and the lay user of health services is a topic much debated in the literature (DOH, 2002b). But with this new coalition comes a shift in power relationships with a repositioning of the service user as a significant player in the determination of the level, nature and standard of care and as a full participant in the delivery and reception of the service. Despite the espoused ambitions of the present government to involve users, knowing how, when and where to involve them and how to prepare staff for their new role remains unresolved. In these respects, this work exposes

some of the sensitivities that are at stake in relation to women's contributions as teachers and assessors.

The UKCC also published a strategy for public involvement in 2000 to ensure the centrality of the public in its activities both in relation to education and practice. The plan attempted to create partnerships with the public to ensure that the Council's policies and decision making practices were made in an open and transparent way and more closely reflected the interests and expectations of the public (UKCC, 2000). The NMC is taking this approach forward with the present Government's requirement for even greater public involvement.

The Government intends to establish from January 2003, a Commission for Public Involvement in Health for which legislation is being drafted. This Commission, membership for which is being sought at present, will oversee an elaborate framework of Change Assessment Groups at Strategic Health Authority level and Patient Advocacy Forums at each NHS Trust (DOH, 2002b).

The Government's plans are complemented by an undeniable appetite for information among women who use maternity services and the Cochrane Consumer Collaboration Network (<http://www.cochraneconsumer.com/>) is but one source of valuable information that is available to them and other service users. This intends to be comprehensible and relatively free from technical language to provide user-friendly information. A respectable literature is also beginning to be assembled to describe the techniques available to consumers when they search for health related information on the Internet (Eysenbach and Kohler, 2002)

Policy strives to achieve greater accountability from the NHS but the extent to which consumer involvement is feasible or desirable provokes a varied response as this study has established. At a theoretical level, there is debate about the appropriateness of the very idea that consumers of NHS services are in any way comparable to consumers in a free market economy (Blaxter 1995). Consumerism implies rationale choices based on information with the ability to evaluate the alternative options that are available. Arguably therefore, NHS users are in a vastly different position than they are for example, when they purchase consumer goods for several reasons. NHS users are within a service that has finite resources and this means that choice will always be restricted. While they might be well informed, there is an inevitable disparity between the technical knowledge possessed by them and that available to the professionals who are managing their care. This has led to an 'in house' convention among professionals that clinical decisions, care and treatment are not seen to be consumer services in the way that for instance, hotel or catering services in the NHS might be judged.

Midwifery services have been something of an exception since the movement began to empower women a decade ago through extended choices in the management of their pregnancy (DOH, 1993). Yet the medical profession in particular is debating vigorously, the entire belief and practical rationale that patients can be consumers and should have unlimited choice and an unbridled access to information. The views of those doctors who are most antagonistic can be summarised as follows:

As an increasing number of patients demand their rights the NHS struggles to meet these demands. Staff feel that they cannot keep up with rising expectations.....the choice facing the government and the media is stark:

either engage in a meaningful debate over the scope of the NHS or the organisation will crumble . (Wardrope, 2002: 1369)

While not attempting to contradict this overall macroscopic debate about consumerism in health care in general, this study poses a distinct challenge to these opinions. Although its interpretation of consumerism occurs at a microscopic level, it nevertheless raises taxing questions about the rightful location and status of women in the preparation of student midwives.

Experiential learning theory and the assessment of student midwives

The study produces a broad recognition of the centrality of clinical experience to student learning, achievement and the overall mastery of clinical skills. The work provides a similar confirmation that giving women a say in student assessments will augment the student learning experience. Many clinical learning experiences for students occur in an ad hoc fashion. What seems to be needed therefore, is more structure. In providing structured learning opportunities, a debate is raised about the timing of women's involvement in student learning and assessment, their level of participation and the value that should be placed on their contribution towards the overall calibration of a student's performance.

Amongst the features associated with experiential learning are the emotions and feelings it can arouse as a result of previous negative experiences. This is of particular relevance to student midwives who are inevitably exposed to a range of emotionally charged human drama that is frequently multifaceted and can be traumatic. There is a partial recognition within the study that negative experiences do impede student learning and that denial is

an aspect of their careers that can prevent them from learning from experience (Neary, 2000). There was enthusiasm to support students in dealing with these dilemmas through the use of interpretative and reflective learning processes that are used in conjunction with the women in their care. This provides a case that students can be helped to make sense of their experiences and become self-aware (Usher, 1993). The development and handling of relationships, knowing one's emotions and managing emotions can be made much more explicit within the curriculum under the banner of emotional intelligence as suggested by Goleman (1996).

The findings reveal that students were somewhat powerless to influence the assessment of their own performance. This suggests that their curriculum emphasises the accumulation of credit through summative judgements at the expense of the more subtle benefits propounded within experiential learning theories. While there was no denial from the students that assessments are rightly judgmental in nature, it seemed that these exercises fail to capitalise on the foundations for learning that they naturally possess. Unattractive assessment methods are uninspiring to students at best and have even at their worst, been held to lead to dysfunctional behaviour in students (Pringle et al, 2002).

The in-vogue view that shifts the emphasis within the curriculum from teaching to learning finds broad favour in the literature. But there was very little evidence that students in this study were seriously involved in the identification of their own learning needs, the design of assessment criteria or had choices in the modes by which they were assessed. The literature argues that the engagement of students in assessment practices can contribute to their development as strategic learners who possess the degree of

responsibility and the skills needed to identify their own limitations. In addition, strategic learners are equipped with the resourcefulness to achieve self-identified learning goals (James and Gipps, 1998; Riding and Rayner, 1998). There is a long tradition of normative needs assessment as defined by experts within pre-registration courses at the expense of the 'felt need' as perceived by the student that has the capacity to afford them opportunities for personal as well as professional growth. This is of particular relevance in midwifery curricula where students are exposed to learning opportunities in the clinical setting that are characterised by unpredictability and uncertainty. The study shows that the stakeholders were conscious of the turbulent and changing nature of the NHS in general and of the nature of maternity services in particular. This requires students to develop highly adaptable behaviours in meeting service users needs and rising expectations. These demands on aspiring midwives require them to develop a self-aware, independent mindedness that was generally acknowledged to be important throughout the study. All of this suggests a strong need to increase the input of students in the development and implementation of assessment strategies. Giving students this seemingly increased authority is still controversial with those who hold more traditional views that students do not know what they need to know. Students have full responsibility for their theoretical assignments and for the preparation for written examinations. What seems certain, is that the failure to give students a similar stake in their own clinical learning experiences and to demand greater accountability from them for this, provides a disincentive for some to become self directed and self evaluating practitioners.

In achieving the best quality outcome for women and simultaneously to optimise the student experience both a top down and a bottom up approach to the inclusion of women in the assessment process can be adopted. The stakeholders suggested that it was the responsibility of the course management team to standardise the approach to assessment and thus help to ensure overall equity for students. They also suggested that both women and students should be involved in the design of any assessment tool that was to be administered, decisions regarding the medium to be adopted, the timing, nature, content and the status of feedback from women to students.

As elsewhere in the literature, the study raises some scepticism about the implications for rigour if women's inputs are to be taken too seriously. It nevertheless, supports a contribution from them that is aimed to nurture student progress, but that this should fall short of determining the eventual decision about a students' progression or award. Within these legitimate concerns were those relating to justice for students arising from biased observations and also the need for sensitivity to safeguard students' personal feelings whenever women have questioned the standard of their performance. The literature is unequivocal that assessment is crucial to learning and attempts to involve the student more fully in the assessment process have existed in higher education for over a decade (Wright, 1992; Stefani, 1998). Reality suggests however, that there is some way to go before students will be truly empowered within most assessment practices. The study produced some evidence that involving students would detract from the dependability of the assessment process yet the data mostly supported their participation and indicate that students are generally not as engaged with clinical assessment to the

extent that they could or would like to be. They do not therefore, always benefit from the motivational aspects claimed for assessment practices that provide students opportunistically timed and appropriately measured feedback about their performance.

A partnership approach to care

The inclusion of women in the assessment process with a view to the enrichment of student learning requires a shared philosophical approach across both the theoretical and practical aspects of the course. This calls for a strategic shift in emphasis. Currently much depends on theoretical assessment and an assessment of practice that relies on artefacts that are a product of knowledge rather than actual practice in real clinical settings (Worth-Butler et al, 1996). This situation is clearly of significance because it sends signals to students about what is worth and not worth learning.

The study reveals some appreciation by the stakeholders of the impact assessment has on student learning with the general acceptance that establishing the appropriate student-woman relationship in the midst of a student-centred curriculum and a woman-centred service is key to the successful involvement of women. This reinforces support for the concepts of partnership, mutuality and the service user as consumer with the recognition that a significant shift in authority and influence are needed if women are to inform and reform assessment conventions (Schott, 1994).

Service users contribute unwittingly to teaching and learning. It is often assumed they are receiving care that meets their expectations and whether this is the case may only become fully apparent if they complain. The study offers scope to formalise this arrangement and

the resulting partnership has several potentially valuable bi products. The contribution of women to student assessment has ramifications for the attitudes towards care of both midwives and women through the shared decision making that it promotes. It opens up a new channel of communication and makes information about clinical effectiveness accessible to women. Furthermore, an avenue is provided for midwives to develop the skills to discuss not only what is effective but also those things that are less certain that women are likely to experience in the course of a pregnancy. Women's increased participation enhances shared decision-making about care and encourages their discernment in making use of midwifery services. It also provides women with a formal means of monitoring the implementation of their care and provides students with a means of setting priorities for the introduction of services that reflect women's values.

The quality of care and the evolving nature of competence

The quality of care women receive is in part, a function of the clinical competence of those who care for them (NMC, 2002). The literature in relation to competence and competence based education has mushroomed over recent years as the concept has been defined and re-defined and hence, this approach to learning has burgeoned and been seen by many as a panacea. The initial competence learning frameworks were very much criticised for their over simplistic, almost mechanistic emphasis on what students are able to do in psychomotor terms rather than the robustness of the rationale they are able to provide for their actions. The more recent integrated approaches to competency have been more favoured by the professions and these seek to combine knowledge, attitudes, skills and personal values attributes that are discussed in the study (Leung, 2002; NMC,

2002). The introduction of holistic models of professional proficiency that also embrace the cultural and social aspects of competence have been welcomed by the midwifery profession and the study confirms the recognition of these as important aspects of care delivery on which women can usefully comment (Wolf, 1995; Frazer et al, 1998). Furthermore, the work recognises that the emphasis implicit within competency based curricula on assessment in the context of naturalistic clinical settings, is also valued for preserving a true representation of reality that is not achieved by assessments that use simulation.

The evidence provided by this work makes the case that women's contributions to both learning and assessment are essential if holistic definitions of competence are to be addressed. The mentor is the undeniable repository of wisdom concerning judgements about the students' knowledge and technical skills. Yet the women are equally well placed to recount their subjective experiences of maternity care in ways that provides added breadth to the humanistic aspects of student assessment and subsequently to the richness of the feedback to students that this can yield. The experience of learning from women generates new insights and can inspire confidence and reduce anxiety. Involving women opens up a new resource and given adequate preparation, enables them to become not just a teaching resource but a colleague in the training process (Wykurz and Kelly, 2002).

Competence is attractive to employers because they feel it describes in behavioural terms with a fair degree of accuracy, exactly what their employees are capable of doing on the job. But it is important to recognise that competent practice is an iterative concept that

undergoes redefinition, adaptation, and reconstruction throughout a professional lifetime. This aptitude of midwives to acclimatise themselves to the changing needs and wants of women is often taken for granted as something that occurs instinctively. It seems from this work therefore, that the competence of student midwives will be more meticulously judged if incremental assessments that involve women's input over an extended period are implemented. In terms of meeting the personalised needs of women this should arguably require the student to care for a number of women from their booking visit through to the post natal period.

Recommendations for further research

Both the recommendations for research and those recommendations for curriculum design that will follow, set out a strategy for working towards a pedagogy of consumer involvement in the preparation of student midwives. This can be depicted as follows:

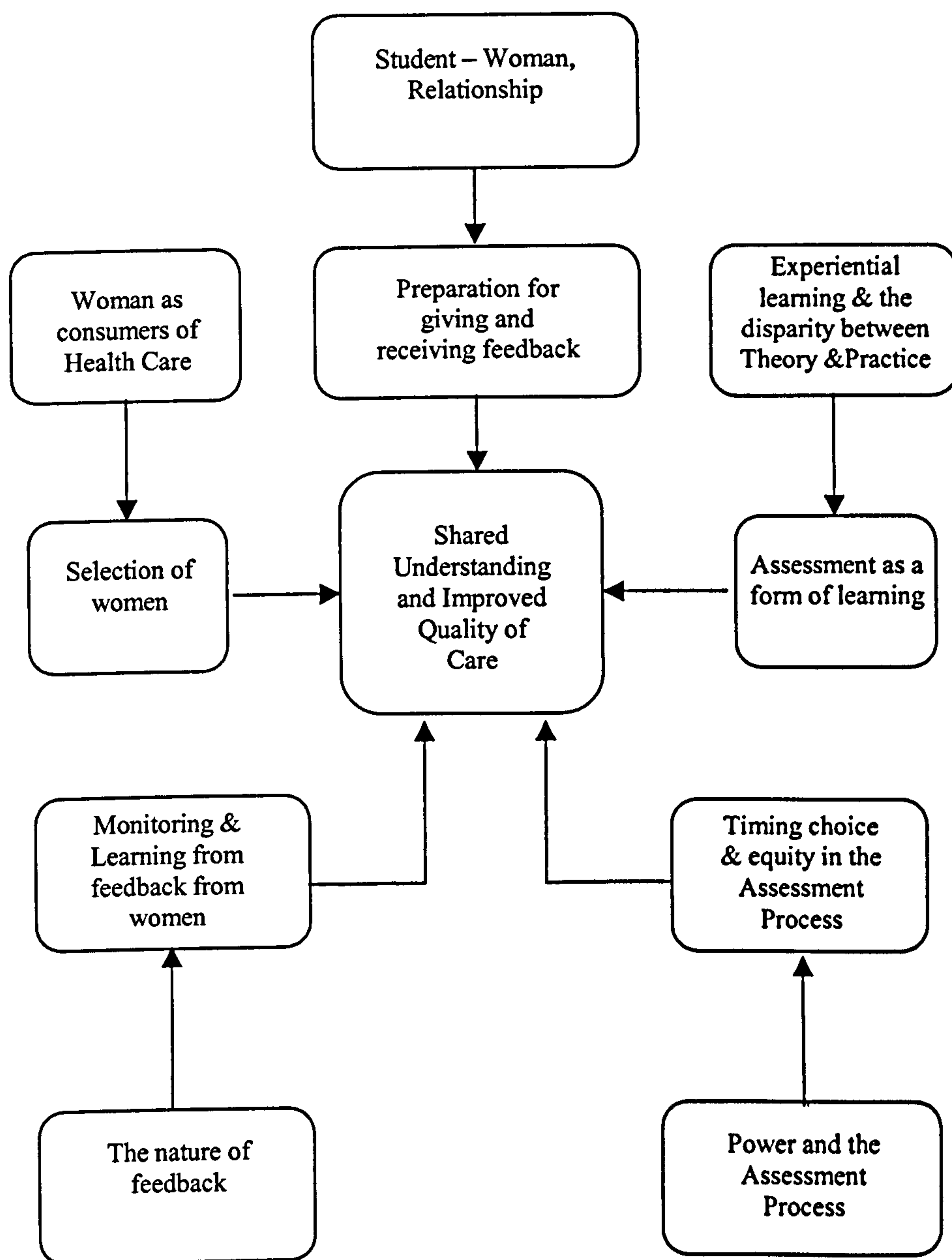


Figure 11 Recommendations for further enquiry

The implications of this study for curriculum design form the starting point for any further research. Its implementation will require these changes to be adopted before a live study of the involvement of women could be conducted. Clearly, more generalisable work than that of the current exploratory study will be necessary. The above conceptual map (Figure 11) however, identifies significant elements in the teaching, learning and assessment process that any proposed investigation into the dynamics of women's participation in student assessment will need to consider if it is to be investigated in the future.

Recommendations for curriculum change to permit women's formal participation in the assessment of student midwives

These recommendations for curriculum change from the study are a precondition to any future research and are the most noteworthy because they can be implemented quickly if imagination is used in their interpretation.

Women as consumers of health care

Involving women in the assessment of student midwives will reflect their role as consumers. This will necessitate the inclusion of consumerism as a discrete topic within the early stages of the midwifery curriculum as a prerequisite to student's exposure to assessments in which women participate.

Experiential learning

The importance of experience as the cornerstone of student learning requires formal recognition within the curriculum. This requires:

- students, mentors and lecturers to have a working knowledge of the theories underpinning experiential learning in order to maximise students' abilities to learn in the work place along with an appreciation of those things that inhibit opportunities to learn from practice.
- explicit teaching, learning and assessment strategies that nurture learning from clinical experience through mechanisms such as reflective cycles and the development of learning portfolios.
- the creation of a supportive learning environment whereby the student experiences can be analysed and discussed.

The disparity between theory and practice

There is a need for an integrated approach to both the theory and practice of midwifery within the curriculum with equal value being placed on both by educators and clinical staff who deliver the curriculum.

Power and the assessment process

The involvement of women in the assessment process requires a clear identification of power relationships within the curriculum to achieve the most advantageous results from their participation. This entails:

- the power traditionally held by lecturers and mentors being shared with women and students.

- the open recognition of the intrinsic value of both students and women as key stakeholders.
- a prescribed contribution from both students and women to the design, content, format and status of any assessment tool that is used.

The selection of women

Women's participation should be by informed consent. The course management team should identify clear inclusion and exclusion criteria. Selection strategies should wherever possible, reflect the demographic makeup of the population cared for by student midwives.

Preparation for giving and receiving feedback

Women should be given an agreed and recognised preparation in the provision of feedback to students. This should include:

- a clear explanation to women regarding their role, its purpose, value and what is expected of them.

They should have options to:

- provide the feedback to the mentor rather than directly to the student.
- choose the format by providing either verbal or written feedback.
- choose when to give the feedback.

Students should engage in workshops designed to familiarise them with the rationale and process for involving women in their clinical assessments and their role within it.

Student-woman relationships

The need to build therapeutic relationships between students, women and their families that are based on empathy and trust require to be made explicit within the curriculum. Specific teaching strategies such as reflective journals are required to interrogate the interpersonal relationships that students form at both a theoretical and practical level.

Assessment and feedback as a form of learning

Learning how to learn must become an unambiguous curriculum outcome for student midwives and assessment should become overtly recognised as integral to the learning process. This will require:

- an overt emphasis on the value of feedback to student learning during the preparation of students, mentors and women for their respective roles in student assessment.
- that feedback provided to students following assessments must be timely, focused, constructive, understandable and wherever possible, interesting to the individual student.

The nature of feedback

Feedback from women should be linked to learning outcomes that describe the students' anticipated competence and progression throughout the programme. The intellectual

demands on students should increase incrementally. In the earlier stages it should be primarily concerned with physical examination and diagnostic skills. More complex professional attributes should form the focus as the student increases in experience.

Timing, choice and equity in student assessment

A common approach to the timing of clinical assessments involving women at distinct stages in the clinical placement programme should be agreed. In addition:

- course management teams should determine standardised assessment procedures to ensure the equitable treatment of all students.
- as well as clearly structured elements within the standardised aspects of assessment, a more open-ended element is also required. This should allow scope for both students and women to either provide or request feedback on the process. This element of choice should enable women to reflect on their care and highlight issues that are of particular relevance to them. It should also enable students to self assess and request feedback on their own interpretation of their strengths and weaknesses.

Monitoring and learning from feedback from women

Students could be encouraged to engage actively with the feedback they receive through:

- a requirement to provide evidence in their practice portfolio of the learning and changes in their practice that have taken place.

- seeking assistance from their mentors in interpreting feedback and especially in acting upon negative feedback.

Postscript

The assessment of midwifery practice has often been interpreted as an activity that, though important, has not been accorded the magnitude of the more intellectual activities such as the assessment of theory. The standing of practice assessment has not been intentionally devalued, rather it has been reduced inadvertently as midwifery has increasingly devolved responsibility to clinicians while simultaneously seeking to establish its academic credibility in HE. Contributing to this position is the undeniable fact that theoretical assessments are seemingly more verifiable than the assessment of clinical practice. This study has served to illustrate that NHS organisations are pre-occupied with the competent performance of the everyday routine activities of the work place. This places a high demand and a high priority on job performance in the curriculum. The investigation has acknowledged the ferociously thorny and convoluted nature of the entire idea of competence in the work place with its interacting psychological, social, and technical as well as its practical features. This has been illustrated graphically as follows,

it is one thing to define competencies and to have views about their assessment but it is quite another to have a pedagogy for competence (Edwards and Knight, 1995:15).

These intricacies however, are no reason to ignore the concept.

Having examined the key dynamics that influence student learning in clinical placements, the study concludes that there is a superficial disharmony between learning and assessment yet the two are mutually complimentary. The inclusion of women in teaching and learning is seen as a potent means to add an extra element to the definition of competence and to add to the authenticity of its assessment.

In the final analysis the work is permeated throughout by the need to,

'be suspicious of the objectivity and accuracy of all measures of student ability and be conscious that human judgement is the most important element in every indicator of achievement (Ramsden, 1992:212).

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APPENDICES

Appendix 1 - Midwives Rules

Midwives Rules - Rule 33

Outcomes of programmes of education leading to admission to part 10 of the register

- 1 The content of programme of education shall be such as the UKCC may from time to time require.
- 2 Programmes of education shall be designed to prepare the student to assume on registration the responsibilities and accountability for her practice as a midwife.
- 3 Such programmes of education shall:
 - (a) meet the requirements of the midwives directive
 - (b) be provided at an approved educational institution
 - (c) enable the student midwife to accept responsibility for her personal professional development and to apply her knowledge and skill in meeting the needs of individuals and of groups throughout the antenatal, intranatal and postnatal periods and shall include enabling the student to achieve the following outcomes:
 - (i) the appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health
 - (ii) the recognition of common factors which contribute to, and those which adversely affect, the physical, emotional and social well-being of the mother and baby, and the taking of appropriate action
 - (iii) the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family
 - (iv) the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and to seek assistance when required
 - (v) the ability to interpret and undertake care prescribed by a registered medical practitioner
 - (vi) the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines

- (vii) the use of relevant literature and research to inform the practice of midwifery
- (viii) the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team
- (ix) an understanding of the requirements of legislation relevant to the practice of midwifery
- (x) an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice
- (xi) the assignment of the midwife of appropriate duties to others and the supervision and the monitoring of such assigned duties

(UKCC, 1998).

