A case study exploring the understanding and application of the concept of woman centred care in a pre-registration midwifery education programme

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Abstract:

Woman centred care is a concept frequently promoted as a core aspect of midwifery practice, policy and education. However, woman centred care often remains ill-defined and an elusive feature of clinical practice. The impact of woman centred care as part of pre-registration midwifery education is underreported and has largely only been investigated as a theoretical concept. Consequently, there is limited evidence of how pre-registration midwifery education not only understands woman centred care but how the concept is contextualised into clinical practice environments.

A case study methodology, according to Yin's deductive framework (Yin, 2014) was utilised to investigate student midwives, midwifery lecturers, Heads of Midwifery and the Lead Midwife for Education perceptions and experiences of woman centred care as part of a pre-registration midwifery programme. The single case study was based on a UK based university that typified pre-registration midwifery programmes. The case study methodology identified pre-ordained theoretical propositions and related variables that guided the entire research design. The case study also aligned to a critical realism ontology with a belief that there was an objective reality to be discovered.

The sampling strategy involved programme documents, semi structured telephone interviews and a focus group. Collectively these were analysed using Yin's (2014) pattern matching and explanation building data analysis strategy. This strategy identified the extent to which the findings aligned to the pre-ordained theoretical propositions alongside the identification of rival explanations unable to be explained through the data.

The case study found that the theoretical concepts of choice, control, mutual collaboration, continuity of care and individualised care were indicative of a pre-registration midwifery programme promoting woman centred care. However, there was differentiation in the understanding and experiences of these concepts that impacted on the ability for woman centred care to be contextualised in clinical practice. The differentiation was influenced by the powerful tendencies of professional identity, type of clinical context, ideologies, the profile of a woman and organisational aspects such as time constraints and policies. As a result, the student midwives were caught between often competing expectations between the university and the clinical practice context.

The study contends that woman centred care needs to be reconceptualised so able to integrate often currently competing ideologies and therefore, able to meet the changing future needs of woman centred care. New models for a critical realist framework and a programme planning tool for a contextual application have been developed as part of new understanding for woman centred care in pre-registration midwifery education.

Chapter 1: Introduction to the Research

1.1 Introduction

The introduction provides a brief insight into some of the core themes influencing woman centred care and pre-registration midwifery education that will continue to be explored and discussed throughout the study.

The research employs a case study methodology which focuses on the perceptions and understanding of woman centred care in pre-registration midwifery education. This investigation encompasses both a professional and education perspective, informed from extensive personal and professional experiences. The thesis is additionally supported by a literature review that suggests woman centred care has a long history of equipping midwifery with a philosophy frequently promoted as a distinguishing feature of the profession (Donnison, 1988; Benoit *et al.,* 2005). Despite these accounts, woman centred care remains an often-quoted illusive feature for midwifery and the maternity services. Whilst studies have explored woman centred care, its relationship to education is less well formed and an identified gap in the literature. Consequently, whilst policies espouse an ongoing model of woman centred care, albeit with a changing terminology, the role of education in making this happen is usually ill formed and under explored. However, pre-registration midwifery education is a location where professional change and validation of practice is created and enforced.

As part of this introduction, a brief history of the midwifery profession in the UK is presented that highlights the political and historical aspects that have impacted on midwifery today and its future trajectory. A summary of UK based midwifery pre-registration education is then depicted that shows its many influences and developments and how these are entwined with the changing scope of the midwifery profession. Collectively, the summary of the midwifery profession and midwifery pre-registration education provide the context of which woman centred care is situated that informed the literature review and the overall scope of the case study.

The study follows Yin's (2014) case study framework that advocates a deductive process, where the theory drives the overall research design. This framework was used as it adhered to ontological and epistemological values that are explored in greater detail in the methodology chapter. The case study's overall methodology also incorporates critical realism as an ontology, where there is commitment to a known objective truth, or independent reality, and where truth is uncovered through the exploration of social practices (Bhaskar, 1979; 1989; Sayer 2000). Consequently, the case study is investigated through qualitative data aimed at exposing social experiences and constructs. However, using Yin's (2014) framework, theoretical propositions were initially identified that directed the data collection and analysis process. In result, the study was able to assess the overall extent to which the findings of the case adhered to pre-ordained theoretical propositions, whilst identifying rival propositions that further developed new understanding of woman centred care in pre-registration midwifery education.

Informed by the literature review and case study methodology, the overall research question became ‘How is woman centred care understood and experienced by student midwives, Heads of Midwifery, the Lead Midwife for Education (LME) and midwifery lecturers in pre-registration midwifery education? The case was based on a large university with a well-established history of providing pre-registration midwifery education. It was anticipated that the research question would align with the identified methodology whilst offering a unique line of enquiry for woman centred care.

1.2 The history of the midwifery profession

The role and remit of the midwife is defined by the International Confederation of Midwives (ICM, 2011; 2017,) and reflected in the UK’s professional body, the Nursing and Midwifery Council’s (NMC) pre-registration midwifery standards (NMC, 2009; 2019). Unlike the NMC, the UK-based professional regulatory body, the ICM states its purpose as ensuring the global recognition of the midwifery profession where autonomous midwifery is promoted as the preferred model of care. The ICM defines the role of the midwife as midwives working in partnership with women and upholding principles of advocacy, respect, cultural awareness and health promotion. The ICM definition also situates the midwifery role as synonymous with autonomous practice. The claim for autonomous practice is largely based on midwives being able to independently conduct births and work across a range of clinical settings such as community, clinics and hospitals. Strengthening midwifery education on a global basis forms part of the ICM’s Strategic Directions (ICM, 2017).

The UK based NMC’s pre-registration midwifery standards set a programme’s necessary entry requirements, content, duration, proficiencies and assessment methods (NMC, 2009; 2019). In addition, the NMC set out the quality assurance process of pre-registration programmes (NMC, 2009; 2018). Successful attainment of the NMC’s required standards enables a midwife to enter the professional register. The NMC, following the Nursing and Midwifery Order (2001), is responsible for maintaining a professional register of qualified nurses and midwives and for setting the standards for entry to this register. The NMC further uphold the protected title of midwifery and its unique function to which midwifery has its own professional NMC register separate to nursing. As part of the NMC oversight, an accredited academic institute is required to appoint a Lead Midwife for Education (LME) as the lead expert for midwifery education (NMC, 2009; 2019).

Recently the NMC committed to a programme of change occurring between 2016-2020 based on reviewing its standards to ensure nurses and midwives were prepared with the necessary skills and competencies for both current and future practise (NMC, 2016). The programme of change has included a review of midwifery pre-registration standards with a scope of developing revised standards fitting for the future role of the midwife. A public consultation of these draft standard was launched in February 2019 (NMC, 2019) and this will result in new pre-registration midwifery standards being implemented.

The distinct role and recognition of the midwife has been shaped by UK legislation and history. Indeed, prior to the Midwives Act of 1902 many midwives were self-

employed and worked as unlicensed practitioners in local communities. In contrast, legislation in 1902 introduced training, regulation and legalisation and by 1905 uncertified midwives were unable to practise (Thompson and Lewis, 2013). In part, the Act of 1902 was one aspect of a larger agenda of the UK's drive to reform public health and improve health outcomes (McIntosh, 2012). However, this explanation cannot be extrapolated from the growing role of professions and their pursuit of identity and control. Donnison (1988), a key author who today is still viewed as one of the main contributors of the historical professionalisation of midwifery, reports part of this journey as a battle between midwives and medical practitioners for the control of childbirth. Donnison's (1988) accounts suggest that much of the history of midwifery and maternity services has been shaped predominately by issues of power between the professions. The concept of patriarchal power frequently frames midwifery's professional history and many other accounts report medical professions seeking to subordinate midwifery and, the role of childbirth, causing women in society to be increasingly male controlled (Mander and Reid, 2013). McIntosh (2012) also argues that the power struggle was not only about the control of the midwifery profession but also the control of women through the domination of medicine. Consequently, the professional power struggle created a narrative with women framed as either 'good' or 'bad'. Women were afforded the status of good when they complied with the medical dominance; whereas mothers were defined as bad when they did not comply with the medical dominance (McIntosh, 2012).

Whilst the Midwives Act of 1902 directly started to change the role of midwifery and narratives of birth, most midwifery care at the time, and following the Act, remained located in the community with birth at home. It was not until the 1960s and 1970s that midwifery and childbirth became significantly altered by the era of growing industrialisation (Benoit *et al*., 2005). During the period of industrialisation increasing technologies led to birth shifting from a home-based activity to one predominately based in hospital. A belief that increasing technology equated with safer births and outcomes. By the early 1970s there were more midwives working in hospitals than those based in the community (McIntosh, 2012). It is reported that by the end of the 1970s only one percent of all births in the UK were taking place at home (Fleming, 2002). It has been argued that although the shift from home to hospital was based on the rationale of improved safety, this was unfounded. Rather it enabled further subordination of midwifery and women to medical control whereby, pregnancy and childbirth became defined by clinical and pathological processes instead of physiology (Benoit *et al.,* 2005; McCourt and Dykes, 2009). In addition, during this period, health was exposed to increasing administration and management systems and Sargent (2013) suggests that midwifery was not immune to this as it became subjected to increasing organisational control evidenced by the drive to achieve targets, formal line management and set shift patterns. Cumulatively, the adoption of these organisational cultures and practices resulted in midwives being ever remote from women and their families. It could be debated this further accentuated an objective, technical model of birth, rather than the historical relational model shared between midwives and the woman.

However, a growing feminist discourse during the 1960s and 1970s was consecutively evolving with women seeking empowerment and control (Thompson and Lewis, 2013). This social movement encompassed the world of pregnancy and childbirth where women sought to celebrate their bodies and sexuality. The move for empowerment encompassed woman looking to reclaim their control over childbirth, which by now was predominately regulated and dominated by men and medicine (Donnison, 1988; Witz, 1992). The increasing exploration of childbirth in society was especially grasped by consumer maternity groups such as the National Childbirth Trust who started to campaign for childbirth and pregnancy to be framed as a normal physiological process and not one of illness and pathology (McIntosh, 2012). Consequently, a shift in midwifery language and policy started to emerge as concepts of choice, woman centred care and continuity of care became central tenants of childbirth and the midwifery profession. The Changing Childbirth Report (1993) is often quoted as seminal maternity UK policy that articulated a new vision for the midwifery profession, whilst shaping childbirth as a physiological process where midwives offered women choice and continuity. This policy not only enabled the voice of women to be heard, it was also seen to reaffirm the role of midwives as having a distinct function in delivering physiological birth and woman centred care (Benoit *et al*., 2005). The policy further cemented ideas relating to professional boundaries, with ‘abnormal’ or ‘pathological’ childbirth belonging with the medical profession, and ‘normal’ physiological childbirth belonging with the midwifery profession (Fleming, 2002). In this way, both medicine and midwifery retained their professional status as it enabled each of them a specific professional identity.

Professional identity is often quoted as one of the defining attributes of a profession denoting it having specialist knowledge, entry criteria, regulation and commonly held values (Abbott, 1988). Many subsequent authors have argued that the intentions of Changing Childbirth (1993) have never been fully realised (Mander and Reid, 2013). However, the same objectives of midwives enabling choice, control and continuity of care, as associated with woman centred care, are legacies of this report and are still commonly held concepts ascribed in current maternity services and the midwifery profession.

1.3 Midwifery today

The midwifery profession and maternity services in the UK continues to be inextricably shaped by the health and social care policy context of which it is part. In UK policy the role of the midwife focuses on providing care during pregnancy, childbirth and the postnatal period (RCM, 2016; NMC, 2019). A large extent of the discourse surrounding the midwifery profession constructs the midwife as able to be the lead carer for women with normal, or often termed physiological pregnancies and childbirth (RCM, 2016a). In turn, this has created professional autonomy, which is perceived to help promote a culture in which the woman is at the heart of maternity services (Smith, 2014).

Professional regulation of the midwifery profession is provided by the Nursing and Midwifery Council (NMC) who also set the standards for pre-registration midwifery education (NMC, 2009; 2019). This regulatory framework, and the educational

standards, portray the midwife working in partnership with the woman and their families and providing holistic and individualised care (NMC, 2009; 2019). A recent UK policy report Better Births, seen as the Five Year Forward View for maternity services (NHS England, 2016), affords a future focused vision for the midwifery profession with personalised care, choice, continuity of care and safety being central themes for developing maternity services. On a global scale, a series of articles published in the Lancet reported a model for what constitutes high quality maternity and neonatal care with evidence to support the specific contribution midwifery has in improving health outcomes (Renfrew *et al.,*2014). This series accentuated high quality, safe midwifery care as synonymous with woman centred care and the series of articles provide a framework for high quality maternity and new-born care (Renfrew *et al.*, 2014; Shaw *et al.*, 2016).

However, whilst midwifery is synonymous with woman centred care, current and future, predicted changes to the midwifery profession and maternity services are causing many to question and reframe the future role of the midwife (Kruk *et al*., 2016). Among these influencing factors are the rising birth rate, the increase in age of women having children and increasing complexity of birth and medical conditions (RCM, 2018). For example, the National Office for Statistics (2016) reported a falling birth-rate among under thirty-year-old women and a rising birth rate in older age groups. The last MBBRACE UK (Mothers and Babies :Reducing Risk through Audits and Confidential enquiries across the UK) Perinatal Confidential Inquiry also highlighted pregnant women as no longer young and healthy. The report states women as more likely to be in their forties and three times more likely to die in pregnancy and childbirth than a woman in their twenties (Draper *et al*., 2018).

Alongside these changes, midwifery is facing professional challenges with an ageing workforce, increase in part time working hours, a predicted short supply of midwives and an ever-expanding professional remit such as inclusion of public health initiatives (RCM, 2017). Challenges facing midwifery have continued to be described and in 2017 the Royal College of Midwives (RCM) reported a shortage of midwives. Additionally, half of the midwives who replied to the RCM midwifery survey felt stressed due to workload demands and an inability to provide care as they would desire (RCM, 2017). Since the 2017 report the RCM have found some positive changes with an overall net increase in the number of students in training (RCM, 2018). However, the plight of midwives feeling unable to provide care as they would desire due to demanding workloads remains prevalent and continues to substantiate initial findings of the 2017 report. (RCM, 2018).

Authors such as Renfrew *et al*. (2014) have continued to evidence the unique contribution midwifery brings to ensuring good health outcomes of women and their new-borns. Although, despite this evidence the midwifery profession has not been without challenge. Indeed, recent reports have highlighted ineffective and unsafe maternity care. For example, Kirkup (2015) conducted a ministerial led maternity services investigation into serious incidents resulting in unnecessary deaths of women and babies at Morecombe Bay NHS Foundation Trust. The investigation found several failings inclusive of a dysfunctional culture where midwives were extreme in their need to maintain normal childbirth rather than referring to medical

practitioners at times of complications (Kirkup, 2015). The report led to a national investigation into the statutory function of midwifery supervision (Baird *et al.,* 2015). Midwifery supervision was a function where midwifery, unlike nursing, utilised supervision as an additional statutory function tied into regulation (DH, 2017). The national investigation found that the statutory function of supervision was ineffective in assuring public protection and it subsequently led to the prompt separation of supervision and regulation with the statutory function being removed and becoming the sole responsibility of the professional body the NMC (DH, 2017). The change to midwifery supervision has now been adopted yet it illustrates the increasing complexity of the midwifery profession trying to retain its professional, and historical roots, whilst able to effectively respond to a rapidly changing context .

As part of the policy for Better Births NHS England established a Maternity Transformation Board for the UK oversight of achieving the markers of success from the Better Births review .This has led to early adopter sites who have identified projects and initiatives aimed at improving outcomes of maternity services as depicted in the vision of Better Births (NHS England, 2016). For example, these projects have promoted the introduction of personalisation pioneers as a way of offering choice for women in maternity services. During recent years there has been an increasing focus on continuity of care as a core method of fulfilling the objectives set out in Better Births (NHS, England, 2016). This increasing focus has led to agreed definitions of continuity of care models and standardisation of measurements (RCM, 2018a). Throughout the ongoing policy drive the emphasis of woman centred care has not dissipated.

1.4 Midwifery education

Whilst there are accounts of formal midwifery education being available from 1705 prior to the Midwives Act of 1902 (Ridgway, 2002), many authors suggest that it was not until after the 1902 Act that education became an established part of the profession (McIntosh, 2012). As noted, access to expert knowledge is one of the often-quoted essential features of a profession (Abbott, 1988; Susskind and Susskind, 2015). Therefore, the Midwifery Act of 1902 provided a basis for the formal recognition of midwifery knowledge and expertise affirming education as necessary for professional status. In part, the attainment of professional status was driven by midwifery struggling for a professional space with medicine and a differentiation to the nursing profession (Fleming, 2002). Indeed, initially midwifery education programmes were primarily developed as a follow on from three-year nursing programmes. It was only after the move to degree status, and changes to education commissioning models, that most midwives became educated through a direct entry route at universities (Barton, 1998). The direct education route to midwifery registration is now firmly established, although over the years the perceived threat of midwifery being subsumed into nurse education remains evident (Fleming, 2002; Williams, 2019). Consequently, midwifery education and the profession has been directly influenced, and shaped, by its desire for professional status against perceived medical and nursing domination.

Whilst, midwifery education is a vehicle for affirming professional status the interpretation of midwifery pre-registration programmes remains varied. For example, the interpretation of the current UK NMC (2009) pre-registration midwifery standards are frequently reported as being inconsistently interpreted and implemented (Bharjk, 2016). Therefore, it may be assumed that the understanding, and application, of the concept of woman centred care is also varied across pre-registration midwifery programmes. The relatively recent global framework for high quality midwifery care from the Lancet series of papers focusing on midwifery and maternity services was based on five key areas as part of a framework necessary to support high quality maternity and neonatal care. The five key areas were; practice categories, organisation of care, values, philosophy and for providers of services to support the framework as having the potential to benefit workforce development and resource usage (Renfrew *et al.*, 2014). The woman and her family are at the heart of this framework that further supports the value of woman centred care being embedded in pre-registration midwifery education. Although the application of the framework to midwifery education is not fully addressed in the article, it could be suggested that woman centred care frameworks such as this offer possible consistent models for midwifery pre-registration education yet to be fully realised.

The NMC, in recognition of the changing demands facing maternity services and the current context of pregnancy and childbirth, has also launched a consultation of the pre-registration midwifery standards that is aimed to future proof the midwifery profession and meet the changing needs of women and their families (NMC, 2019). A new NMC educational quality assurance framework for nursing and midwifery has also been developed based on five core pillars pointing toward education able to promote person centred care (NMC, 2018). The new framework further confirms how changing global and social drivers have necessitated professional regulators to respond with subsequent effects on midwifery pre-registration education. Likewise, it demonstrates how education has a pivotal role in supporting policy and workforce initiatives. In all the recent changes for the new proposed NMC standards and educational frameworks the call for personalised, or woman centred care has not diminished. In fact, it could be postulated woman centred care is increasingly accentuated as a hallmark of a ‘good ‘ outcome of midwifery care (Shaw *et al.,* 2016).

The new draft NMC midwifery standards for pre-registration education are primarily focused on ensuring education is meeting the ever-changing needs of women and maternity services. Therefore, the proposed new standards are referred to as meeting the needs of the future midwife (NMC, 2019). However, pre-registration midwifery education is also part of the context of higher education meaning evermore political and social influences. Walker (2013) claims that higher education theories and propositions are often concerned with power and relationships are centred on the theory of knowledge. Eraut (2009) asserts that the overt focus of knowledge is due to higher education largely only focusing on the acquisition of subject knowledge expertise rather that the acquisition of knowledge in the workplace. It may be contested that midwifery education continues to be exposed to these often-competing objectives of knowledge, professions and the workplace. As

part of higher education, and in affirmation of professional status, midwifery strives for theoretical knowledge expertise. Whilst as a work-based profession it also seeks practical knowledge. Although, the current NMC pre-registration standards seek to combine these two aspects, it is questionable how far this has been achieved to date and may explain some of the remaining inconsistences in the application of the pre-registration midwifery standards across higher education organisations.

A UK based study, known as the Midwives in Teaching (MINT) project, commissioned by the NMC (Fraser *et al.,* 2013) illustrates the context of pre-registration midwifery education being exposed, and shaped, by both the demands of higher education and practice. The study was a large evaluation exploring pre-registration midwifery education with the aim of evaluating the impact midwifery teachers had on the outcomes of women and their families. The evaluation employed both quantitative and qualitative data through three main phases consisting of a UK survey of Lead Midwives of Education (LMEs) and midwifery lecturers. Phase two utilised six selected case studies from the four nations in the UK and phase three employed an exploration of newly qualified midwives' competence with data collection methods of semi-structured interviews and the use of diaries. The overall finings found that midwifery lecturers appeared to make a specific, and valuable, contribution to midwifery education primarily through their ability to enhance application of educational content to clinical practice.

In the MINT study the credibility of midwifery lecturers was largely attributed to situations where the student midwives witnessed them undertaking the clinical applied lecturers such as clinical skills. In result, the midwifery lecturers who undertook skill sessions were viewed as more credible to their counterparts. Ebert *et al.* (2016) also found that students frequently privilege clinical skills teaching over theoretical aspects of curriculum delivery. The student midwives also reported they would have benefited from more skills sessions and an overall increased emphasis on items they were experiencing in clinical practice such as, medicine management and caring for women with complex conditions. These results illustrate the dilemma of accommodating both theoretical and vocational work place education in midwifery education. Overall, the midwifery students were more readily able to identify with aspects of their midwifery education related to their clinical practice experiences. Indeed, clinical skills were ascribed higher value to other theoretical components such as research and psychology (McIntosh, 2013). However, a further finding was the strong influence the clinical practice experience had on the student midwives' education. The study found that student midwives quickly learnt there was an expected way for doing things in clinical practice. The expected way was not necessarily reflective of their taught programme but governed by the power dynamics in clinical practice. To be accepted in clinical practice student midwives needed to adhere to the established norm of the right way of doing things (McIntosh, 2013).

The findings from the MINT study illustrate pre-registration midwifery education has, and continues to be, caught between multiple demands and drivers. These include the professional body; the clinical context, the higher education institute, the student population and the woman and her family. It is questionable how far these demands

align and McIntosh (2013) proposes that midwifery education is not part of a theory practice gap but of two competing cultures. One culture sees higher education with knowledge as autonomous and centred around the student. Another culture focused on clinical practice with knowledge as an external validation through the acquisition of skills and competencies. A culture of external verification of knowledge also explains the ongoing emphasis on the constitution of competency as part of pre-registration midwifery education (Reeves *et al.*, 2009). The MINT study appears to promote students attaining competency through the acquisition of skills and knowledge. In contrast, other authors have suggested that competency and skill acquisition is a narrow concept and instead competency should extend to include relational, social activities necessary for effective maternity care (Butler *et al*., 2008). The proposed global framework for high quality maternal and neonatal care found in the Lancet series also appears to support competency as one of knowledge, skills and interpersonal qualities rather than only skill acquisition (Renfrew *et al.,* 2014).

It is apparent that midwifery education has been subjected to historical, political, professional and socio influences and Bharj *et al.* (2016) confirm that there is wide variation in the content and application in pre-registration midwifery programmes. Indeed, it may seem daunting to have less variation when midwifery education is trying to assert so many often-competing drivers such as professional autonomy, higher education, and clinical care. There are many accounts of this struggle but there are also gaps in evidence to substantiate the role pre-registration education has for the women midwives care for. If a woman centred care philosophy is really to be core to education further synthesis and researching of this complex picture is necessary to help inform the evidence base on which to build and situate pre-registration midwifery programmes.

1.5 Policy context

The RCM publish annual reports on the state of maternity services with national data on the UK trends for maternity services and midwives. The state of maternity services report in 2018 affirmed significant changes facing maternity services with the most salient points being an increasing complexity, an ageing profile of women having babies and an estimated gap in the number of midwives able to meet maternity services demands (RCM,2018). The previous RCM report published in 2017 reported over one third of midwives were aged over fifty with an increase in part time working patterns; this was consistent across all the nations in the UK (RCM, 2017). A subsequent report published in 2017 by the RCM entitled a ‘Gathering Storm’ further accentuated the growing pressures facing maternity services and the impact this was having, such as Heads of Midwifery experiencing financial cuts and units being closed (RCM, 2017a). The 2018 RCM report indicated an increase in the number of midwives in England had started to emerge, largely attributed to increased numbers in training (RCM, 2018). However, the report had a cautionary note that despite this increase, the number of midwives required was likely to continue to rise due to the level of care complexity demanding higher numbers of staff. The assumption of increasing complexity in maternity services has been previously reported and connected with midwives adopting new models of care

and roles to respond to levels of complexity and expanding public health interventions (RCM, 2016).

As already documented, over recent years maternity policy and clinical services has been heavily influenced by Better Births, a Five Year Forward View for Maternity Services (NHS, England, 2016). The policy has influenced the continued focus on personalised care including themes of choice, individualisation, access to information and working in partnership with the woman and her family. Better Births has been pivotal in reenergising discussions of continuity of care where it is understood as a core enabler for the successful implementation of Better Births. Because of this work early adopter sites for continuity of care models have been established across the UK, part of which includes an evaluation of the model to inform future practice (NHS England, 2017).

The Better Births policy also represents part of the macro UK health and social care policy context. Recent years has seen the acknowledged increasing demands facing health and social care services in the UK. The increasing demand is attributed to people living longer, population growth of an ageing society, globalisation , expanding use of technology, rising consumer expectations, a care shift to the community and increasing complexity of health conditions (Willis 2015; Council of Deans 2017). The Five Year Forward View (NHS England, 2014) and its implementation plan (NHS England, 2016b), provide a framework to the stated challenges and calls for an increasing emphasis on population health, prevention and engagement with local communities. Ham and Murray (2015) report that for the Five Year Forward vision to be fully implemented attention must be given to current regulatory frameworks causing the fragmentation of services and impeding innovation. They conclude that instead attention should be provided on the ability of leaders to lead and transform their services to meet the needs of their local population. During 2016 Sustainably and Transformation Plans (STPs) were established with the aim of implementing the recommendations of the Five Year Forward View. However, these have not been without challenge, with reported conflicts between the authority and accountability of individual organisations versus the collective responsibility of the STP footprint resulting in varying levels of engagement from the necessary stakeholders (Alderwick *et al.,* 2016).