Appendix 2 - Midwifery Competencies

Competences required in pre-registration Midwifery Programme

Domain	Competencies to be achieved for entry to part 10 of the register
Effective midwifery practice	<p>Communicate effectively with women and their families throughout the pre-conception, antenatal, intrapartum and postnatal stages.</p> <p>Communication will include:</p> <ul style="list-style-type: none"> • listening to women, jointly identifying their feelings and anxieties about their pregnancies, the birth and the related changes to themselves and their lives • enabling women to think through their feelings • enabling women to make informed choices about their health and health care • actively encouraging women to think about their own health and the health of their babies and families, and how this can be improved • communicating with women throughout their pregnancy, labour and the period following birth.
Effective midwifery practice	<p>Diagnose pregnancy, assess and monitor women holistically throughout the pre-conception, antenatal, intrapartum and postnatal stages through the use of a range of assessment methods and reach valid, reliable and comprehensive conclusions.</p> <p>The different assessments will include:</p> <ul style="list-style-type: none"> • history taking • observation • physical examination • biophysical tests • social, cultural and emotional assessments.
Effective midwifery practice	<p>Determine and provide programmes of care and support for women which:</p> <ol style="list-style-type: none"> 1 are appropriate to the needs, contexts, culture and choices of the women, babies and their families 2 are made in partnership with women 3 are ethical 4 are based on best evidence and clinical judgement 5 involve other practitioners when this will improve

	<p>health outcomes.</p> <p>This will include consideration of:</p> <ul style="list-style-type: none"> • plans for birth • place of birth • plans for feeding their babies • needs for postnatal support • preparation for parenthood needs.
Effective midwifery practice	<p>Provide seamless care and interventions in partnership with women and other care providers during the antenatal period which:</p> <ol style="list-style-type: none"> 1. are appropriate for women's assessed needs, context and culture 2. promote their continuing health and well-being 3. are evidence-based 4. are consistent with the management of risk 5. draw upon the skills of others to optimize health outcomes and resource use. <p>These will include:</p> <ul style="list-style-type: none"> • acting as lead carer in normal pregnancies • contributing to providing support to women when their pregnancies are in difficulty (such as women who will need operative or assisted delivery) • providing care for women who have suffered pregnancy loss • discussion/negotiation with other professionals about further interventions which are appropriate for individual women, considering their wishes, context and culture • ensuring that current research findings and other evidence are incorporated into practice • team-working in the best interests of individual women
Effective midwifery practice	<ol style="list-style-type: none"> 1. refer women who would benefit from the skills and knowledge of other individuals: 2. to an individual who is likely to have the requisite

	<p>skills and experience to assist</p> <p>3. at the earliest possible time</p> <p>4. supported by accurate, legible and complete information which contains the reasoning behind making the referral and describes the woman's needs and preferences</p> <p>Referrals might relate to:</p> <ul style="list-style-type: none"> • women's choices • health issues • social issues • financial issues • psychological issues • child protection matters • the law.
Effective midwifery practice	<p>Care for, monitor and support women during labour and monitor the condition of the fetus and conduct spontaneous deliveries.</p> <ul style="list-style-type: none"> • communicating with women throughout and supporting them through the experience • ensuring that the care is sensitive to individual women's culture and preferences • using appropriate clinical and technical means to monitor the condition of mother and fetus, providing appropriate pain relief • providing appropriate care to women once they have given birth
Effective midwifery practice	<p>Undertake appropriate emergency procedures to meet the health needs of women and babies</p> <p>Emergency procedures will include:</p> <ul style="list-style-type: none"> • manually removing the placenta • manually examining the uterus • managing post-partum haemorrhage • resuscitation of mother and/or baby.
	<p>Examine and care for babies immediately following birth.</p> <p>This will include:</p>

	<ul style="list-style-type: none"> • confirming their vital signs and taking the appropriate action • full assessment and physical examination.
Effective midwifery practice	<p>Work in partnership with women and other care providers during the postnatal period to provide seamless care and interventions which:</p> <ol style="list-style-type: none"> 1. are appropriate to the woman's assessed needs, context and culture 2. promote their continuing health and well-being 3. are evidence-based 4. are consistent with the management of risk 5. are undertaken by the midwife because she is the person best placed to do them and is competent to act 6. draw on the skills of others to optimise health outcomes and resource one <p>These will include:</p> <ul style="list-style-type: none"> • providing support and advice to women as they start to feed and care for the baby • providing any particular support which is needed to women who have disabilities • post-operative care for women who have had caesarean and operative deliveries • providing pain relief to women • team working in the best interests of women and their babies • facilitating discussion about future reproductive choices • providing care for women who have suffered pregnancy loss, stillbirth or neonatal death.
Effective midwifery practice	<p>Examine and care for babies with specific health or social needs and refer to other professionals or agencies as appropriate</p> <p>This will include those with:</p> <ul style="list-style-type: none"> • congenital disorders • birth defects

	<ul style="list-style-type: none"> • low birth weight • pathological conditions (such as babies with vertical transmission of HIV, drug-affected babies).
Effective midwifery practice	<p>Care for and monitor women during the puerperium, offering the necessary evidence-based advice and support on the baby and self-care</p> <p>This will include:</p> <ul style="list-style-type: none"> • providing advice and support on feeding babies and teaching women about the importance of nutrition in child development • providing advice and support on hygiene, safety, protection, security and child development • enabling women to address issues about their own, their babies' and their families' health and social well-being • monitoring and supporting women who have postnatal depression or other mental illnesses. • advice on bladder control • advising women on recuperation • supporting women to care for ill/pre-term babies or those with disabilities.
Effective midwifery practice	<p>Select, acquire and safely administer a range of permitted drugs consistent with legislation, applying knowledge and skills to the situation which pertains at the time.</p> <p>Methods of administration will include:</p> <ul style="list-style-type: none"> • oral • intravenous • intramuscular • topical • inhalation
Effective midwifery practice	<p>Complete, store and retain records of practice which:</p> <ol style="list-style-type: none"> 1. are accurate and legible 2. detail the reasoning behind any actions taken 3. contain the information necessary for the record's purpose

	<p>Records will include:</p> <ul style="list-style-type: none"> • biographical details of women and babies • assessments made, outcomes of assessments and the action taken as a result • the outcomes of discussions with women and the advice offered • any drugs administered • action plans and commentary on their evaluation
Effective midwifery practice	<p>Actively monitor and evaluate the effectiveness of programmes of care and modify them to improve the outcomes for women, babies and their families.</p> <p>This will include:</p> <ul style="list-style-type: none"> • consideration of the effectiveness of the above and making the necessary modifications to improve outcomes for women and their families.
Effective midwifery practice	<p>Contribute to enhancing the health and social well-being of individuals and their communities.</p> <p>This will include:</p> <ul style="list-style-type: none"> • planning and offering midwifery care within the context of public health policies • contributing midwifery expertise and information to local health strategies • identifying and targeting care for groups with particular health and maternity needs and maintaining communication with appropriate agencies • involving users and local communities in service development and improvement • informing practice with the best evidence shown to prevent and reduce maternal and perinatal morbidity and mortality • utilising a range of effective, appropriate and sensitive programmes to improve sexual and reproductive health.
Professional and ethical practice	<p>Practice in accordance with the NMC's <i>Code of professional conduct</i>, within the limitations of the individual's own competence, knowledge and sphere of</p>

	<p>professional practice, consistent with the legislation relating to midwifery practice.</p> <p>This will include:</p> <ul style="list-style-type: none"> • using professional standards of practice to self-assess performance • consulting with the most appropriate professional colleagues when care requires expertise beyond the midwife's current competence • consulting other health care professions when the client's needs fall outside the scope of midwifery practice • identifying unsafe practice and responding appropriately.
Professional and ethical practice	<p>Practice in a way which respects and promotes individuals' rights, interests, preferences, beliefs and cultures.</p> <p>This will include:</p> <ul style="list-style-type: none"> • offering culturally-sensitive family planning advice • ensuring that women's labour is consistent with their religious and cultural beliefs, preferences and experiences • acknowledging the roles and relationships in families, dependent upon religious and cultural beliefs, preferences and experiences.
Professional and ethical practice	<p>Practice in accordance with relevant legislation</p> <p>This will include:</p> <ul style="list-style-type: none"> • practicing within the contemporary legal framework of midwifery • demonstrating knowledge of legislation relating to human rights, equal opportunities and access to patient records • demonstrating knowledge of legislation relating to health and social policy relevant to midwifery practice • demonstrating knowledge of contemporary ethical issues and their impact upon midwifery practice • Managing the complexities arising from ethical and legal dilemmas.

Professional and ethical practice	<p>Maintain the confidentiality of information</p> <p>This will include:</p> <ul style="list-style-type: none"> • ensuring the confidentiality and security of written and verbal information acquired in a professional capacity • disclosing information about individuals and organisations only to those who have a right and need to know it once proof of identity and right to disclosure has been obtained.
Professional and ethical practice	<p>Interact with other practitioners and agencies in ways which:</p> <ol style="list-style-type: none"> 1. value their contribution to health and care 2. enable them to participate effectively in the care of women, babies and their families 3. acknowledge the nature of their work and the context in which it is placed. <p>Practitioners and agencies will include those who work in:</p> <ul style="list-style-type: none"> • health care • social care • social security, benefits and housing • advice, guidance and counselling • child protection • the law.
Professional and ethical practice	<p>Manage and prioritise competing demands.</p> <p>This will include:</p> <ul style="list-style-type: none"> • working out who is best placed and able to provide particular interventions to women, babies and their families • alerting managers to difficulties and issues in service delivery.
Professional and ethical practice	<p>Support the creation and maintenance of environments which promote the health, safety and well-being of women, babies and others.</p> <p>This will include:</p> <ul style="list-style-type: none"> • preventing and controlling infection

	<ul style="list-style-type: none"> • promoting health, safety and security in the environment in which the practitioner is working, whether it be at a woman's home, in the community, a clinic, or in a hospital.
Professional and ethical issues	<p>Contribute to the development and evaluation of guidelines and policies and make recommendations for change in the interests of women, babies and their families.</p> <p>Evaluating policies will include:</p> <ul style="list-style-type: none"> • providing feedback to managers on service policies • representing the midwife's own considered views and experiences within the context of broader health and social care policies in the interests of women, babies and their families.
Developing the individual midwife and others	<p>Review, develop and enhance the midwife's own knowledge, skills and fitness to practice.</p> <p>This will include:</p> <ul style="list-style-type: none"> • making effective use of the framework for the statutory supervision of midwives • meeting the NMC's continuing professional development and practice standards • reflecting on the midwife's own practice and making the necessary changes as a result • attending conferences, presentations and other learning events.
Developing the individual midwife and others	<p>Demonstrate effective working across professional boundaries and develop professional networks.</p> <p>This will include:</p> <ul style="list-style-type: none"> • effective collaboration and communication • sharing skills • multiprofessional standard-setting and audit.
Developing the individual midwife and others	<p>Apply relevant knowledge to the midwife's own practice in structured ways which are capable of evaluation</p> <p>This will include:</p> <ul style="list-style-type: none"> • critical appraisal of knowledge and research evidence • critical appraisal of the midwife's own practice

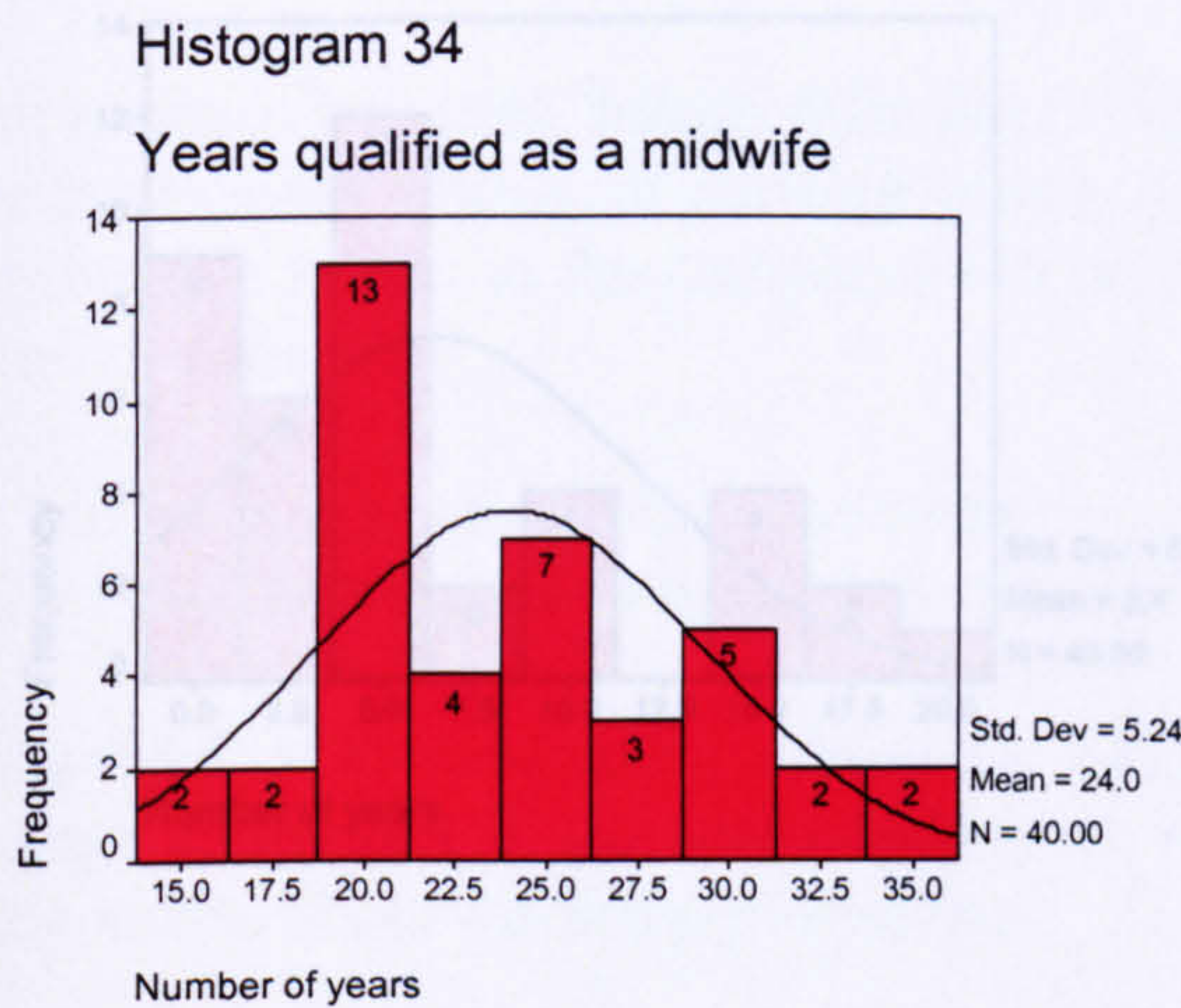
	<ul style="list-style-type: none"> • gaining feedback from women and their families and appropriately applying this to practice • disseminating critically-appraised good practice
Achieving quality care through evaluation and research	<p>Inform and develop the midwife's own practice and the practice of to hers through using the best available evidence and reflecting on practice.</p> <p>This will include:</p> <ul style="list-style-type: none"> • keeping up-to-date with evidence • applying evidence to practice • alerting others to new evidence for them to apply to their own practice.
Achieving quality care through evaluation and research	<p>Manage and develop care utilizing the most appropriate information technology (IT) systems.</p> <p>This will include:</p> <ul style="list-style-type: none"> • recording practice in consistent formats on IT systems for wider-scale analysis • using analysis of data from IT systems to apply to practice • evaluating practice from data analysis.
Achieving quality care through evaluation and research	<p>Contribute to the audit of practice to review and optimise the care of women, babies and their families.</p> <p>This will include:</p> <ul style="list-style-type: none"> • auditing the individual's own practice • contributing to the audit of team practice.

(NMC, 2002)

Appendix 3 - Questionnaire - Section 7 Personal Information

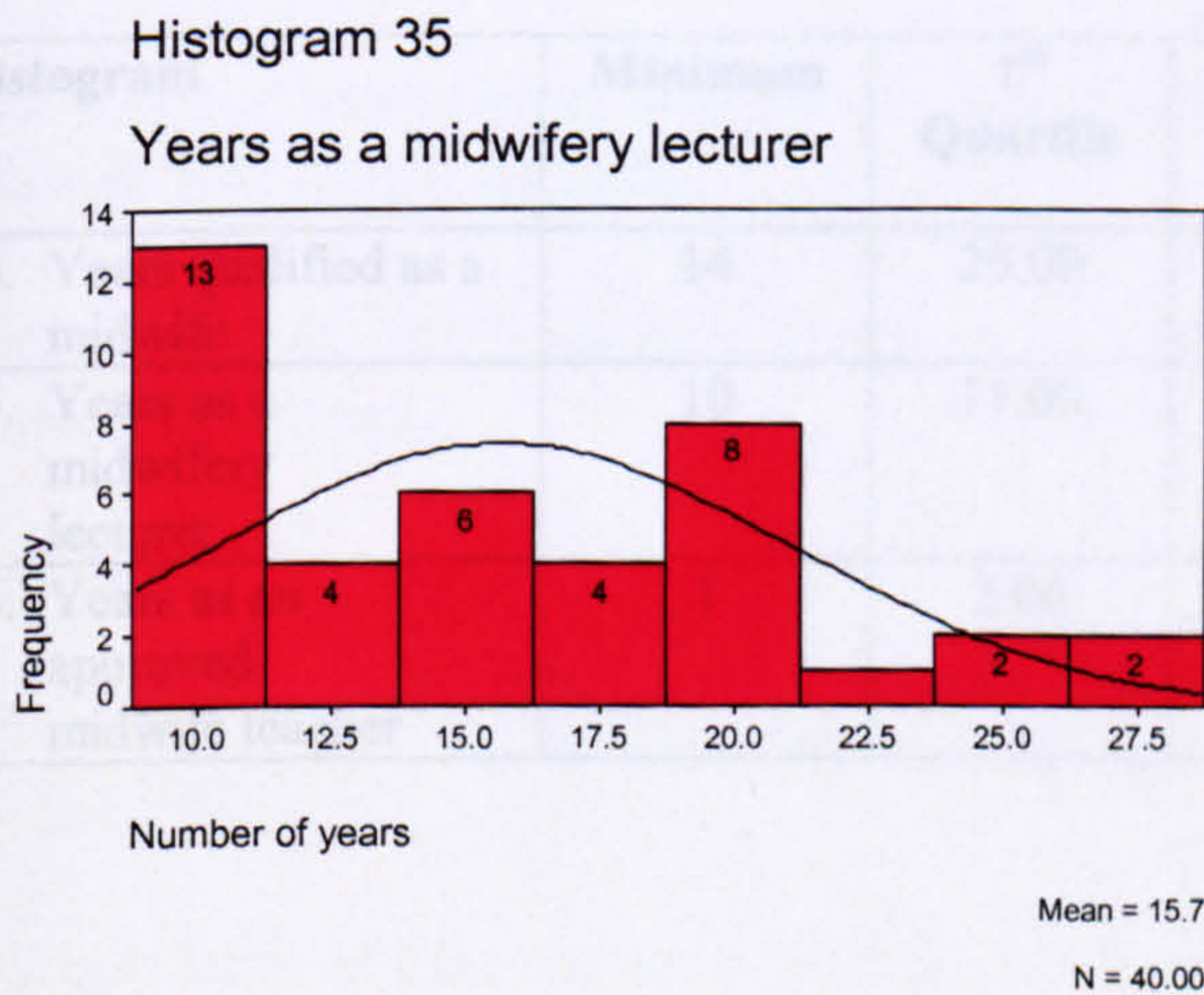
Question 34

The average number of years qualified as midwife was 24, with nine being qualified over 30 years.



Question 35

The average number of years employed as a lecturer was almost 16 with 8 having over 20 years experience.



Question 36 - Interview Schedule

Over half of the respondents had between 10 and 20 years experience.

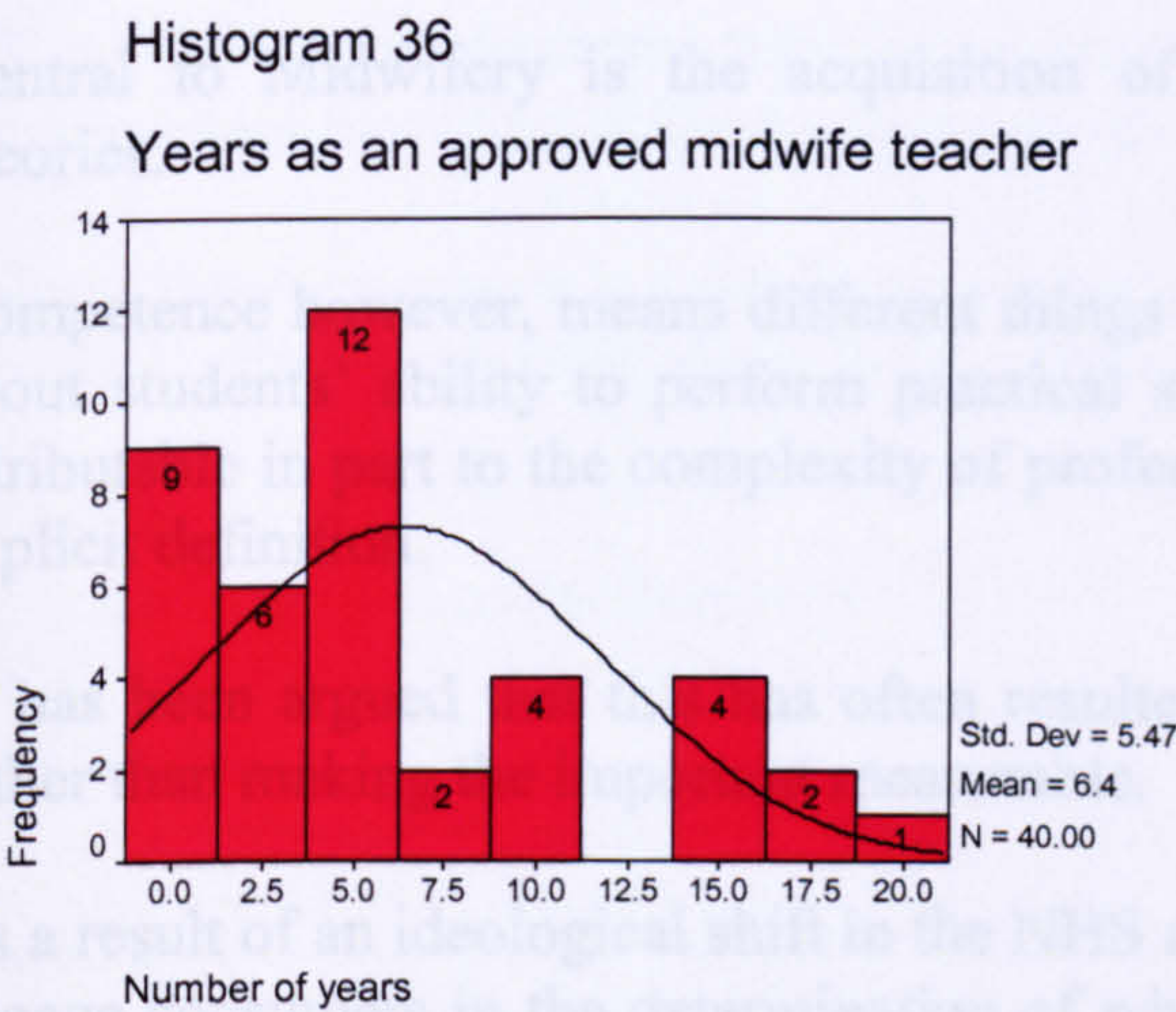


Table 7. Questionnaire Section 7-Personal information summary statistics

Histogram	Minimum	1 st Quartile	Median	3 rd Quartile	Maximum	Inter-quartile Range
34. Years qualified as a midwife	14	20.00	23.00	27.75	35	7.75
35. Years as a midwifery lecturer	10	11.00	14.50	20.00	28	9
36. Years as an approved midwife teacher	1	2.00	5.00	9.75	20	7.75

Appendix 4 - Interview Schedule

Interview Schedule - question prompts

Preamble

Central to Midwifery is the acquisition of practical competence linked to relevant theories.

Competence however, means different things to different people and making judgements about students' ability to perform practical skills has always been problematic. This is attributable in part to the complexity of professional competencies and their resistance to explicit definition.

It has been argued that this has often resulted in the measurable being made important rather than making the important measurable.

As a result of an ideological shift in the NHS and in education attempts are being made to engage consumers in the determination of what is important and of relevance in making judgements about student performance.

In view of your experience of midwifery services/education I should like to explore your views about some aspects of the involvement of women in student midwives' learning experiences and the assessment of them.

Fitness for Purpose

Question 1

The focus of assessment systems can often signal to students what is 'worth' learning and what is 'not worth' learning.

How useful do you believe it might be to routinely involve women in the assessment of student midwives?

Question 2

Education programmes have been criticised for failing to prepare students of midwifery to do the job.

Do you believe that the involvement of women in the learning and assessment process might go some way to address this ?

Feedback to students

Question 3

When fulfilling professional roles individuals are expected to demonstrate a repertoire of competencies including skills, knowledge, understanding, values and attitudes.

Taking these on one at a time do you believe women could make a contribution to the feedback given to students about their performance ?

- (a) skills
- (b) knowledge and understandings
- (c) values
- (d) attitudes

Question 4

Do you believe that feedback from women could assist students to understand care from a consumer perspective ?

Question 5

In what ways do you believe the elevation of the status of clients might influence the student learning process ?

Question 6

Do you believe that the involvement of women might help educationalists to ground the curriculum in the reality of contemporary human experience ?

Feasibility

Question 7

Assessment is a normal part of any social interaction. Assessment can be descriptive without being judgmental or a combination of both description and judgement.

Do you believe women can provide student midwives with descriptions or judgements about their practical performance?

Question 8

Providing feedback to students has been described as intimate and potentially difficult.

Do you believe women could be prepared for such a role?

Question 9

Do you believe women should make a contribution to the following:-

- a) formative assessment?
- b) summative assessment?

Question 10

How do you believe women could be rewarded for their involvement in student learning and assessment?

The Partnership Approach to Service Delivery

Question 11

Do you believe the involvement of women in the learning and assessment process would improve the partnership between them and the students caring for them?

Question 12

Students learn to manage the kinds of impressions they give to their assessors and key staff.

Do you believe that engaging women in the assessment process would help students to provide more client centred care?

Question 13

Do you believe that women should be the final arbiter of quality judgements?

Validity and Reliability

Question 14

Women's views of student midwives have often been judged as self serving and little more than a testimonial.

Do you believe that women's views of students' performance could be collected in a more useful way?

Question 15

What effect would the involvement of women have on the reliability and validity of both learning and assessment?

Question 16

Do you believe women's expectations of the service they receive could introduce bias against students?

Autonomy in the Learning Process

Question 17

Many educational theorists argue that adult learners should enjoy a degree of autonomy in identifying their own learning needs.

Do you believe that feedback from women might assist students to identify these personal learning needs?

Question 18

It is known that assessment can motivate students.

Do you believe that students would be motivated differently through the involvement of women?

Ethical Issues

Question 19

It is only when individuals give an opinion that their thoughts and experiences become publicly available and influence personal power.

Do you believe the involvement of women will influence the historical power that has been held by teachers?

Appendix 5 - Questionnaire

QUESTIONNAIRE

Involving women in the assessment of clinical competence in student midwives

This questionnaire is part of a research study which is exploring the assessment of clinical competence in student midwives and in particular the involvement of women in the assessment process.

The issues covered in this questionnaire emanate from a review of the literature, interviews with key informants and focus group interviews with parents, student midwives and qualified midwifery assessors.

The questionnaire consists of the following:-

Section 1 Fitness for practice

Section 2 Partnership approach

Section 3 Autonomy in the learning process

Section 4 Feedback to students

Section 5 Validity of the assessment process

Section 6 Feasibility

Section 7 Personal information

Please tick the response you feel is most appropriate in each section

There is a comments area at the end of each section for you to use if you wish.

The term “woman” used throughout this questionnaire refers specifically to women using maternity services who are cared for by student midwives.

Thank you for your kind assistance

Section 1 : Fitness for practice

1. The focus of assessment systems can often signal to students what is “worth” learning and what is “not worth” learning.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

2. Feedback from women which is individual to the student and focused on particular skills will be helpful to the students’ learning experience.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

3. Feedback from women has the potential to enable students to develop as women friendly practitioners.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

4. Feedback from women will help students to develop the *art of caring*, and establish their own professional bedside manner.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

5. Education programmes have been criticised for failing to prepare students to *do the job*, particularly in nursing. Do you believe that the involvement of women in the assessment process will strengthen this feature of midwifery programmes?

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

6. Involving women in the assessment process will enable them to influence practice.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

Comments

Section 2 : Partnership approach

7. The involvement of women in the assessment process will improve the partnership between them and the students caring for them.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Students can learn to manage the kinds of impressions they give to their assessors and key staff. Engaging women in the assessment process will help students to provide more client centred care.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Women take a particular interest in student midwives involved in their care.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. It is possible for students to learn from women in their care.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Involving women in the assessment process will empower them.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Involving women in the assessment process by giving students feedback will enable the student midwife to understand the consumer perspective in relation to the quality of care.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Section 3 : Autonomy in the learning process

Many educational theorists argue that adult learners should enjoy a degree of autonomy in identifying their own learning needs.

13. Feedback from women will assist students in identifying their personal weaknesses and strengths.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Certain modes of assessment can motivate students particularly if they develop an inherent interest in the assessment task.

14. Involving women in the assessment process will enhance the student midwives' motivation to learn and develop their professional practice.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Feedback about performance plays an important role in the learning process.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Feedback from women in relation to clinical competencies will provide students with additional information when reflecting on their practice.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Section 4 : Feedback to students

When fulfilling professional roles individuals are expected to demonstrate a repertoire of competencies including skills, knowledge, understanding, values and attitudes.

17. Feedback from women will enable students to integrate theory and practice more effectively.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Women are able to provide student midwives with feedback in relation to their clinical skills.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Women are able to provide student midwives with feedback about their knowledge base.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Women are able to provide student midwives with feedback about the professional values they demonstrate.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Women are able to provide student midwives with feedback about the attitudes they adopt.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Section 5 : Validity of the assessment process

Women's views of student midwives can inform judgements made by midwifery assessors in the clinical area.

22. Including evidence from women will enhance the validity of judgements made about student midwives performance.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

23. Women's expectations of maternity services will introduce bias when giving feedback to students.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

24. By inviting women to differentiate between the care provided by the student midwife and maternity services generally the validity of the assessment process will be enhanced.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

25. In order to ensure fair treatment of the individual student essential feedback areas should be identified by the course management team.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

Comments

Section 6 : Feasibility

Making judgements is a normal part of any social interaction. Assessment can be descriptive without being judgmental or a combination of both description and judgement.

26. Women will need formal preparation for their role in providing feedback to student midwives.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

27. Feedback from women to student midwives should be included as a summative component of the assessment process.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

28. Feedback from women to student midwives should be included as a formative component of the assessment process.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

29. Students should be encouraged to identify areas where they would particularly benefit from feedback from the women in their care.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

30. Women can be a significant learning resource for students.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

31. All women should have the opportunity to provide feedback to student midwives involved in their care.

Agree strongly ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Disagree strongly ☐

32. Women should have the choice to give feedback about student midwives who care for them if they wish to.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. Women should have choice about the format of the feedback.

Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

Section 7 : Personal information

34. How long have you been qualified as a midwife? Years

35. How long have you worked in midwifery education..... Years

36. How long have you been an approved midwife teacher Years

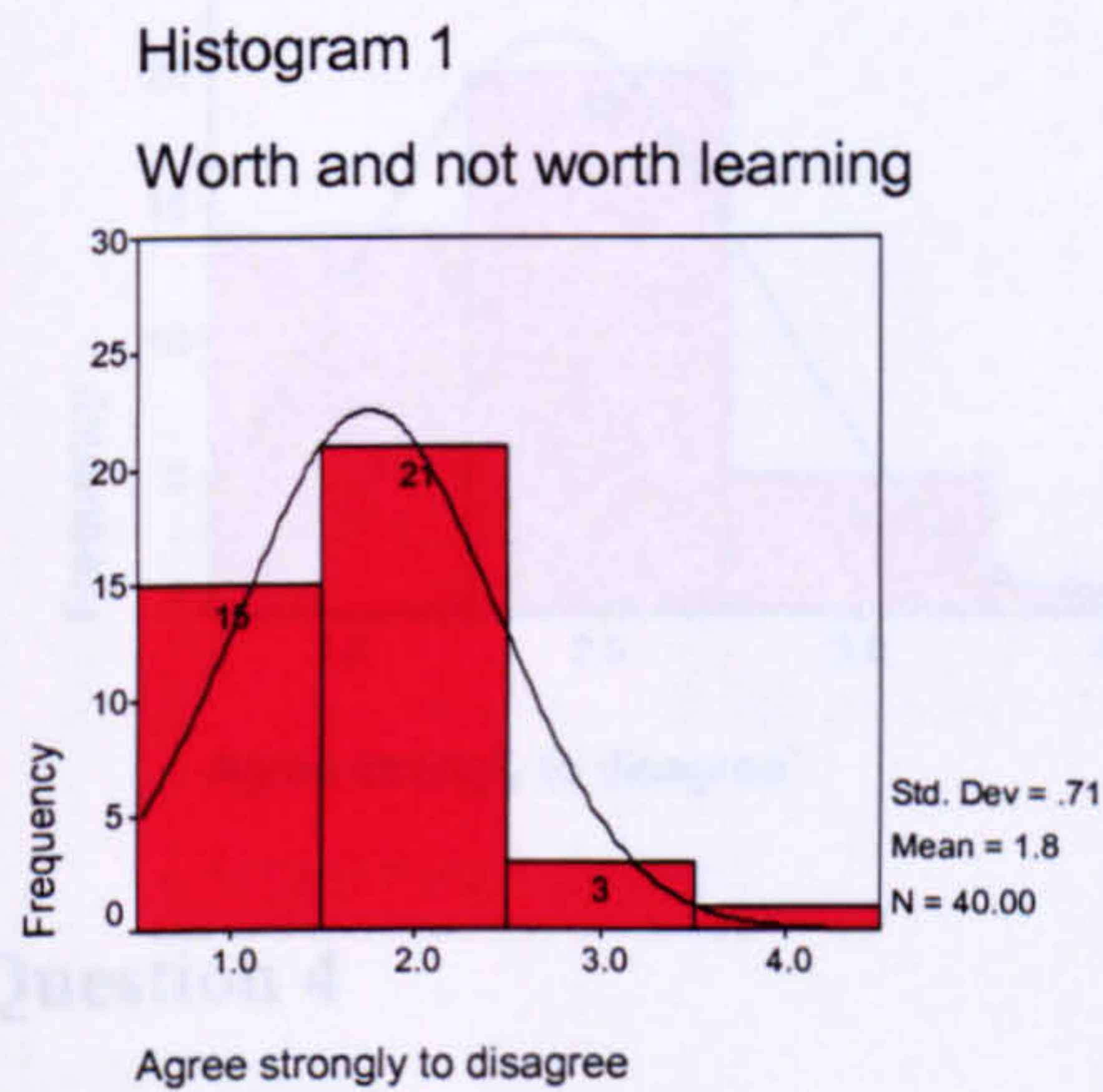
Thank you very much for taking the time to complete this questionnaire

Appendix 6 – Histograms

Section 1 Fitness for purpose

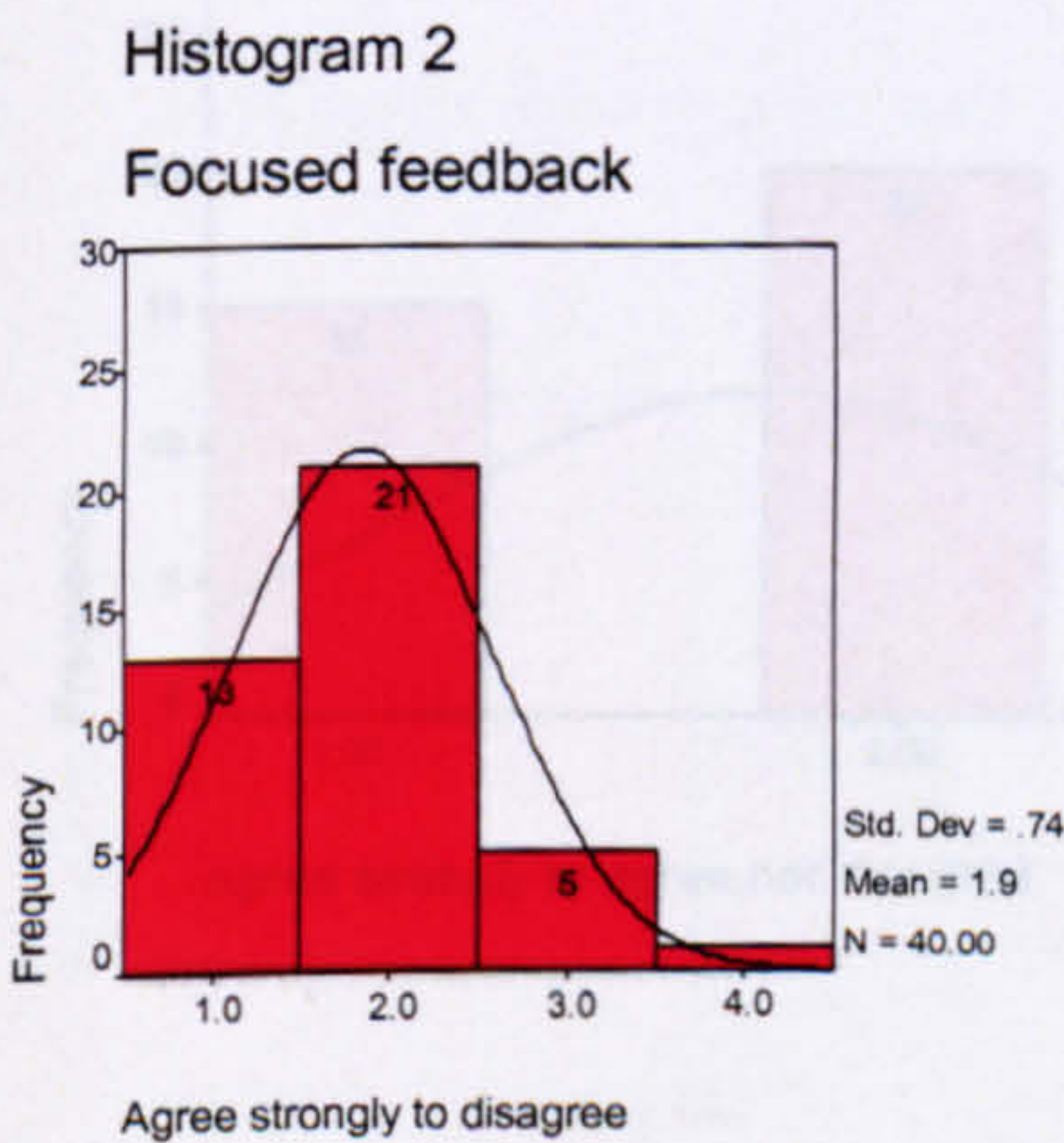
Question 1

There was little disagreement with the notion that the focus of assessment systems influences students’ concept of what is worth and not worth learning. Only one respondent disagreed and three neither agreed nor disagreed.



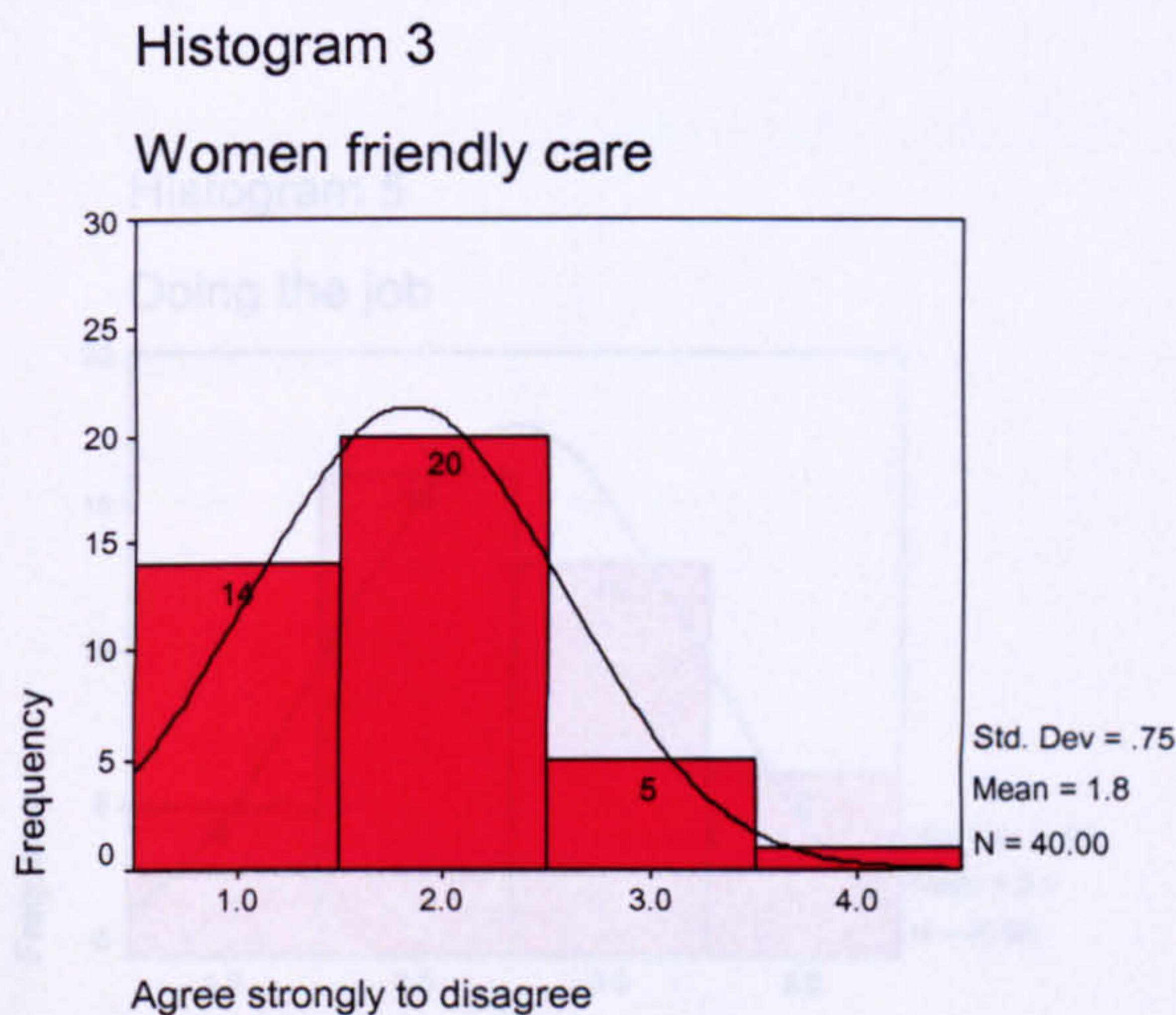
Question 2

Again only one respondent disagreed with the idea that feedback from women which was individualised and focussed on particular skills would help in the students’ learning experience. Only five neither agreed nor disagreed.