Whilst, significant change is occurring within health and social care the world of higher education has also been exposed to similar levels of turbulence. The Higher Education White Paper (BIS, 2016) set out many new directions for higher education with an emphasis on promoting market forces; enabling new providers to have degree awarding powers and enhanced quality of provision monitored through metrics such as the National Student Survey and the Teaching Excellence Framework. Changes to health programmes in higher education have been further compounded by the Governments Spending Review announcements made during 2015 resulting in pre-registration health education programmes moving away from a commissioned bursary model to a student loan system (HM Treasury, 2015). The rationale for this change was to open market forces and enable increased numbers of students to be educated to meet workforce supply demands (Council of Deans, 2016). Since the introduction of the funding change the number of applicants

entering health care programmes has nationally decreased with a younger age profile of students (Council of Deans, 2017). Collectively these policy contexts will have possible longer-term implications for woman centred care and pre-registration midwifery education.

1.6 Summary

The rest of this thesis will provide a detailed account of the study, inclusive of a more detailed analysis of maternity policy and associated literature. The research utilises a case study methodology, according to Yin's framework (2014), and is located within an NMC UK approved provider of midwifery education.

The overall research is :

> *How is woman centred care understood and experienced by student midwives, Heads of Midwifery, the Lead Midwife for Education and midwifery lecturers in a pre-registration midwifery programme*?

The overall question became underpinned by further questions and theoretical propositions which directed the research design. This direction ensured coherency and consistency of the study and its adherence to the method as advocated by Yin (2014).

Chapter 2: Literature Review

A literature review of identified policy and empirical studies in relation to woman centred care and pre-registration midwifery education is presented. The literature review enabled core themes to be identified that informed the overall design and structure of the study. The literature review process led to the development of a conceptual framework. The conceptual framework helped guide the entire study as it ensured coherency throughout the research process. At the end of the research process a repetition of the literature review was undertaken aiming to capture any newly published material. A critical framework was employed for the analysis of the identified literature and policy.

Chapter 3: Methodology

The chapter presents the underlying epistemology and ontology of the study, its alignment to critical realism and the selection of Yin's (2014) case study as a methodology. It provides an account of why, and how, the study was undertaken and how the findings were arrived at. The chapter also contains an account of pre-ordained theoretical propositions as part of the case study process as recommended by Yin (2014). As part of the methodology chapter ethical issues are discussed, inclusive of the role of my positionality in the study. The final section documents the data analysis process according to Yin's (2014) analytic strategy.

Chapter 4: Findings

The chapter presents the findings from the data analysis process documented in chapter three. Sub headings are used reflecting the identified variables according to the pre-ordained theoretical propositions. The findings are supported through the illustration of quotes from the data collection methods. Identification of new rival

understanding, as recommended by Yin (2014), is encompassed as part of the findings. Quotes from the data sources are used to substantiate and illustrate the reported findings.

Chapter 5: Discussion

The findings from the study are critically examined and discussed in relation to the pre-ordained theoretical propositions. The adherence to the pre-ordained theoretical propositions ensured Yin's (2014) deductive case study methodology was evident as a framework throughout the thesis. As part of the chapter rival propositions are debated that further builds new knowledge and understanding of woman centred care and pre-registration midwifery education. The chapter also discusses the findings in relation to critical realism and education theories .

Chapter 6: Reflections and recommendations

The chapter initially reflects on core aspects of the findings .As a professionally aligned thesis applied recommendations for midwifery policy and education are extrapolated from the case study and its findings. Opportunities for future work, alongside tangible suggestions for the future of woman centred care as a concept in pre-registration midwifery education are offered. A model of pre-registration midwifery education is developed based on a critical realist lens and for future curriculum development .

Chapter 7: Overall reflection and conclusion

The chapter offers overall reflections on the research process inclusive of identified. limitations. In the final section there is a summary of the thesis responding to the overall research question.

Chapter 2 : Literature Review and Conceptual Framework

2.1 Introduction

The intention of the case study is to investigate woman centred care in pre-registration midwifery education. Therefore, a first essential step in the literature review process was exploring the concept of woman centred care from a range of sources. Ringstead *et al.*(2011) recommend that part of a qualitative research method entails identifying the analytic tasks necessary to inform the study including a literature review to help identify both what is known and any gaps on the selected topic. Following this guidance, a literature review of previous research and policy exploring, or influencing, woman centred care was undertaken. This search was extended to include literature specifically examining woman centred care and pre-registration midwifery education. The literature review process facilitated depth of knowledge and critical analysis that refined the area of enquiry and led to the development of the research design. The literature review process culminated in the formation of a conceptual framework that, as supported by Ravitch and Riggan (2017), guided the overall case study.

2.2 Literature review method

An initial search of the key terms woman centred care and pre-registration midwifery education was undertaken. The two key terms were then broadened for words with similar meanings and connections. Phelps and Fisher (2007) advocate the use of alternative meanings as part of the literature search method as it ensures no loss of relevant literature. The key words and terms used for the literature review may be found in appendix 3 page 158.

In searching the literature Boolean operators of ‘And’ /Not’ and OR along with truncation symbols were used to structure the process. Their application enabled relevancy to the selected focus of woman centred care and pre-registration midwifery education. Throughout the literature searching process an audit trail was maintained including a record of results obtained from each step of the search activity. Initially no limitations were set on the searching process. However, after this yielded excessive amounts of literature, along with research no longer contemporary to the current context of midwifery or midwifery education, limits were set for literature to be identified between the time periods of 2000 and 2018. The timeframe reflected the currency of the subject matter and the political context surrounding maternity services and education. As part of the search, reference lists of accessed papers were scrutinised to identify any further materials. Hart (2018) supports this as an acceptable part of ‘backward chaining’ in a literature review. During the backward chaining process, any literature published prior to the set time periods was reviewed for pertinence and included as deemed relevant.

For enhanced application to a UK based study the literature review initially focused on UK and European based studies. However, the focus was extended to include significant international papers making explicit references to woman centred care deemed to be highly pertinent to the study. Whilst it was recognised some of the international papers had varying maternity care and education contexts, the review

process revealed that for those included papers the concept of woman centred care resonated with the UK interpretation of the concept. Therefore, literature was included from Australia, New Zealand, Europe, and South Africa. The databases and search engines accessed for the literature review are identified as part of Appendix 3 page 158.

Once the relevant literature was identified it was subjected to a critical analysis using a critical appraisal framework as shown by Moule *et al.*(2017). Throughout the literature review, electronic files of the critiqued research were maintained facilitating ease of access and structure. For the identified policy from the literature review, the policy analysis framework as developed by Buse *et al.* (2012) was utilised. This framework provided critical appraisal of the policy through the analysis of policy content and the role of the actor in the policy process. Whilst the literature review contained international papers the policy was only accessed from the UK. This was to ensure included policy was highly relevant, and reflective, of the UK context.

2.3 UK based woman centred care maternity policy

On review of the maternity policy it was evident of a long history of policy situating the woman as the central focus of midwifery practice and maternity services. Changing Childbirth (DH, 1993) is often portrayed as seminal maternity policy, (Carolan and Hodnett, 2007),which evoked the focus of maternity services being centred on the needs of a woman. The policy emphasises the necessity for care to be centred around the woman and family. Prior to this time UK maternity policy had been predominately led, and shaped, by health professionals (Boyle *et al.*,2016). Instead, Changing Childbirth (DH, 1993) declared that with maternity services centred on the woman, the woman would be able to make informed choices, experience continuity of care and be in control of her care. Changing Childbirth (DH,1993) is frequently seen to reflect the then gathering consumer movement in maternity services where women were feeling dissatisfied with medicalised maternity care not recognising their voices or experiences (Benoit *et al.*, 2005). Hodnet (2007) claims that this movement introduced a catalyst in maternity services resulting in less medicalisation and the promotion of midwives as the named lead professionals for women with no known complications in their pregnancies and childbirth.

In terms of policy analysis, Changing Childbirth (DH, 1993) may be understood as a point in time that brought about rapid policy transformation whereby, new actors emerge and influence policy by causing change otherwise unavailable (Baumgartner and Jones, 1993). The new actors were the women seeking change in contrast to the previous professional, largely medical actors. However, it may also be contested that whilst Changing Childbirth (DH, 1993) offered new possibilities for woman centred care, it was based on a naive assumption that policy only needed to provide the best practice to bring about the necessary acceptance and resultant implementation. Instead, Russell *et al*.(2008) report policy making should consider the context, commonly held values and whether the actors calling for change have the position of influence in the policy process. For example, whilst Changing Childbirth (DH, 1993) was heavily influenced by new emerging voices of women interest groups, it failed to fully consider the contexts and structures maternity

services operated within and how these influenced the possibility of change. It could be argued that without recognition of the context and structures Changing Childbirth only presented a woman centred ideology never able to be fully realised. This may explain why after considerable time many of the objectives of Changing Childbirth (DH, 1993) remain unfulfilled despite being on-going aspirations of maternity services.

A later, though important, document in 1997 from the Audit Commission focused on the state of maternity services in England and Wales. The policy was based on the findings from a survey of women's experiences of maternity care and from interviews with health professionals involved in maternity care. Whilst the condensed report was available for analysis, the raw data of the conducted interviews of over two thousand women was not available. The lack of data made detailed analysis of the full report especially challenging. Despite the lack of raw data, the decision was made to include the policy as it provided the sequence of the maternity policy and its relationship with woman centred care.

The Audit Commission report also reflects the growing discourse of health policy during the 1990s with an increasing role of policy being driven by interest groups rather than the experts who frequently occupied professional and government roles (Buse *et al.,* 2012). The Audit Commission report found that although there had been demands for woman centred care in maternity services, women still reported feeling uninformed and involved in their care and remained seeking enhanced information and continuity of care. The similar findings from that of Changing Childbirth (DH, 1993) would appear to indicate little progress had been made on embedding a woman centred care philosophy in maternity services. A possible rationale for the lack of progress may be women were seeking changes, but the power of influence remained with the experts and professionals. Russell *et al.* (2008) contest that policy, and policy analysis, often overlook the significance of identifying the actors possessing the power of influence possibly explaining the lack of significant changes evident in maternity services.

By 2007, the ambition of woman centred care in maternity services had not diminished and a UK government public policy document Maternity Matters (DH, 2007) set a vision for safe and modern maternity services highlighting the woman and her family at the centre of care. The themes synonymous with woman centred care found in this policy are choice, access to services and continuity of care. Unlike Changing Childbirth (DH, 1993), the concept of the woman having more control as part of woman centred care is not so explicit. Instead, the policy discusses the shifting nature of woman centred care as part of a larger health reform promoting a patient led NHS. The enhanced focus on a patient led NHS demonstrates the UK health and social care system also increasingly looking for a clinical service focused on the needs of the patient and not the professional (Frampton and Charmel, 2009; Constand *et al.*, 2014).

However, the shift to patient centred policy may have served to detract from the power of the voice of a woman. As Hill and Mullet (2010) claim, the use of the term woman centred upholds a gender inclusive policy valuing the relationship between

midwives and women. As such, the loss of terms such as woman centred from policy may be seen to further distance the unique relationship between midwives and women and neglecting the gendered voice of women. Perriman *et al.*(2018) also found that a positive relationship formed between a woman and a midwife as an essential precursor for personalised care and empowerment.

In 2010, against on-going health and societal changes influencing maternity services and the midwifery profession, a government led policy Midwifery 2020 (CNO, 2010) shared a further vision for midwifery and maternity services. The policy aimed to identify the specific contribution midwives made to maternity services. In result, the policy defined the future requirements of the midwifery profession with midwives needing to be able to work across settings, provide care for all women whilst, continuing to be the lead professionals for healthy women with normal pregnancies. The term both patient-centred and woman centred are used in the policy and both are synonymous with the themes of choice, building effective relationships and continuity of care. The policy also begins to increasingly acknowledge the changing profile of the women being cared for in the maternity services, such as rising numbers of births to older women, complex physical needs and increasing social and ethnic diversity. Therefore, the policy proposes the need for midwives to balance being the lead carers for women with no known complications against also being the key coordinators for women with complexity. Midwifery 2020 (CNO, 2010) is one of the first maternity policies that explicitly acknowledges the impact of women with more complexity resulting in midwives needing to shift their remit to a much broader scope than caring for low-risk healthy women. It was also during this time that there was a growing critique of woman centred care only being synonymous with low-risk women creating an exclusive concept not inclusive of all women (Hodnett, 2007). Therefore, Midwifery 2020 may be construed as starting to provide a more inclusive concept of woman centred care.

In addition to a more inclusive concept of woman centred care, Midwifery 2020 linked woman centred care with enabling a quality and improvement culture in maternity services. From a policy analysis perspective, the focus on quality may be understood as Midwifery 2020 aligning to a rational, modernist policy making model with an assumption of best practice automatically leading to implementation (Russell *et al*., 2008). It assumed that the calls for best practice associated with woman centred care would follow a rational logic of quality and improvement. However, policy is far more complex, and the rational policy process has been criticised for not recognising the political dynamics involved in policy making and its implementation (Shams *et al.,* 2010). Indeed, although Midwifery 2020 depicts a clear vision for woman centred care there are significant gaps on the detail of how this may be realised in practice.

The impetus for an improved maternity service continued after Midwifery 2020 and in 2016 a significant UK policy document from the National Maternity Review was published titled ‘Better Births, a Five Year Forward View for Maternity Care’ (NHS England, 2016). The policy was a direct response to the 2014 published NHS England Five Year Forward policy that depicts the vision for health and social care in the UK, continuing to place the patient at the centre of services (NHS England,

2014). The Better Births policy articulates a future framework for maternity services with a central theme of personalised care centred on the needs of the woman and her family. Although the term woman centred is not specifically used the themes of choice, continuity of care, partnerships and relationships are evident. These themes are depicted as enabling personalised care with the woman and her family at the centre of maternity services.

Like the policy Midwifery 2020 (CNO, 2010), Better Births describes person-centred care not woman centred care. Whilst person centred as a concept may support maternity policy aligning with the broader health and social care policy context, it may also be seen to weaken the unique gendered voice of women in maternity services. As Buse *et al.*(2012) raise, the crux of policy-making lies with the status and power certain actors or groups have in the policy process. Indeed, Better Births portrays a framework for maternity services providing a clinical service with the woman and her family at its core. However, whilst there are set objectives for clinical services to adhere to there is, once again, limited focus on how a woman can fully actualise their power and influence the espoused objectives of choice and continuity of care. Choice is an espoused objective of woman centred care, and therefore reflected in maternity policy, as it is perceived to enhance a woman's autonomy (Mander and Melender, 2009).

The policy movement leading to the concept of person-centred care in midwifery may be further understood as part of the boarder health and social care policy context. Although, during the 1990s woman centred care was predominately used as a policy concept its replacement to person, or patient centred, was indicative of the resurgence of a personalisation of care agenda in health services. The personalisation agenda was based on a philosophy of care whereby; transformation of care could be brought about by giving people more choice and control in their care (Foot *et al.,* 2014). Indeed, Berwick (2013), in a government commissioned report tasked with improving safety for patients in England, recommended patients being at the heart of services as 'engaged' and 'powerful'. The NHS Five Year Forward (NHS England, 2014) continued to cement this ideology and one of the keys steps for enabling the future vision for the NHS highlighted the need for people having more control.

Gluyas (2015) reports that the shift toward patient centred care represented a fundamental shift in policy moving from a professionally led, paternalistic model to policy placing the patient at the centre of decision making and relationships. McCormack and McConce (2010) further support the policy shift toward person centred care as a response to the medically dominated and fragmented systems of care prevalent in health and social care systems. Against this changing policy backdrop, it is unsurprising maternity policy also started to adopt similar terminology of person and not woman centred care. However, Foot *et al.*(2014) argue despite the shift to person centred care there has been a lack of information explaining how this can be achieved. The lack of action for how to realise policy objectives resonates with much of the reviewed maternity policy.

This section has discussed, and critiqued ,the UK maternity policy perceived as having the most significant influence on woman centred care. It is acknowledged that other maternity policy exists pertaining to aspects of care such as safety. However, these were not included due to their lack of synergy with the research topic of woman centred care. In summary, woman centred care, patient centred care, or personalised care in UK policy are all linked with themes of choice, continuity, control and working in partnership. The choice of language has changed in specific maternity policy over the years and whilst the themes remain strongly evident, woman centred as a term has become increasingly replaced by the more homogenous term of person or patient centred. Furthermore, the policy literature has been found to be largely based on a rational model of policy making that has set objectives based on the best available evidence. This model assumes a rationale logic where woman centred care is perceived as the best choice able to evoke the best quality, outcomes and experiences for those receiving care. Although, this assumption does provide a philosophy of care for maternity services and midwifery, it fails to provide detail of the complexity of implementation or any recognition on how best practice can be influenced by ingrained dimensions of power, culture, values and context (Wrong, 2002).

2.4 The concept of woman centred care

O'Malley *et al.* (2016) conducted a discourse analysis of the term woman centred care used by known midwifery professional bodies from across the world. The study employed purposive sampling that identified, and subsequently analysed, midwifery scope of practice statements publicly available from websites. The statements were analysed using a linguistic tool where language was recognised as a primary source of social meaning and therefore, key to understanding power dynamics involved in social processes. This data collection method supports discourse analysis methodology using language to explore the construction of meaning in the social world (Gray, 2014). The researchers who conducted the study were both women who at the time had recently given birth. It may be contested that this introduced a personal subjective bias of their own recent experiences. The authors acknowledge their subjective position and state they overcame any bias by the data analysis being independently checked for inter reliability. Whilst, this may have gone someway to overcome the bias from subjectivity, the study still fails to fully address the dual occupied positions as both mothers and researchers. Denzin and Lincoln (2013) suggest subjectivity is an inevitable part of qualitative research as the researcher brings with them personal values and beliefs influencing the research. However, the core objective is how this is managed as part of the research process. For example, there is an expectation in discourse analysis methodologies that the interactive process between the researcher and the researched is made explicit and contributes toward the co construction held as a core component of the research (Taylor, 2013). Therefore, a fuller account of the reflexive process from the authors, as new mothers and researchers, would have enhanced the overall level of credibility; a frequently quoted quality marker of qualitative research (Denzin and Lincoln, 2013).

The data analysis process rated the midwifery scope of practice as to how far they were deemed to reflect a woman centred philosophy. A woman centred care

philosophy was predicated on the perceived evidence of the woman being visible and active in the analysed statements. The rating then formed part of a continuum from the woman being absent, to one portraying the woman as the primary agent involved in woman centred care. The results found that most of the identified statements portrayed the woman as a largely passive recipient. Consequently, the study proposes woman centredness, as part of scope of midwifery practice, was largely based on the interests of the midwifery profession and not the woman. The authors contend that woman centred care was primarily for the benefit of the midwifery profession as it allowed the perpetuation of clear professional boundaries.

Hodnett (2007) also reported that the concept of woman centred care primarily served as a method for midwifery to exert its scope of professional identity. A finding recently further supported by Hunter *et al.* (2017) who, in an Irish based study, found woman centred care synonymous with midwifery professional status. An earlier study by Kirkham and Stapleton (2004) investigated choice as part of the midwifery profession. The study revealed that the ability of midwives to recognise the central role of the woman, and provide them with choice, was heavily influenced by professional and organisational contexts. Consequently, care choices were often for the benefits of the profession rather than the woman.

Other studies investigating power and professionalism in relation to woman centred care were also identified in the literature review process. A UK based study by Pope *et al.* (2001) explored the implementation of the UK policy Changing Childbirth (1993) and its associated concepts of woman centred care. The study utilised a national postal survey sent to midwives and medical staff, as well as the use of detailed case studies from three selected sites in England. It investigated if, or how, the policy recommendations from Changing Childbirth (1993) for woman centred care had been implemented. The study found that there were many examples of how midwives were trying to increasingly promote woman centred care in their clinical practice. However, there were wide variations in how the policy was being implemented with no common standard of practice. It also found that whilst, woman centred care was evident as part of maternity services guidelines and policy, the language used by the professionals during the data collection process seemed to indicate something different. This difference was evident through midwives using language symbolising a passive relationship of the woman to the midwife. For example, midwives used terms such as ‘allowing’ the woman to have choice appearing to indicate ultimate control remained with the midwife. This study is primarily focused on the role of the midwifery profession and its relationship to the concept of woman centred care in clinical practice. There is scant attention given to the clinical environment midwives were working in, or the profile of the woman being cared for. This information would have provided valuable insight of possible explanations, or influences, of context on woman centred care. Nonetheless, it illustrates the on-going tenuous relationships between the policy narratives of woman centred care and the actual perceived relationships in clinical practice.

A South African qualitative research study by Maputle, (2010) also explored the concept of woman centred care by investigating women’s and midwives’ experiences of childbirth. The study’s overall aim was to develop a model of woman centred care

for childbirth in maternity services in South Africa. The data collection entailed interviewing 24 mothers and 12 attending midwives within 24 hours of giving birth that took place in an obstetric referral hospital. In addition, participant observation of the birth was undertaken using a visual analogue scale and field notes. Collectively, the methods enabled triangulation of the data seen to enhance the accuracy of information as data is collected from more than one source (Denzin and Lincoln, 2013; Moule *et al.,* 2017). Adherence to the ethical principles of informed consent and confidentiality, as seen as key components of effective research governance (May, 2011; BERA, 2018), are evident in the study.

Following data analysis, five themes were identified reflective of the level of woman centred childbirth as experienced by both the midwives and the woman. The identified themes were: mutual participation /responsibility sharing, dependency and decision making, information sharing /informed choices; open communication and listening; accommodative or non-accommodative midwifery actions and maximising infrastructure. Whilst there was some evidence of midwives offering woman centred care, the study found that care was often devoid of mutual participation and information sharing. This finding was deemed to indicate childbirth experiences, from both the woman's and midwife's perspective, failed to embody the philosophy of woman centred care

In response to the findings of the study, Maputle (2010) went on to develop a new conceptual model of woman centred care. The model theorised that through effective mutual participation, as portrayed in the identified themes from the study, woman centred care could be activated as it facilitated partnership and equal power sharing between the woman and the midwife. The study was based in South Africa and consequently, there is a different clinical context and culture to the UK that poses challenges for comparability in the clinical application of the concept. However, the study was predominately aimed at investigating the theoretical concept of woman centred care to which the identified themes highly resonate with themes in UK studies of woman centred care.

Bradfield *et al.* (2018) in another theoretical study of woman centred care also identified that the concept was frequently understood as a mutual relationship between the midwife and the woman leading to empowerment and improved agency of the woman being cared for. However, Bradfield *et al.* (2018) suggest that, despite woman centred care being a long-standing feature of theoretical midwifery philosophy, there is limited research on midwives' experiences of the concept. The study recommends that studying actual midwifery practice as part of woman centred care, inclusive of the relationship between a midwife and woman, would enables a contemporary understanding of the concept.

Following the Maputle (2010) study, Maputle and Hiss (2013) performed a related investigation focusing on woman centred care. In this research they used an inductive, descriptive research design employing the same data from the 2010 study. The primary aim was to understand the definition, and theoretical concepts, associated with the term woman centred care. It was anticipated this would lead to the development of a method able to measure the application of woman centred care

in clinical practice. The research found that there was no clear definition of woman centred care. In result, Maputle and Hiss constructed a new theoretical concept with the aim for it to be applied in clinical practice. As part of the research methods, Walker and Avant's (2011) concept analysis framework was employed. The framework advocates identifying the antecedents required for the concept to occur, the consequences of the concept being evident and the empirical referents indicating the existence of the concept (Walker and Avant, 2011).

Through the application of the findings to Walker and Avant's (2011) concept analysis, the study provides a possible model for the concept of woman centred care centred around the concepts, antecedents, consequences and empirical referents. Maputle and Hiss (2013) conclude that for woman centred care to occur, (the antecedents), there must be a context of mutual respect, open communication, competent staff, cultural awareness, participative decision-making and informed choice. The effect (the consequences) of woman centred care being applied resulted in mutual participation, partnership, shared power dynamics, collaboration, a woman's independence and ability to be self-determining. Finally, the evidence of woman centred care in clinical practice (empirical referents) were empowerment, mutual decision-making and participation and open communication. The constructed conceptual framework was subsequently used as a method for assessing documented clinical cases of care and deducing if they did, or did not, exemplify woman centred care being evident in clinical practice.

The analysis of the concept of woman centred care from Maputle and Hiss (2013) corroborates findings from UK based maternity policy and research capturing woman centred care as facilitating collaboration, choice and equal power relationships between the woman and midwife (Pope *et al.*, 2001; Kruk et al, 2016; O'Malley *et al.*, 2016). However, the Maputle and Hiss 2013 study starts to further acknowledge woman centred care from a purely theoretical concept to being situated in a clinical context. The findings suggest that the presence of woman centred care in clinical practice can be evidenced by empowerment, mutual decision-making, participation and open communication. These findings provide the opportunity for a tangible appreciation of an often-theoretical concept of woman centred care. Indeed, Leap (2009) also claims that theories of empowerment and self-determination, associated with woman centred care, provide tangible measures for an often hard to define concept. Silverman (2013) also supports the view that theories aligned to concepts help the identification of the studied concept in research. Therefore, the Maputle and Hiss (2013) study has valuable insight of the interplay between theories and concepts of woman centred care and their manifestation in clinical practice.