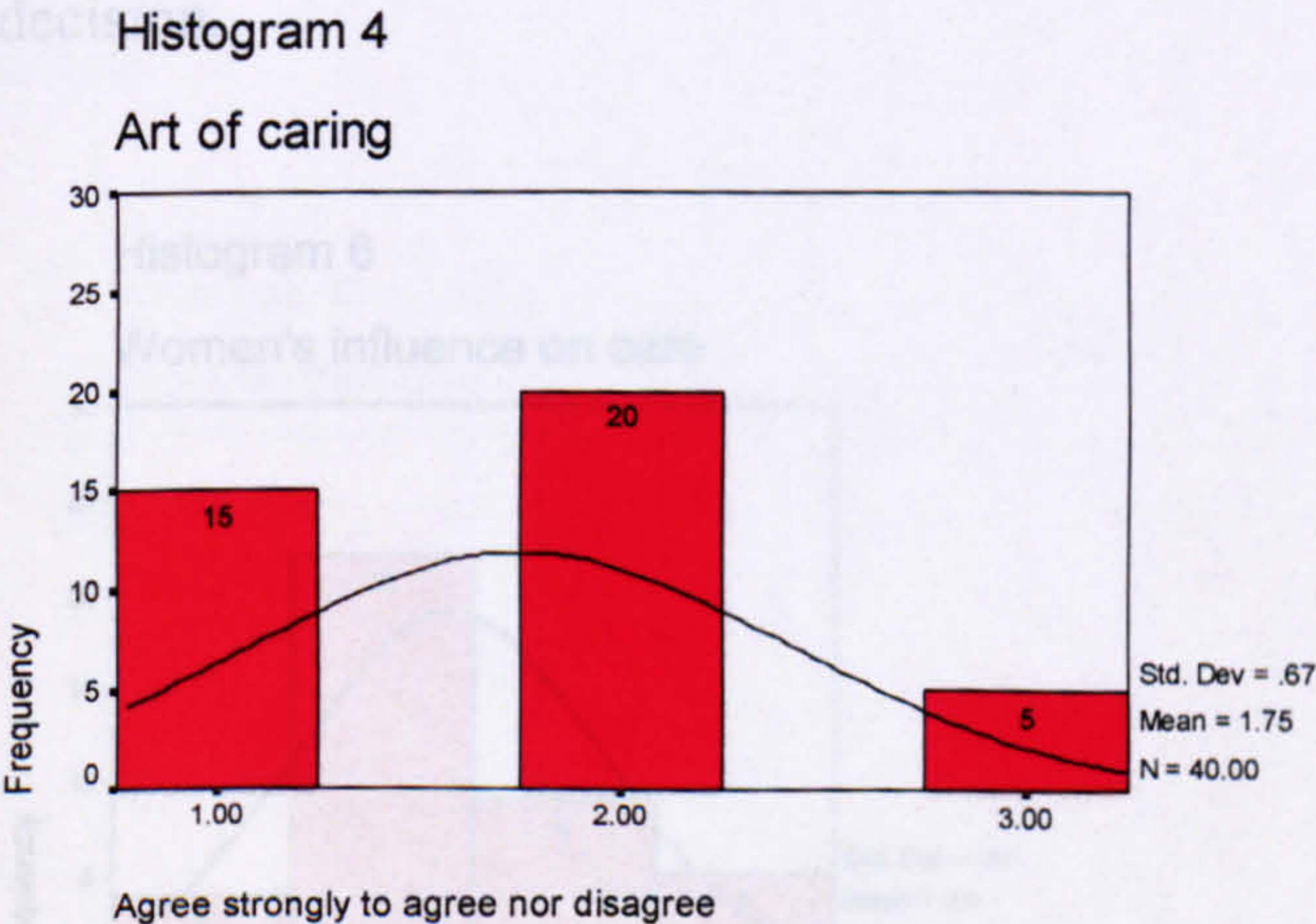
Question 3

Again there was general agreement that feedback from women has the potential to enable students to develop as women friendly practitioners. Only one respondent disagreed.



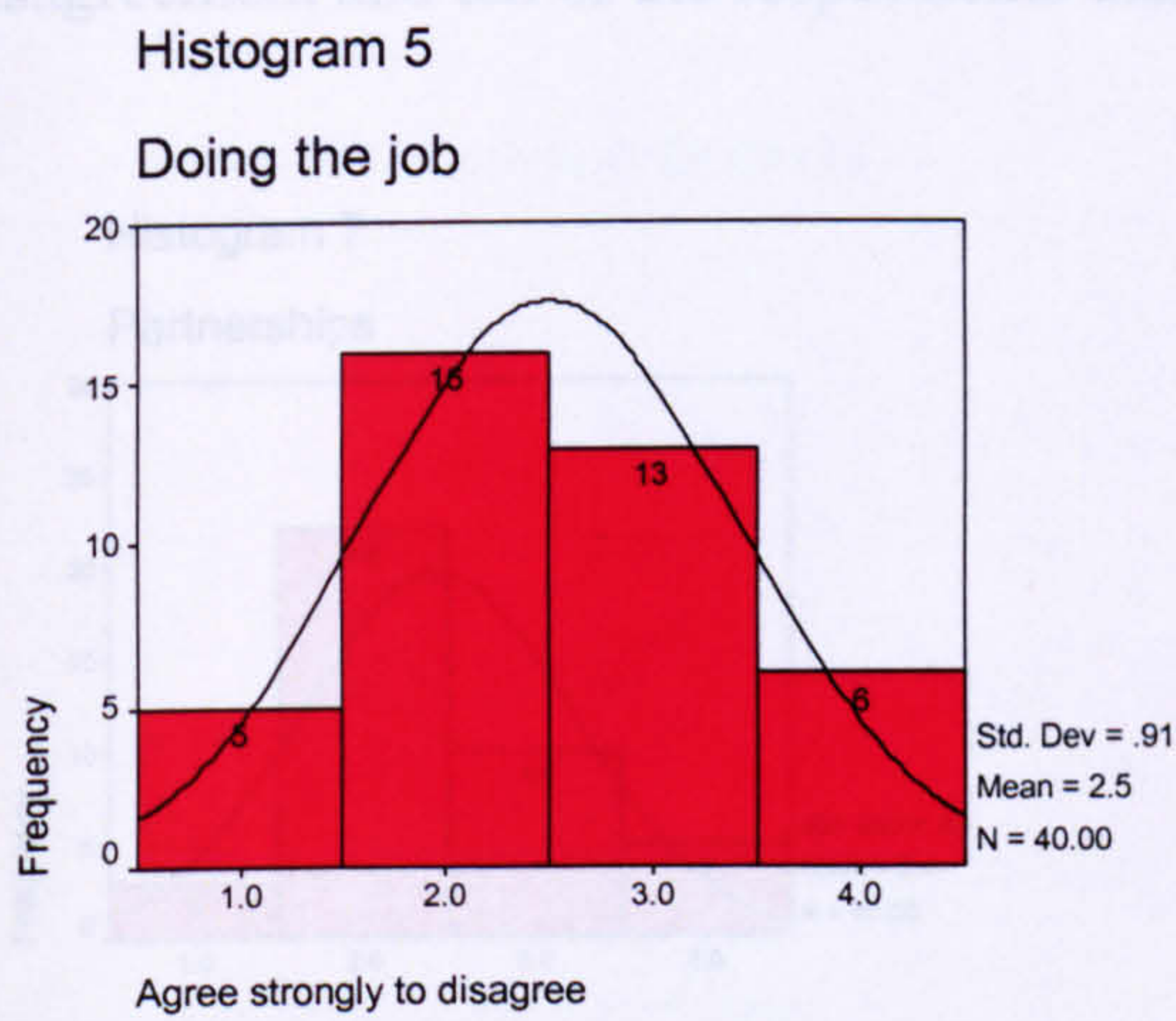
Question 4

Although five respondents neither agreed nor disagreed, all of the remaining respondents agreed that involving women would help students to develop the art of caring.



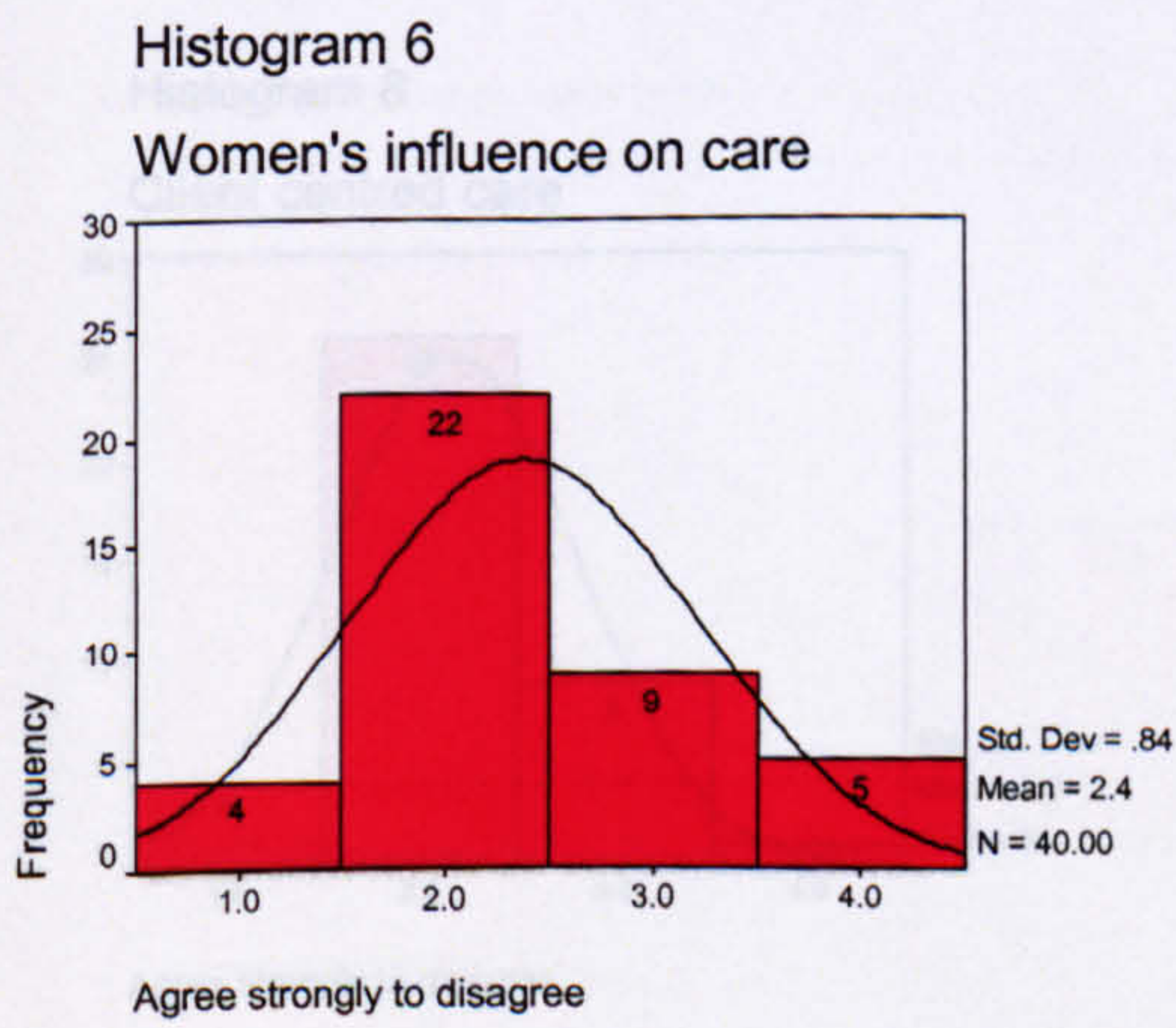
Question 5

The success of a curriculum that included women in a formal way in preparing students who are able to do the job created a wider range of views with six respondents disagreeing and thirteen neither agreeing nor disagreeing.



Question 6

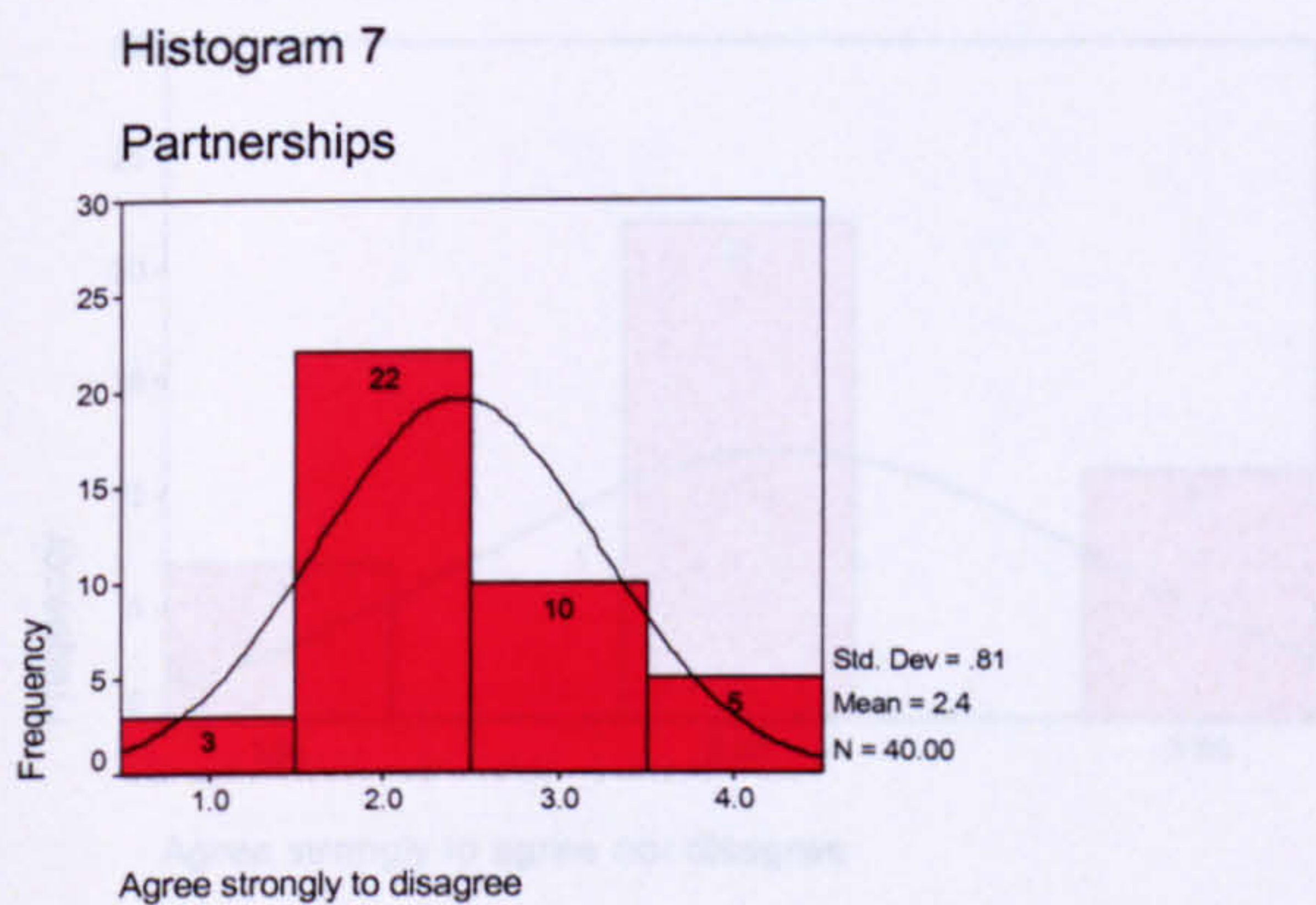
There was clear support for the notion that involving women in the training of student midwives would enable them to influence practice although there was an element of indecision.



Section 2 Partnership approach

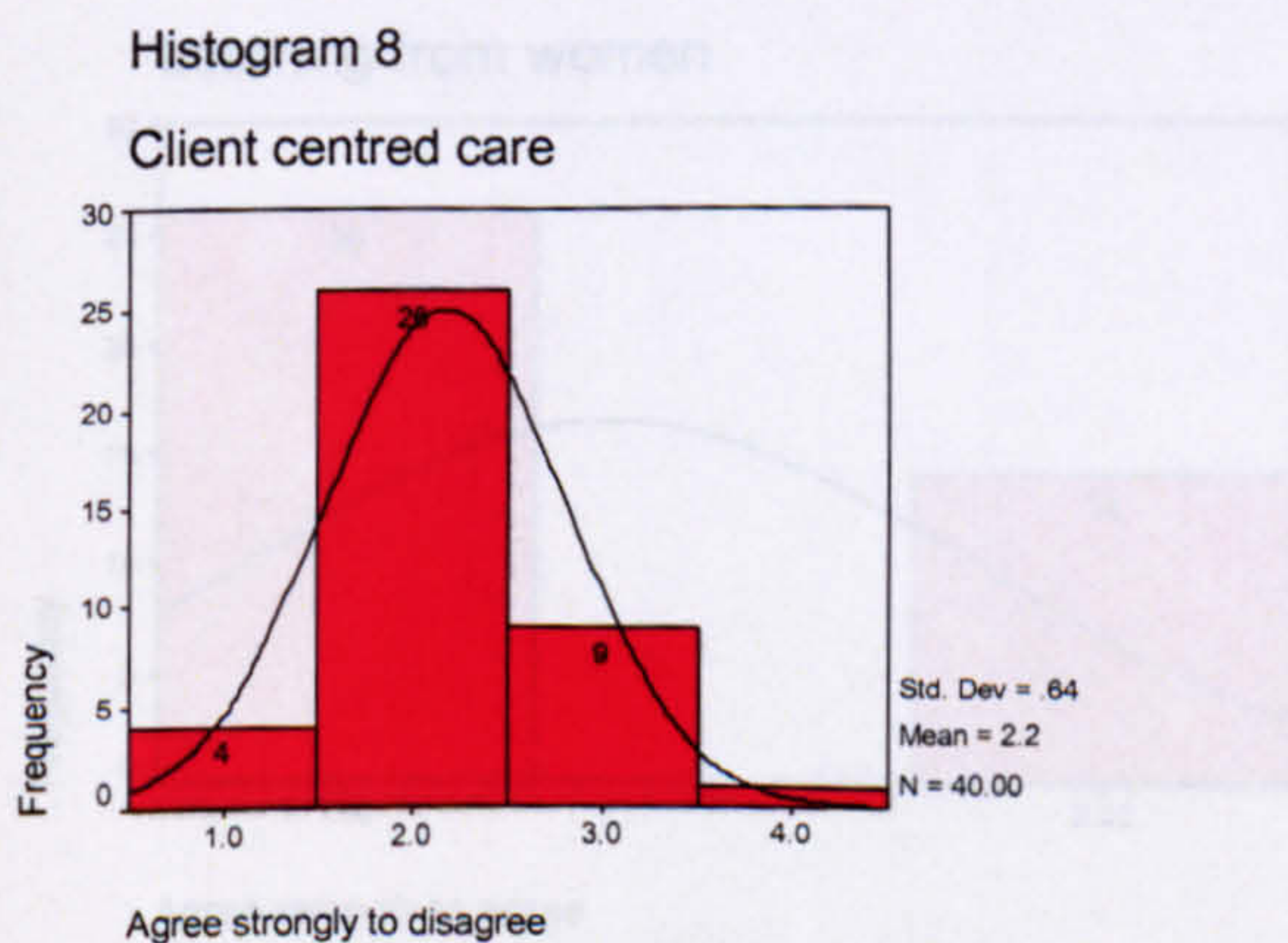
Question 7

There was general support for the view that by involving women in a formal way in assessing students that their relationship would be more of a partnership. There was some disagreement and ten of the respondents did not have a view one way or the other.



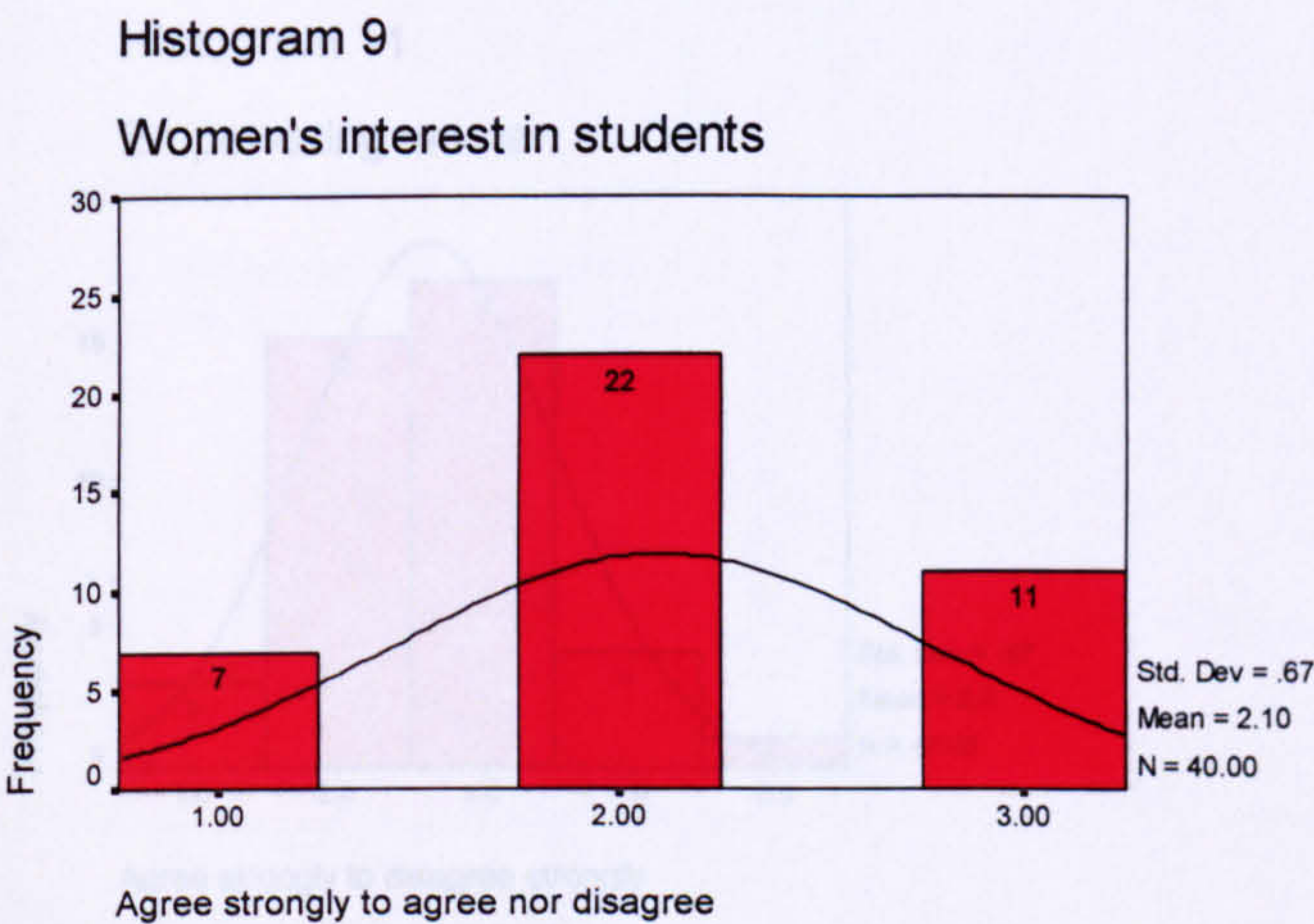
Question 8

Only one respondent disagreed with the idea that if women were involved in the assessment process students would respond by providing care that was more client centred.



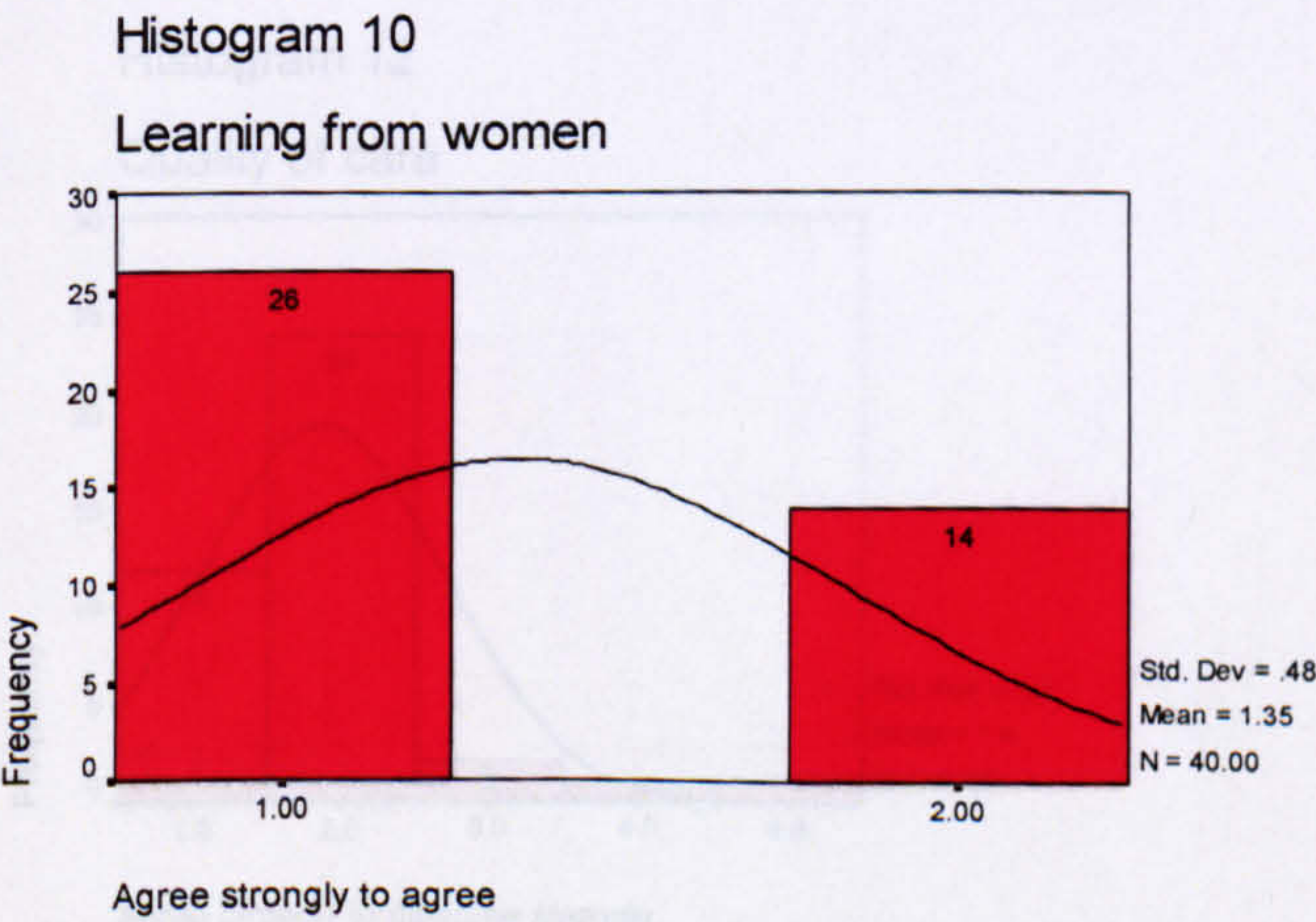
Question 9

Although none of the respondents disagreed with the belief that women did take an interest in the students that cared for them eleven did not express a view one way or the other.



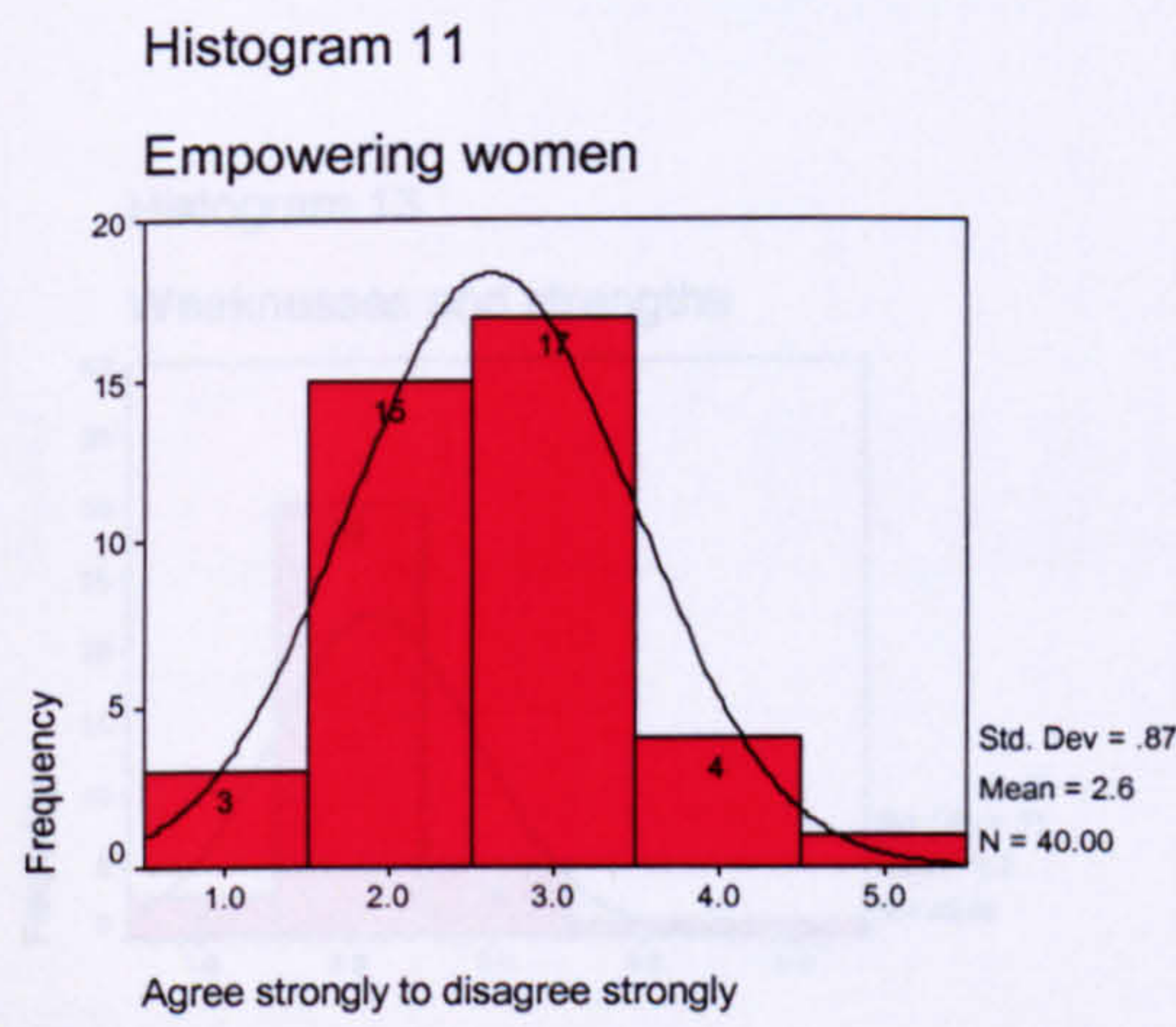
Question 10

All respondents agreed that students can learn from the women in their care with the majority agreeing strongly.



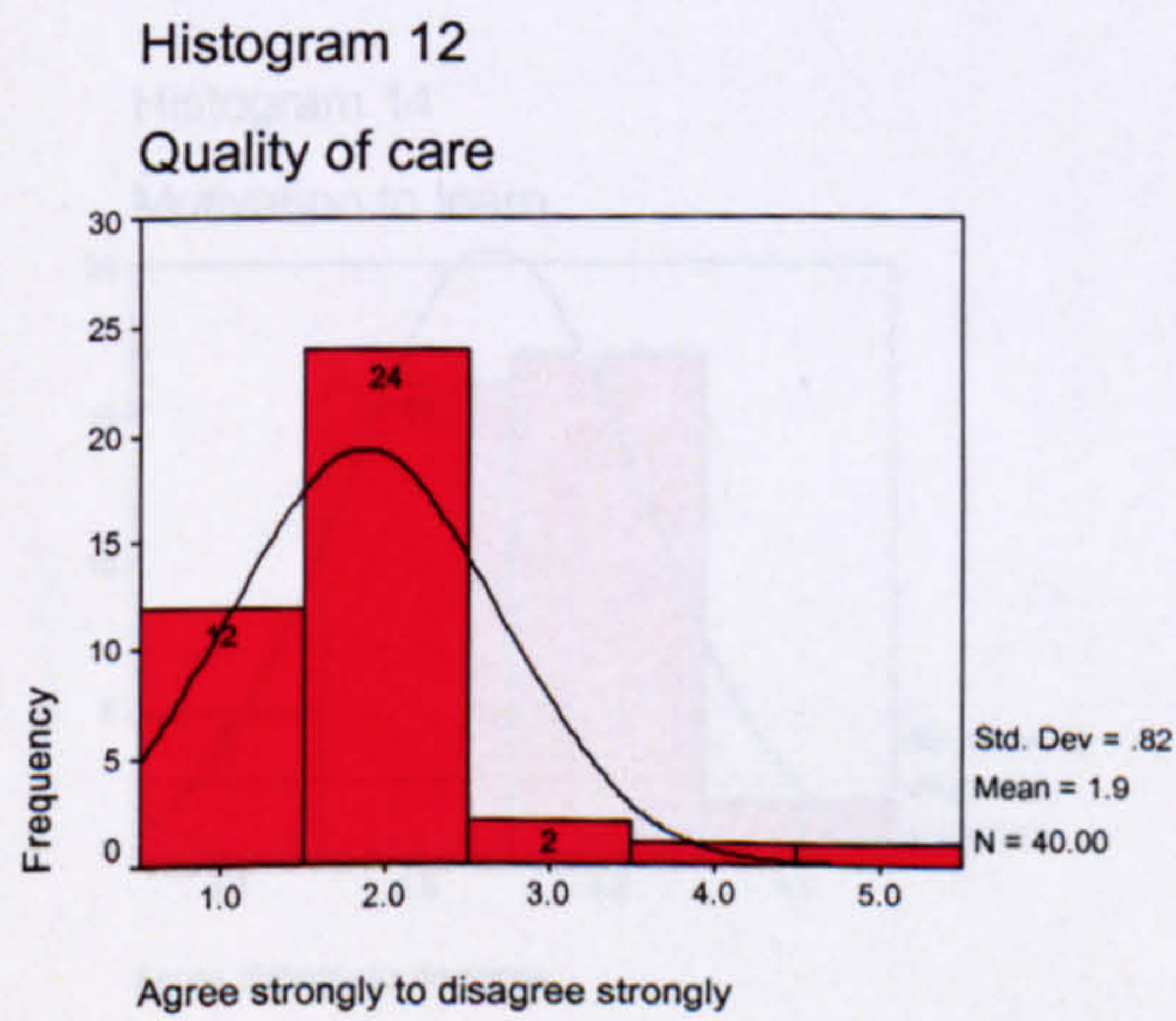
Question 11 *...only in the learning process*

Question 13
Just over half of the respondents either did not have a view or disagreed that women could be empowered by being involved in the assessment process. Eighteen did agree that it would be an empowering experience for them. *...ing their weaknesses and strengths on the basis of feedback from the women they cared for.*



Question 14
Question 12

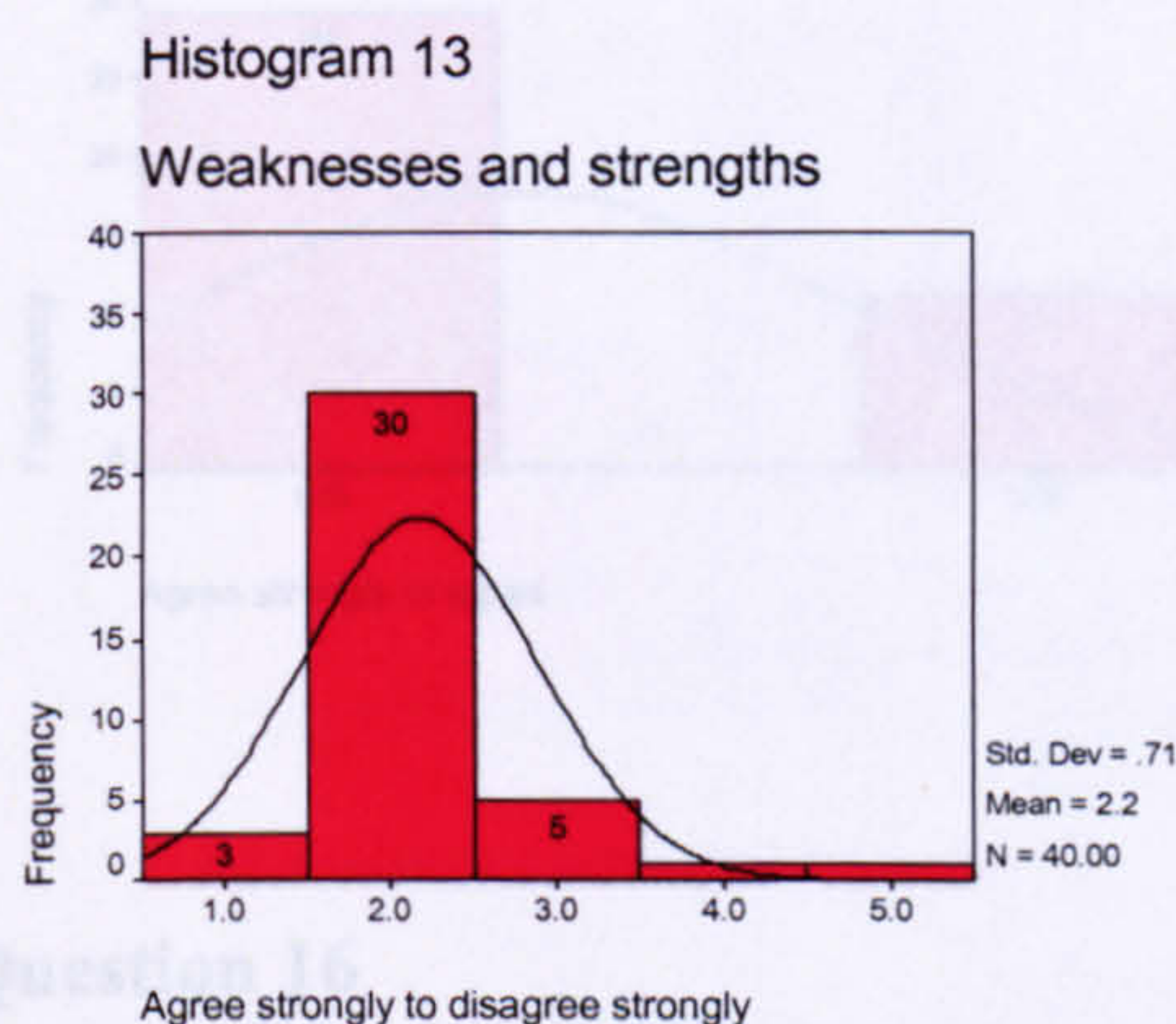
Although almost half of the respondents did not express a view, the remainder did agree with five agreeing strongly that women could be empowered to improve the involvement of women.
The majority did agree that students would gain a better understanding of the women's expectations regarding the quality of care if women were involved more directly.



Section 3 Autonomy in the learning process

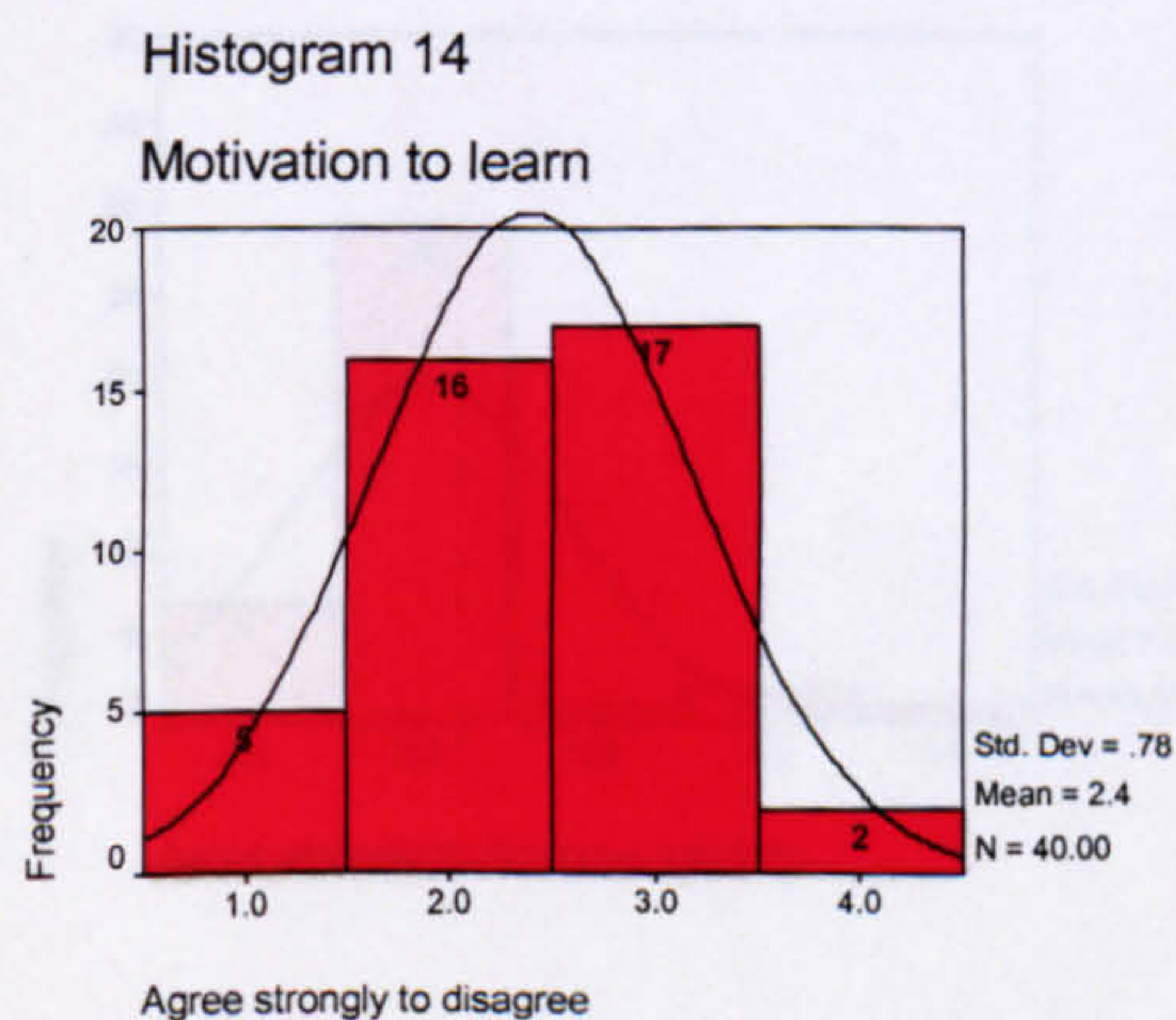
Question 13

Only seven respondents either did not express a view or disagreed with the statement that suggested that students would be assisted in identifying their weaknesses and strengths on the basis of feedback from the women they cared for.



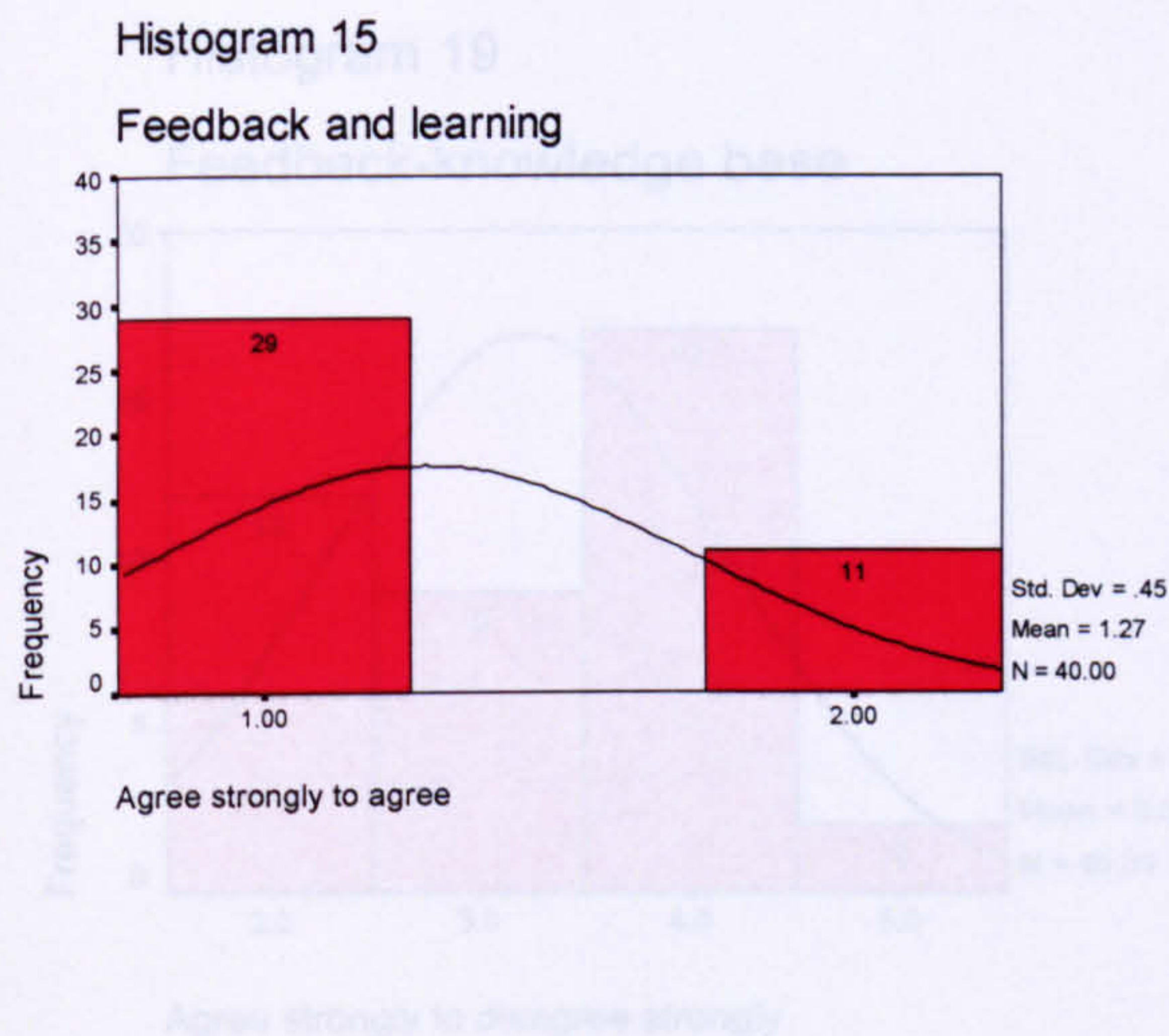
Question 14

Although almost half of the respondents did not express a view the remainder did agree with five agreeing strongly that students would be motivated to learn by the involvement of women.