However, on examination of the findings it is challenging to decipher the differences in the conceptual analysis of woman centred care in the antecedents, consequences and referents. Many of the utilised theories are equally as complex and difficult to define as the concept of woman centred care. This complexity makes the research, and its findings, challenging to decipher and although the aim was for a clinical application, it is questionable how accessible this would be outside of an academic audience. It is also difficult to understand how feasible it would be to measure the referents such as empowerment in clinical practice. Hermansson (2015) argues that

empowerment is not only an outcome but also a process that obscures any meaningful measure of the theory. In result, although there is an effective descriptive account of the concept of woman centred care there is a less convincing theory for how the concept may be translated and measured in clinical practice. Without an effective depiction of a clinical translation of woman centred care the study risks providing another aspirational concept failing to acknowledge the reported challenging clinical context facing maternity services (Van Kelst *et al.*, 2013; Mander, 2016)

A UK based exploratory research study by Boyle *et al*. (2016) investigated how key attributes associated with the concept of woman centred care of choice and partnership working were experienced, or desired, by women during pregnancy and childbirth. Women were recruited at ten weeks of pregnancy and data was collected using diaries and interviews throughout their pregnancy and following childbirth. The exploratory research utilised a social constructivist theoretical framework, a fitting design as social constructionism believes meaning is socially constructed as individuals engage and interact in their world (Crotty, 1998). The study found that women reported midwives being preoccupied with physical tasks and activities with limited time for relational activities or conversations. Furthermore, it found woman centred care, associated with choice and partnership, was directly influenced by the type of care setting and culture of an organisation. This finding was evidenced by women, reporting higher levels of woman centred care when cared for in birthing units. Birthing units are midwifery led units perceived as being less medicalised where midwives are the lead carers for a woman with no known complications (Mohajer *et al.*, 2009). Outside of the low-risk birthing units women reported their care as largely functional where care was based on tasks and not individual need. The study starts to show the influence of the clinical context on woman centred care and the void between espoused policy and the reality. It generates questions as to why, despite many calls for woman centred care, midwives were unable to offer this in clinical practice, albeit it more prevalent in low-risk birthing units. The study could have been further enhanced by a more detailed exploration on the role of the clinical context and organisational culture on woman centred care.

Whilst Boyle *et al*. (2016) did not fully address the impact of the clinical context on woman centred care previous studies have focused on the impact of clinical practice contexts on the midwifery profession. Hunter (2004) studied the emotional world of work associated with midwifery and found that the type of clinical context directly influenced midwifery. The study claims that there are primarily two opposing maternity clinical contexts; one of medicalised high-risk contexts and another of low risk, midwifery led contexts. The low risk midwifery led clinical contexts were seen to be increasingly synonymous with woman centred care, whereas the medicalised contexts were more likely to be aligned to the needs of the organisation. Therefore, a midwife's emotion was exacerbated by the tensions of having to work across, and within, what appeared to be competing ideologies. This finding illustrates the impact that culture and clinical contexts plays as part of understanding woman centred care. Indeed, Deery *at al.* (2010) in a study exploring the development of a UK based birthing centre reported that hospital contexts were largely understood as the

mainstream of care where midwives adhered to more medicalised practices such as working according to policies.

The gap between the espoused and the reality of woman centred care is also found in an Australian based study by Freeman and Griew (2006). The study investigated woman centred care by reviewing one well known clinical guideline pertinent to childbirth in Australian and New Zealand maternity units. The authors also conducted a literature review of maternity guidelines from several electronic databases that were assessed for the extent to which they demonstrated shared decision-making. In the study, decision-making is used as a central theme associated with woman centred care and the midwife-woman relationship. The study uses a conceptual model of shared decision making explained as a mutual relationship between the woman and the midwife and related to aspects of choice, control and negotiation. The use of a conceptual model helps clarify a research design as it links data to research objectives and indicates what may be both known, and unknown, about the topic being investigated (Vaughan, 2008). However, whilst the inclusion of the conceptual model helps explain the definition of decision making and woman centred care; it is unclear how the model was used throughout the study

Freeman and Griew (2006) found that in the reviewed guidelines, there was limited articulation of the woman's role in shared decision-making. On this basis the authors conclude there was no evidence of woman centred care and the desired midwife-woman relationship driving maternity services. This was a small study primarily aimed at providing a clinical application of a conceptual model of shared decision-making evidenced through its existence in clinical guidelines. The study does resonate with themes of woman centred care but the implication of a guideline representing a clinical manifestation of the concept is an over ambitious objective. Instead, the study may have been improved by locating the investigation as part of exploring policy making, through clinical guidelines and woman centred care.

Berg *et al.* (2012) provide a similar study that constructs a model of woman centred care through the identification of associated themes. The European study involved a meta synthesis of literature from Iceland and Sweden focused on women's and midwife's experiences of childbirth. Key themes associated with the concept of woman centred care were identified which became constructed into a model for woman centred care in childbirth. The core identified themes from the study were; a reciprocal relationship between the midwife and woman; the birthing environment based on trust and calmness; midwives being able to use 'grounded' knowledge; knowledge used to meet the individual needs of a woman ; the impact of the culture as either enabling or disenabling and the needs for midwives to become expert at a juggling where they were able to meet the needs of both organisations, policies and the woman they care for. These themes also resonate with previous reported studies of woman centred care. However, whilst the research reinforces understanding of the concept of woman centred it also fails to provide any explanation for the enablers, or inhibitors, of the themes and, in turn, woman centred care. Consequently, it is a theoretical study of woman centred care that cannot be assumed to equate with the existence of the concept in a clinical setting.

A more recent study by Fontein-Kuipers *et al.* (2018) also investigated the concept of woman centred care and midwifery. This was a theoretical based study exploring the related literature for clarification of the meaning ascribed to the concept of woman centred care. The study found that there was no explicit definition of woman centred care and the main common defining factor associated with the concept was a relationship between the woman and the midwife. In addition, woman centred care was used as both a philosophy for midwifery and a framework for more practical application. The study contends that the concept's overreliance of the midwife-woman relationship may be detrimental as the focus is the relationship rather than the woman. Furthermore, the concept's understanding of a midwife relationship has been restrictive and does not encompass more expansive understanding such as cross disciplinary working. Brady *et al.* (2019) also confirm woman centred care fails to have one shared consensus of meaning despite it being a foundation for perceived 'good' midwifery practice. Although, Carolan (2013) has previously found that being a 'good' midwife was usually understood when a midwife conformed to professional long-established norms.

It is impossible not to address the concept of woman centred care without discussing the feminist principles attached to the concept. Leap (2009) claims that woman centred care has a vital feminist stance as it aims to empower the woman and her family. Though not solely midwifery focused, a Canadian study by Hills and Mullett (2010) used action research to assess if there were any differences to where policy used the term woman centred rather than person centred. As commonly found in action research, the design aimed to bring about change through the process of action and reflection (Gray,2014). Consequently, the action research investigated how professional groups could further promote government policies, specifically those of woman centred care. The involved professional groups, one of which was the midwifery society, worked collaboratively during the research process to analyse and develop agreed woman centred care principles for polices.

The study found that the term woman centred care was an important differentiation as it acknowledged the impact of gender on health. In turn, recognition of the gender on health enabled professional groups to reduce heath inequalities related to women in society, whilst accommodating women's experiences and diversity. This finding may be seen to support a feminist philosophy with the concept of woman centred care possessing the power to change and empower the lives of women that would be missing if the term was replaced by person centred care. However, it is not without critique as it may be conversely argued linking the woman centred care with feminism risks the concept becoming even more exclusive and unattainable for women and midwives. For example, a feminist perspective of woman centred care suggests a process of emancipation (Leap, 2009). However, the woman may not always be seeking emancipation; rather for care to be based on the best-known care and expertise (Carolan and Hodnett, 2007). Furthermore, Freeman *et al*. (2004) suggest that a partnership between the woman and midwife does not always have to be based on ideas of equality as this fails to acknowledge the influence of structures and organisations that do not enable equality. Instead, of searching for an evasive principle of equality, or emancipation, Freeman *et al.* (2004) suggest a

partnership can be formed through processes of negotiation and participation. These differing philosophical feminist positions associated with woman centred care may be due to what Denzin and Lincoln (2004) report as the complexity and lack of conformity of feminist research. This is where some feminists seek emancipation and others look to challenge oppression through modest transformation.

The gender affirming influence of the term of woman centred care should also be considered for the changing societal composition such as non-binary women and transgender individuals. Ellis (2019) states that gender identity accounts for an individual's own understanding of their gender irrespective of their biology. There are limited studies that consider, or understand, the concept of woman centred care for anything other than for cisgender woman, a woman that identifies with their biological sex from birth (Ellis, 2019). This was identified as a significant gap in the literature review for as Hoffkling *et al*. (2017) note transgender men have the capacity for pregnancy of which many actively desire and plan.

Both Ellis (2019) and Hoffkling *et al*. (2017) found that non-binary individuals did not have the same access to health information as part of maternity, or womens health services, and frequently experienced discrimination when services were accessed. Consequently, these experiences often led to individuals concealing their identity in order to receive the necessary maternity care.

Therefore, the term woman centred care has a potential restrictive definition only relevant to a cisgender woman and not reflective of society. Without a more inclusive understanding there is a risk, as Ellis (2019) found, of individuals being exuded from gaining the necessary care during childbirth and pregnancy. Instead both Ellis (2019) and Hoffkling *et al*. (2017) as part of their studies investigating non-binary and transgender individuals as part of maternity services recommend that the term woman should be understood as any individual woman who identifies as a woman. As Ellis (2019) states, an inclusive understanding is both 'life affirming' whilst also ensuring an individual has the necessary access to care.

2.5 Pre-registration midwifery education and woman centred care

Whilst several studies have explored aspects of pre-registration midwifery education few were found to have specifically explored the concept of woman centred care. One study capturing the two areas was by Brady *et al.* (2016), an Australian study aiming to test a pre-developed woman centred care behaviour scale on student midwives. Brady *et al*. (2016) also proposed there was limited clarity on what woman centred care meant and that in midwifery education it was often seen as a theoretical concept with little attention to how it was taught and practised. This claim supports previous work discussed by Maputle (2010) , Maputle and Hiss (2016) and Fontein-Kuipers *et al.* (2018) who report limited definitions of woman centred care.

The authors constructed a model of woman centred care informed by a literature review; although on examination this was not an extensive literature review as only five sources were acknowledged. Nonetheless a conceptual framework was developed identifying eight key constructs necessary for woman centred care behaviours. These constructs were: individuality, continuum, informed decision-

making, midwife/mother relationship, woman's sphere, holism, self-determination and a shared power relationship.

Using a nested study design, often known as a type of case control study, (Gerring, 2006), Brady *et al*. (2016) applied the constructed woman centred care conceptual framework to a simulated clinical skill undertaken by first year midwifery students. The conceptual framework was applied to three different types of simulation from low fidelity, involving only the use of a bed and clinical model; medium fidelity using a visual representation of a woman; to high fidelity using patient actors. A total sample of 69 first year midwifery students were randomly allocated to each group with a relatively even number across each group. The authors hypothesised the higher the fidelity of the simulated experience, the higher the evidence of woman centred care behaviours from the student midwives. The research design supports nested research claims as it was prospective and aimed to construct a model of the phenomenon being studied, able to be applied to a larger sample of cases (Gerring, 2006). To reduce bias in the case control study the students were not informed they were being observed for woman centred behaviour but of undertaking the simulation.

Following appropriate statistical analysis, findings showed that a higher presence of woman centred care behaviours, as those depicted in the conceptual framework, were demonstrated as the level of fidelity in the simulation of the clinical experience increased. The evidence between woman centred care and high-fidelity simulation supported their proposition of increasing fidelity resulting in increased woman centred care behaviours from student midwives. The proposition was explained by the suggestion of higher fidelity enabling enhanced integration of knowledge and skills necessary for the clinical application of woman centred care. Fullerton *et al.* (2013), in an account of competency-based midwifery education, argue effective education relies on the integration of context, critical thinking and decision-making. This assertion may account for the findings of Brady *et al.* (2016) as the higher fidelity teaching methods may have created enhanced synthesis of these three aspects enabling students to gain understanding, and application, of woman centred care in a simulated environment. Henriksen *et al* .(2018) in a study investigating simulation as a teaching method also found simulation was able to effectively integrate education and clinical practice.

In the study Brady *et al.* (2016) employed two independent raters who viewed recordings of the clinical skills and scored student behaviours. Despite having consistent briefings on the behaviours perceived as evidence of woman centred care, there were levels of inconsistency between the rater scores. The variation of scoring is a limitation of the study and illustrates the subjectivity often ascribed to the term of woman centred care. Furthermore, it may be contested that first-year students had limited exposure to forming woman centred care behaviours. A wider student recruitment sample from across all years of study may have potentially overcome this limitation and offered valuable insight into when students formulate associated behaviours with woman centred care. Although, the study does provide evidence of woman centred care and the influence pre-registration midwifery education can have on its clinical application.

The specific concept of woman centred care was also explored in a study by Yanti *et al*. (2015), an Indonesian based study investigating how models of education associated with continuity of care supported student midwife's understanding of woman centred care. In the study, a conceptual model of woman centred care was not developed but the concept was defined as a philosophy recognising an individual woman's social, emotional, physical, spiritual and cultural needs. Continuity of care is frequently portrayed as a core facet of woman centred care by facilitating an equal partnership between the woman and the midwife (Bradfield *et al.,* 2018; NMC 2019). In the study the employed model of continuity of care was where students cared for a woman throughout the antenatal birth and postnatal period. Whilst, the research was based in Indonesia the definition of woman centred care, and the model of continuity of care, were the same as those used in UK maternity policy and education (NHS England, 2016).

The study design was quasi-experimental where two similarly matched midwifery schools in Indonesia were identified and each one allocated to either the experiment group of offering students a model of continuity of care, or a control group with the conventionally established fragmented care package. Pre and post-survey questionnaires were used for data collection capturing student midwives understanding of a midwifery philosophy of practice as ascribed to woman centred care. The total sample for each group was (n=54) in the experiment group and (n=52) in the control, both of which reported a 100% response rate. Analysis found in pre-questionnaires, prior to any clinical learning experience, there was no statistical difference in the group's understanding of woman centred care as measured through the survey. However, in the post survey results there was a significant statistical difference ($P<0.01$) with the experimental group reporting higher levels of understanding of woman centred care than the control group.

Yanti *et al*. (2015) propose that the results confirm continuity of care, as a part of midwifery education, helps affirm a woman centred care philosophy. By large, the proposition assumes continuity of care promoted effective relationships with a woman and optimum support for students. The study highlights how clinical models of care in midwifery education influence a student's ability to both understand, and apply, woman centred care. However, it does not provide detailed explanation as to why this may be the case and tends to offer an over simplified rationale for evidence of woman centred care and its link to education. It is also noteworthy this was a purely quantitative study and a mixed methods approach with student qualitative data may have captured the social context of woman centred care and midwifery education. Indeed, a limitation of surveys is they often fail to capture the social context of research (May 2011).

Whilst the literature review identified the already documented specific studies related to woman centred care and pre-registration midwifery education, the review process also considered relevant theories of education. It was apparent that education, and methods of learning, were equally influenced by theoretical debate and investigation. Similar to the actual concept of woman centred care, education has been understood as both part of a theory and practice orientation. Winch and Gingell (2004) argue that in modern society education has become a liberal aspirational theory whereby

education has an ideological claim. The ideological claim has constructed knowledge as largely theoretical and rational. Winch and Gingell (2014) and Carr (2006) argue that the ideological claim of knowledge explains why education organisations are perceived to gain higher status, and value, when they identify with a theoretical application of knowledge. In contrast, Pring (1999) argues liberal education theories that solely focus on aspirational objectives of education fail to encompass the social and work contexts of education. Rolfe (1996) and Roth *et al.* (2014) contend these two opposing values of education has resulted in the theory being separate to practice with practice as the inferior.

Sarid (2018) further espouses that education always aligns to a certain set of values. As part of this alignment Sarid (2018) describes education as either having an objective to prepare a person for their social context, or as an ideological framework to bring about behavioural change . However, Carr (2010) argues it is impossible to seek any meaning on the purpose of education as it will always be shaped by political and social constructs. Therefore, it is not about either a practice or aspirational model of education rather a recognition of their equal value.

2.6 Power

During the literature review process, it became apparent that many of the analysed studies had an underlying concept of power. Although, power was frequently not addressed in the studies its dynamics would have had a large role to play in woman centred care and pre-registration midwifery education. Indeed, many of the concepts such as informed consent and partnership working are underpinned by power dynamics between the woman , the midwife and the student midwife. The omission of power in the critiqued studies has been identified as an overall limitation and therefore, it felt fitting to also concentrate on an analysis of core theories related to power .

Wrong (2002) asserts a traditional definition of power as being where there is the capacity to exercise its effects over an individual . This assertion is often reported as one dimensional, or the first face of power, as originated from Dahl (1957) who saw power largely concerned with notions of domination (Hathaway, 2016). This theory of power places the emphasis on the individual, the social actor seeking dominance over others; although as Wrong (2002) argues, it is questionable if individuals always seek domination. Indeed, if applied to woman centred care this would situate power being predisposed to an individual's subjectivity where the evidence of its existence, or nonexistence, would be based on power being exerted through processes of domination. Whilst, domination may evidence the role of power, it fails to account for the complexities associated with power.

Lukes (1974; 2005) provides an extension to the dimensions of power by claiming that there are three 'faces' of power. In the framework Lukes outlines the first dimension or 'face' whereby, power has a visible process resulting in a behavioural change through direct control. The second dimension, or face of power; is less visible and controlled by the influence of setting the agenda, in other words the power to influence what gets discussed. Finally, the third face is more manipulative as individuals act in ways that may not always be in their best interests but is brought

about by an ideological power persuading an individual in believing what they are receiving is what they want. Lukes is frequently quoted as providing a political framework of power. Authors such as Dowding (2006) have therefore, used the framework to argue social movements, through areas such as the media and education, have been based on the manipulation of policy makers ensuring their on-going control of society and the powerless. Lukes framework highlights how power may operate in different ways ,and functions, and especially resonates with understanding power as part of a policy framework. However, despite Lukes (2005) later recognition of power existing in different forms, the framework is largely dependent on an ideology of power as domination with limited attention to a consensual theory of power. In response to the over reliance on domination Gaventa (2014) reconfigured the three faces of power. In the reconfiguration of Lukes theory of power Gaventa (2014) proposes that the three faces of power can be mutually dependent, and the interdependence leads to a relational theory of power.

Foucault situates power as a core part of his guiding philosophy found within many of his key texts and papers (Dore, 2009). According to Foucault, power can be both positive, and negative, and rather than situated in individual action he sees power as relational. It is through the relational concept Foucault proposes power can be productive. In this theory Foucault presents power as being everywhere and constantly exercised though connections and relationships (Foucualt,1980; 2007). Power becomes real when it is actioned through the relational processes. Consequently, power influences, not only from a dominant top down process, but from bottom up as resistance may form through relational activities. In the philosophy Foucault suggests that alongside the relational notion of power is norms, as normalisation becomes the driving purpose of the need for conformity in social processes. Foucault illustrates the power of norms through his accounts of normalisation found in schools and hospitals that he contests was formulated by state power to promote knowledge and power relationships. Therefore, Foucault claims disciplinary knowledge is primarily there to establish collective norms to incur conformity (Foucault, 1982; 1989). This claim is also based on his belief that power can only ever be exercised through the '*discourse of truth'.* However, truth is not conceptualised as portrayed in the enlightenment period where there was one absolute truth (Crotty, 1993). Instead Foucault holds what some authors see as a relativist version of truth (Dore, 2009) where all truth is held through discourse at many different levels. This means discourse shapes the truth that enables power to be exercised by creating the momentum for normative behaviour; the validation of power.

Ball (2013) is often recognised as introducing education to the works of Foucault (Butin, 2006) and his work is viewed as important for supporting educationalists to challenge established norms (Castrodale, 2015). Ball (2013) also asserts power can both dominate individuals and offer opportunities for liberation. Ball (2013) claims that in education, power may be attributed to the construction of discourse that has brought about a professionalisation. Through the professionalisation process what is defined as knowledge has been shaped by discourse and this sets the 'agenda' for what may, or may not, be discussed (Ball, 2013). He proposes that this type of

discourse serves to dominate and can be harmful to educationalists as their autonomy, and role of decision making, become diminished. Therefore, when individuals become aware of the dominant discourses, they operate within they achieve liberation from power. The self-awareness is achieved through self-reflexivity (Ball, 2013).

However, both Foucault and Ball are not without challenge and there are many critiques of their work. For the purposes of this literature review a couple of the perceived pertinent critiques are explored. Butin (2006) in a brief, but succinct critique of Ball's work, asserts that Ball holds a belief of power being able to control /dominate and liberate. Butin argues that this is a naïve interpretation of Foucault. Instead, Butin (2006) suggests domination and liberation are not the purpose of Foucault's theory as rarely will individuals become liberated or more adept at knowing how to manage the systems that they are part of. Instead, Butin claims that Foucault's primary objective was to provide a philosophy not showing a one directional concept of power but power as a relational activity. Butin (2013) states instead of authors seeking unrealistic claims of liberation they should situate their objectives on relational power dynamics offering simple exposure of dominant discourses. Whilst it is true liberation may be an over-simplified version of Foucault's complex philosophies Butin (2006) may be equally critiqued as offering a nihilistic discourse further suppressing and controlling the powerless. Indeed, Owen (2005) also proposes that Foucault is mainly concerned with the role of the individual and this role is over socialised. Instead, Owen (2005) argues that the focus on the individual fails to account for the impact of the social context on power and the relational concept of power does not effectively acknowledge a more systematic concept of power. Owen (2005) claims shifting the analysis of power away from the individual to broader accounts of systems offers new possibilities and understanding of power.

A detailed critique of Foucault is also found by the critical realist Sayer (2012) who argues that Foucault's theory of power is solely focused on the 'how' of power and lacks detail on the why power may, or may not, be exercised. Sayer therefore contends that Foucault fails to accept any causality of power where causality is necessary as an operation of power. Without the causality of power Sayer argues it is impossible to have a relational framework of power. Sayer (2012), writing from a critical realist's perspective, does not frame causality as one of regularity excluding relational power concepts, Instead, Sayer perceives all known objects having power where the powers of the object are found in the structures surrounding them. Sayer (2102) asserts that the crux omitted from Foucault's work, is the recognition of contingency that Sayer sees as providing the explanation for why power may, or may not, be activated.

Simply applied, Sayer (2012) believes social, or relational processes, do not generate power but rather all objects have power attached to them. The operation of these powers is an essential focus as it helps explain the influence of structures and the exercise of power is enabled through a process of contingency. In this theory liberation from a dominant force of power is enabled when the objects and powers take full advantage of the contingencies from which they are surrounded. From

Sayer's theory it is difficult to clearly ascertain when, and what, the full advantages of contingency are. However, it starts to increasingly explore contexts, and structures, as part of the process of power rather than only the involved individual actor or actors. In terms of woman centred care, this may help situate power being examined both from a social process and from the surrounding context already identified as a gap in much of the literature of woman centred care.

Furthermore, power should be considered as underlying the medicalisation of childbirth during what is frequently documented as the industrial era of pregnancy and birth (Benoit *et al*., 2005). Midwifery history demonstrates that during the second part of the twentieth century birth became controlled by concepts of time, with birth becoming increasingly a technical production process (McIntosh, 2012). Prior to this time midwifery and childbirth had been largely based in home environments and managed through relational activities (Benoit *et a*l. 2005) The change in emphasis led to midwifery care moving into large hospitals where there was less focus on woman centred relationships and more of the organisation with midwives working as part of a large system ,or organisation, with set routines and outputs (McCourt and Dykes, 2009).

The medicalisation of childbirth may be seen to represent concepts of power and how these directly influenced woman centred care and midwifery. Indeed, Foucault claims that medicine operated power by constructing the body as largely pathological requiring control by medicine (Foucault, 1994). This construction resulted in the body being an objective entity of which medicine was then able to apply its pursuit of knowledge. The objectivity of the body had a particular impact for a woman as it was a stark contrast to how a woman's body was commonly understood and constructed. King (2004) reports that a woman is often portrayed as having affinity with nature and emotion with the body defined through its reproductive biology. Consequently, the medicalisation of childbirth rendered the constructs of emotion, and nature, as a pathology requiring control and scientific inquiry (Foucault, 1990; 1994).

Amigot and Pujal (2009) suggest that Foucault provides feminism with a theory of power due to the identification of the normative constructs of the body and specifically a woman's body. Foucault (1990) asserts that women were mainly constructed by their ability for reproduction and childbirth which resulted in them being understood as responsible for care and nurture. These became powerfully constructed norms to which women became defined and often unable to change. In contrast, McNay (2013) claims that masculine bodies were less defined by the norms of a physical, biological body and rather the rational mind. Therefore, women were seen as less able to transcend the physical, emotive body making them vulnerable to medical control. Although, many feminist authors argue that, whilst Foucault analyses the body and sexuality, his work does not fully respond to the subordination of women in society and the concept of gender (Amigot and Pujal, 2009).

Foucault (1989; 1994) clearly asserts the body as a focus of power and knowledge of which it is part of historical and cultural constructs .In this way the body can never be understood outside of power which means the body becomes exposed to the regulatory forces of power. Indeed Foucault argues that the sexual body became the

major focus of modern disciplinary power, whereby the female body was constructed with norms of hysteria and pathology. In turn, this led to knowledge being required to control and regulate the body, especially in relation to controlling reproduction (Foucault, 1990). Foucault (1994) extends this theory of power by suggesting that when a body is subjected to constructs of knowledge it positions medicine with a disciplinary role to examine and monitor through a process of surveillance. Therefore, birth became understood through the way it was managed thereby, creating disciplinary control. It led to a woman being cared for under a 'clinical gaze' in hospitals in what Foucault (1994) describes as technology of power where a pathologised woman's body required control through rational expert knowledge. The role of surveillance became pivotal to Foucault's theory as surveillance was the powerful force by which expert knowledge was applied that led to disciplinary control (Foucault, 1994; Gutting, 2005). Disciplinary control was also exercised through a process of self-internal regulation as an individual assessed themselves against commonly held accepted norms.

It may be debated that Foucault's theory of power helps explain the medicalisation of childbirth and movement of birth into large scale hospitals. The medicalisation represented a powerful norm whereby expert, rational knowledge was perceived as necessary to manage the increasingly pathologised pregnant body. In turn, this brought about tasks and processes focused on the surveillance of the pregnant body, a form of disciplinary control. Before this midwifery had been part of a norm whereby, the profession cared for a woman in their home environment based less on rational surveillance but relationships and care (McIntosh, 2012). Therefore, the emphasis of expert knowledge resulted in midwifery becoming subordinate to the medical profession. In order to be accepted midwives were required to conform to the changing constructs of a pathologised process of childbirth where care became focused on surveillance and less on relationships. McCourt and Dykes (2009) suggest that the whole industrialisation of birth left a woman no longer able to know, or trust, their own bodies.

Indeed, Finlay and Sandall (2009) have found that in standard UK models of maternity care, childbirth is predominately managed through routines, hospital and fragmented care where midwives are less likely to align to the woman and their care needs. Instead, midwifery allegiance tends to be toward the organisation. In contrast, continuity of care models ,with the midwife as the main care provider through all episodes of pregnancy and childbirth, resulted in midwives increasingly focusing on the needs of the woman rather than the organisation. Finlay and Sandall (2009) suggest this finding may be understood as continuity of care models allow midwives to avoid the many powerful constraints of the healthcare organisation. Sandall *at al*.(2016) subsequently undertook a Cochrane review of continuity of care models in midwifery care. The review identified that women receiving continuity of care were less likely to experience regional analgesia , instrumental and pre term birth, episiotomy and amniotomy. The review also found that in continuity of care models women were more likely to have a spontaneous vaginal birth and increased satisfaction scores. These findings would appear to indicate that despite the powerful

constructs of a medical model of care, improved outcomes for birth can be achieved through less routinised models of care that locate the woman as the focus.

These studies resonate with Foucault's theories of power by illustrating the ongoing powerful constructs surrounding woman centred care and the midwifery profession. Midwifery studies have shown that there are powerful ideologies of both medicalisation and normality associated with woman centred care (Hunter 2004; Downe, 2008; Deery *et al.*, 2010). Normality is understood as women who are low risk and able to receive midwifery led models of care such as continuity of care whereas, high risk models of care are associated with hospitals and medicalisation (Downe, 2008). Both of these ideologies have been reported as acting as powerful normative constructs for women and midwives to comply (Downe, 2008; Bryar and Sinclair, 20011; Davis and Walker, 2012). Jomeen (2010) defines these constructs as two competing discourses that shape maternity care; one of medicalisation and one of normality. Indeed, Jomeen (20100 argues that the discourse of normality has afforded midwifery its own professional power and expertise. In this way, when applied to Foucault, medicalised and normality norms, associated with woman centred care, both act as forms of disciplinary control. For as Dore (2009) writes, the links held between knowledge and power continually act as normative discourses for governing individuals.

2.7 Choice and risk

As part of the literature review the norms and theories of choice and risk were recognised to occupy substantial literature related to woman centred care and maternity services. Choice is frequently presented as facilitating woman centred care through the midwife empowering the woman to have choices in their care options . In turn, by offering choice the woman is perceived to become increasingly autonomous and in control of their care (Mander, 2009). Indeed, choice is often seen as a hallmark of modern health care systems where care providers enable shared decision making leading to enhanced choice of care options (Armstrong and Kenyon, 2017).

Jomeen (2010) has written extensively about choice and control as part of childbirth and the midwifery profession. As part of this analysis Jomeen (2010) claims that choice has become linked with control where there is an assumption having choice brings about enhanced control and quality of care for a woman in maternity services. The claim contends that choice is understood as a rational model whereby, a woman is able to have all the available choices and then select their preferred option by considering the benefits and risks. This understanding assumes that a woman has the requisite knowledge and desire to consider the options and make the choice.

However, Jomeen (2010; 2012) suggests that despite these claims, choice has been hard to fulfil with limited evidence of both its benefit, and actualisation, as part of maternity services. Instead, knowledge and information continue to be predominately held by professionals, including midwives. Consequently, women are not in receipt of all the information on which to assess the available options necessary for them to have the realisation of choice as part of their care. Jomeen (2010) argues that choice has become an idealised norm that women and midwives feel the need to conform.

This analysis is attributed to what Jomeen understands as the competing discourses shaping maternity care. One discourse of normality ; the optimum experience where women are low risk and achieve normal physiological birth without medical intervention. The other discourse of risk whereby, pregnancy is framed by alleviating risk with expert knowledge.

As part of this this work Jomeen (2010) undertook a study that explored a woman's experience of choice as part of maternity services. The study found that choice was a complex process where the idealised normal discourse associated with choice often resulted in women feeling pressure to conform to a low risk normal model of maternity care. Therefore, if women did not fulfil the normal criteria of childbirth, they were left feeling disillusioned and outside of the powerful constructs surrounding childbirth. Furthermore, Jomeen (2010) found that the constructs of choice were defined by professionals and not the woman. In this framework choice was part of the professional accepted norms of childbirth and if a woman failed to comply with these norms they were seen as making the incorrect choices. Jomeen (2010) concludes that professionals need to become aware of how they reinforce powerful norms that influence choice in maternity services. Instead, of an idealised aspirational norm of choice, Jomeen calls for a more realistic concept of choice able to offer accessible participation of a woman in making choice as part of their maternity care.

Broda *et al.* (2018) undertook a study exploring choice in midwifery that explored how a rational choice model versus habitus theory influenced a woman's choice on place of birth . The rational choice model was defined as one where individuals act in a rational manner to assess risks and benefits to reach an overall choice. This model was contrasted with a habitus theory where choices and decisions are determined by social processes such as values and culture. The study found that rational models were more likely to be applied as part of medical contexts and resulted in women choosing hospitals as a place of birth. Habitus models were applied when there was enhanced context focused on a person's beliefs resulting in women choosing home births or midwife led models. Broda *et al* .(2018) argues that maternity services tend to privilege the rational choice model which accentuates best practice and expertise. It was therefore, unsurprisingly that the majority of the women in the study opted for a hospital-based place of birth. In order for a woman to choose homebirths, or midwife led models, Broda *et al*. (2018) proposes that maternity services need to offer a habitus model choice emphasising social relationships and culture .

The study by Broda *et al*. 2018) corroborates previous studies exploring choice as part of maternity services. Noseworthy *et al.* (2013) also found that Western models of maternity care favoured choice and decision making as a process of the rational appraisal of options rather than relational models of choice and decision making. Noseworthy *et al.* (2013) also support a shift toward relational choice as able to recognise the social, cultural and political influences in healthcare . Kirkham and Stapleton (2004) also identified that choice was usually for the benefit of the expert professionals and based on the avoidance of risk. This emphasis of risk and expertise explained the differentiation between choice when part of hospital environments to birthing centre contexts. The latter being more removed from expert

knowledge and the discourse of risk thus inducing an increasing person centred, relational process of choice (Kirkham and Stapleton, 2004).

Winch and Gingell (2004) contend that choice has been framed as a largely rational process due to modern society increasingly focusing on an individual and their ability to become autonomous. As part of this rational focus education has a central role to play where to be educated leads to becoming a rational individual able to make necessary choices. The rational model has, in turn, led to the accentuation of risk where in an individualised modern society an individual becomes at risk if they are outside of the accepted norms. Therefore, there is an assumption that risk can be effectively controlled through the rational application of expert knowledge (Lupton, 1999; Lawler, 2014).

Lawler (2014) suggests that expert, rational knowledge is often perceived as a means to bring about autonomy and therefore, liberation from dominant forces of power. However, Lawler (2014) acknowledges that Foucault positions power and knowledge as relational where power produces the knowledge for which truths become established. As part of understanding woman centred care choice and risk have established norms whereby, a woman is offered rational choice predominately defined by expert knowledge. Likewise, risk is a process when a woman is outside of accepted norms with an assumption risk can be controlled through rational expert knowledge (Jomeen, 2010; 2012).

2.8 Conceptual framework

Having critiqued the literature pertaining to woman centred care and theories of power, a method was sought to coordinate the work and guide the subsequent research design. Consequently, the development of an underpinning conceptual framework was undertaken as espoused by Vaughan (2008) and Ringstead *et al.* (2011). Vaughan (2008) contends that conceptual frameworks assist researchers to move from description to consider the why and how guides the research questions, the associated data and the boundaries of the work. Ringstead *et al.* (2011) summarises that conceptual frameworks enable synthesis of literature allowing the researcher to set clear research questions and a design based on a concrete knowledge of what is known and what is not known about their proposed topic. As part of developing the conceptual framework an initial action, as advocated by Saldana (2015), was the identification of key concepts ,or variables, within the proposed study. The variables were identified from the literature review and potential connections between the variables were developed. This activity resulted in the conceptual framework providing an oversight of the proposed research investigating woman centred care in pre-registration midwifery education. The conceptual framework helped guide theoretical propositions and focused the main intent of the study. The table 2.1 on page 36 depicts the identified variables, their connections with woman centred care and pre-registration education. In turn, the variables were developed into a conceptual map.

The conceptual map may be found on page 38 Figure 2.1.

Table 2. 1 Variables for woman centred care and pre-registration midwifery education

Variable	Connection
Choice	Linked to concept of woman centred care
Control	Linked to concept of woman centred care
Mutual collaboration /partnership	Linked to concept of woman centred care
Individualised care	Linked to concept of woman centred care
Continuity of care	Linked to concept of woman centred care
Knowledge and understanding	Seen as evidence of enabling woman centred care in pre-registration midwifery education
Clinical practice context	Identified as influencing woman centred care in pre-registration midwifery education
Theory practice gap	Evidence of divide between theoretical concepts of woman centred care in pre-registration midwifery education and clinical practice
Synergy between clinical practice and theory	Evidence of application between pre-registration midwifery education and clinical practice
Changing profile of the woman	Women influencing concept of woman centred care in pre-registration midwifery education
Professional identity	Power interest of professionals influencing woman centred care
Methods of pre-registration education	Employed methods of pre-registration midwifery education influencing concept and clinical application of woman centred care
Power	A core theme throughout policy analysis and involved contexts and relationships relating to woman centred care

2.9 Summary

This chapter has explored the concept of woman centred care in maternity services and its relationship with pre-registration midwifery education. It revealed that the concept of woman centred care may be attributed to core themes, or variables, that subsequently informed the rest of this study. These variables are identified in table 2.1 page 36 . From the literature review it became apparent that woman centred care is viewed as a core aspiration of midwifery practice, by both midwives and the women experiencing the clinical service. However, although there are core themes

the use of the concept is variable and often ill-defined, especially in relation to a clinical practice context. In result, a large part of the related literature and policy displays an aspirational, theoretical concept of woman centred care.

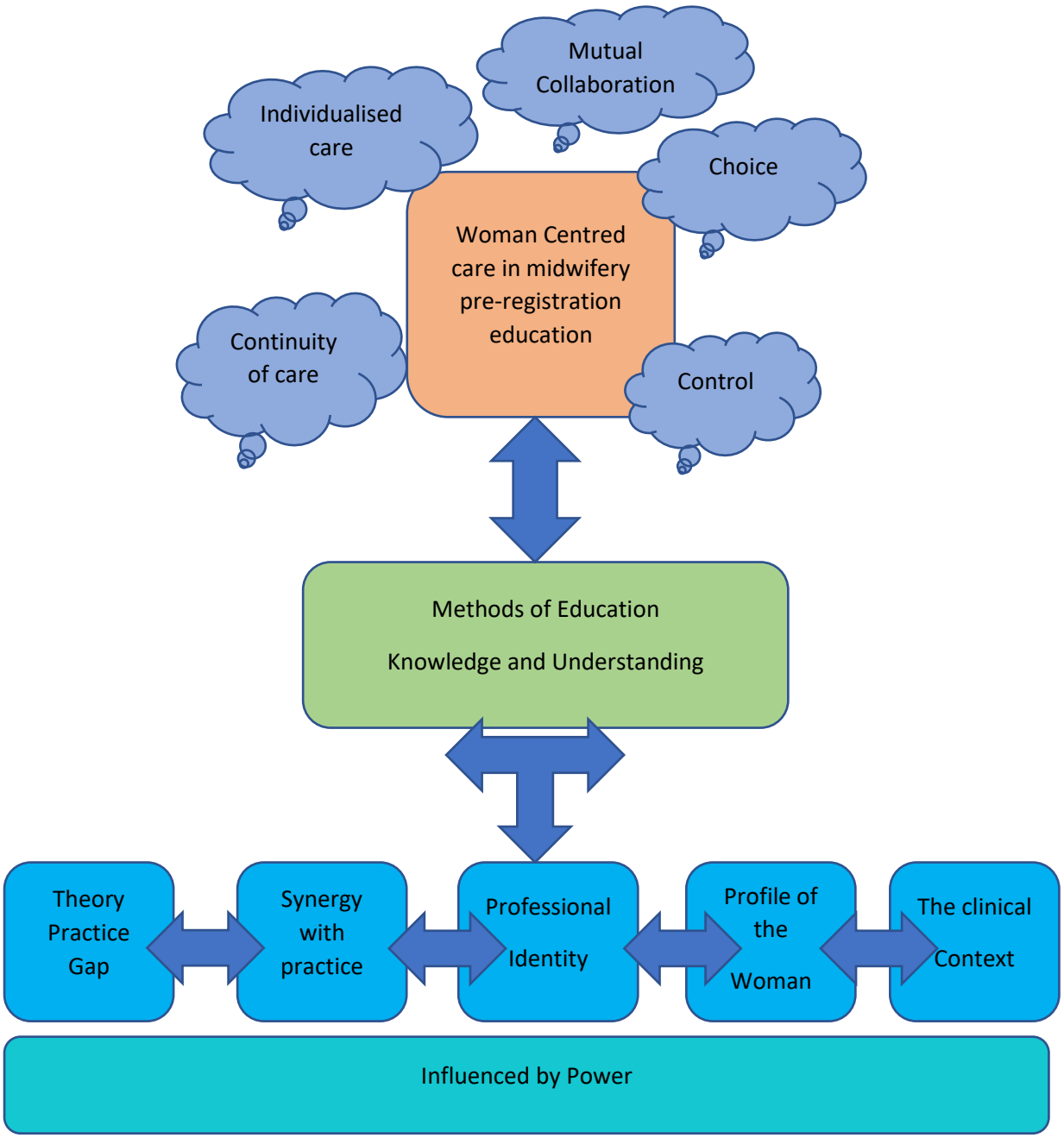
The same variables associated with the concept of woman centred care were also found when woman centred care was explored as part of pre-registration midwifery education. The similarity of themes for woman centred care illustrates a level of synergy between policy, maternity services and education. By large, the midwifery education literature was focused on the impact of the clinical environment and the selected methods of education for influencing woman centred care. However, this body of evidence is small and although results claim to explain when, and why, woman centred care is effective in midwifery education there is a lack of detailed rationale, or strategies, to help maximise the impact of the relationship between these two facets. Furthermore, there appeared to be a gap in understanding student midwives' contextual experiences of woman centred care as part of their pre-registration programmes.

From the literature it was apparent that power is inextricably entwined with woman centred care, both in terms of its definition, status and application. Indeed, the discourse associated with the concept itself could be viewed as establishing a set of norms evoking certain power dynamics. Whilst some of the studies alluded to power this was not well articulated, and most of the studies conveyed power as a process of dominance between professionals and the woman.

Collectively the literature review, and subsequent identified variables, were used to develop a conceptual framework. The conceptual framework shown as Figure 2.1 on page 38 illustrates woman centred care and pre-registration midwifery education along with the associated variables as identified in the literature review. The conceptual framework was used throughout the study as a visual representation to aid an overall cohesive research design.

Figure 2.1

Conceptual Framework for Woman Centred Care and pre-registration midwifery education



Chapter 3: Methodology

3.1 Introduction

This chapter provides an account of the research design, inclusive of associated ontology and epistemology, with an applied review of critical realism. My professional background is briefly described to enhance contextualisation of the study. Case study per Yin's (2014) methodology is then explored with contrasting critiques of case study in qualitative research; largely that of Stake (1995) and Flyvbjerg (2006). The later parts of the chapter outline a rationale for the use of Yin's (2014) case study design and its application to the study in question. The rationale is inclusive of the proposed research questions, guiding theoretical propositions and the quality indicators of the research design.

3.2 Professional context

As part of the research process a personal reflection, and acknowledgment of professional background, is provided to enhance reflexivity and rationale for the selected topic. I am a practising midwife in the UK and until recently occupied a professional position of Head of Department for nursing and midwifery in a large university department. I have subsequently become an Associate Director of Education in a large inner-city NHS Foundation Trust. Both roles have an executive function with strategic responsibility for education at under graduate and post graduate levels. The roles have also encompassed working with commissioners, patients, diverse multi-disciplinary teams, regulators and multiple education providers.

Previously, I have held several clinical and senior leadership positions in midwifery spanning both acute and community models of care. The combination of senior NHS and higher education roles has formed personal exposure to a wide scope of experiences from leading curriculum design, partnership working, policy development and direct teaching. The Head of Department role, though not directly involved with teaching midwifery, had responsibility for the strategic oversight of all nursing and midwifery education with line management of the senior executive Lead Midwife for Education (LME). The Head of Department role also involved external networking with Heads of Midwifery, Chief Nurses and Chief Executives. My relative new role as Associate Director of Education has a portfolio of work across all staff groups in the organisation such as medicine, pharmacy, nursing, midwifery, technical, apprenticeships and allied health professionals.

Consequently, I have been involved in national health and policy work such as maternity workforce projects and maternity policy development. The combination of clinical, education and policy experience has developed a personal passion, and interest, in workforce development and the part education plays. In my current role as Associate Director I am responsible for aligning education to strategic workforce priorities for the organisation I work in, and across, the wider health and social care communities as part of the sustainability and transformation work of NHS England. Through these varied positions one of my constant reflections has been how

education is frequently undervalued as a solution for workforce design and improving clinical care.

Alongside personal work experiences I have continued to possess a personal passion for midwifery and maternity services. As a junior midwife I led the introduction of a successful low-risk birthing unit and, as I progressed through levels of seniority and experience, I continued to lead projects aimed at improving the care received by women in maternity services. In many of these situations I found myself trying to negotiate what appeared to be tensions of maintaining the professional status of midwifery against the needs of the organisation and the women being cared for. Over recent years, being involved in maternity policy from within an education position led me once again to consider the often misalignment between policy, education and clinical practice. From this perspective I became enthused at the opportunity to explore the area in greater detail and especially from the position of education. Therefore, with a professional background of midwifery, and a passion for education influencing policy and strategy, I was keen to focus my study on these two areas.

3.3 Critical realism

Prior to the detailed account of critical realism an application of its relationship to ontology and epistemology will be covered. Gray (2014) perceives epistemology as a way an individual makes sense of the world they occupy and the resultant authentication of knowledge. Ontology is a term used for how reality is seen to be created (Neuman, 2014). In terms of this study it became apparent exploring understanding and experiences of woman centred care was based on knowledge, with reality underpinned by social meanings rather than seeking to uncover one objective truth. An objective reality, or the notion of an absolute truth, is often synonymous with a scientific positivist research paradigm whereby, research looks to discover an independent reality (Crotty, 1998). On this assumption, if a positivist approach were to be applied to this study, it would be focused less on uncovering social meaning and understanding and more on finding objective facts linked to woman centred care generalisable through a process of cause and effect. As Goertz and Mahoney (2012) report, positivist research paradigms used for the enquiry of concepts are primarily focused on producing measurable and objective findings able to be replicated in different settings.

Rather than a measurable, and objective, finding this study was looking to uncover a deeper understanding of meaning ascribed to woman centred care in pre-registration midwifery education. It was based on a belief that meaning is socially constructed through an individual's interaction with their world (Gray, 2014). However, although it was apparent the study was based on a social meaning, the position that all reality is only constituted through the subjectivity of people leading to not one objective reality but multiple interpretations (Merriam and Tisdell, 2016), was equally as challenging. This is often framed as interpretivism (Moule *et al.,* 2017), and, if applied to this study, it would mean the concept of woman centred care could only be understood through its many individual and subjective experiences. Whilst this offered an exploration of social meaning attached to woman centred care, a perceived limitation

was this meant there could never be a recognition of any independent entity and the concept would be limited to being located within one of on-going interdependence between individuals and the world they are part of (Crotty, 1998). Indeed, Blaikie (2010) describes research based on multiple subjective interpretations an idealist ontological assumption.

Consequently, neither the paradigm based on scientific objectivity nor on-going subjectivity felt a fitting match to the purpose and objectives of the study. Indeed, it led to a belief these two polarised positions create an artificial divide where objectivity, or subjectivity ,are the only possibilities for research designs. As Sayer (2000) writes, this outcome has resulted in frequent misconceptions in social scientist research. In contrast, critical realism positions research as not having to be either solely objective or subjective (Bhaskar, 1975; 1998). Bhaskar (1998) proposes that there is an independent reality to be discovered and this independent reality is one of order where structures and mechanisms have significant importance. It is the interplay between structures and mechanisms bringing about causal powers that, in turn, produce an independent reality.

Critical realist theorists such as Bhaskar (1975; 1989; 1998) and Sayer (2000; 2012) portray a stratified world, whereby, structures possess powers and generate actions. As a critical realist the researcher's role is to is to identify, and understand, the stratified world that often exists at a deeper level of reality. Although there is an independent world, critical realists propose that this is rarely accessed, and knowledge is socially constructed, meaning for researchers to investigate and uncover the independent world they must focus on social practices (Sayer, 2012).

Critical realism is often explained as the world being stratified whereby reality consists of three core layers . The top layer, the empirical world where experiences are witnessed and observed. The middle layer of the actual world where events take place without any human influence and finally the real world where the structures triggering causation are situated (Fletcher, 2017). Critical realists look to understand and explain social events through these stratified layers of reality based on the assumption the causal real-world mechanism can be understood by examining the empirical world layer (Bhasker, 1979; 2014). This understanding also provides critical realism with an intrinsic element of power as the stratified world assigns power to structures where they can evoke actions. In this way all objects possess causality as to whether to act or not. Sayer (2000) sees this as the contingency of power being activated or not . It infers that the structures placed in the real world can enable powers for agency and change. Likewise understanding why power may not be activated for action can be equally as illuminating.

Authors such as Bhaskar (1975; 2010) and Sayer (2000) promote critical realism as a new type of ontology outside of the belief that researchers must uphold either a social construction of reality or an objective positivism. This claim has not been without challenge and it has been argued critical realism is located only on the relevance of local and specific situations failing to pay attention to the macro level, or often termed system wide influences (Brown, 2014). Without a system wide focus, Brown (2014) disputes critical realism can effectively bring about change as it never

amalgamates research findings to a large, or systematic, understanding and therefore, risks producing more confusion. This position is especially problematic as it suggests despite critical realism aiming to create change it can only be located on small-scale change. It implies if understanding is only applied contextually then nothing can be applied outside of this given context and therefore, unable to evoke systematic understanding and subsequent change (Brown, 2014).

Archer (2010) provides a version of a social realist theory holding some synergy with critical theorists such as Bhasker and Sayer. However, Archer further examines the role of structures and agency and the relationship they have. Rather than situating these as inseparable in their outcomes, Archer (2010) claims it is possible to separate structure and agency as this explains the process of structures being evident and restructured as part of a social process. Archer (2010) calls this process the 'morphogenetic approach' whereby; both structures and agency become transformed in a change process. Archer also recognises that for this to occur the conditions to influence changes in structures, and the ability for agency to be exercised, is largely dependent on agents being able to undertake termed 'reflexive deliberation'. This is where the individual can consider the way they desire to respond in a given situation. Archer and Layder (1997) report that the relationship between structure and agency means, irrespective of the structural context, agents always need to make a choice and studying the interplay between choice and agency provides further opportunities for social explanation. As a result, Archer (2010) argues critical realism needs to pay more attention on the role reflexivity has in determining social change as this cannot only be attributed to an interdependent relationship of structure and agency. Instead, it requires consideration on the contingency of agency. Although Archer's theory enables an enhanced focus on the role of agency in critical realism, it is important to note the theory remains based on the premise structures pre-exist agency and agency is examined to help understand the impact of the pre-existing structures. Therefore, it also helps dispute claims critical realism fails to explain the existence of varying levels of agency or behaviours in the same structural context (Kemp and Holmwood, 2000) as it frames the role of agency not as a static process but possible of transformation (Lukes and Bates, 2014).

The opportunities, and possible challenges, of critical realism were carefully considered with the conclusion critical realism reflected the underlying ontology and objectives of this study. Its application was aimed at investigating woman centred care in a pre-registration midwifery programme with the identification of associated structures and mechanisms able to provide both an independent reality whilst uncovering, and understanding, the social construction attached to the concept. The application of critical realism necessitated examination of both structure and agency of which aspects of power were inherent. Indeed, critical realism is frequently associated with a high regard for examining power relations as part of the worldview, especially in relation to the contexts and structures causing and generating power dynamics (Merriam and Tisdell, 2016). It was anticipated understanding and identifying structures, events, agency and the associated power dynamics involved in woman centred care in a pre-registration midwifery programme, would potentially

uncover new understanding and possible explanations able to be applied in similar models of midwifery education. Indeed, Bryman (2016) purports critical realists seek to understand and change the social world by identifying the structures producing the visible events.

For the purposes of this study, and for clarity of methodology, critical realism has been employed as the ontological position whilst the epistemology constructs knowledge as part of a social process (Crotty, 1998; Blaikie, 2010). There is a critical realist assumption of the worldview and knowledge as separate entities and whilst knowledge can be socially constructed, the world still exists independently of these constructions (Sayer 2000; Crossley, 2005). In result, critical realism is employed as a general approach to the research for a methodology able to study complex situations and provide explanations of the social world, both in terms of its objective reality and the subjective interpretations that influence the objective world (O'Mahoney and Vincent, 2014).