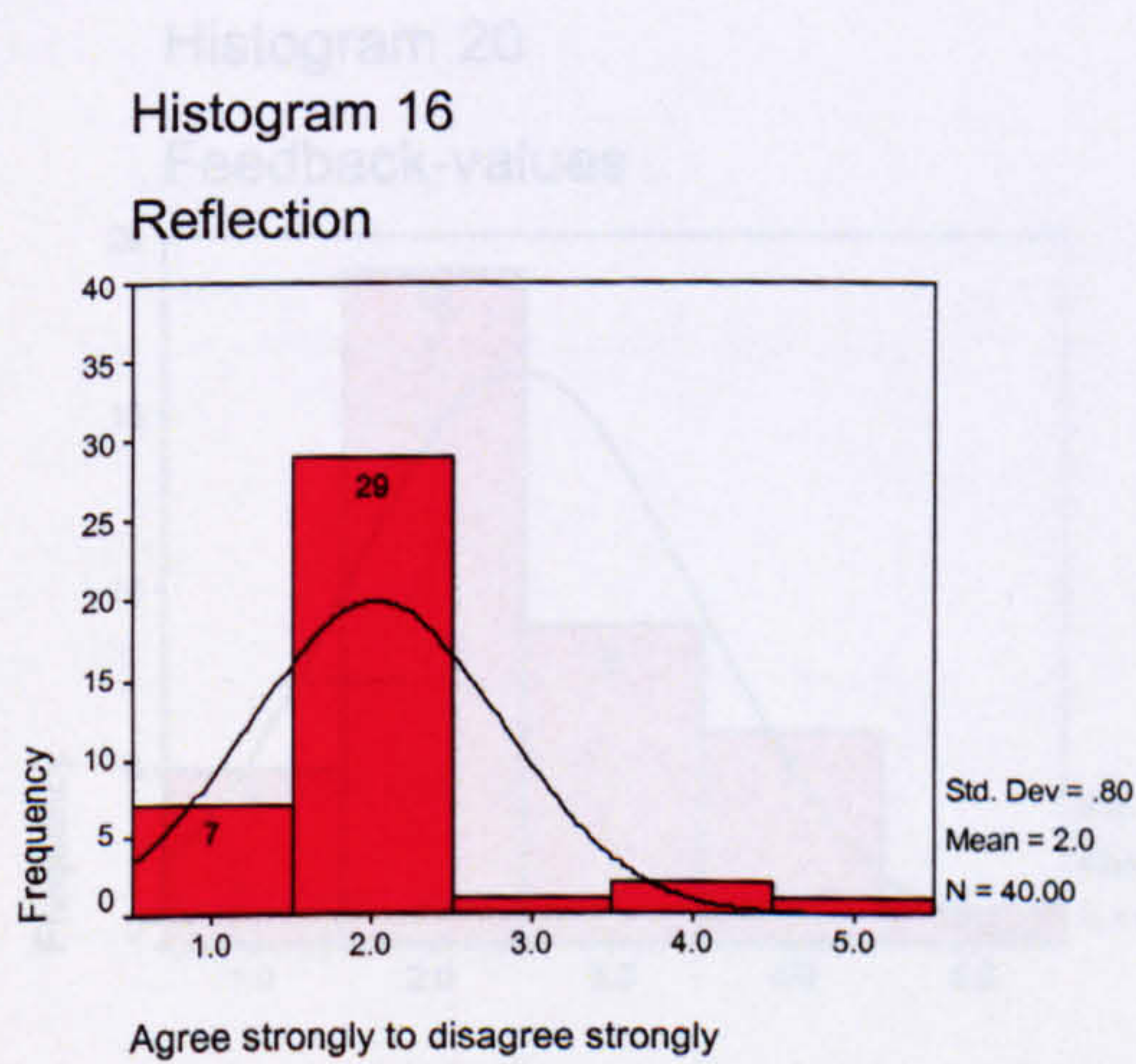
Question 15

All respondents agreed that feedback was an important feature of the learning process with twenty nine agreeing strongly.



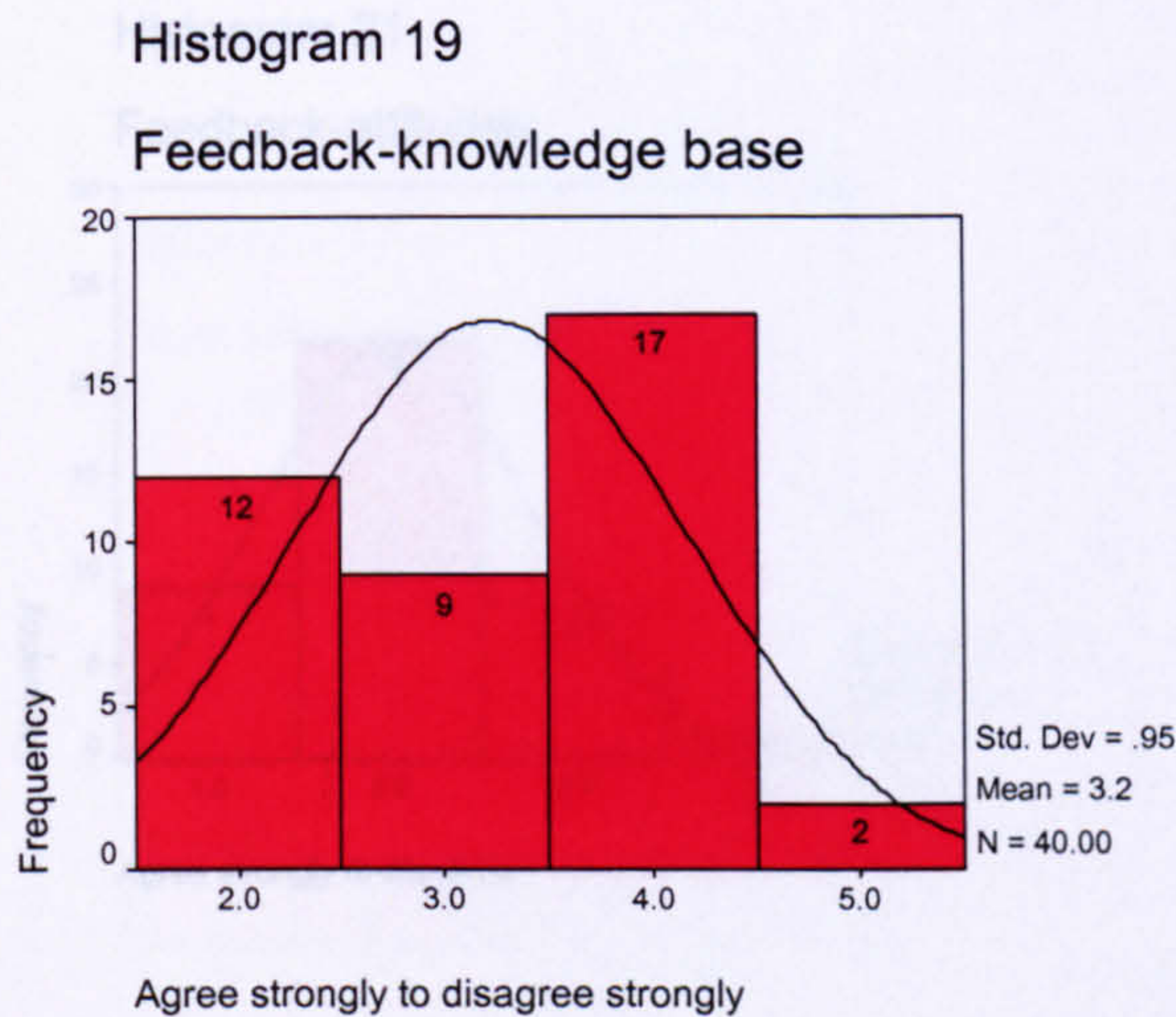
Question 16

Again there was strong support for the statement that suggested that feedback from women would assist the students to reflect on clinical skills. Only seven disagreed with the statement that suggested that women would be able to provide feedback concerning students' values. Only four either expressed no view or disagreed.



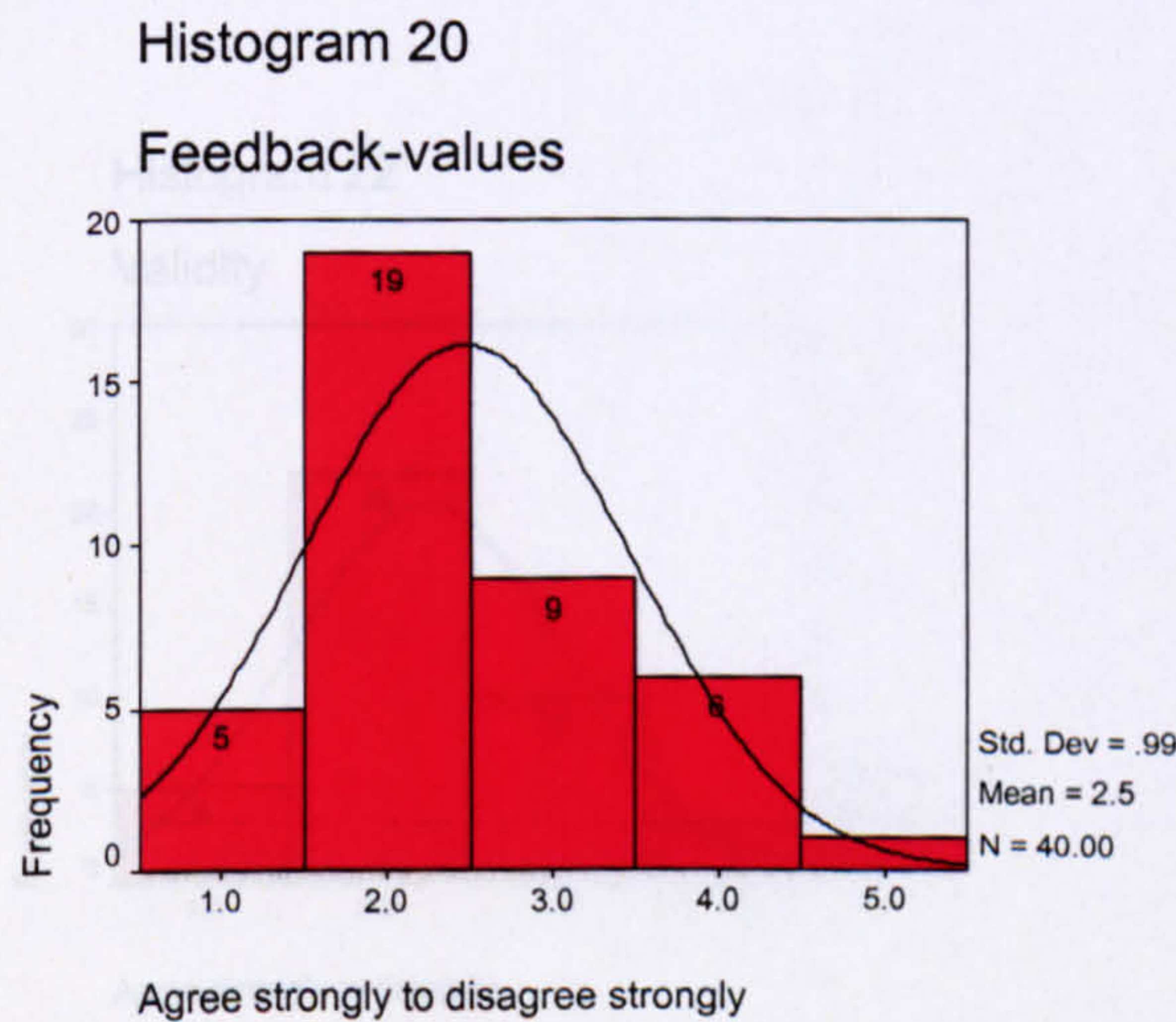
Question 19

Twelve agreed that women would be able to provide feedback concerning the student's knowledge base. However half of the respondents disagreed.



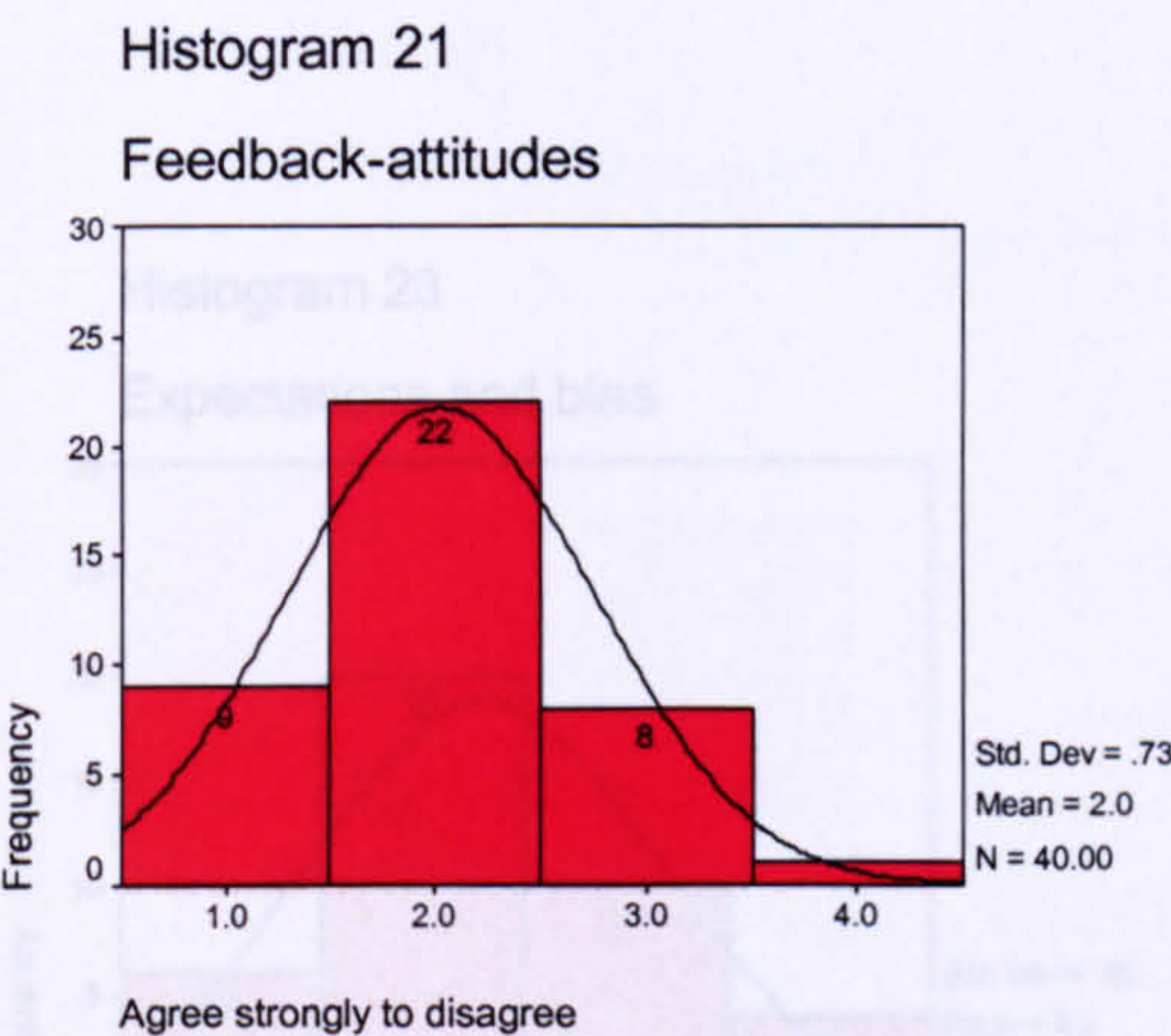
Question 20

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Question 21

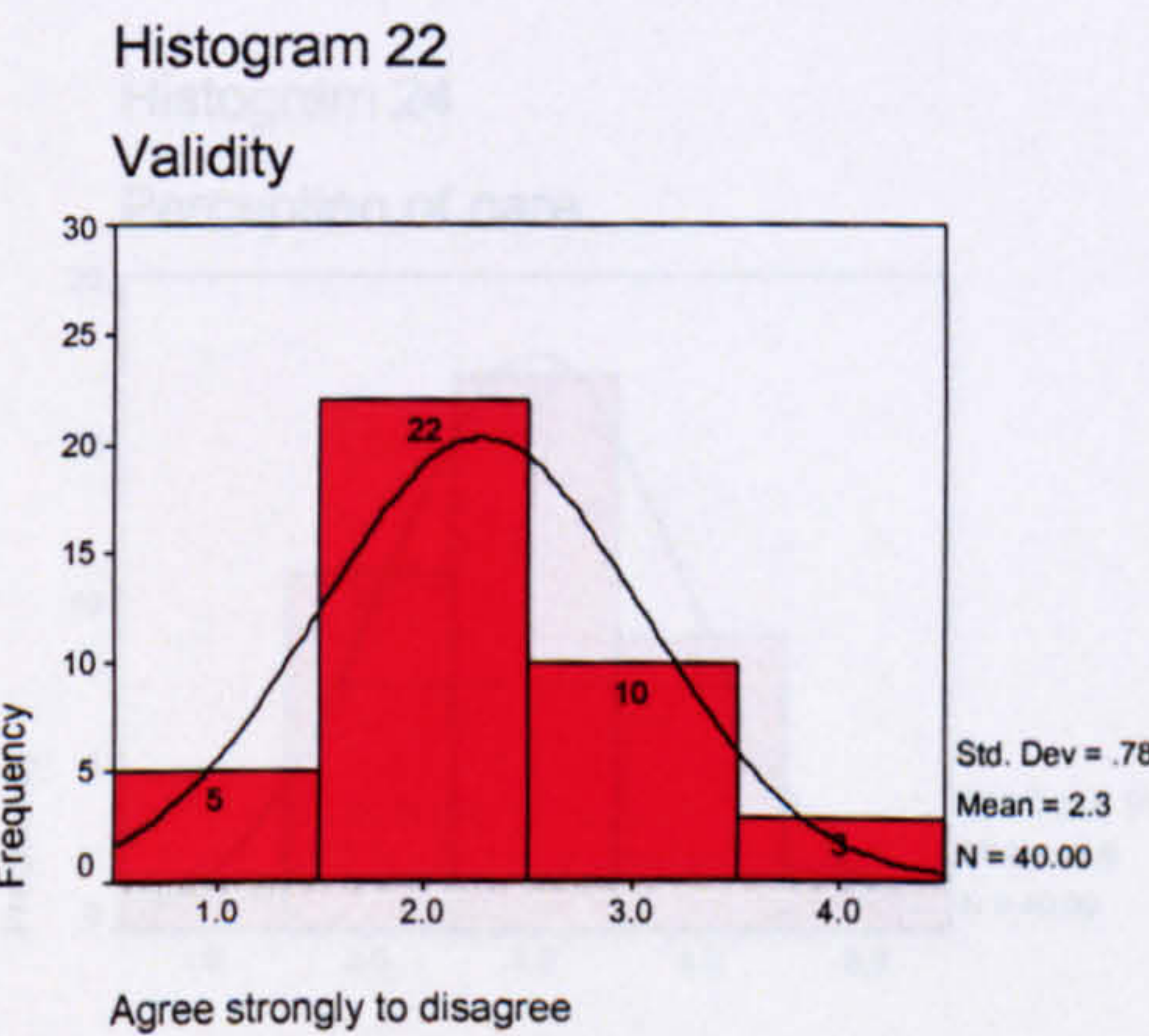
There was strong support for the idea that women would be able to provide feedback concerning students' attitudes with nine agreeing strongly. four disagreed.