3.4 Case study methodology

Easton (2010) supports critical realism as well matched to case study methodology as it enables in-depth understanding and exploration whilst, upholding access to an objective world and questioning of occurrences. Case study methodology and critical realism is further supported by Ackroyd and Karlsson (2014) who suggest that case study is a suited design for critical realists as it enables the study of exploring, and then identifying, causation and causal mechanisms leading to explanation and potential change.

Therefore, a case study methodology is a fitting design for a critical realist perspective and for a study aimed at exploring social practices and meaning. However, as part of the development of the methodology, attention was given to the evidence and literature surrounding case studies in social research. It soon became apparent, despite case studies being popular in social science and educational research, there were opposing definitions of the case study. The varying definitions has resulted in different interpretations of case studies being either a research design, method or methodology (Hamilton and Corbett-Whittier, 2013). The complexity of case study research may explain why it is often seen as a broad label for varying purposes and research approaches and as Swanborn (2010) claims, only adds to the confusion in definition of the term in research.

Yin (2012; 2014) argues that a weakness of case study is it is often viewed as part of a research design alongside other methods. Instead, Yin (2014) sees case study as an overall methodology able to capture the complexity of a studied situation; or rather the case, with how and why questions well suited to its strategy. This is the stance adhered to through this study whereby, case study is used as a methodological approach seeking to explore, gain understanding, and offer potential explanation focused around how and why questions. Yin (2014) contends that case study has incorrectly been part of an overall research strategy, not a strategy itself, due to it being associated as a method within other research methodologies such as ethnography. Instead, Yin (2012; 2014) presents the case study as an empirical form of investigation.

With this stated intent of case studies Yin (2014) continues to debate where there is no clear separation of the studied phenomenon, and its context, there are necessary approaches in a case study design of:

- A reliance on multiple methods of data collection to facilitate triangulation of data of the studied phenomenon
- Prior development of theoretical propositions that provide the direction for data collection and analysis

Yin (2014) suggests that these approaches indicate case study is a methodology as it involves the overall research design, data collection and data analysis in the research process. Yin strongly supports case study as a methodology facilitating empirical enquiry through a set of pre-specified research processes. Through the approach of a preordained theoretical framework, the case study can identify general or universal patterns (Abma and Stake, 2014). A preordained theoretical framework is defined as a deductive research design approach whereby, a theoretical position is claimed from the start of the study that subsequently, guides the whole research process (Blaikie, 2010; Yin, 2012; 2014).

This definition has not been without contest and there are competing viewpoints on what case study research constitutes and represents. Stake (1995) does not focus on case study as an empirical methodology but rather sees the importance resting on the 'particularities' of a case. The 'particularity' of a case is a core component of Stake's naturalistic approach for case study research. Stake (1995) argues that the aim of a case is not to discover, or explain, a structured pre-ordained theory but to understand the 'particularities' of the case due to the recognition of multiple perspectives. Consequently, for Stake (1995) the value of case study is based on its ability to expose meanings and the context of a case is primarily concerned with understanding rather than explaining.

Stake (1995) states his approach presents a fundamental difference between Yin's case study research. Stake's naturalistic approach is where the researcher, and the researched, are entwined with not one known world to be discovered but rather an interactive world where meanings are socially constructed through many interactions. In contrast, Stake (1995) declares Yin's approach to case study is where the researcher is more detached from the case as they seek to explain meanings and findings through universal laws. Flyvbjerg (2006) also supports Stake's view and argues that case study research has been confused with more traditional paradigms seeking to test a hypothesis. Instead Flyvberg (2006) believes case studies are about providing 'context dependent' knowledge that can never be focused on discovering a predictive theory and their value is through the learning gained from context dependent knowledge. Flyvbjerg (2006) advises it is not about positivist, quantitative research designs being privileged over context specific qualitative designs but recognising both are uniquely different with each offering a valuable approach according to what the research is seeking to investigate.

However, Flyvbjerg (2006) argues that Yin is endeavouring to promote a positivist, deductive paradigm for case study research that is inappropriate as it does not fully recognise the interactive and constructive nature of knowledge. This approach is

commonly framed as an inductive strategy where there is no preordained theory guiding the research, rather the research uncovers and generates meanings and theory (Gray, 2014). Although, Swanborn (2010) states a case study can never be fully holistic as the complexity of context means at some point all researchers have to simplify their models and results. Swanborn' s critique suggests that even if the researcher aims to reveal deep understanding and context dependent knowledge it is naive to assume this is not influenced by the researcher and the research process.

The theories of case studies in social research were carefully considered in relation to the already acknowledged critical realist ontology. The naturalistic case study design discussed by Stake (1995) shares a worldview of multiple realities where case studies cannot offer predictive theories or explanations but only context dependent knowledge. Therefore, the naturalistic theory did not align to a critical realist ontology. Instead, a critical realist paradigm aligned to Yin's (2012; 2014) case study methodology able to uncover, with possible explanation of social meaning was employed. The application of Yin's case study methodology also supports a deductive process acknowledging there is one accessible real world. For as Baxter and Jack (2008) acknowledge, Yin's case study methodology does not reject notions of some attainable objectivity.

3.5 The case study questions and theoretical propositions

The overarching research question informed by the literature review became constructed as; *How is woman centred care understood and experienced by student midwives, Heads of Midwifery ,the Lead Midwife for Education, and midwifery lecturers in a pre-registration midwifery programme*?

Silverman (2013) acknowledges differences between 'what' and 'how' questions, with the latter indicting a process of social construction through the research. Indeed, Goertz and Mahoney (2012) suggest researching concepts fundamentally means the researcher is asking about the nature of reality that further supports methodologies from a qualitative paradigm where searching for meanings or concepts is sought. However, although it is acknowledged the research process was aimed at exploration of social meaning, it also aimed to uncover and understand a reality independent to the social meanings as attributed to a critical realist ontological position (Bhaskar, 1998). Therefore, this section will extend the application of Yin's case study methodology with a critical realist worldview.

The initial focus of the research became exploring understandings and experiences of woman centred care in pre-registration midwifery education. Research questions were identified, and informed, following the literature review process. These became 'how' and 'why' focused questions that Yin (2012; 2014) supports as suited to his proposed case study methodology. With questions identified, theoretical propositions were also developed, Yin (2014) sees these as setting the direction of the study. The identification of theoretical propositions also adhered to a deductive case study methodology both supported by Yin's approach, and critical realism. It resulted in theory being used to aid explanation of the analysed structures in the identified context of pre-registration midwifery education (Blaikie, 2010).

Table 3.1 on page 46 depicts the research questions and their aligned theoretical propositions. As according to Yin (2014), the developed theoretical propositions were set as deductive theoretical principles acting as a predictive framework for the rest of the study to be tested against. Consequently, a deductive case study methodology was in place from the onset of the study and guided its entirety. During this time the research questions, and theoretical propositions, were frequently discussed with the supervisory team aiding overall clarity.

Table 3.1 Research Questions and Theoretical Propositions

Research Question	Theoretical Propositions
How do student midwives, Heads of Midwifery, the LME and midwifery lecturers understand, and experience woman centred care in a pre-registration midwifery programme?	P1) Woman centred care is likely to be linked to theoretical concepts of choice, control, continuity of care, mutual collaboration and individualised care. P2) Evidence of these concepts will illustrate woman centred care as a guiding philosophy in pre-registration midwifery education.
How do student midwives , Heads of Midwifery, the LME and midwifery lecturers perceive the theoretical concepts of woman centred care from the pre-registration programme are applied to the woman and her family in clinical practice ?	P3) If woman centred care is effectively taught and understood student midwives will be able to articulate how the associated theoretical concepts are contextually applied to the woman and their families they care for in clinical practice.
Why do student midwives, the Heads of Midwifery, the LME and midwifery lecturers understand, and experience woman centred care in this way?	P4) Understanding perceptions and experiences will help identify a contextual, practice-based concept of woman centred care for pre-registration midwifery education
How do student midwives, Heads of Midwifery, the LME and midwifery lecturers perceive the concept of woman centred care from a midwifery pre-registration programme is more broadly applied in clinical practice?	P5) Identifying the broader clinical context of woman centred care will help expose any associated theory practice gaps and points of synergy between midwifery education and clinical practice.

3.6 The case study definition

Having developed the research questions and theoretical propositions, the next essential step was the identification of the case. Yin (2012; 2014) distinguishes between single and multiple case studies whereby, multiple designs promote a more robust process and greater success of theoretical analytical replication. A primary

objective of Yin's case study methodology is to test pre-ordained theories leading to theoretical generalisation. This objective means that theory directs the research where the results of the case study are tested against the predicted theory and thereby, enabling theoretical analytical generalisation. In multiple case studies the theory and results can be compared with new cases. As part of this Yin (2014) contends that a process of theoretical replication occurs that further supports theoretical analytical generalisation.

In contrast, Yin (2014) sees single case studies as less robust, with a harder role in justifying their findings. Whilst recognising the acknowledged limitations of a single case study design, the case became defined as a pre-registration midwifery programme located in a university. Overall it was felt despite the limitations of the single case study, the focus of the study afforded itself to this design.

However, the study was mindful of maintaining clear boundaries in the definition of the case. As Yin (2014) confirms, having a clear definition and boundary to the case offers the opportunity to investigate the selected phenomenon in a real-world context. It could be contested that this is an over simplification of defining a case, for as Dumez (2015) states, no social phenomenon has a neat boundary around it. Instead Dumez (2015) suggests that a case definition should acknowledge a more narrative structure as a continual process with the case situated and acknowledged as part of past, present and future.

Donnelly and Wiechula (2012) promote the use of Yin's (2014) case study methodology and case definition as appropriate for the selection and definition of cases in higher education. They explain this synergy due to the methodology facilitating the investigation of how education is contextually applied in different settings such as clinical practice. Therefore, although the single case study was a limitation the identified case was felt to typify national UK based pre-registration midwifery programmes. Yin (2014) endorses, single cases as more favourable when they represent a typical case. The selected case was perceived as typical as it was a three-year pre-registration midwifery programme with a similar number of students and comparable demographic data to other midwifery programmes across England. The typicality of the case aimed to overcome the limitation of a single case study design as reported by Yin (2014). Furthermore, it was anticipated that a critical realist perspective would further respond to the known limitations of a single case study by offering an innovative approach to the identified case. It hoped critical realism would offer possibilities of change and transformation through the identification, and explanation, of the relationship between structures and agency in woman centred care and a pre-registration midwifery programme (Bhaskar, 1989; Tsang, 2014).

3.7 The case study quality criteria

Validity is a term used to describe the necessary quality in the research process and where the data collection methods are measuring what they set out to achieve (Moule *et al.,* 2017). Reliability is the consistency of the measurement achieved by the data collection (Silverman, 2013). Yin (2014), as part of the case study methodology, outlines the importance of construct validity, internal validity, external

validity and reliability as key criteria for judging the quality of a case study. Consequently, each of these aspects are discussed below in relation to the selected case study of the pre-registration midwifery programme being investigated.

3.71 Construct validity

Yin (2014) displays construct validity as a marker for assessing how far the data methods employed in the case study measure what they intended to measure. He states that this is addressed using multiple sources of evidence providing results that then align, or 'unite', together. This is a quality indicator for case studies as the coming together, or synergy of findings from different sources, suggests the data collection is addressing what it intended to do. Yin (2014) outlines the process as producing a 'chain of evidence' able to be replicated and providing part of the case study's operational guide for demonstrating a high-quality research process. Therefore, the research employed multiple sources of evidence including semi-structured interview data, a focus group and relevant documents. A protocol recording how, and when, the evidence was obtained was maintained throughout the study ensuring replication could be undertaken by another investigator.

3.72 Internal validity

Internal validity in Yin's (2014) methodology is used when the study is looking to explain an event often found in exploratory case studies. Yin (2014) states that this is often needed for case studies using why and how questions and when the research begins to make inferences or explanations about events that may not be objectively observed. This study employs how and why questions. Therefore, internal validity was carefully ensured through the data analysis process whereby, the theoretical propositions helped guide and organise the analysis as supported by Yin's (2014) pattern matching and explanation building data analysis strategies.

3.73 External validity and reliability

In many well-known research texts, such as Silverman (2013) and Donmoyer, (2000) generalisation is a primary aim of research and is achieved by identifying regularities that become part of the cause and effect of the studied phenomenon. However, Stake (1995) argues that this stance of generalisation is reductionist as it simplifies the studied phenomena to a set of generalisations synonymous with rational, positivist research paradigms and ill-suited to case studies and a qualitative research paradigm. Instead, Stake (1995) suggests an alternative conceptualisation of generalisation is required; one more applicable to qualitative case studies and experiences located in the context of the studied phenomenon (Stake, 1995).

Consequently, Stake (1995) presents a framework of 'naturalistic generalisation', which is based on the case study recognising the importance of its context and providing rich descriptions of the studied phenomenon thereby, producing deep understanding able to be applied to similar situations. Lincoln and Guba (2000), with a comparable stance, use the term 'fittingness' rather than generalisation and look to how findings can be transferable to other settings. Whilst these accounts provide a different interpretation of generalisation, they contain many basic assumptions on which generalisation is based. Indeed, the complexity of a social situation makes it

questionable if results are transferable to a similar setting, or if the aim is only to provide thick descriptions of the particular (Geertz, 1973; 2016). It could be argued that this defeats the objective of applied research trying to seek solutions (Gomm *et al*., 2000). Denzin and Lincoln (1985) support this stance and propose generalisability is only applicable to scientific research domains and cannot be achieved by qualitative research. Therefore, they argue it is incongruent to even seek the concept when undertaking a qualitative research design.

Yin (2014) does use the term generalisation as part of his case study methodology and situates much of his claim for generalisation around the vital role of theory. In a deductive approach, Yin reports theory development as driving the case study and should be undertaken before any data collection; it is this process that offers a differentiation of case study to other methodologies such as ethnography. Through the deductive process theoretical propositions need to be identified to support research questions and informing the overall study. In turn, Yin (2014) responds to the dilemma of generalisation in case study research by suggesting that the theoretical framework facilities the process of generalisation by what is termed 'analytical generalisation'. This is where the theory provides a template for the results to be tested. Here generalisation is not seeking to replicate findings rather it is situated on being able to generalise the findings of a study to a theoretical framework. Yin (2014) also notes generalisation is harder to achieve using the single case study and multiple case studies further support case study methodology. However, as already noted, this limitation was potentially lessened by the case reflecting a typical case of a pre-registration midwifery programme in terms of its applicants, structure and context.

Critical realists also promote theory as needing to direct the entire research strategy (Merriam and Tisdell, 2016), an aspect already reported as a key feature of Yin's (2014) case study methodology. However, Tsang (2014) highlights a differentiation between the theoretical generalisation, as used by Yin in case studies, to critical realists in case studies. Tsang (2014) suggests that Yin looks to theoretical generalisation as building a theory from the case, whilst in critical realism it is directed at developing explanations of the identified structures and mechanisms with the observed events, they cause being evident in similar settings. However, as with Yin's account of generalisation, a key shared component drawing Yin's (2014) case study methodology and critical realism together is they both look to investigate the phenomenon within its context (Tsang, 2014; Yin, 2014). In result, case study is an appropriate methodology for critical realism as the deductive, theory-laden process enables generalisation to be aimed at what Sayer (2000; 2012) sees as identifying the conditions, structures and mechanisms producing the events being studied. It is this that enables the possibility of change; or transformation often found in critical realism. Therefore, whilst Yin's analytical generalisation was adhered to it was further extended to seek an explanatory theory with a potential for transformation and understanding through the identification of structures, their activated, or possible causal powers, and human experience (Bhasker, 1975; 2010; Blaikie, 2010). As Tsang (2014) suggests, critical realist generalisation aims to theoretically explain the occurrence of structures and mechanisms that may then also cause similar

outcomes in other settings. It is through this process the potential of change, or transformation, may then occur (Bryman, 2016).

3.8 Sampling strategy

The sampling strategy of the study involved the consideration of the most relevant way of identifying a sample to support the case study design. As Blaikie (2010) proposes, all research requires the researcher to make decisions regarding data collection. Therefore, it was acknowledged that the population of the study was a defined case of a pre-registration midwifery programme in a university, and from this case a fitting sample needed to be identified. Yin (2014) stresses the importance of researchers being able to differentiate between the overall unit of analysis of the case study, and individualised data collection processes. Otherwise the focus and objectives of the study can become blurred. The study's research questions, methodology, and theoretical propositions directly shaped the sampling strategy as aiming to illicit further understanding and explanation of woman centred care in pre-registration midwifery education. However, the study's propositions were not only aimed at a purely theoretical university-based exploration but of a contextual understanding of woman centred care in a clinical practice setting. In result, it was recognised that the sampling strategy needed to capture data from both the university and application to the practice setting as defined by the case of the pre-registration midwifery programme.

The sampling strategy was initially translated as a convenience sample of student midwives studying on the midwifery pre-registration programme and a purposive sample of Heads of Midwifery (HOMs) and the LME connected to the university, who would be able to provide insight into both the clinical and educational setting as articulated through the pre-registration programme. Silverman (2013) reports that purposive sampling enables the selection of a sample as it reflects features, or processes of the given context the study intends to focus on. In total, this represented four Heads of Midwifery (HOMs) and their organisational description and experience is detailed in table 3.2 page 50 and 3.3 page 51.

Table 3.2 Profile of the Heads of Midwifery (HOMs)

Head of Midwifery	Years as Head of Midwifery	Years qualified as a midwife
HOM1	>10 years	25-30 years
HOM 2	< 5 years	25-30 years
HOM 3	< 5 years	25-30 years
HOM 4	>10 years	25-30 years

Table 3.3 Detail of the organisations led by the Heads of Midwifery (HOMs)

Type of Maternity Service
Inner-city hospital with a co located birthing centre, obstetric led unit. A tertiary referral centre with more than 6000 births per year Allocated 15 student midwives per year from across all years of the programme
Inner-city hospital with a co located and separate birthing centre. Also, an obstetric led unit and a tertiary referral centre with more than 6400 births per year 210 FTE midwives Allocated 15 student midwives per year from across all years of the programme
Consultant led unit, co located birth centre and community care services. Not a tertiary referral centre Allocated 15 student midwives per year from across all three years of the programme
Obstetric unit, co located midwifery led unit Allocated 15 student midwives per year from across all three years of the programme

The HOMs are not connected to any of the denoted organisations to further support their anonymity in the study.

The sampling strategy recognised that the HOMs occupied senior leadership and managerial positions and therefore, a limitation of the study may be not sampling junior midwives directly involved in supervising students. However, it was felt the initial objective of the study was aimed at the strategic organisational level whereby, it was anticipated the HOMs would have an enhanced understanding of the university's pre-registration programme and able to reflect the full range of the contextual understandings, and applications, of woman centred care.

In terms of the university, consideration was given to sampling midwifery lecturers, the LME and student midwives. This became further refined to a strategy initially focused on the LME as by the same virtue of the HOMs this aligned to the objective of the study and aimed to provide a similar access route of the senior lead able to represent insights and understandings of the case and line of inquiry.

The details of the LME and the pre-registration midwifery programme that they led are depicted in table 3.4 page 52. To further support anonymity of the LME broad ranges are used for describing their details.

Table 3.4 Details of the Lead Midwife for Education (LME)

Years as LME	Years qualified as a midwife	Pre-registration programme	Total number of student midwives
5 years	20-25 years	Two intakes per year of 80 total midwifery students all exposed to birthing centres, acute hospital settings and community placements	236

In terms of the student midwives the first sampling strategy submitted for ethical approval was for 3 focus groups of 5 to 7, third year student midwives studying on the pre-registration programme. Third years were selected based on the premise they had greater exposure to the programme and therefore, the contextual application of woman centred care in the clinical environment. However, as outlined in the data collection section below, this sampling strategy became adapted to one of a convenience sample of second and third-year student midwives resulting in a total number of 8 respondents. The characteristics of the student midwives are shown in the table 3.5 page 52.

Table 3.5 Details of student midwife

Student	Year of study	Age	Previous health /social care experience prior to starting programme
STMA	Third Year	20-25 years	Private care sector
STMB	Third Year	35-40 years	None
STMC	Third Year	20-25 years	Voluntary work
STMD	Second Year	25-30 years	Health care worker
STME	Second Year	35-40 years	Private Care sector
STMF	Second Year	20-25 years	Voluntary work
STMG	Second Year	30-35 years	Health care worker
STMH	Second Year	45-50 years	Health care worker

As the study progressed to enhance the amount of data, and to ensure as per construct validity the data was testing what it was aiming to as according to Yin (2014), a further sample was added to the sampling strategy. The addition was a convenience sample of the midwifery lecturers who were part of the teaching team involved in the pre-registration midwifery programme. The sample consisted of a total of 9 participants representing 60% participation of the midwifery team based at the university and involved in delivering the pre-registration midwifery programme.

In addition to the sample of HOMs, student midwives, the LME, and midwifery lecturers was documentary evidence related to the pre-registration midwifery programme. The documentary sample was a purposive sample of all programme documents related to the pre-registration midwifery programme representing an academic term from September 2017 until September 2018. Table 3.6 page 53 depicts the number and nature of these documents.

Table 3.6 Documentary Data

Type of Document	Number of documents
Programme handbook	X1
Theory Module Handbooks	X4
Practice Module Handbooks	X3
Clinical Practice Document	X1

3.9 Data Collection

3.91 Semi-structured telephone interviews

Ethical approval was initially granted for undertaking semi-structured telephone interviews with the HOMs, the LME and for up to 3 focus groups of third year student midwives consisting of between 5 and 7 participants. Yin (2014) contends that an important feature of case study methodology is the multiple use of data sources as it enables triangulation that strengthens construct validity in a study. For this reason, alongside semi-structured interviews data collection included available documentation relating to the pre-registration midwifery programme.

The semi-structured interviews for the HOMs and LME were conducted between April 2017 and June 2017. Semi-structured interviews are seen to be a well-suited data collection method for case studies and qualitative methodologies (Corbin and Strauss, 2008; Yin, 2014). Although it is acknowledged that many authors suggest face-to-face contact offers the ideal medium for an interview (Arksey and Knight, 1999), accessing HOMs, who were geographically dispersed and busy, was judged to be significantly challenging. For this reason, a pragmatic decision was made to enhance access by offering telephone or Skype interviews. Whilst the Skype medium was offered, with the aim to overcome any limitations of not having face-to-face contact, it soon became apparent through the data collection process that the Skype facilities were not readily available to the HOMs. Consequently, the data collection became digitally recorded telephone interviews. It is recognised that there are reported shortcomings of telephone interviews such as the lack of body language negatively impacting on the ability to develop an effective rapport (Farooq and Villiers, 2017). However, recent evidence suggests with an increasingly social media led world, telephone conversations have become a natural medium and less likely to bring about difficulties in understanding or responses in research (Irvine *et a*l., 2012). Indeed, when conducting the interviews there did not appear to be any challenges in terms of maintaining dialogue or understanding. This corroborates findings from Vogl (2013), who in a small study comparing the use of telephone and face-to-face interviews found no differences in the experienced levels of rapport.

Each individual telephone interview with the HOMs and the LME lasted approximately 30-40 minutes. They yielded between 10- 12 pages of transcript. The interviews were undertaken during daytime working hours. To ensure the participants could fully focus on the interview they were advised to undertake the interview in a quiet area away from any distraction, and to book a full one-hour for the scheduled time. This advice ensured, despite busy schedules, they were able to focus on the study and the questions being asked. During all the interviews rapport was perceived to be easily gained and methods were actively employed so the voice of the participant was the one largely heard. For example, only using prompts as needed, not interrupting and actively listening to the participants. A copy of the interview schedule may be found in in appendix 3 page 158.

The interview with the LME was carefully managed with a self-awareness of both my role as part of the organisation and to ensure their anonymity. With only one LME in the study there was recognition of the additional attention to detail necessary to uphold anonymity. Therefore, interview questioning techniques ensured that the predominance of the time was spent listening to the responses of the LME so that their voice was both heard and represented. Furthermore, it was hoped this would help diminish any perceived power dynamics. On subsequent listening to the interview recording, and its analysis, there appeared to be a flowing conversation with no overt signs of uneven power dynamics or reticence of participation.

Having successfully commenced data collection with the HOMs and LME it was anticipated that the focus groups would be consecutively undertaken with the third-year student midwives. Due consideration was given to the third-year of the pre-registration midwifery programme as it is known to be a challenging time with students focused on completing dissertations and looking ahead to employability options. Therefore, an optimum time devoid of any assessments was identified for the data collection process. The study was communicated by disseminating an electronic message with attached information sheets and consent forms as part of the student's on-line platform used at the university. The on-line platform was perceived as the best method of communication as this was a repository third-year student were used to accessing for programme and university information. The first posted message received no responses therefore, as supported through the ethics application, a second message was sent in the same way. The second communication further emphasised the study could be taken at the student's convenience and that it had been subject to a full ethical review. Despite this additional measure no responses were gained from the posted communication.

This was an extremely challenging point in the study and led to a period of intense reflection and supervisory team discussions. I acknowledged it was possibly unrealistic to expect third-year students, with demanding schedules, to want to participate in a seeming additional workload. Having previously taught third-year midwifery students I was mindful of the pressure of the third-year with students applying for jobs and completing dissertations. Furthermore, I wondered if the focus group method required too much personal organisation and commitment for the canvassed students. Indeed, whilst the focus group method aimed to promote

inclusivity of student contribution and discussion, it may have also been inversely seen as not enabling open and honest conversations.

During this time, personal reflections on the positioning of my role as a researcher, and the then post of Head of Department, became more acutely felt. Much deliberation became focused on the impact of the occupied role and if this insider position as part of the organisation, and as a perceived figure of authority, may have caused students to further question the motives and transparency of the study. In result, reflexivity was employed enabling consideration and analysis of the impact of my role and assigned power dynamics. Gough (2003) suggests that reflexivity can be understood and used in research in many ways and if it is only based on personal introspective reflection important aspects of power and bias may be missed.

Personal reflections addressing these thoughts were provided through field notes and discussions with the supervisory team. In this way immediately after every data collection episode a reflective written document was produced that became a reflective diary maintained throughout the research process. To enable this process additional time was diarised as part of the data collection schedule, and the written reflection occurred in the same quiet location away from any distractions. Each documentary addition was a personal reflection on the data collection process that recorded thoughts and feelings about the event. For example, if the interview had felt a mutual two-way process, when there had been more challenging responses , why they may have felt challenging and any prompts that were perceived to symbolise positionality in the process. All of the documented reflections were kept and utilised as part of the data analysis. The supervisory team meetings also provided another important component of the reflexive journey. Through these meetings prompts, and discussions, ensured consideration was provided for my own role as a researcher, the participants and the actual data collection event. Enosh and Ben-Ari (2016) perceive examining the components of the researcher, the participants and the research event as the essential components of ensuring reflexivity in the research process.

The documented reflections provided analysis of my own position as a midwife and as a Head of Department and the impact these may have been exercising on the data collection process. On one perspective owning the same profession as a midwife may have afforded a sense of being an insider in terms of professional identity and knowledge. However, the role of Head of Department may have introduced a power dynamic of students not wanting to openly share for fear of discrimination or judgement. In view of these personal reflections it felt both remiss, and unfeasible, to continue with the same data collection objective. Therefore, other feasible, and more fitting options were explored able to potentially enhance participation and possibly diminish the impact of the occupied role and perceived power as Head of Department. The anticipated enhanced participation was based on a rationale of data collection methods providing a more individuated approach, away from group or peer pressure with flexibility for the timing of the data collection. Consequently, amendments to the existing ethical approval were submitted requesting a change from focus groups to semi-structured telephone interviews with both second and third-year student midwives. Additionally, permission was sought to

introduce the study in a face-to-face setting to cohort of students. The face to face introduction was felt increasingly personalised whilst offering the students the opportunity to ask any immediate questions, such as the purpose of the study and how the results would be disseminated. The requested ethical amendments were successfully approved .

The face-to-face sessions introducing the study were undertaken with the second and third-year cohorts of student midwives studying on the pre-registration midwifery programme. During these sessions the student engagement was high with a genuine interest of the study and its subject area. It is hard to assume this interest could have been captured in the same way through an on-line posting as the face-to-face contact became one of energy and mutual dialogue. Although, in the face-to-face introduction sessions students were aware of the occupied position of Head of Department, the framing of the discussion was of a doctoral research student talking about their proposed research. Consideration was given to body language and clothing so that a less formal appearance to that of perceived Head of Department was portrayed. In addition, the face to face introduction was undertaken through invitation to enter into the student's classroom setting and not a given expectation. It was hoped this would also minimise the external symbols associated with the position of Head of Department. At no point in time were students asked to volunteer to participate during this session, it was purely for information provision. Following the face-to-face session students were left with a follow up contact and offered time to consider their involvement with the study. This activity was in accordance with good research conduct (BERA, 2018).

Over the next few weeks students made contact for further information at which point they were electronically sent an information sheet and consent form. In result, a convenience sample of eight semi-structured interviews over the period of three months from September 2017 to November 2017 was gained . The flexible telephone access appeared especially effective as students reported they were able to participate at a time that suited them and without any peer pressure. Indeed, many of the interviews were conducted after 18.00 hrs as this fitted with the student's busy schedules; something not possible with the original method of focus groups. Farooq and Villiers (2017) support telephone interviews offering enhanced flexibility of access well-suited to many respondents. Of the eight interviews, six were recorded and two not. One was not recorded due to unforeseen technical reasons and one due to student preference and consent. Although two were not recorded this was overcome by copious note taking made during the interview process.

Each interview lasted approximately 30-40 minutes and, as fitting with a semi-structured interview, a question guide was used to help steer the interview (Rowley, 2012). The interview guide may be found in appendix 4 page 160. The interview guide, as advocated by Gillham (2000), followed an introduction to set the scene, the main body of the interview, a summary and ending. The interview questions were aligned to the identified theoretical propositions so ensuring they adhered to Yin's overall data sampling strategy (Yin, 2014). To help prepare for the interview the student participants were advised to be in a quiet room or space, so they would be able to listen and engage with the questions. The majority of interviews were also

conducted in a different location to my own office. As although these were recorded and students unaware of the locality, I was conscious that my own office environment could have potentially influenced my own sense of position more toward that of Head of Department than student researcher . Prior personal preparation was also undertaken consisting of revising principles of active listening, questioning techniques and testing of the questions with supervisory team discussions.

Most of the performed interviews occurred without any problems. There was one occasion during a recorded interview a participant became distracted when answering their home doorbell. This situation was managed by reminding the participant of the interview purpose and the recent responses that had been provided. This enabled the participant to re-engage and focus and the rest of the interview progressed with what appeared to be good engagement. The encounter was also documented as part of the reflective dairy and contributed toward the data analysis.

Although, the semi-structured interviews were not the initial intended data collection strategy for the student midwives they did enable the collection of detailed individual data providing rich findings for the study. However, it may be contested the convenience sample and individual interviews, rather than focus groups, may have conflated selection bias found in convenience samples. For example, bias may be introduced as individuals often agree to take part due to their own personal motivation rather than that of the study (Moule *et al.,* 2017).Therefore, it may be some of the participants self-selected as they had a reason or personal motivation affiliated to the concept of woman centred care. In contrast, a focus group may have provided a greater access to the sense of a group identify of student midwives' collective knowledge, for as Bloor *et al*. (2001) reports, focus groups provide access to norms rather than individuality. Whilst it is true the sample was self-selecting the data was subsequently scrutinised for bias of participants wanting to only contribute a personalised version of their understanding of woman centred care in pre-registration education. However, any self-selection was not highly apparent as during the conversation's students appeared to respond as a student midwife and they did not share stories of their own experiences of woman centred care. In addition, the demographics of the students provided a range of ages and prior experiences not appearing to indicate any notable bias in the sample's demographics.

3.92 Midwifery lecturers focus group and semi structured interviews

Once the interviews were completed, initial data analysis was undertaken. The process of the data analysis is reported in fuller detail in a subsequent section of this chapter. The initial data analysis involved the critical review of the amount of data and its findings; both of which were discussed with the supervisory team. In total the data represented three hundred and fifty-two hours of data recordings/notes and key themes and patterns were beginning to emerge. Although, a reasonable amount of data had been collected, a progression exam induced a discussion as whether further data collection would enhance the overall study. Due consideration was given to this discussion leading to a decision to gain additional data. Consequently, a further amendment to ethics was granted for additional data collection of either a

focus group or semi-structured interviews of midwifery lecturers involved in the delivery of the pre-registration midwifery programme. The amendment was requested in May 2018 and granted within the same month.

The additional data collection became a convenience sample of midwifery lecturers resulting in 6 semi-structured telephone interviews and a focus group of 3 midwifery lecturers. The midwifery lecturers were accessed through individual email with an attached information sheet and consent form with a choice of participating in either a focus group or a semi-structured telephone interview. A decision was made to offer either a focus group or telephone interview to provide choice and flexibility for the midwifery lecturers. As with the previous data collection, a maximum of two prompts for the email communication was undertaken with no further follow-up. This aimed to ensure the midwifery lecturers did not feel pressurised to participate.

Overall, the midwifery lecturers appeared to be interested in the study and willing to participate. Power dynamics were openly acknowledged, especially in relation to my role as Head of Department. Conscious steps were taken to minimise power dynamics associated with the Head of Department role such as positioning myself as a student, observing body language and being self-ware of any symbols or language that may have affirmed positions of authority and power. Three of the midwifery lecturers selected to take part in a focus group arranged at a mutually convenient time. The focus group took place in June 2018. To further address power dynamics, the focus group was undertaken on the university's premises but in a location neutral to both parties and away from any possible interruptions. Prompts were used however; the dialogue between the participants appeared to be natural with equal contribution. The focus group became an active discussion between all the participants focused on the research questions. Bloor *et al.*(2001) contend focus groups provide a group narrative where norms are often articulated as part of a group social process. Therefore, the focus group was a useful addition as it offered further data triangulation, a new data collection method for testing the emerging norms from the data already analysed and a rich source of data in a concentrated time. With the midwifery lecturers' consent, the focus group was digitally recorded so active listening skills and questioning techniques could be fully employed during the data collection.

The remaining midwifery lecturers consented to semi-structured telephone recorded interviews. Each interview lasted between approximately 30- 40 minutes and was undertaken between June and July 2018. There were no perceived difficulties during the interviews and there was an ease of discussion and general interest in the research. The interview schedule may be found in appendix 4 page 160. The midwifery lecturers appeared to be highly motivated and positive about participating in the study. Having found the positive impact of undertaking the telephone interview away from my own office location with the previous data collection, this was again employed. By moving to a different environment I was able to have the time to position myself, not as a Head of Department, but as a doctoral student. During the data analysis process language was closely examined to identify any unconscious signs of formal power from my role. Indeed, as part of the recruitment process the midwifery lecturers requested if rather than be assigned a code, they could be given

a name related to a flower. The request was fully supported and in the results section the midwifery coding has employed anonymised names of flowers rather than alphabetical and numerical codes. This request was seen as an extremely positive aspect and representative of the midwifery lecturers positioning themselves as active, mutual participants and part of signifying a different relationship to the working day one with the Head of Department role. .

Although, the initial design had not intended to have midwifery lecturers as part of the sample, their inclusion was deemed to be a valuable addition and provided enhanced construct validity and data. Without this addition the same level of analysis, findings and recommendations against the theoretical propositions would have been harder to justify and manage.

3.93 Documentation

As part of the case study, documents related to woman centred care and the pre-registration midwifery education were reviewed. Publicly available documents were selected seen to have high relevance and levels of accuracy in relation to the study. This data was primarily programme documentation developed by the LME and midwifery lecturers and available to students for guidance and assessment of their competence through their pre-registration programme. All the available programme documents consisting of module, programme and clinical assessment documents were part of the sample. The detail of the sampled documents is provided in table 3.7 page 59. Creswell (2009) acknowledges that the use of publicly available documents offers a non-invasive sampling method whilst Moule *et al*. (2017) recognise it also provides data free from any researcher bias.

Table 3.7 Sampled Documents

Type of Document	Number	Brief description
Programme Handbook	1	Student facing handbook outlining the midwifery programme.
Module handbooks	6	Student facing handbooks providing content of each module contributing toward the overall programme with specific learning outcomes and an assessment strategy.
Clinical practice document	1	Clinical document utilised by student midwives in clinical practice for the assessment of clinical competencies and skills as set by the professional body (NMC).
Programme reports	1	Report submitted internally as part of the quality assurance of the programme

Once the relevant documents were located each was separately downloaded and saved as part of the study database.

3.10 Ethics

The study was submitted to the university's ethics review panel with full approval granted. The entire research process followed the upholding of good research conduct as outlined in the British Ethical Guidelines for Educational Research BERA (2018) and the Research Councils UK (RCUK, 2013) Policy and Guidelines on the governance of good research conduct. As part of the process information sheets and consent forms were developed which may be found in appendix 5 page 164. These entailed showing adherence to ethical principles of informed consent, data protection, justice, non-maleficence, beneficence and confidentiality that are the main components of research governance frameworks (Moule *et al*., 2017).

The study adhered to the principles as set out in the Data Protection Act (2018) and the General Data Protection Regulation (2018). All participants were informed of the use of any personal data and the time this would be kept for. Keeping any identifiable personal data was minimised for as short a timescale as possible. Therefore, immediately following telephone interviews contact numbers were destroyed as were any e mails. Any identifiable data was removed from transcripts and all data was kept on a strong password protected computer and not shared. The information sheet and consent form supported transparency of data by stipulating the use ,and methods, of data. Any written information was locked in a secure location with any identifiable data removed.

Informed consent warrants further discussion in view of the selected case study being part of the organisation I was part of and held, what can be perceived, a position of authority. For the HOMs and LME an individual email was sent to each participant with the information sheet and consent forms attached. The separate e mail enabled any concerns, or queries, to be raised on an individual basis that may have felt unfeasible through a collective email. Indeed, the email stressed the opportunity to discuss any concerns or queries. Only one query was asked by a HOM who wanted assurance that confidentiality and anonymity would be maintained throughout the research process. The email to the LME was scrutinised with particular intent to ensure it upheld principles of informed consent and anonymity. Assurance was provided, and all participants were given the opportunity to request to read transcripts from the data collection process and to enable data verification. This procedure was employed as best practice to ensure participants were able to withdraw, or amend transcripts, especially for any information that may have been perceived to negatively impact their anonymity. . Prior to any data collection commencing, despite having obtained written consent forms, verbal consent was again sought. The verbal assurance outlined the data collection process inclusive of emphasising any names or identifying features would be removed from the transcripts as according to ethical principles (BERA, 2018). Immediately following data collection, participants were allocated a unique study number and contact telephone numbers were destroyed. All data was password protected and written field notes kept in a secure locked location.

Miller *et al*.(2012) suggest accessing participants, and gaining their consent, involves implicit power dynamics needing to be fully understood and transparent in the

research process. Indeed, the relationship between researchers and participants is fraught with constant shifting power relationships negotiated according to perceived differences and similarities (Vahasntanen and Saarinen 2012; Frederick, 2013). In terms of this study, it was apparent that occupying the same professional role of a registered midwife did enable enhanced access of information as through the dialogue all the participants demonstrated a sense of shared knowledge and identify. For example, during the interviews participants freely talked about midwifery knowledge in a way that presumed there was an insider role. Some authors claim an insider role forms a mutual shared understanding otherwise more difficult to gain (Berger, 2015). However, there were also points of self-awareness highlighting how the occupied role of Head of Department potentially caused, what Berger (2015) frames, a positioning of power as part of the co-construction of knowledge in social processes. For example, some participants during the interview asked for assurance that they were providing the 'right' response to the questions. Seeking reassurance may be evidence of an unbalanced power dynamic being acknowledged by the participants. As Florczak (2016) states, despite contrary arguments, there remains an inherent domination of a researcher over participants in qualitative research. In these situations, the role of being a student undertaking research was stressed rather than talking to a Head of Department. Although, it was also recognised irrespective of steps taken to overcome perceived power dynamics, these would be an inherent part of the study requiring careful consideration throughout the research process.

Reflexivity became a core part of the research process and was threaded throughout the research design. Reflexivity is being self-aware of the role a researcher plays in the research process such as influencing and co-producing knowledge (Enosh and Ben-Ari, 2016). To support reflexivity memos and a reflective diary were kept during data collection and they also became part of the data analysis process. As Roulston (2016) claims, reflective accounts assisted in the exposure and analysis of how personal positioning may have influenced the study. It has been argued even with a process of reflexivity it is ambitious to accept power relations between researchers and participants can ever be truly balanced (Karnieli-Millero *et al.,*2009).

Therefore, whilst inherent power dynamics may be viewed as a limitation of the study, reflexivity was applied to someway lessen the impact of power. The process of reflexivity facilitated a detailed analysis of how the occupied role of Head of Department and related dynamics influenced the study. Berger (2015) describes reflexivity as a process where a person continually makes sense of the role of the 'self' in relation to the creation of knowledge. It implies that knowledge is not neutral but part of a social construct. Consequently, the reflexive process led to a continual critical examination throughout the doctoral study. For example, this was employed through examining use of language, appearance, context, roles and status and the occupied worldviews of both the participants and researcher.

3.11 Data Analysis

The recorded semi-structured interviews were transcribed verbatim and recordings listened to with additional reflections in memos made whilst this was being

undertaken. The memos became similar to the reflective dairy following the data collection process as they enabled instant reflections during listening to the recordings. These memos often captured reflections that would have otherwise been lost. As an illustration; one recording revealed the participant seeking consent to a question with a long pause before replying. The memo was able to capture reflection on the possible perceived power dynamic that became part of the reflexive process entwined with the data analysis. Two of the interviews were personally transcribed and the rest transcribed by an independent organisation. However, all the recordings were frequently listened to and reflections and memos continually made. Frequent listening and memos ensured a close familiarisation of all the data. The interviews that were not recorded were read and reread on numerous occasions with reflections also made in the form of memos. The process of listening and reading further provided embedded reflexivity as previously discussed and enabled nuances such as tone of voice to be analysed. This process was completed on numerous occasions throughout the data analysis process.

An analytic strategy was then developed using Yin's (2014) case study framework and comprised of initially looking for themes or identifying patterns in the data that became guided by the theoretical propositions of the study. Swanborn (2010) also discusses the importance of case study research having an analytical strategy documenting the employed analytic tasks. In order, to effectively manage the analysis NVivo version 11 was used as a recognised software package suitable for qualitative data analysis. As Yin (2014) advocates, NVivo was employed as an assisted tool and not a tool able to undertake the analytical process. NVivo also enabled the development of an on-line case study database that as Yin (2014) proposes helps increase reliability in case study research.

With the theoretical propositions guiding the data analysis, Yin's (2014) pattern matching analytic technique was employed to all the collected data. The technique aimed to identify patterns aligning to the predicted theoretical propositions identified at the start of the study. To support the data analysis, the NVivo package was guided by the five-stage qualitative data analysis method offering a framework for the stages of the analysis process as reported by Woolf and Silver (2018) of:

- Reported objectives of the study and methodology
- Analytical plan
- Translation of analytical tools to the available software tools
- Choice of selected tools in the software
- Identifying the need for any constructed software tools

Woolf and Silver (2018) state that the five-stage process enables researchers to effectively utilise the full powers of NVivo as it aligns the research plan, or strategy, to the tactics required from the employed software.

The identified variables from the theoretical propositions were used as part of the empirical pattern matching technique as advocated by Yin (2014), to which the data from the study was coded. The data coding was completed through NVivo whereby each variable became a Node (code) with an assigned colour to enhance visual

representation. This approach to coding supported a cohesive case study data analysis strategy linked to the research questions, theoretical propositions and variables. With Yin's (2014) pattern matching, the data analysis results were reviewed for the extent to which they matched the predicted variables. Where data did not support the predicted variables from the theoretical propositions rival explanations were developed. Yin (2014) reports rival explanations as an important part of pattern matching, as independent variables different from the empirically identified variables are uncovered. The rival explanations were then explored and analysed according to what Yin (2012, 2014) documents as their 'plausibility'. This is defined as dismissing a possible rival explanation if it can be explained from the data, or likewise keeping it as a rival explanation if it cannot be explained from the predicted data (Yin, 2014).

The data analysis stage for the pattern matching and rival explanations was further verified by sharing work with the supervisory team. At this point the data analysis also started to introduce another component of Yin's (2014) data analysis strategy of explanation building. Yin (2014) states explanation building starts to construct an explanation about the case study with causal links about what was found. Therefore, in the case study possible explanations about how ,or what, was found were developed. The explanation building part of the data analysis also enhanced the use of a critical realist framework. As Edwards *et al.*(2014) affirm, critical realist data analysis as part of case study research design should aim to not only describe variables but to build possible explanations of the mechanisms or structures possibly causing the observed and analysed events.

To help illustrate the data analysis process table 3.8 page 63 outlines a summary of the theoretical propositions, empirically identified variables and coding process.

Table 3.8 Application of Yin's data analysis framework

Table 3.8 displays the links formed between the research questions, theoretical propositions and the variables. The variables were then used as the codes for data analysis and data from all sources were coded to these, using NVivo version 11. NVivo tools were also employed for pictorial representations of the coding that helped with the visualisation of the distribution of coding and data sources.

Research Question	Theoretical Propositions	Variables
How do student midwives, Heads of Midwifery, the LME and midwifery lecturers understand, and experience woman centred care in a pre-registration midwifery programme?	P1) Woman centred care is likely to be linked to theoretical concepts of choice, control, continuity of care, mutual collaboration, and individualised care. P2) Evidence of these concepts will illustrate woman centred care as a guiding philosophy in pre-registration midwifery education.	Choice Control Continuity of care Mutual Collaboration Individualised care Node Colour- Purple

How do student midwives, Heads of Midwifery, the LME and midwifery lecturers perceive the theoretical concepts of woman centred care from the pre-registration programme are applied to the woman and her family in clinical practice?	P3) If woman centred care is effectively taught and understood they will be able to articulate how the associated theoretical concepts are contextually applied to the woman and her family in clinical practice.	Methods of Pre-registration education Knowledge and Understanding Node Colour Green
Why do student midwives, the Heads of Midwifery, the LME and midwifery lecturers understand, and experience woman centred care in this way?	P4) Understanding perceptions and experiences will help identify a contextual, practice-based concept of woman centred care for pre-registration midwifery education	Clinical Context Experiences Professional Identity Power Node Colour Blue
How do student midwives, Heads of Midwifery, the LME and midwifery lecturers perceive the concept of woman centred care from the midwifery pre-registration programme is more broadly applied in clinical practice?	P5) Identifying the broader clinical context of woman centred care will help expose any associated theory practice gaps and points of synergy between midwifery education and clinical practice.	Theory Practice Gap Synergy between clinical practice and education Profile of the woman in maternity services Node Colour Orange

Table 3.9 Data coding and sources of data

Table 3.9 illustrates the amount of data and its sources from the data analysis process. The code column represents the variables previously mapped to the theoretical propositions. This coding further enabled analysis of not only the data but the range, amount and types of data sources. Separate columns for the analysis of documents to enable enhanced clarity of the data analysis process. The data coding and the sources of data were maintained as part of the case study database held within NVivo version 11.

Code (Variable)	Number of sources and references in interviews	Source (n20)	Number of sources and references in documentation	Source (n9)
Choice	16 sources 41 refs	HOM1, HOM2, HOM3. HOM4, LME STMA, STMB, STME, STMG.STMH, Focus Group, Poppy, Daisy, Blossom, Rose, Olive	2 sources 3 refs	Programme handbook Yr 2 Theory Module handbook
Control	12 sources 23 refs	HOM2. HOM3, LME STMB, STMC, STMD, STMF, STMG, Focus group, Daisy, Blossom, Rose	3 sources 5 refs	Programme handbook Yr 2 module handbook Yr 2 practice module handbook
Mutual collaboration	12 sources 23 refs	HOM1, HOM3 LME, STA STMB, STME, STMF, STMG Focus Group, Poppy, Daisy, Blossom	4 sources 6 refs	Programme handbook Yr 3 theory module handbook Yr 2 theory module handbook, Yr 3 skills module
Individualised care	12 sources 37 refs	HOM3, HOM4, STA, STB, STME, STMF, Focus Group, Daisy, Blossom, Rose, Olive, Violet	4 sources 10 refs	Programme handbook Yr 1 theory module handbook Yr 2 theory module handbook Yr 3 theory module handbook
Code (Variable)	Number of sources and references in interviews	Source (n20)	Number of sources and references in documentation	Source (n9)
Continuity of Care	11 sources 23 refs	HOM3, HOM4, STB, STC STME, STMH, Focus Group, Poppy, Blossom, Rose, Olive	1 source 1 ref	Programme handbook

Knowledge and Understanding	17 sources 41 refs	HOM1, LME, STA, STB, STMD, STME, STMF, STMG, STMH, Focus Group, Poppy, Daisy, Blossom, Rose, Olive, Violet	3 sources 17 refs	Programme handbook Yr 3 theory module handbook Yr 1 skills module handbook
Clinical Practice context	18 sources 70 refs	HOM1, HOM2, HOM4, LME, STMA, STMB, STMC, STMD, STME, STMF, STMG, STMH, Focus Group, Poppy, Daisy, Blossom, Rose, Olive, Violet	2 sources 10 refs	Programme handbook Yr 1 theory module handbook
Theory Practice Gap	19 sources 82 refs	HOM1, HOM2, HOM3, HOM4, LME, STMA, STMB, STMC, STME, STF, STMG, Focus Group, Poppy, Daisy, Blossom, Rose, Olive, Violet	1 source 6 refs	Programme handbook
Synergy between theory and clinical practice	15 sources 48 refs	HOM2, HOM3, HOM4, LME, STMC, STME, STMF, STMG, STMH, Focus group, Daisy, Blossom, Rose, Olive, Violet	2 sources 11 refs	Programme handbook Yr 1 theory module handbook
Changing profile of woman	13sources 30 refs	HOM1, HOM2, HOM4, LME, STMC, STMG, STMH, Focus Group, Poppy, Daisy Blossom, Rose, Olive	4 sources 7 refs	Programme handbook Yr 1 theory module Yr 2 theory module Yr 1 practice module
Code (Variable)	Number of sources and references in interviews	Source (n20)	Number of sources and references in documentation	Source (n9)
Professional identity	17 sources 53 refs	HOM1, HOM3, HOM4, LME, STMA, STMB, STMD, STME, STMH, Focus Group, Poppy	5 sources 25 refs	Programme handbook Yr 1theory module Yr 2 theory module Yr 3 theory module Dissertation

		Daisy, Blossom, Rose, Olive		
Methods of pre-registration education	18 sources 69 refs	HOM1, HOM2, LME, STMA, STMB, STMC, STMD, STME, STMF, STMG, STMH, Focus group, Poppy, Daisy, Blossom, Rose, Olive, Violet	5 sources 13 refs	Programme handbook Yr 1 theory module Yr 1 practice module Yr practice module Dissertation
Power	17 sources 60 refs	HOM2, HOM3, HOM4, LME, STMA, STMB, STMD, STME, STMF, STMG, Focus Group, Poppy, Daisy Blossom, Rose, Olive, Violet	6 sources 20 refs	Programme handbook Yr 1 theory module Yr 1 practice module Yr 2 theory module Yr 3 theory module Yr 3 practice module

Chapter 4 : Findings

4.1 Introduction

This chapter presents the study findings. The empirical variables have been used as subheadings, and thus align with Yin's (2014) case study framework. The chapter also depicts the extent the empirical, predicted variables were found in the data. Yin (2014) claims that the extent predicated variables are found evidences the internal validity of a case study. Quotes from the data are employed for illustration purposes and, unless otherwise stated, the selected quotes represent a convergence of all the findings in the data. The data has been collectively reported under each variable heading for the purposes of accessibility. At the midwifery lecturers request pseudonyms have been used which enhance their overall anonymity in the case study.