Section 5 Validity of the assessment process

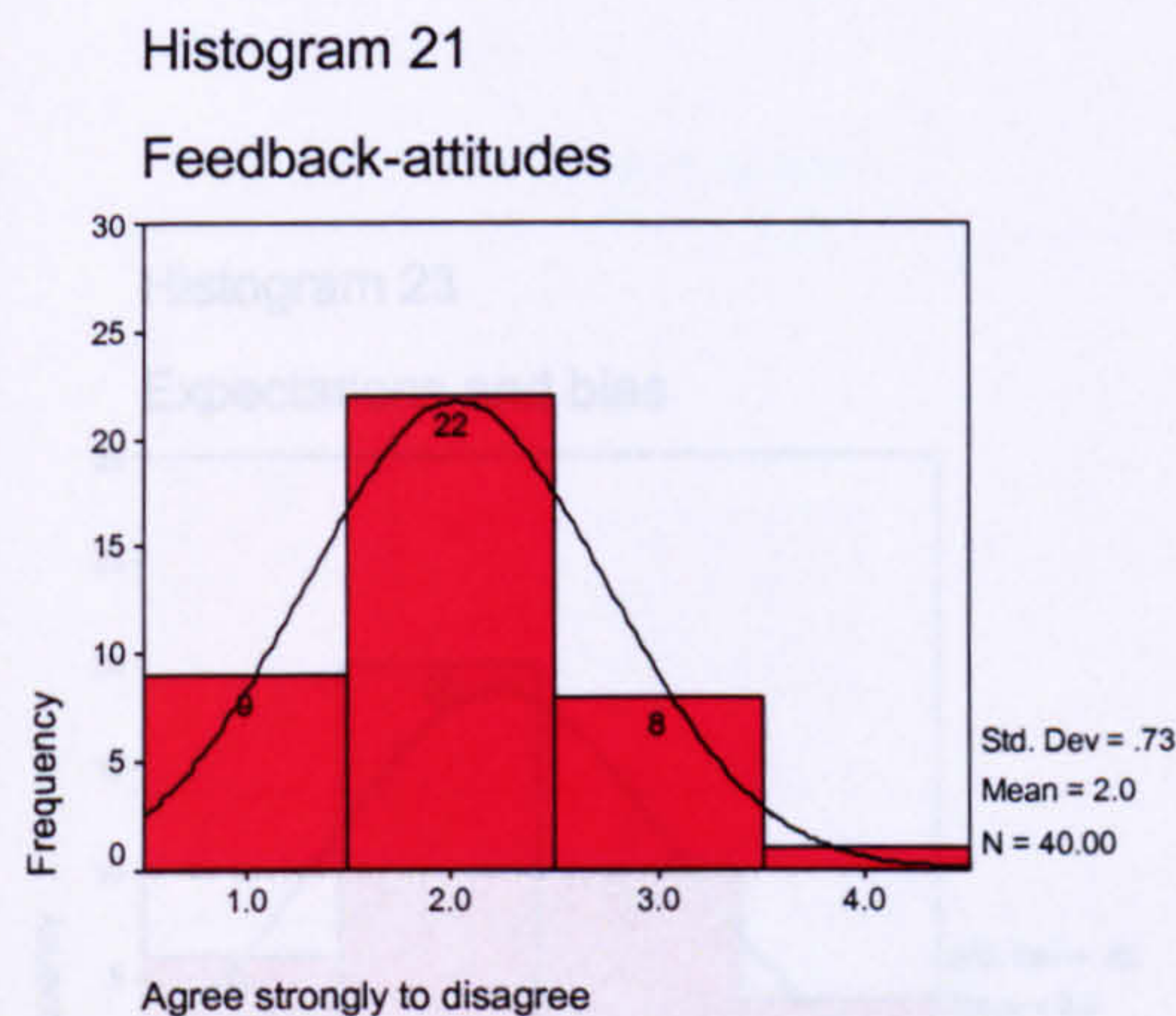
Question 22

Again there was strong support to suggest that by involving women in the assessment process its validity would be enhanced.



Question 21

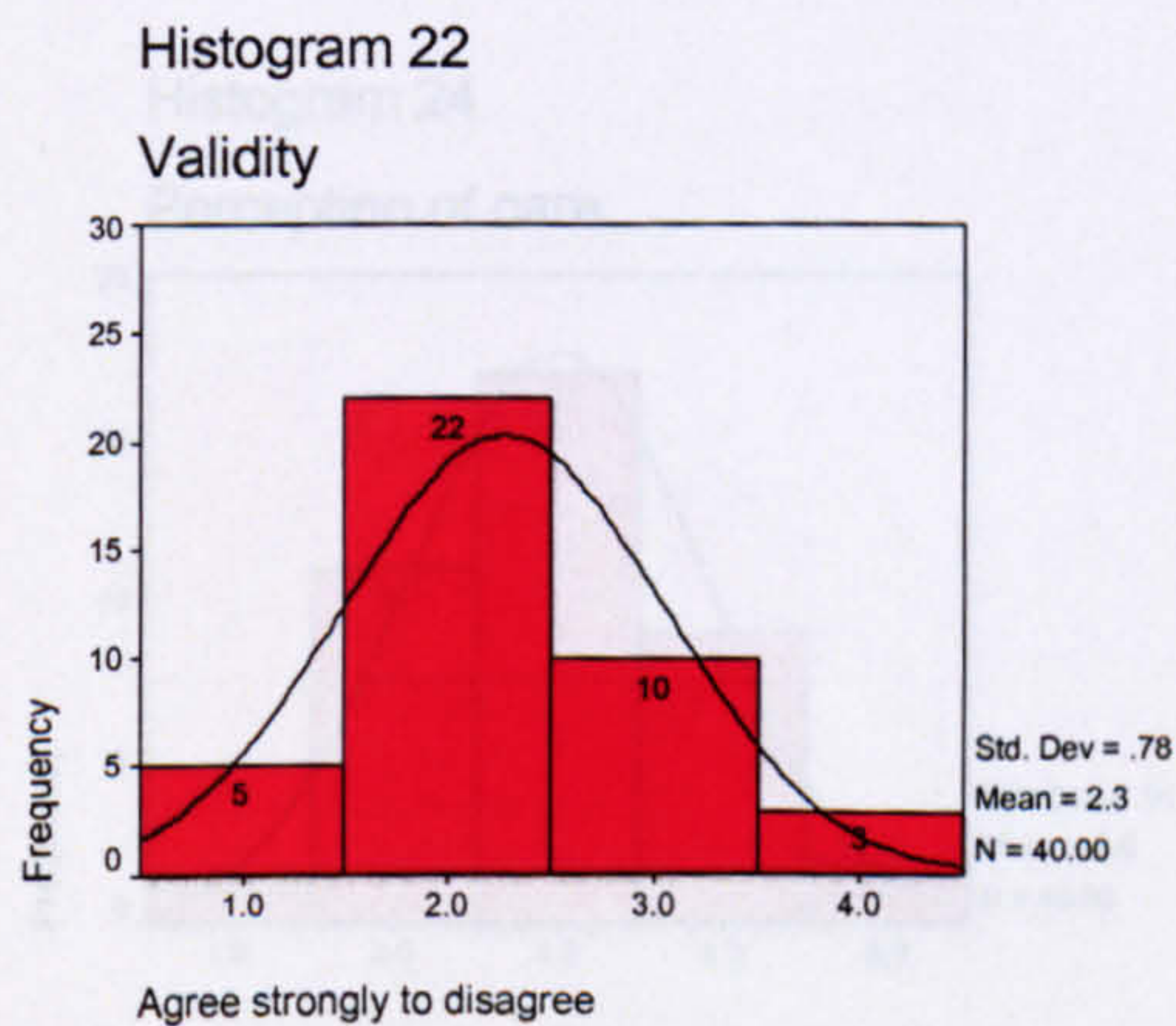
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Section 5 Validity of the assessment process

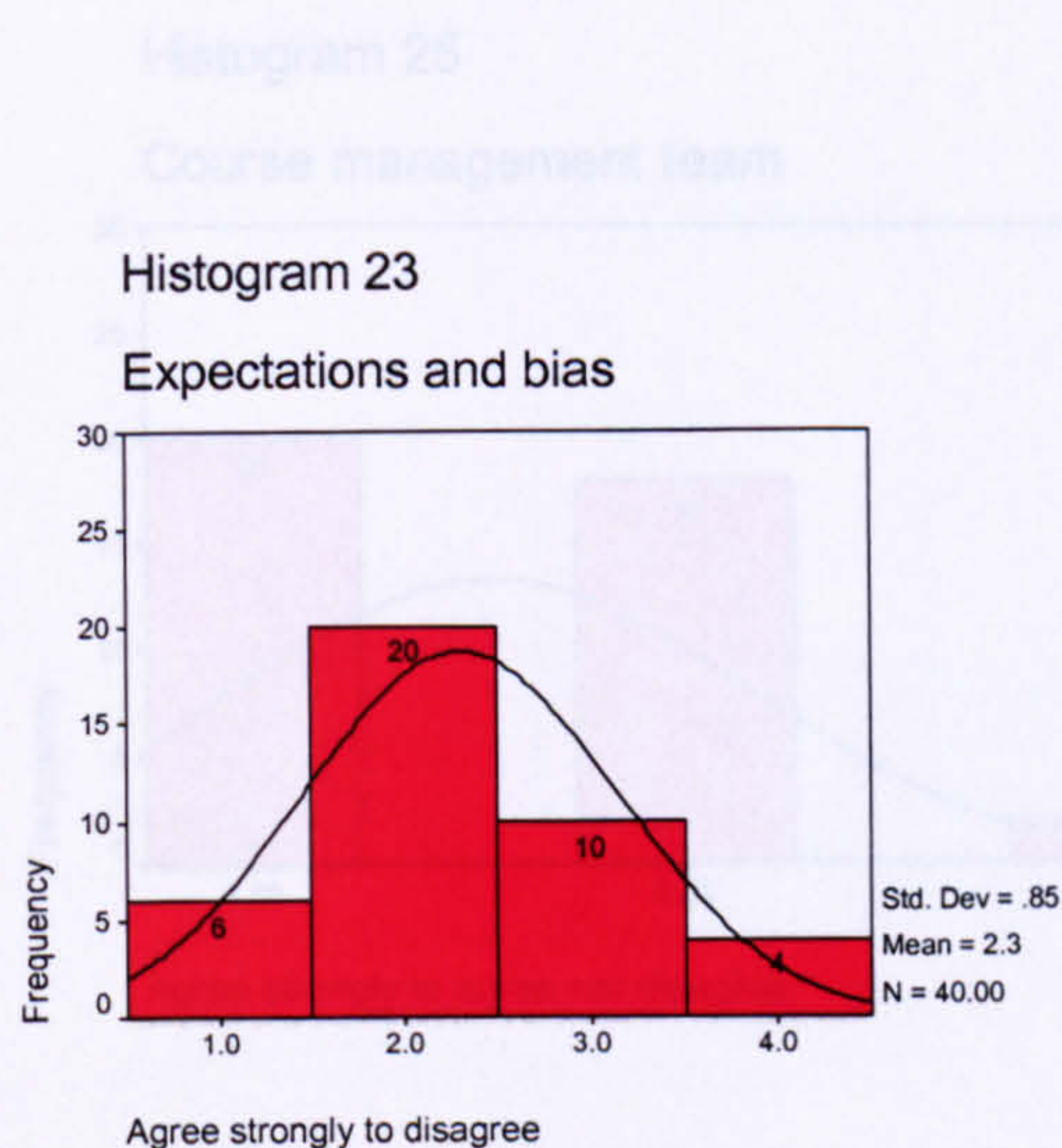
Question 22

Again there was strong support to suggest that by involving women in the assessment process its validity would be enhanced.



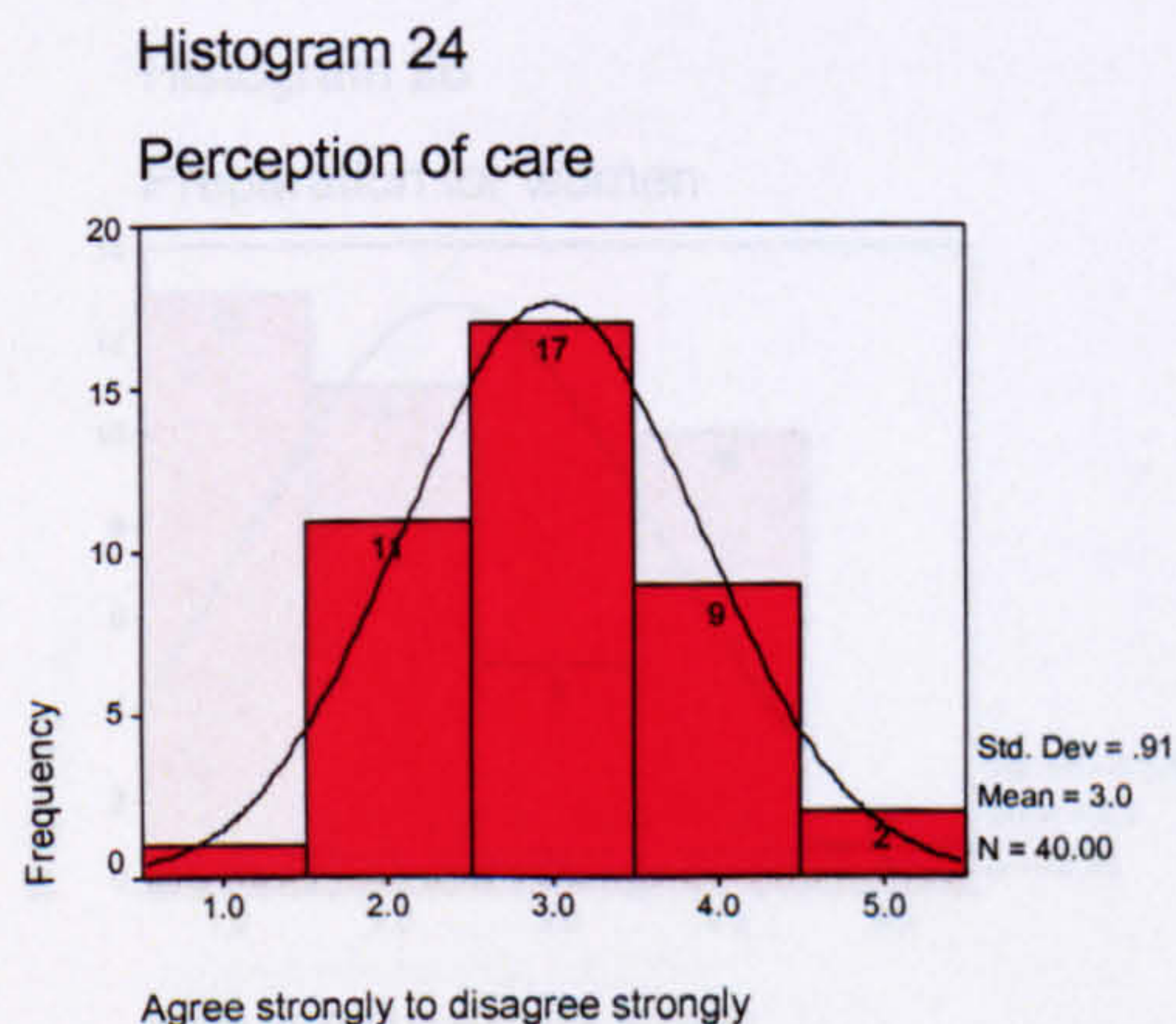
Question 23

Over half of the respondents agreed that women's expectations of maternity services could introduce bias whilst ten did not express a view and four disagreed.



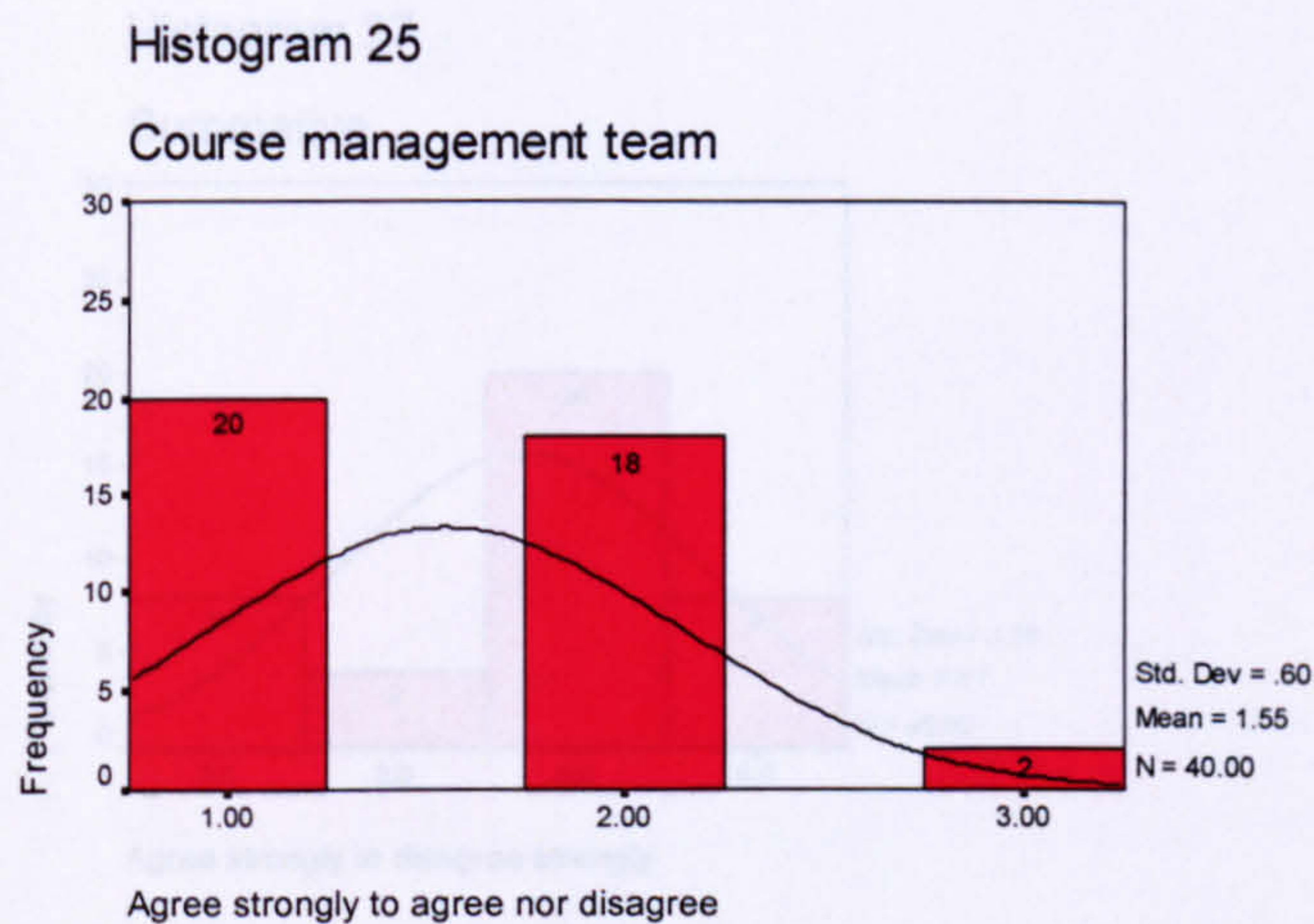
Question 24

Opinion was divided as to whether or not validity would be enhanced by enabling women to differentiate between services generally and the care provided by the student.



Question 25

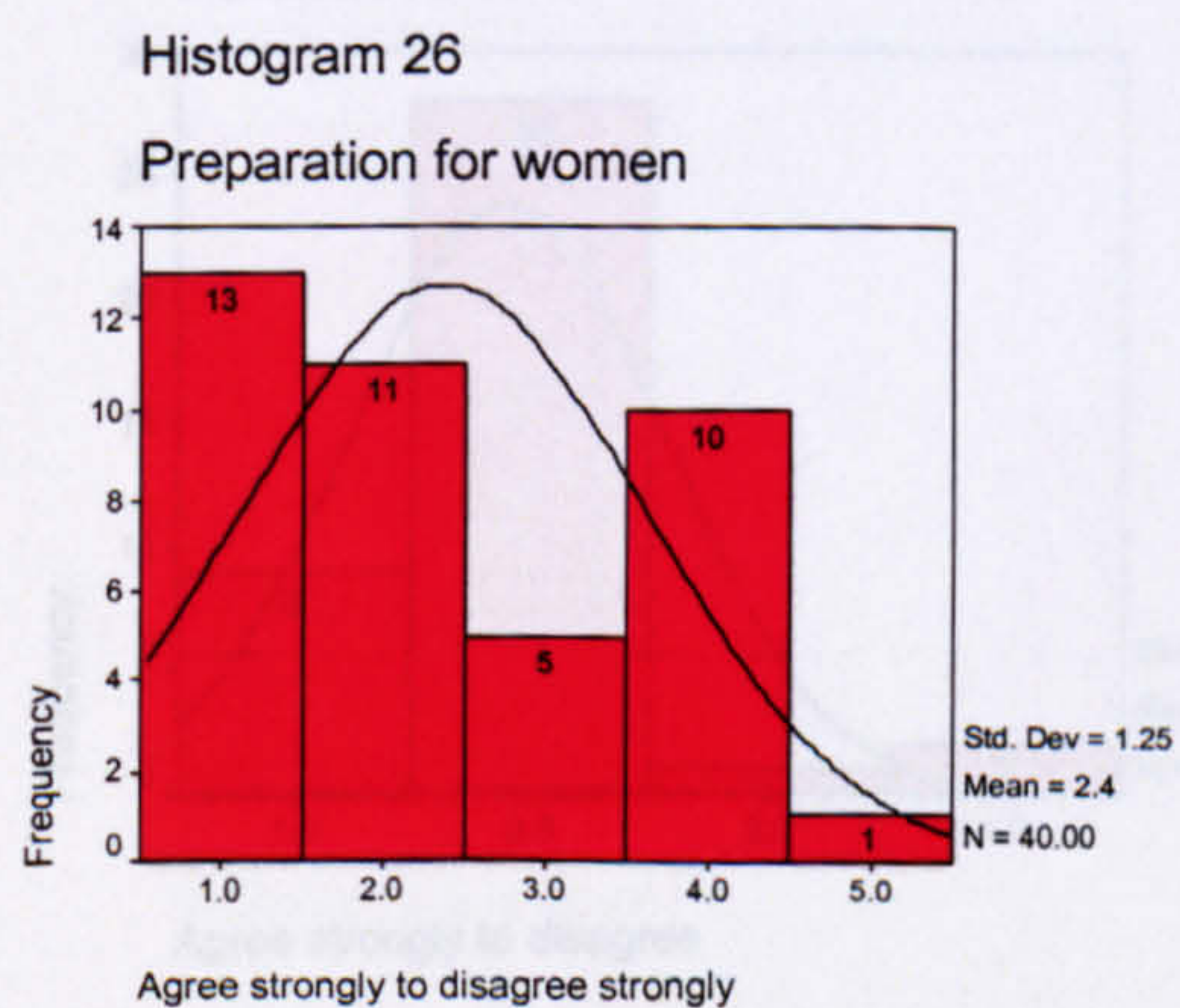
Practically all respondents agreed that the course management team had a part to play in ensuring equity for the students should the women be involved in providing feedback.