This chapter also illustrates rival positions found during the data analysis process. These were the findings not aligning to the pre-ordained theoretical propositions. According to Yin (2014), case study methodology necessitates the identification of rival propositions as part of the pattern matching process used in data analysis. Whilst, the chapter endeavours to maintain discrete boundaries of content for each variable subheading, it was apparent there were multiple entwined themes running throughout many of the variables. In result, this is managed by the findings being presented under the variable it was primarily found in.

4.2 Choice

Woman centred care based on a woman being offered choice was present in the full range of the analysed data sources. The LME, student midwives, midwifery lecturers, HOMs and programme documentation defined choice in the pre-registration programme as a process with the woman, and her family presented with information enabling them to make informed choices in their care. The informed choice was portrayed as involving the woman in the decision-making process and devoid of professional bias.

> *'I think we learn a lot about informed choice um, so giving all the information, no bias, no opinion and providing a woman and her family with the information to support her.' (STMA*)

> *……..'it comes down to informed choice I suppose is what I'm saying to summarise it, I mean it's about facilitation of informed choice in a way that, that supports the woman and makes her feel supported and not pushed into making decisions.' (HOM3)*

Therefore, providing choice was viewed as a positive concept necessary to position the woman at the centre of care. For the LME, midwifery lecturers, and evident in the programme documentation, the concept of choice was largely interpreted as offering all available choices to the woman for a clinical care decision. To ensure the student midwives could offer this concept of choice, the programme documentation appeared to indicate students needed to develop their leadership and advocacy skills. In result, choice for the midwifery lecturers and LME was enabled by ensuring

students were not only well versed with the meaning of the concept, but also the skills and competencies deemed to bring about its clinical application.

> *'…..leadership necessary for autonomous practice and the promotion of women's choices, in all settings.' (Programme handbook page 11)*

The midwifery lecturers held an emphatic belief that promoting the concept of choice, as part of the pre-registration programme, was paramount to their roles being able to promote woman centred care. Indeed, many of the midwifery lecturers talked about the necessity of choice with high emotion reflected in the use of emotive language and repetition of terms to emphasise the point being made. Choice was also seen to be synonymous with the role of the midwife and the midwifery lecturers did not discuss other professional groups as part of the choice process in woman centred care.

> *'And in terms of how we teach our students it, I think we've got a real responsibility to teach them about ways that midwives can be true advocates and really, really facilitate woman centred care, about giving these women those choices as well, I think that's really important.' (Olive, midwifery lecturer).*

The emphasis on choice found from the LME, midwifery lecturers and programme documentation were portrayed as a mechanism to directly counterbalance against the perceived constraints in clinical practice. These constraints were primarily attributed to clinical areas operating within policies and guidelines in a risk adverse manner. The risk adverse nature of clinical practice was a direct inhibitor of the choice necessary for woman centred care.

> *'I think we've also become quite risk-averse, quite focused on the risk, and have put in place more stringent policies and guidelines that prevent that true women-centredness and the offer of choice.' (Poppy, midwifery lecturer)*

The student midwives also upheld the concept of choice as a guiding philosophy of woman centred care and part of their pre-registration programme. However, they reported a differentiation in the way choice was portrayed in their programme to how it was interpreted, and evident, in clinical practice. Largely, clinical practice was seen to not reflect their taught experiences of choice. Consequently, the student midwives provided examples of where they had been exposed to the woman not having the choices as they would have expected in clinical practice. This dissonance was present across all students with no difference between the second or third-year students. For example, student midwife B recalled a situation whereby a woman had requested a waterbirth where it had not been offered with no apparent evidence of why this was the case. This example was quoted as a clinical scenario reflective of the limited convergence of choice between clinical practice and their pre-registration programme.

'…….often I've seen midwives say oh you know, well you can't really use the water as you, we need to be able to do this, but you think well actually this woman, I think she doesn't because it's her choice, it's her choice there's no, you know, this isn't a prison.' (STMB)

The HOMs also verified the importance of choice as part of the pre-registration education and woman centred care. They clearly expected choice to be evident in the education received by student midwives. However, where the midwifery lecturers and student midwives interpreted choice as offering everything to the woman in clinical practice, the HOMs saw it as a more bounded concept. They reported the woman was not necessarily able to have all her choices met, as choice needed to be cognisant with what was safe and what was realistically available from within their clinical services.

'But it's about understanding what you're offering and actually you're not offering everything that's in the sweetie jar are you ,you know you'd like to um but that's not, that's not true either so it's um I think it's a challenge, that's one of my biggest challenges it's about how do I possibly you know pay and get that sorted and make it right when I know I've got other people that aren't getting basic stuff.' (HOM, 2)

Therefore, choice as a concept for woman centred care offering the woman all available choices was deemed by the HOMs as unrealistic and unachievable. Primarily this assertion was explained due to the scarcity of resources such as numbers of midwives and available finances. The HOMs were faced with the dilemma of wishing to offer choice as aligned to the pre-registration programme, whilst being responsible for managing and leading a clinical service with multiple demands. The HOMs were also acutely aware of choice having to be balanced against a safe and equitable service for all women. As shown in the quote above from HOM2, there was a belief if choice were available to a few women this would be at the expense of a consistent level of choice for all women.

Offering a woman , the choice, as reflected in the pre-registration programme, was unfeasible and no HOM talked about this as an achievable objective of their services. Instead, they discussed whilst they were aware of choice in the pre-registration programme being defined as a process of offering all available choices to a woman , this was not reflective of what was available in their services or applicable to the women being cared for.

'I mean some of our options um, one might argue that some of those options could be unrealistic for that woman, although we give her all the options, I'm not trying to say we limit her options, but some options are more realistic than others aren't they'. (HOM, 4)

The LME was aware of the contrast between the theoretical component of the programme's concept of choice with clinical practice. As a solution, the LME advocated a more explicit process of negotiation between the woman and clinical services for a mutual gain in choice. However, although the LME reported this

sentiment through the interview, the same level of conviction for a process of negotiation in choice was not found in the programme documentation or with the midwifery lecturers.

> *'……cards on the table about what, what the service can achieve and what women want and then somehow marry that up.' (LME)*

Overwhelmingly the emphasis of finding a solution between the known mismatch of choice for the woman and what a service could offer was largely seen by the midwifery lecturers as the responsibility of the clinical service. The responsibility resting with clinical practice was attributed to the perceived constraints only existing in the clinical context. In contrast, the HOMs perceived the rationale for the differentiation in the concept of choice due to the wide variation in how it was being presented to the student midwives in their pre-registration programme. In result, none of the findings offered any solutions for overcoming this differentiation.

4.3 Control

The concept of control, as part of woman centred care in the pre-registration programme, was evident in the data. In comparison to other variables, there were limited sources of supporting data found (16) and related references (23). However, the findings were inextricably linked with other variables such as power, choice and professional identity. These apparent links with other variables made control a recurring theme throughout the data analysis process.

A key finding was that offering choice, as a component of woman centred care, was equated with providing the woman with more control of her care. This finding was apparent from all the data sources.

> *'You know she's in the middle of it. It's her decision. She's got that choice I suppose, that control over her care. I think I see it as that probably' (STMG)*

However, according to the student midwives, the level of control was related to the type and level of choice offered to the woman. When choice was offered mirroring the midwifery lecturers and programme documentation view of providing a woman with all available options, the students perceived a woman as having more control in their care. Consequently, many of the student midwives provided examples of a woman being in control of their care when they had witnessed a woman having all her choices acknowledged and achieved. They equated control as a woman being empowered to have all her choices fully met.

> *'After she'd had her baby she explained that she just felt like she was in control and that her wishes had been met and she just felt empowered in that process because it was what she desired' (STMF)*

Therefore, the student midwives very much saw a relationship between choice leading to a woman having control in her care. The relationship was rationalised by a belief of providing a woman with information and choice would automatically lead to control and, in turn, woman centred care.

As with the variable of choice, the LME and midwifery lecturers perceived clinical practice as disenabling of control due to service constraints. Furthermore, there was a sense control often resided with the clinicians to which the woman was subordinate. During these accounts the midwifery lecturers used the term clinician rather than midwife appearing to suggest this was present with other team members caring for woman in maternity services. The midwifery lecturers, and LME, also promoted control as a concept dependent on the woman being offered choices in her care. It also followed a logic that if the woman was provided with information, she would be in control of her care leading to the facilitation of woman centred care. However, as with the concept of choice, for the midwifery lecturers, LME and student midwives' clinical practice was often shown as unable to offer a woman's control in care. There was a collective belief control often resided with the clinicians to which the woman was subordinate.

> *'I think they will find that challenging because I think it is in the nature of clinicians to want people to do what clinicians want them to do.' (Daisy , midwifery lecturer)*

Once again there was a perception of clinical practice being over reliant on policies and guidelines of which were quoted as the key reasons why women were unable to be in control of their care. Indeed, one student midwife presented this over reliance as a struggle for the women being cared for as she witnessed women having to battle against clinical guidelines to gain choice and, in turn, control.

> *'She was against being induced and they did listen, although she did have to fight for it. Women do have to fight the policies and guidelines to get what they want but it does happen.' (STMD)*

Although the midwifery lecturers and LME saw control as enabled through a woman having their full choices met there was an increasing recognition of the impact of the clinical environment on a woman's sense of control. Therefore, they discussed control needing to be available for all women and when choices or plans did not progress as intended, control could still be provided to the woman. This process was primarily facilitated through involving a woman in decision-making. One midwifery lecturer acknowledged control should be available to all women and in high-risk cases with known complexities control could play an ever-important part for enabling woman centred care.

> *'Things happen to you that are out of your control. So, the more complex the pregnancy the more important it is to involve that woman in decisions and to help her feel in control over the things that she can be in control over'. (Rose, midwifery lecturer)*

Although, the relationship between choice and control were found as important components of woman centred care in pre-registration education, the HOMs findings held contrasting interpretations to those of the midwifery lecturers, student midwives and LME. This interpretation was not concerned with either the clinician or the woman being in control, nor was it attributed to any constraints such as guidelines

and policies. Instead, the HOMs saw control needing to shift to a process of negotiation between clinicians and the woman. There was an inference that an enhanced accentuation of negotiation, rather than control, would be a positive way forward for student midwives' pre-registration education.

> *'So, I think, I think woman centred care for me…. I probably still have that inherent midwifery view that it's about a negotiation with the woman and that is what I would like to see in the students.' (HOM 2)*

The HOMs understanding of control in woman centred care resonated with the already reported bounded concept of choice where they were looking for a process of negotiation. This finding appeared to indicate the HOMs were seeking a reconceptualisation of control moving toward negotiation.

4.4 Mutual Collaboration

Mutual collaboration was primarily associated, across all data sources, as a concept meaning a mutually beneficial relationship, or partnership, between the midwife, student midwife and the woman being cared for. Consequently, it was strongly associated as an aspect of woman centred care in pre-registration midwifery education. For example, programme documentation indicated by the end of the pre-registration programme student midwives would be able to work in an effective partnership with the woman and thus promote woman centred care.

> *'Develop the personal and professional capacity and interpersonal skills required to work in partnership with women.' (programme handbook page 8).*

The programme documentation accentuated mutual collaboration as enabled through care planning processes privileging the role of the woman.

> *'Demonstrate a critical understanding of care planning, to include partnership approaches and collaborative working.' (year 2 module handbook page 1)*

The necessity of collaboration, as part of woman centred care, was also found in all the interviews and focus group. Mutual collaboration was evidenced through a trusting, sharing relationship with the woman. The significance of mutual collaboration was viewed as pivotal in supporting the midwife as an advocate for the woman in their care and facilitating the sharing of information.

> *'If you don't know the woman and the woman doesn't know you, how can you develop that trusting relationship and how can you share information both ways and how can you provide that information and how can you advocate for a woman.' (Jasmin ,midwifery lecturer focus group)*

The LME and midwifery lecturers were keen to promote mutual collaboration as part of the pre-registration programme with the aim of student midwives able to role model partnership working with the woman. It was anticipated the role modelling

would continue once the students qualified as a midwife. In the model of mutual collaboration, or partnership, the woman being cared for was positioned at the centre of care where collaboration was based on meeting the needs of the woman and her family.

> ‘So, actually the service meets the needs of the woman and the, and her and her needs and her family needs are defined by her. Um so that its very much a partnership model.’ (LME)

The HOMs also reported mutual collaboration as a part of woman centred care in pre-registration midwifery education. However, unlike the LME and midwifery lecturers, they acknowledged a wider range of clinicians other than midwives involved in the mutual collaboration model. Indeed, this led one HOM to reflect if the shift toward multi-disciplinary teams as part of partnership models of care risked the mutual relationship of woman, her family and midwife becoming diluted.

> *‘Woman centred care when you’ve got and you …..maybe there is a risk of that, that midwife and family and mother relationship being not as close as it was in terms of other people being involved in the care’(HOM3)*

The student midwives also verified mutual collaboration as an important component of woman centred care in their pre-registration programme. As with the midwifery lecturers and LME, the term partnership was used as a mutually inclusive term with collaboration and experienced as the woman being the centre of the collaboration.

> ‘ ….they should be at the centre of everything.’ (STME)

It was only in the student midwives’ data where a link was found between mutual collaboration and communication. The student midwives discussed clinical based scenarios as representing mutual collaboration between a midwife and a woman when two-way effective communication had been witnessed. These clinical scenarios were based on clinical situations when their clinical mentors were judged to be effective at discussing; explaining and listening to the woman they were caring for.

> *‘She’d always make sure that we had a discussion with her first and foremost’. (STMF)*

Unlike the HOMs, none of the student midwives discussed mutual collaboration involving a wider care clinician group. In result, mutual collaboration for woman centred care was located as part of a midwife and woman relationship.

4.5 Individualised care

Individualised care was found in the data from the HOMs, midwifery lecturers, student midwives and documentation. Like the variable of mutual collaboration, it was often defined as the pre-registration programme placing the woman at the centre of care and able to meet her specific care needs.

> *'To me it means that woman is… the steps that are taken to ensure that that woman remains at the centre of the care, individualised care'. (Blossom, midwifery lecturer)*

For individualised care to be actualised through the pre-registration programme the midwifery lecturers used a range of strategies for constantly acknowledging the individual and primacy position of the woman.

> *'Every session we teach, every conversation we have, every assessment we do they're at the forefront'. (Daisy, midwifery lecturer)*

Many of the programme documents had learning objectives based around student midwives providing individualised care. Although, the documentation frequently interpreted individualised care as encompassing the social, cultural and spiritual aspects of the woman.

> *'Appreciate the importance of woman centred care, and the ethical requirement for midwives to be sensitive and respectful of different psychological, spiritual, emotional and sociological perspectives, cultures and beliefs.' (year one module handbook page 1)*

The midwifery lecturers also understood the term holistic care as a more appropriate term to individualised. Holistic was perceived as a more fitting term as it was able to encompass a woman's spiritual and social context of which she was part. Furthermore, alongside holistic care the term family centred was also reported as a more accurate reflection of the model of care required for woman centred care.

> *'Because if you really thought about it, it would be that woman and her partner and the family and the social context, that's what holistic means. (Rose, midwifery lecturer)*

The student midwives and HOMs also supported the shift from individualised care to family centred. The family increasingly influencing a woman's care and a part of her support network explained the rationale for the shift.

> *'…..but the bigger picture is looking after a family because she, she should have a support network around her and that's supporting them as well.' (STMA)*

The only term used by the HOMs, other than individualised care ,was personalised care. Personalised care was portrayed by the HOMs as the application of individualised care in the clinical setting. The HOMs suggested that the pre-

registration programme needed to provide the theory of individualised care and their roles in practice was to assist in the application and making it become a reality.

> *'Hopefully what they're seeing in practice is, is those um, principles you know, living principles, you know, how we approach women, the opportunities we give them, the choices we give, how we give them information, personalised care' (HOM4)*

4.6 Continuity of care

Continuity of care was seen to further facilitate woman centred care by helping build the mutual relationships /collaboration thus placing the woman at the centre of her care. In result, there was a convergence in the data framing continuity of care as a positive concept in the pre-registration midwifery programme. In the interviews, focus group and documentation, examples of continuity of care models were provided as models of care able to decrease the often-experienced fragmented care whilst, increasing the opportunity to build a trusting relationship with a woman.

> *'I also think continuity of care is really important, some women see different people all the time and they have to keep repeating the same stories, telling the same things all the time'. (STMH)*

The midwifery lecturers, and HOMs, interpreted continuity of care with the model of case loading where a midwife was responsible for a woman's care throughout her pregnancy, birth and postnatal period. The HOMs were especially aware of the policy interventions to expand continuity of care in clinical practice leading to a significant impact on their services and, in result, the pre-registration programme.

> *"..we're looking at woman centred and one of the things in better births is having that continuity of carer you know that's likely to have maybe a significant impact. ' (HOM3)*

Indeed, the midwifery lecturers and LME provided examples of how the pre-registration programme had introduced a yearly student midwife-led model of case loading in the pre-registration programme. Whilst, there was recognition the case loading model could be further improved there was an overriding belief of the model equipping students with a positive experience and enhanced understanding of woman centred care.

However, the midwifery lecturers felt, despite the programme using continuity of care as a model for woman centred care, the clinical services failed to offer a consistent opportunity for the model of care to be taken forward.

> *'I'd really like to see the continuity of carer element of that rolled out and come into play as it should, but I'm worried that we're not in a time where that's feasible.' (Poppy, midwifery lecturer).*

Consequently, although the pre-registration programme was actively promoting continuity of care, the midwifery lecturers were unconvinced of the ability for students

to gain the necessary experience in clinical practice. Furthermore, the midwifery lecturers indicated not being involved or able to influence clinical practice discussions pertaining to case loading. The inability for clinical practice to consistently support the case loading models in the pre-registration programme was associated with the sporadic clinical placement organisation and services not yet fully on board with the model.

> *'I'm seeing my – all the students, the September group of students now at the end of their first year, and I saw one yesterday and she hasn't case loaded any women, and yet she's been in a community setting all year, because they're moved around she's done three different community placements in a year.' (Rose, midwifery lecturer)*

The student midwives also confirmed continuity of care as part of woman centred care in their pre-registration programme. However, the students largely talked about the theory of continuity of care and no one applied the theory to their clinical experiences of case loading. When care was linked with continuity of care it was not in relation to a case-loading model but rather the ability of the midwife building a close relationship as already reported in the variable of mutual collaboration.

> *'Like she would sit and as soon as the woman came in, regardless of kind of what stage she was at, she'd always make sure that we had a discussion with her first and foremost'. (STMF)*

4.7 Methods of pre-registration education

The midwifery lecturers and LME accounted for the overall philosophy of woman centred care being enabled through specifically employed methods of education. This claim was also reflected in programme documentation. There was a strong belief of education possessing a core role for assisting woman centred care with certain methods of education more suited than others. Primarily, the more effective methods of education were deemed to be those able to provide enhanced application to the clinical context. Consequently, the programme team, and the LME, relayed examples of employing the education methods of simulation, reflective activities and student-led discussions. These reported methods were perceived as upholding woman centred care as they privileged the role, and voice, of the woman being cared for in clinical practice. A paramount activity to counteract against a belief of woman centred care not always present in clinical practice.

> *'You are actually confident you're actually facilitating woman centred care through that and we had a really effective simulation. I think simulations are really quite powerful actually. Really powerful.' (Amber, midwifery lecturer focus group)*

A midwifery lecturer, Rose, also passionately shared how they compiled a resource of women's stories used as a method to ensure the students were aware of the woman's perspective.

> *'Yeah, for me I think the most important thing that I do is try and get them to think about the woman's perspective and the way that I do*

that is really through narratives through women's stories' (Rose, midwifery lecturer)

The student midwives corroborated these results as they also emphasised methods such as simulation and reflection as powerful methods for teaching woman centred care. Reflection was viewed as a particularly effective method for assisting them in gaining a woman centred care insight as it enabled a retrospective and prospective review of their clinical experiences. Many of the students talked about how afforded 'space' in the classroom for reflection allowed them the time to make sense of their clinical experiences that may have been otherwise missed.

'I think the reflection is a large part of how we learn because we can experience something and not quite realise every aspect of what we've experienced.' (STMA)

The midwifery lecturers and LME reported that the education methods employed in the pre-registration programme were based on an overall objective to transform learning and the learner. The focus on transformation led to accounts of student midwives being changed through the duration of the pre-registration programme. Change was largely linked toward changing student behaviours and values which more closely mirrored those necessary for being able to practise woman centred care.

'They're not here to do the on the job training, as such, they're here to shape as learners as well and I think that's really important, that we change that student and there's an outcome at the end which is much more than we've passed those modules, that actually you become a different person, that learning experience was very transformative as a person and I think that's where our responsibilities lie.'(Olive, midwifery lecturer)

At this point the midwifery lecturers and LME made frequent references to their employed pedagogy of enquiry-based learning (EBL) used throughout the programme. The use of an enquiry-based learning pedagogy was reported as enhancing woman centred care due to the student midwives having to investigate learning triggers that were always based on the woman and directly applied to clinical practice. The midwifery lecturers suggested that a woman centred care approach would be less evident without enquiry-based learning. Indeed, programme documentation also indicated enquiry-based learning as a positive method due to it enhancing the clinical application of education.

'The woman and her maternity experience are seen as core in relation to the role of the midwife. It is for these reasons that enquiry-based learning is our educational pedagogy' (programme handbook page 7)

Despite the midwifery lecturers and LME accentuating enquiry-based learning, none of the HOMs specifically raised it as a known method of education in the pre-registration programme. Furthermore, no student midwives raised enquiry-based learning as a method of education supporting woman centred care. Although, all the

students were aware of woman centred care as a philosophy threaded throughout their entire programme.

> '*we do talk about it a lot at uni, so I mean in terms of my education, it is brought up a lot. You know it's kind of mentioned a lot in everything we do. We learn a new thing and then we always kind of try to bring it back to woman centred.'* (STMG)

4.8 Knowledge and understanding

Findings revealed reflection, simulation, women's stories and discussions were the preferred education methods used to support the development of woman centred care through the pre-registration programme. However, there was also a distinction between the types of knowledge and understanding associated with the concept of woman centred care. The midwifery lecturers accepted the actual concept of woman centred care had varying definitions to those endorsed by the pre-registration programme.

> *'It's kind of a concept but not everybody's sort of – I suppose everybody has a slightly difference stance on it' (Violet, midwifery lecturer)*

The midwifery lecturers and LME were aware of the variation and saw this as especially apparent in the clinical context. In response to the variation, they perceived it as their responsibility to develop the student midwives' knowledge and understanding so they would be able to be advocates and champions of woman centred care. Therefore, references from the midwifery lecturers and LME were about student midwives needing to 'speak up*'*, 'challenge*'* and *'*develop critical thinking'. Developing these skills, as part of the student midwives' knowledge and understanding, was seen to provide them with the confidence to apply woman centred care in the clinical context.

> *'Enabling students to think differently and learn differently, enables students to be different in practice as well and put the woman back as the focus of the care. And that's when – they can't challenge if you haven't given them that skill and that confidence.'(Olive, midwifery lecturer)*

The term competence was also associated with knowledge and understanding required for implementing woman centred care. Unlike confidence, competence was explained as student midwives achieving an ascribed standard through assessments in the university and in clinical practice. The competencies associated with woman centred care found in programme documentation, and reported by the LME and midwifery lecturers, largely described professional proficiencies such as acting as an advocate, leadership skills and holistic care principles.

> *'There are competencies in there around promoting holistic woman-centred care and being flexible, being professional, advocating for women.' (Blossom, midwifery lecturer)*

The LME and midwifery lecturers privileged the classroom-based learning as an environment for supporting the acquisition of knowledge and understanding necessary for woman centred care. In turn, it implied the same level of knowledge and understanding was missing in the clinical environments and references were made to the midwifery lecturers having to 'plug the gaps' of clinical practice.

> *'And sometimes what you'll see is students will come back into university with very skewed, is that the right word, very kind of superficial views about well that's woman centred care'(Olive, midwifery lecturer)*

With the conjecture of clinical practice not being able to support the programmes ascribed woman centred knowledge and understanding, the LME and midwifery lecturers were emphatic in their resoluteness of it being down to them to impart it to the students they were teaching. In the interview transcripts, and audio recordings, language often became passionate and energised. This finding was also reflected in terminology used by the midwifery lecturers such as 'opening their minds', 'driving change ', 'thinking differently' . Therefore, there was an emphatic perception of their roles needing to constantly assert woman centred care.

> *'We really, really hammer it home' (Daisy, midwifery lecturer)*

The student midwives were aware of the strong conviction coming from the LME and midwifery lecturers for them to gain the necessary knowledge and understanding to achieve woman centred care. Indeed, the student midwives understood the conviction as them needing to demonstrate this expected level of knowledge and understanding as part of their classroom-based activities and assessments For example, the student midwives perceived, in order to obtain a good pass rate in their theoretical assessments, they needed to demonstrate a good level of knowledge and understanding of woman centred care which reflected the midwifery lecturers and LME's understanding.

> *'I really did get a good grasp this time round of what woman-centred, and I did much better, I got a, you know I got 70%...'(STMB)*

This finding was substantiated by the LME who also commented the midwifery lecturers were mindful of students often '*buying into'* woman centred care at the university as they knew this would ensure a good award of academic marks.

> *'…..they buy into it in uni, they know what to say, they know what to write, on these case-based presentations I think we catch them out a little bit.' (LME)*

In contrast, the HOMs were predominately seeking a knowledge and understanding based on student midwives undertaking tasks and activities in the clinical practice environment for promoting woman centred care. Competency for the HOMs was a term used for describing tasks and practical skills for care delivery in the workplace.

The HOMs also perceived simple clinical tasks fundamental to supporting woman centred care had been lost from the knowledge and understanding in the pre-registration programme. This finding was evidenced by the HOMs. They provided examples from their experiences of student midwives suggesting they were unable to perform basic clinical tasks such as oral mouth care, changing bed sheets and physical health assessments. There was a collective agreement of more attention needing to be given to basic care skills as this would support their clinical service requirement for advancing woman centred care.