Section 6 Feasibility

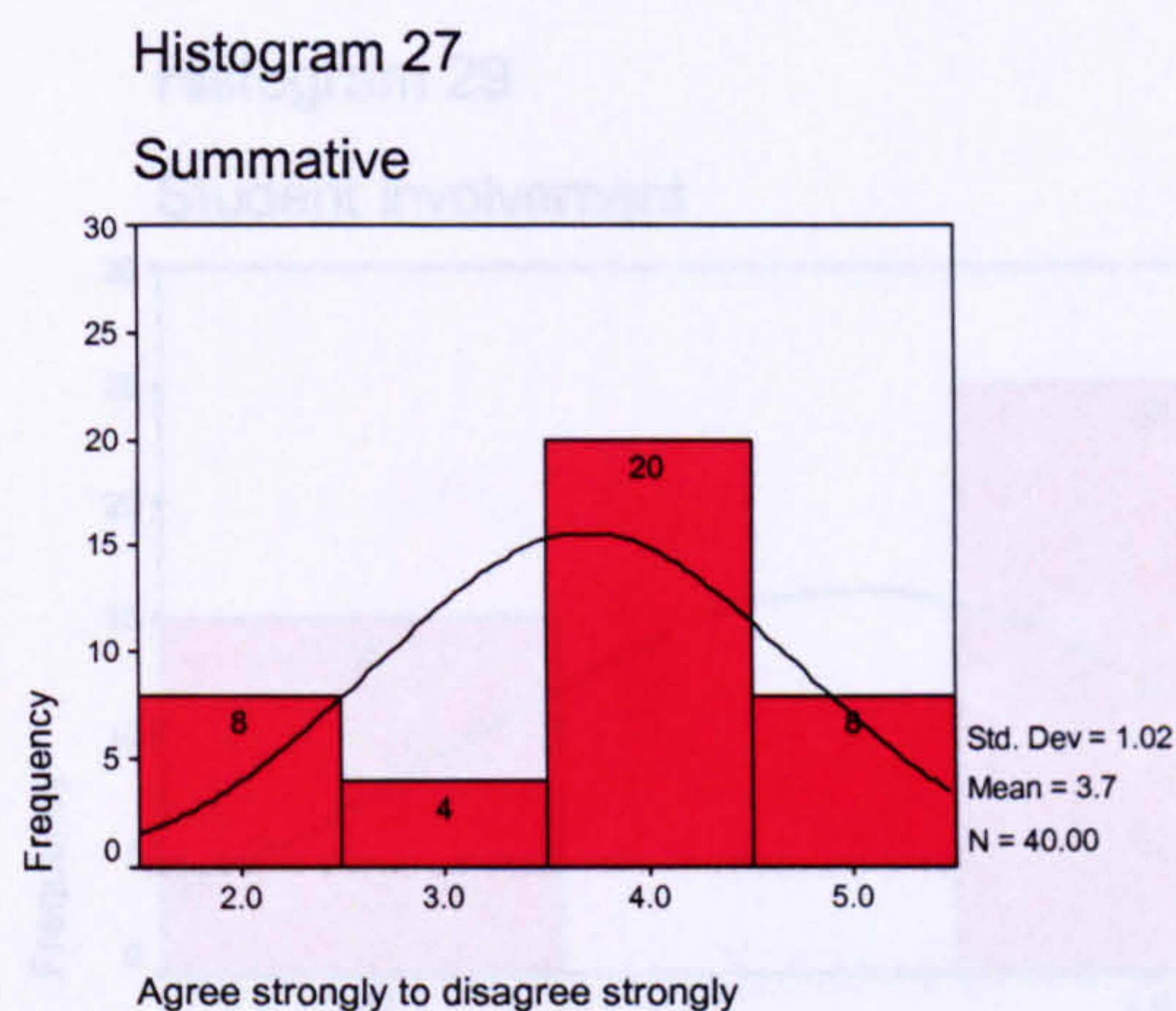
Question 26

Again views were almost equally divided as to whether or not women would require preparation for the role.



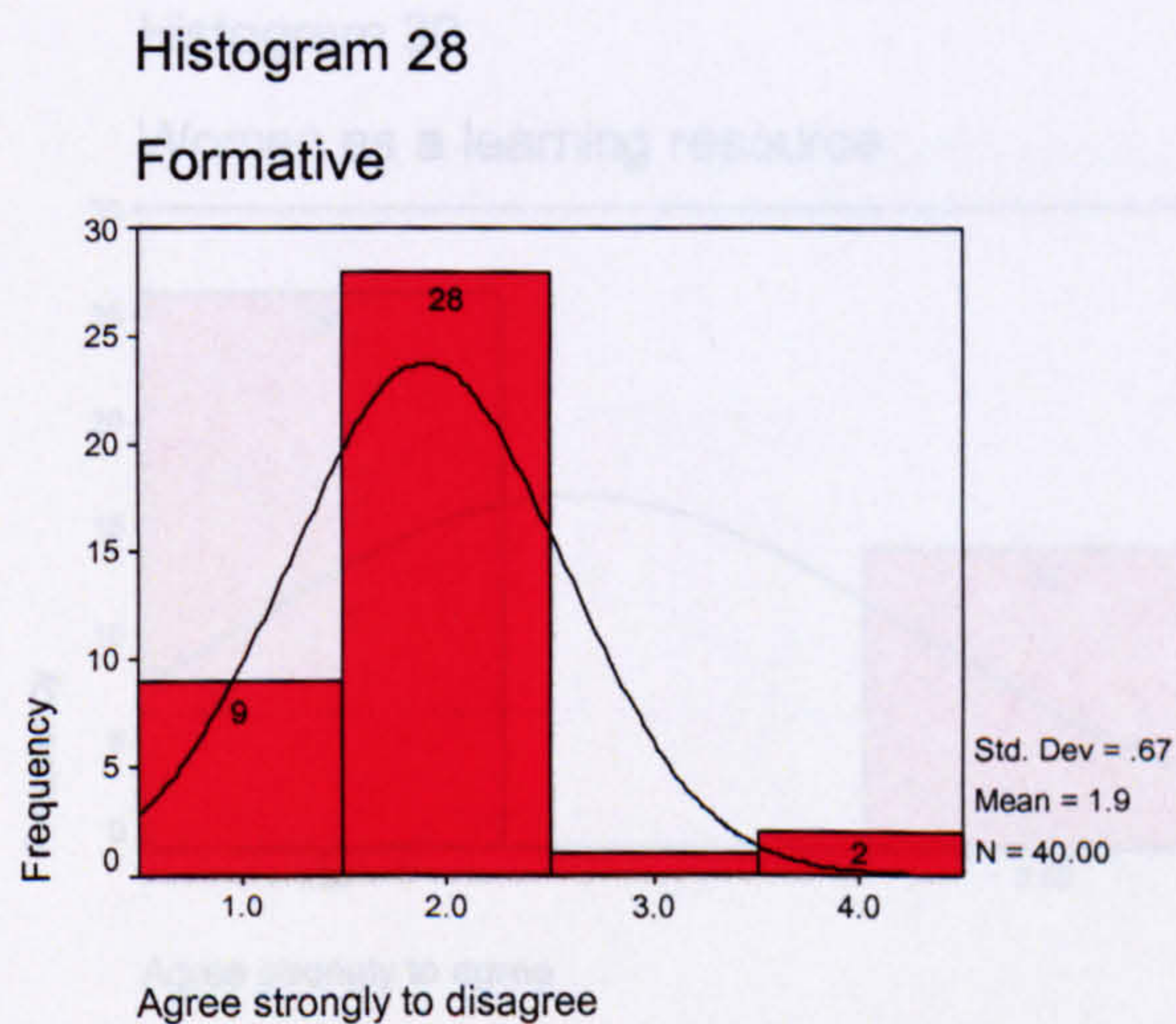
Question 27

The majority disagreed that women's feedback should form part of the summative judgement about the student.



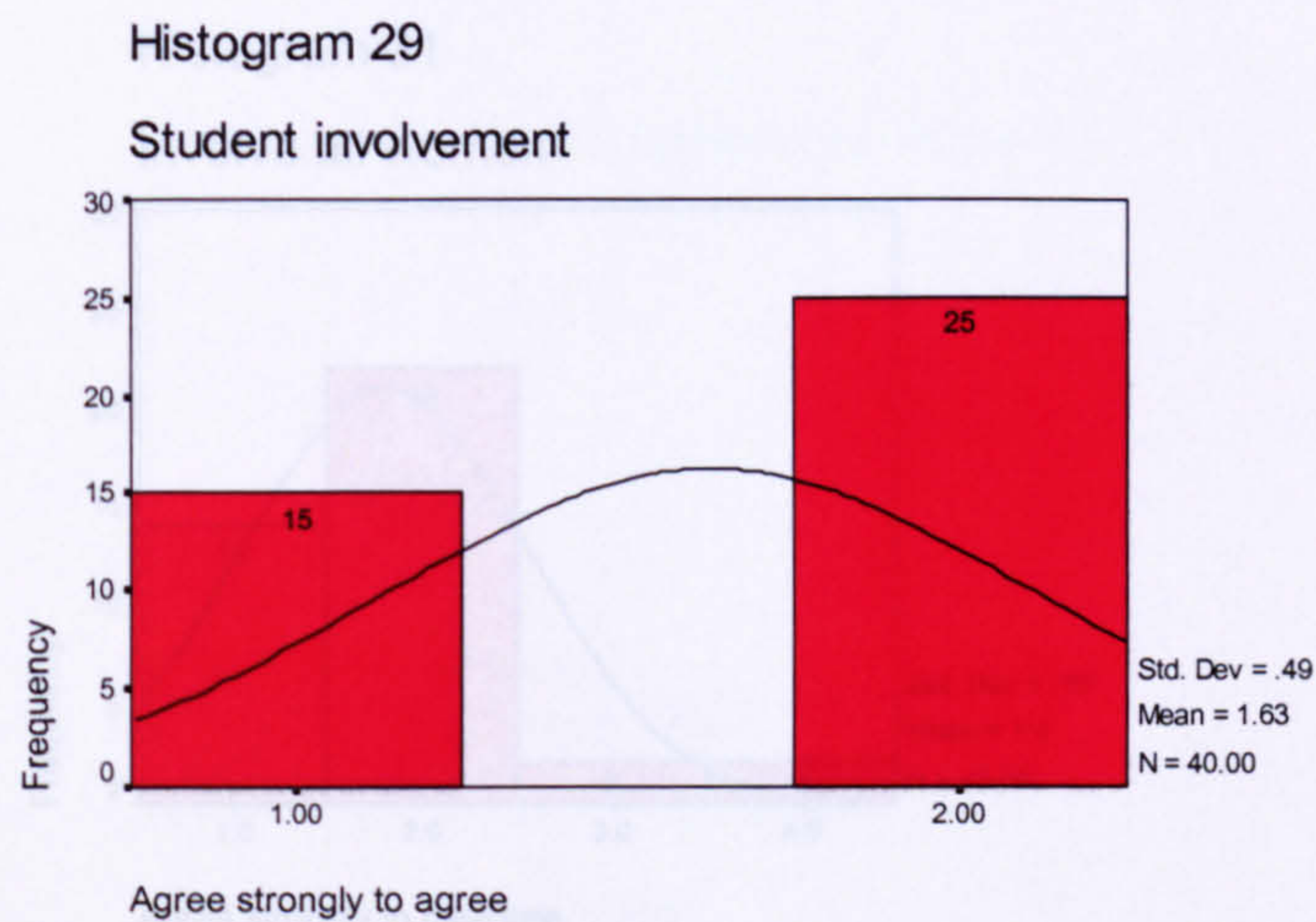
Question 28

There was strong support for the feedback from women to be assigned as formative. Only two disagreed.



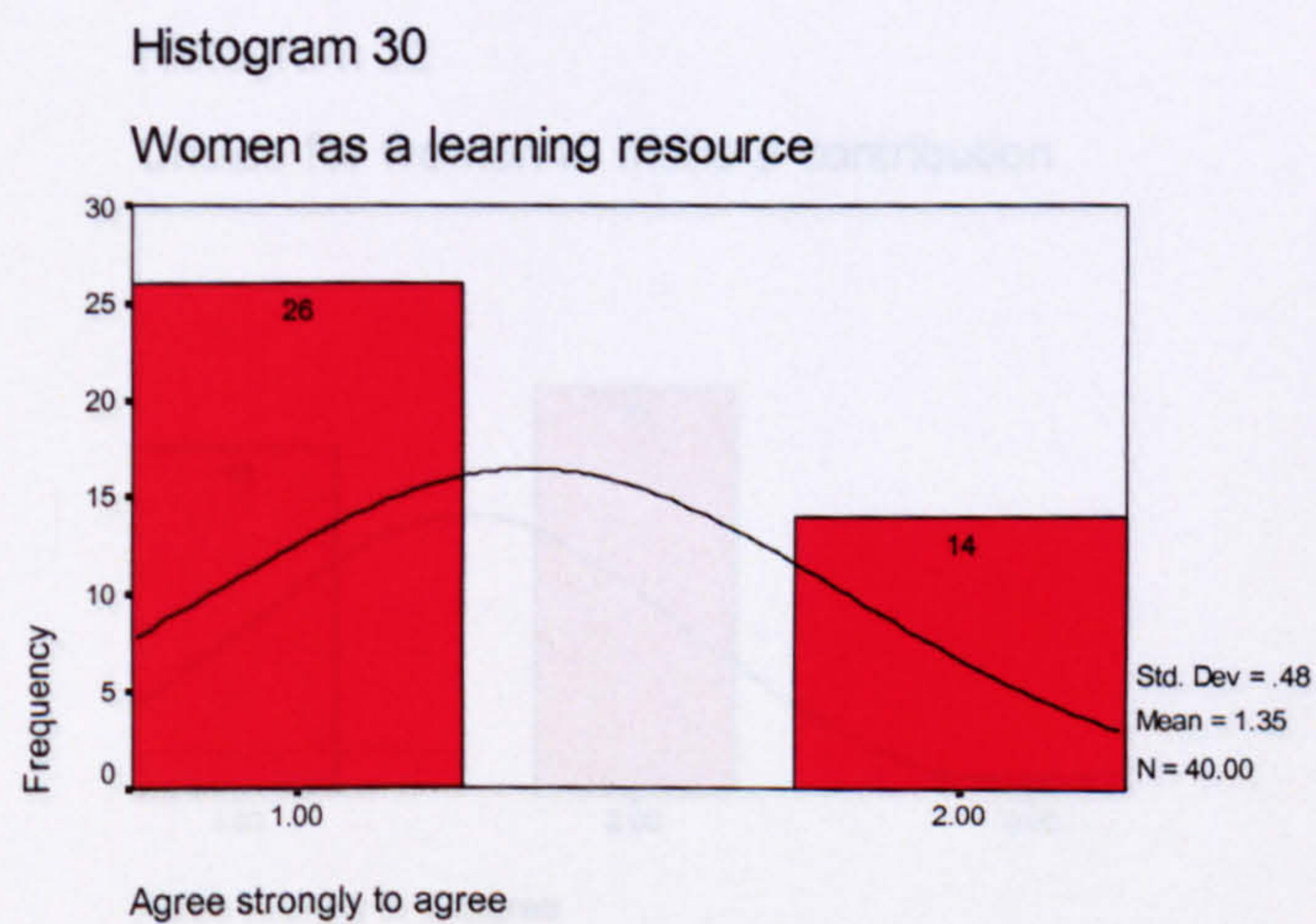
Question 29

The respondents agreed strongly that the student should have some involvement in determining the content of the feedback they received.



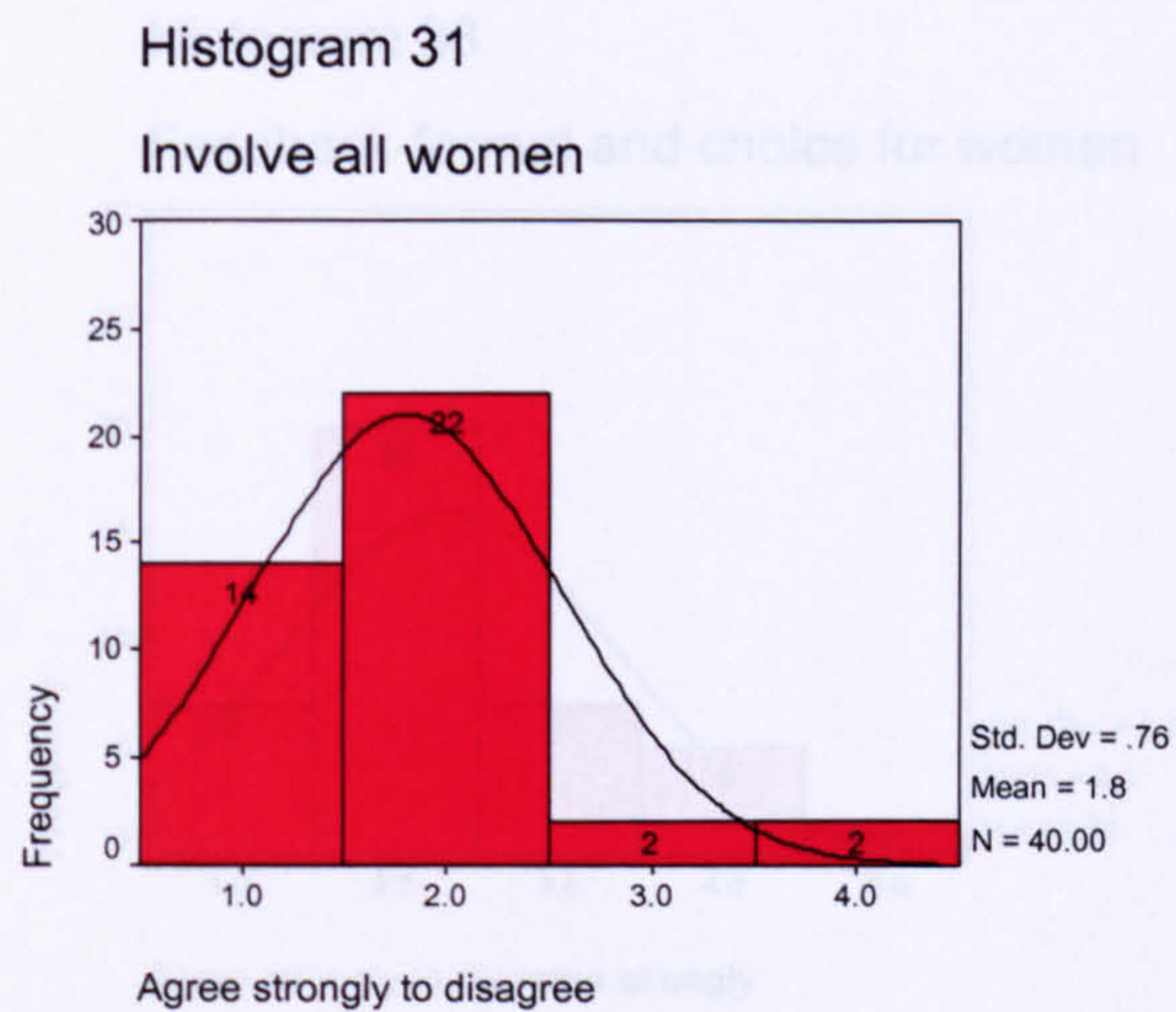
Question 30

Again there was very strong support for the statement that suggested that women could be a learning resource for students.



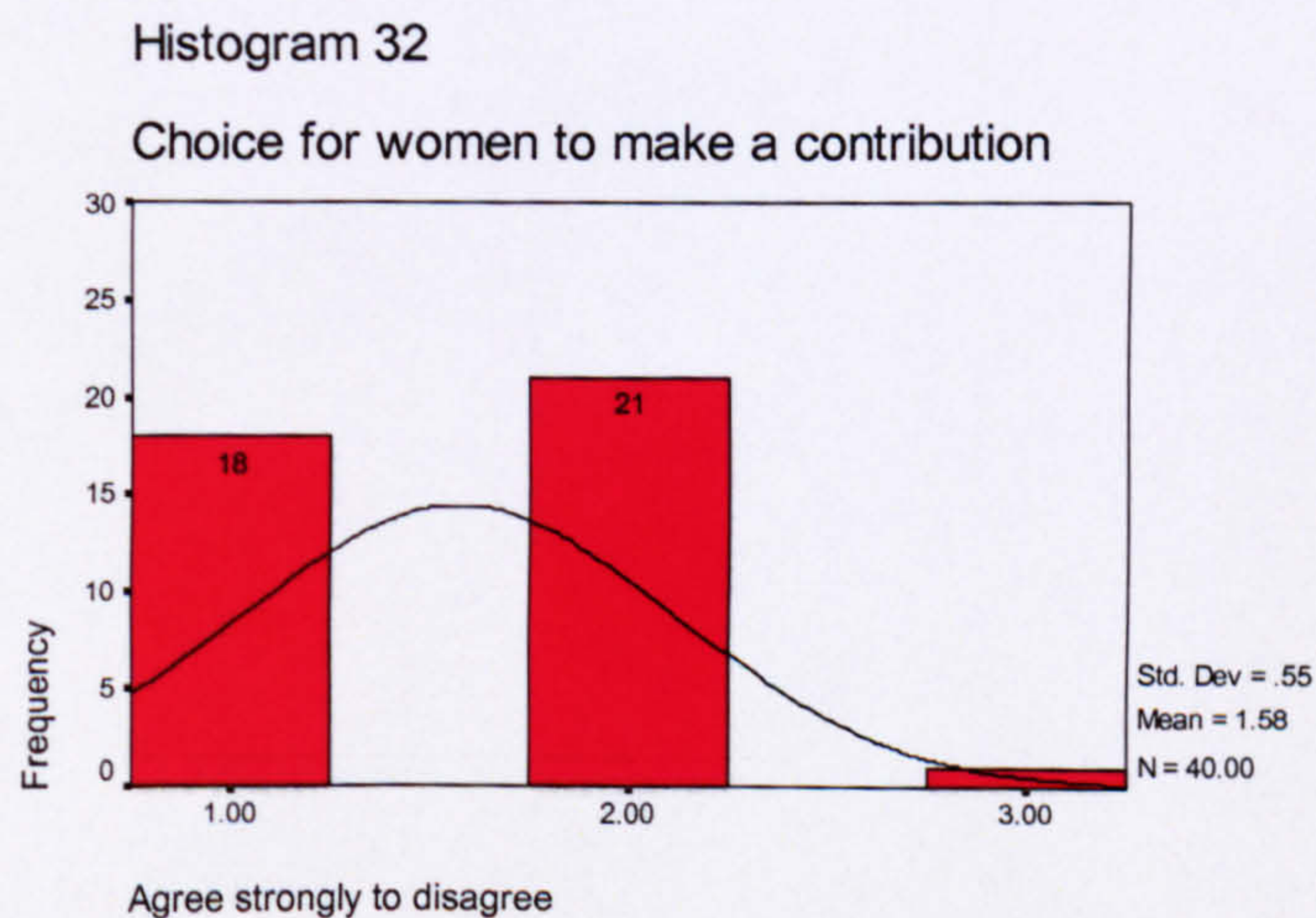
Question 31

All but two of the respondents felt that all women should have the opportunity to provide feedback to students.



Question 32

All respondents agreed that women should exercise choice as to whether or not they provided feedback.



Question 33

Not all respondents agreed that women should have choice regarding the format of the feedback with six disagreeing.