> *'I was quite aghast really because to me the basics have gone.' (HOM1)*

The HOMs were very much focused on student midwives needing to acquire a knowledge and understanding of woman centred care that prepared them for clinical practice and 'work ready'.

> *'It's important that we work that out actually so that we can prepare them in education for the model that we want them to work in' (HOM4)*

Knowledge and understanding associated with woman centred care was also found to differ according the type of clinical environment such as birthing units, low and high-risk clinical areas. The midwifery lecturers acknowledged the need for knowledge and understanding of woman centred care to change according to the clinical context.

> '…..but actually you have to change your scope of practice depending on what situation you're in.' (Blossom, midwifery lecturer)

However, the differentiation according to clinical environment was more evident in the student midwives' data. The students were increasingly able to identify knowledge and understanding of woman centred care in low-risk clinical areas with low levels of complexity as experienced during the first year of their pre-registration programme. The same level of knowledge and understanding of woman centred care was not evident for their high-risk, complex clinical placements. Therefore, the student midwives suggested that the pre-registration programme could have provided an enhanced application of woman centred care for their high-risk clinical placements.

> *'I don't know maybe something within the education at university in the second year or before the second year so before you go out on placement, that would help you kind of adapt to going to low risk to high risk and still putting the woman first. '(STMF)*

Unsurprisingly, the differences in knowledge and understanding according to the clinical context left the student midwives feeling unprepared for woman centred care outside of the low-risk areas. Consequently, the students were looking for increasing flexibility where woman centred care could be applied across the full range of clinical settings.

'Um I guess not teaching people absolutes so make sure people obviously are adaptable but by teaching them kind of how to be so like not teaching them an absolute this is how everything is done'. (STMG)

Data from the HOMs also supported this finding as they called for the pre-registration programme to provide knowledge and understanding of woman centre care based on both medical and midwifery models of care. Recognition of both models of care was deemed necessary to prepare the student midwives to work across all the clinical environments.

'I think it's about giving that student that medical understanding as well as the maternity understanding in their placements'. (HOM2)

4.9 The clinical context

The clinical context was found to have a direct influence on woman centred care in the pre-registration midwifery programme. Out of the 20 sources of data, 18 made references to the clinical context pertaining to woman centred care and, collectively, this was the second highest number of references for a variable. As with the variable of knowledge and understanding, it was apparent from the LME, midwifery lecturers and student midwives that the low risk clinical areas were more readily associated with woman centred care. This finding was explained as low-risk environments promoting holistic care with the emphasis on the woman rather than time demands or guidelines. Many of the student midwives fondly recalled situations where they had been able to care for a woman in a low -risk area. These situations epitomised 'true' woman centred care as they had been able to effectively apply the theories of woman centred care such as individualised care and mutual collaboration.

'In the first year in the birthing centre you are able to sit and talk to women, build trust and a relationship with them and I think that's really about being with women. '(STMH)

Not only were the low-risk clinical areas seen to embody woman centred care, but they were actively promoted as positive beacons by the midwifery lecturers and LME. In result, conscious decisions were made to place students in low-risk clinical placements in the first year of their pre-registration programme as part of providing student midwives with a positive foundation for woman centred care. There was also a perception of the low-risk clinical placements exposing students to strong midwifery leadership from the managers and midwifery teams working there.

'Um, well we hoped that there would be a difference, so we put them in, in their clinical placement in Year 1, community birth unit, we wanted them to see strong midwifery leadership'. (LME)

The LME and midwifery lecturers viewed strong midwifery leadership as the ability of a midwife to work autonomously devoid of any constraints on their decision-making. Therefore, autonomous decision making was assumed to lead to woman centred

care and this relationship was, in the main, only found in the low-risk clinical environments.

> *'Year one we were trying to get students to go to a birth unit placement so that they could see decision making made by midwives.' (Amber, midwifery lecturer focus group)*

High-risk clinical placements, where the woman with known complications was cared for as part of a multi-disciplinary team, was consequently seen as a clinical context constraining autonomous decision-making and thus inhibiting woman centred care. This perception was also endorsed by the student midwives who were acutely aware of having to adhere to clinical guidelines and policies in high-risk, hospital settings. Guidelines and policies, rather than providing assurance, were reported by the student midwives as preventing them from implementing woman centred care as promoted in the pre-registration programme. The student midwives experienced this dilemma as feeling conflicted between the need to 'fit in' with the clinical environment whilst also being responsible for upholding woman centred care. Therefore, the student midwives wanted to challenge polices and guidelines but felt unable to do so due to perceived negative consequences.

> *'It's just something I thought there's always a protocol for something, we're always going on like how, how am I going to do this, like, there's literally a list of how you need to, to sort of um, to sort of treat labour and you kind of think, oh no, if I, if I don't do that then I'm going against policy therefore I'm up for, if something happens'. (STMB)*

The LME was also aware of the students being caught between a desire to 'fit in' against wanting to also adhere to the pre-registration programme philosophy of woman centred care. The need to 'fit in', or rather conformity, was viewed as detrimental to student midwives' challenging and taking forward woman centred care.

> *'The experience they have is time pressured, very heavily reliant on protocols and guidelines um and the culture of midwifery, of fitting in.' (LME)*

Whilst the theme of time pressures in clinical context was apparent from the LME and midwifery lecturers it was highly visible from the student midwives' experiences of clinical practice. Again, student midwives described high-risk clinical environments as time pressured , with an overreliance on administrative tasks. The student midwives felt unprepared for the clinical areas time demands which left them feeling unable to provide woman centred care and disheartened with midwifery.

> *'Ummm the time restraints as I've said I couldn't prepare myself for this the sheer business of the units, you can't give the care what you want to give all time, it's so busy'. (STMC)*

In contrast, student midwives experienced low-risk clinical areas as enabling the time and space for implementing woman centred care as they desired. Therefore, the

student midwives experienced woman centred care differently according to the clinical context. The low-risk clinical areas epitomising woman centred care and the high-risk clinical areas as not.

> *'……so little time to spend with women. When on birthing unit it was different and able to spend time but in main hospital goodness it's so different, it was just no chance to give them any reassurance to think they need to know how to feed, it was too busy fighting the paperwork to give them any reassurance or time'. (STMD).*

The HOMs did report known busy clinical environments with guidelines and policies. However, these types of clinical environments were not perceived as a constraint for woman centred care. Instead, examples were provided of how woman centred care needed to be adapted to all clinical environments able to recognise high-risk care and multi-disciplinary working.

> *'So we're giving guidance to the midwives in how they deliver that information to the women but what we are saying is well they're the general principles and policies and practice but your role, when you're talking to the woman, is to take that information and to make an individual plan for that woman'. (HOM4)*

Although, the midwifery lecturers, student midwives and LME appeared to perceive high-risk areas as inhibiting woman centred care, programme documentation supported the HOMs view of woman centred care being applicable across all clinical contexts.

> 'S*upports the student to appreciate the context in which practice occurs.' (*Programme handbook page 21)

Therefore, there was a marked difference between what the programme documentation was stating for preparation across all clinical contexts to what the LME, midwifery lecturers and student midwives expressed as their lived experiences.

4.10 Professional identity

Professional identity, in relation to the midwife, was referred to throughout the programme documentation. Programme documentation set learning outcomes suggesting passing the programme students needed to evidence a clear sense of their professional identity as a midwife, and this identity would support woman centred care. Professional identity, out of all the variables, was the one with the highest number of references in the data sources (n=25) in the programme documentation.

> *'Appraise the skills, values and professional attributes for midwifery practice and how these can inform professional identity and enhance women centred holistic care'. (3rd year module handbook page 1)*

Throughout all programme documentation the need to achieve a sense of 'strong' professional identity was frequently referenced. The emphasis was placed on students having to understand their professional identity across all care settings and as part of the multi-disciplinary team.

> *'Recognise the importance of professional identity and the midwife's scope of practice, to include working in partnership with women and multi-disciplinary/ interagency teams.'* (1st year module handbook: page 1).

The data from the LME and midwifery lecturers demonstrated a mutually dependent relationship between the professional identity of midwifery and woman centred care. Therefore, upholding woman centred care ,as part of the pre-registration programme, was understood as essential to ensure the on-going success of midwifery professional identity. Due to the already reported perspectives of the clinical context, the LME and midwifery lecturers had high concern that the current midwifery professional identity was under threat. This threat was linked to midwives having to take on more medical roles, or a belief of midwifery being subsumed into a nursing identity. This finding was opposite to the programme documentation depicting professional identity as embracing team working and diverse clinical areas.

> *'I am fearful we're going to lose our professional identity, if I'm perfectly honest'. (Poppy, midwifery lecturer)*

> '*That's what makes it so interesting that actually we don't want to be obstetric nurses, we want to still provide a midwifery service*.' (Daisy, midwifery lecturer)

As well as the LME and midwifery lecturers, the HOMs also shared views of increasing complexity found in maternity services posing a threat to the professional identity of midwifery. There was a belief in high-risk care midwives were unable to act as autonomous professionals; instead they were left to 'follow orders'. This belief was also contrasted against a view of midwifery needing to expand its professional remit outside of low-risk midwifery led care. The need for an extended professional remit was explained due to a perception of midwifery possibly limiting its scope and identity if it only aligned itself to low-risk care. However, paradoxically encompassing more high-risk care threatened the very nature of midwifery's professional identity.

> *'I think one is making sure that we get that midwifery-led care right in obstetrics and we as midwives don't become sort of, you know, in our minds we were the one who deliver midwifery-led care but only when it's midwifery-led and when it's, when it's involving doctors we, you know, we could lose a bit of interest for want of a better word' (HOM4)*

The stark contrast between autonomous low-risk care and high-risk changing clinical demands impacting on midwifery professional identity was evident in the programme documentation, and the interviews with the LME, HOMs and midwifery lecturers. There appeared to be a general recognition of professional identity needing to adapt

to the changing demands. However, specifically how professional identify could change or respond was less evident in the data.

As part of the discussion surrounding midwifery professional identify, the HOMs and LME indicated the drive for midwives taking on new roles and skills as influencing the scope of the midwifery profession. These extended roles were predominately seen as positive opportunities to support woman centred care. Although, it also evoked questions in relation to the boundaries and scope of the midwifery profession.

> *'I think we might see midwives having to take on some more sort of roles advanced practitioner type roles and I know in some places they've already started developing those um' (HOM1)*

Across all data, inclusive of the student midwives, the pace of change experienced in maternity services was understood as the main impact facing the midwifery professional identity. The many changes facing maternity services left respondents feeling unsettled about their professional role and the resultant implications for woman centred care.

> *'I think that's, the challenge to try and you know, keep women in the centre whilst everything else is going on around you kind of thing'. (STME)*

Although, acutely aware of these changes influencing professional identity, no participant provided possible solutions of how the balance between a changing maternity service and professional identity could be taken forward in the pre-registration programme. By large the situations were described as ambitions or challenges with no attached methods for what this meant for the future of the pre-registration programme.

In result, the student midwives also lacked a cohesive response to the necessity of maintaining professional identity against significant changes in maternity services. Although, as with other data, professional midwifery identity was also seen as an inherent part of enabling woman centred care. Unlike other sources of data, student midwives provided exemplars of clinical midwives that embodied the necessary professional identity for woman centred care. All these exemplars were midwives seen to go '*above and beyond'* the boundaries of their role and being able to self-sacrifice their own needs to promote woman centred care.

> *'This midwife just put her heart and soul into giving everything um, caring, extra time' (STMA)*

4.11 Power

In the programme documentation a recurrent learning objective was for students to gain the skills and competency to empower the woman being cared for. To achieve this there was an assigned power to the status of the midwifery profession where students were expected to verify how they would utilise their professional power to both challenge other professions and embed woman centred care in clinical practice. Empowering the woman, as part of woman centred care, was dependent on student midwives becoming empowered.

> *'Discuss how research and other sources of evidence can inform or challenge professional values and practice' (1st year module handbook page 1)*

Students were acutely aware of the power dynamic and reported feeling responsible for demonstrating woman centred care as sought by the LME and midwifery lecturers.

> *'I could see just how much they wanted us students to, to demonstrate that they've taught us about woman-centred care '(STMB)*

However, the student midwife accounts exposed that they were not only part of a power dynamic with the LME and midwifery lecturers but also with their clinical mentors in practice. The student midwives perceived the clinical mentors as having power over them as they were responsible for signing off their clinical competencies in practice. In result, students talked about having to comply with mentors and not wanting to undermine them. This compliance was interpreted as conflicting with them being able to provide woman centred care as desired by the LME and midwifery lecturers. The students were unwilling to challenge their clinical mentors for fear that they would not pass their clinical competencies or gain future employment. Due to this perception student midwives were left feeling powerless and many pondered if this would change when they were qualified as a midwife with the hope that they would them be able to find 'their voice'.

> *'I mean because you're kind of up against, as a student, the midwives and you don't want to kind of step on their toes and feel like you're undermining them' (STMB)*

The LME and midwifery lecturers were equally aware of the perceived inequitable power relationships between student midwives and clinical mentors. They deemed the presence of the unequal power relationship as inhibiting student midwives in woman centred care in clinical practice as students were scared 'to rock the boat'. In response to the inequitable power dynamic between the clinical mentors and student midwives, the LME and midwifery lecturers saw the solution as students employing their personal assertion skills as a method to challenge the power dynamics. This identified solution was personified by a quote from the midwifery lecturer Daisy who expressed it as the student midwives being 'brave' for woman centred care or inversely not being brave resulted in less woman centred care.

'But I always say to students, 'Be as brave as you want to be or not as brave as you want to be' (Daisy, midwifery lecturer)

The data also found a power dynamic between the midwifery lecturers and the clinical environment. The midwifery lecturers felt powerless to influence clinical practice. Despite all of the midwifery lecturers occupying link roles with clinical areas they reported feeling like 'visitors' in the clinical areas with limited authority or status to influence its context. Only two of the midwifery lecturers explicitly stated a perceived position to have any influence on clinical practice and even then, this was of a limited sphere of influence.

'I still have a little bit of influence in some of the trusts.' (Poppy, midwifery lecturer)

The LME and midwifery lecturers therefore, saw their main opportunity to influence woman centred care through the university environment. In addition, the LME and midwifery lecturers talked of a power dynamic with programme information provided from them to clinical practice often residing with senior roles and failing to filter to clinical mentors.

'I think sometimes information doesn't necessarily trickle down to the actual shop levels, the shop floor for want of a better word, so hope we could engage all these key stakeholders, not just the heads but clinicians.' (Jasmin, midwifery lecturer focus group)

The other main power dynamic found was the power of the organisation. The LME and midwifery lecturers suggested that the clinical organisation demands were frequently placed before the requirements of woman centred care. This was akin with the previous variable of the clinical context, with reports of organisations having an over reliance on policies and guidelines resulting in them becoming risk adverse and fearful of litigation.

'We're afraid to support a woman because of litigation. I think the students come back quite disheartened in that way.' (Lily, midwifery lecturer focus group))

The power of the clinical organisations was largely portrayed as a negative impact on student midwives and woman centred care. Because of this culture the midwifery lecturers claimed student midwives were left feeling 'disillusioned' and 'despondent'.

The student midwives also talked about the power of the organisations based around guidelines and policies of which women being cared for had to battle against.

'Women do have to fight the policies and guidelines to get what they want but it does happen.' (STMD)

'….is it genuinely women centred care or is it actually women centred care that fits in around policy/guidelines and trust guidelines and midwives working hours.' (STME)

This ‘battle ‘ power dynamic was opposite to their understanding of woman centred care espoused by the midwifery lecturers and LME. Many students confirmed what they understood as woman centred care, was not the norm in clinical practice . In result , they felt frustrated, anxious and compromised.

The HOMs data also found evidence of power dynamics involved in woman centred care. The HOMs were aware of the power of the organisation alongside trying to achieve woman centred care. However, unlike the LME, midwifery lecturers and student midwives they did not see this as forming a ‘battle’ between the two. Instead, they perceived power as a mutual process with the ongoing theme of negotiation between the woman and her care provider.

> *‘ I think it’s learning how to negotiate with someone, how to understand where they’re coming from, understand what they’re trying to say to you and why they’re trying to say it to you’ (HOM2)*

Therefore, in describing woman centred care the HOMs employed terms such as ‘adaptive’ ‘negotiation’ and ‘accepting’ rather than ‘battle’ and ‘fight’ as found in the student midwives’ data. It appeared to indicate woman centred care was a mediated position with multiple power dynamics.

4.12 Theory practice gap

The variable of theory and practice gap was one of the most substantial areas of data and yielded the highest number of sources (n=19) and references (n=82) from the HOMs, midwifery lecturers, LME and student midwife’s data. As already reported in previous findings, the student midwives perceived woman centred care in their pre-registration programme was an idealised concept not able to be fully actualised in clinical practice. The idealisation served to further accentuate their feelings of disillusionment, frustration and anxiety. The audio of the transcripts was especially revealing in this part of the data analysis as student’s voice intonation often changed when talking about the theory practice gap reflecting feelings of high emotion alongside the need for hope things could get better. Students were acutely aware of the perceived differences between the woman centred care concept located in the university and in clinical practice. In result, they were left feeling compromised.

> *‘I went out with this really fabulous idea that this was what I was going to do and this is what I want to do and then the reality came back ‘(STME)*

The theory practice gap was especially marked in the first year of the pre-registration programme where there was a strong emphasis on models, and clinical placements, of low- risk care synonymous with woman centred care. The student midwives recalled how even in the first year during low-risk clinical placements their expectations for woman centred care had not been fully met. The student midwives, when describing their lived experiences of woman centred care in clinical practice, frequently used the word ‘reality’.

'I know like in first year we talked about woman centred care and it was such a lovely idea and we were really excited about it but we realised when we went on placement that the reality is sometimes and quite a lot of the time, not um – not like that' (STMF)

This already reported finding of lack of preparation for the 'reality' of clinical practice served to accentuate the student midwives' perceived large theory practice gap. Due to the gap the student midwives felt let down by their pre-registration programme as, from their perspective, it had not adequately addressed the theory practice gap. Instead of an idealised version of woman centred care the student midwives wanted a pre-registration programme able to prepare them for the known realties of clinical practice.

'I think somebody needs to say and you're only gonna have an hour to do this and you're gonna have a mentor breathing down your neck whose got you know, 12 women to see and you're under pressure' STME)

The midwifery lecturers, and LME data also confirmed a theory practice gap surrounding woman centred care. The midwifery lecturers confirmed student midwives relayed this phenomenon during their class-based sessions at the university. In response, they believed the theory practice gap caused the student midwives to be either deflated or dismissive of the pre-registration programme.

'They often were more – some of them were quite sort of pessimistic or quite sort of dismissive of actually 'Well that's the ideal but that's not happening in practice.' (Violet, midwifery lecturer)

The LME and midwifery lecturers reconciled the theory practice gap as a necessary method as they were focused on providing the aspirational, or gold standard, of woman centred care.

'I try and talk to them about that a lot and say that this is important that we always teach you the gold standard of everything, but there's no point in us teaching you something that's third rate just because that's what you're likely to see.' (Daisy, midwifery lecturer)

Consequently, providing anything less than gold standard , even if reflective of reality, was perceived as undermining the pre-registration programme's ambition for woman centred care. Instead, the role of the pre-registration programme was not to bridge the theory practice gap but to lead the way for perceived best practice of woman centred care.

'So, I think probably that students do have a bit of a, there is a bit of a disconnect, however I don't want to move, I don't want to have a programme that reflects the realities of practice when the realities of practice are not women centred.' (LME)

The HOMs also revealed a theory practice gap between clinical practice and woman centred care. Unlike the LME and midwifery lecturers, they did not support the view of woman centred care being presented as a gold standard, aspirational concept. Instead, they were seeking a woman centred care more closely reflecting the realities of clinical practice. The term reality, like the student midwives, was frequently used when the HOMs talked about woman centred care as part of the pre-registration programme.

> *'..making sure that the students understand the role of the midwife and actually um what that… what it entails in reality' (HOM1)*

HOMs were actively seeking a closer union of woman centred care between the university and clinical practice. When prompted, they explained this was so when students entered the workplace they would not be disillusioned in their selected career as a midwife.

> *'But it's really important because I think one of the key things is if you give them an expectation in education and then we're not meeting it when we come to practice as a career' (HOM4)*

Therefore, the HOMs were primarily concerned of a theory practice gap surrounding woman centred care possibly leading to student midwives not being socialised into the profession and risking them leaving the profession. Both the HOMs and LME portrayed opportunities for reconciliation in these different expectations caused by the practice gap surrounding woman centred care. Although, they were also resigned to the competing priorities between university-based education and the work place existed.

> *'No, I, I know, so I'm worried about the um, philosophy the, the model of midwifery, they're worried about the day to day workings of their staff '(LME)*

4.13 Synergy between theory and clinical practice

Whilst there was an acknowledged theory practice gap, simultaneously there were facets of data supportive of the synergy between theory and clinical practice in woman centred care in the pre-registration programme. This synergy was especially evident in programme documentation with frequent references of the pre-registration programme promoting integration of education and clinical practice.

> *'The introduction of essential concepts such as experiential learning, critical thinking and the integration of theory and practice,' (Programme handbook page 19)*

Although the theory practice gap variable was perceived by the LME and midwifery lecturers necessary for a best practice concept of woman centred care there was also an intent for enhanced integration between the university and clinical practice. The HOMs, midwifery lecturers and LME all proposed closer working between their organisations. The midwifery lecturers interpreted synergy as being visible in clinical

practice and the HOMs interpreted it as more visible at the university. From both perspectives, enhanced synergy between theory and practice was sought to further facilitate woman centred care.

> *'But it's just making that a bit more visible I think, and that's something I'm passionate about is making that more visible to the students so they really feel that it's not two separate entities'. (Blossom, midwifery lecturer)*

The HOMs, LME and midwifery lecturers gave examples of synergy between clinical practice and the university. These included lecturers attached to clinical areas, clinical mentor updates, joint meetings and working parties. However, even with these examples there was a perception of much greater synergy being required. The LME was particularly mindful of students more likely to positively regard the university staff if they were deemed to be up to date and visible in the clinical environments.

> ….'*if we just sit in our little, you know, box in here and preach something, we're not actually out there then of course the students don't accept it.' (LME)*

The HOMs were especially vocal in their desire to be more involved in the planning and delivery of the pre-registration programme. One HOM commented that they had felt especially involved during a re-approval of the pre-registration programme but subsequently, involvement had diminished. They stated involvement of the HOMs and more clinical staff was necessary, not only to show the integration of theory and practice required for woman centred care, but to enhance practicalities such as the organisation of clinical placements.

> *'Well working together with the universities to, to agree the programme, the curriculum for the training based on obviously the NMC requirements but also from a practice point of view to ensure that the environment that we're providing for placements facilitates achievement of that programme really.' (HOM3)*

The midwifery lecturers also positively recalled the experience of the re-approval of the pre-registration programme as facilitating enhanced synergy between clinical practice and theory. The reapproval was seen to have provided the midwifery lecturers with the consent or authority to actively involve clinical practice in the pre-registration programme.

> *'I know when the last curriculum revalidation happened I was actively going out and talking to stakeholders and going out and talking to midwives in the trust and just saying how is the current curriculum?' (Amber, midwifery lecturer focus group)*

Student midwives' interpreted synergy between clinical practice and theory for woman centred care as primarily occurring through a positive mentor in clinical practice. A positive mentor was perceived as a mentor facilitating them in being able

to implement the more theoretical models of woman centred care found in the university.

> *'I had a really good mentor who was very much an advocate for woman centred care' (STMF)*

The impact of a clinical mentor providing woman centred care appeared to be a positive role model resulting in the students feeling supported and representing the university and clinical practice working in unison.

4.14 Profile of the woman in maternity services

The profile of the woman being cared for, and the impact this had on woman centred care, was frequently referenced across all the data sources. The HOMs perceived the woman being cared for in clinical practice was not always reflective of the woman presented as part of woman centred care in the pre-registration programme. The HOMs attributed the difference due to women no longer being healthy as found in low-risk midwifery care. Consequently, the HOMs believed the pre-registration programme was inadequately addressing the increasing complexity as part of woman centred care.

> *'Yeah I suppose…. yeah I think um there maybe should be a little bit more emphasis on um the fact that women aren't you know healthy young fit people anymore '(HOM1)*

The HOMs explained their maternity services were more commonly caring for women with higher maternal age, pre-existing medical conditions and mental health conditions. In view of the reported changing profile of the woman the HOMs interpreted woman centred care as also incorporating caring for 'sick women' as part of a multi-disciplinary team. Therefore, the HOMs were looking to the pre-registration programme to reflect the changing profile of the woman and for student midwives to be prepared to work as part of a team of care providers.

> *'At the end of it we're going to have a really good qualified midwife that I'd want to employ and that she's ready to, and confident in the practice and ready to go really as part of a team.' (HOM4)*

The midwifery lecturers and LME also reported the changing, more complex profile of the woman being cared for in maternity services. The changing profile was also evident throughout the programme documentation. The complexity of the profile of the women resonated with the profile presented by the HOMs. However, the LME and midwifery lecturers accentuated complexity needing to be balanced alongside maintaining woman centred care. This finding supports the professional identity variable which highlighted midwifery lecturers and LME locating woman centred care as an integral part of maintaining midwifery professional identity.

> *'You can be a really highly educated midwife who is able to care for somebody who needs fairly critical care. But still understand what normality around birth is, and understand family bonding, and*

understand breastfeeding and the normal physiological changes of the body as well. It doesn't have to be lost'. (Daisy, midwifery lecturer)

The midwifery lecturers and LME were accepting of the changing profile of women and that it would inevitably require midwives to work differently. Therefore, woman centred care was perceived to have to be effectively managed and understood to accommodate the changing profile of the woman .

'It is changing a lot, and midwives are going to have to be working very differently to ensure that women are – kind of risk is managed in a way that allows woman centred care to still be delivered.' (Olive, midwifery lecturer)

The student midwives also verified the existence of a changing profile of the women. As stated above, this change was largely attributed to increasing complexity and women no longer being fit and healthy. However, the student midwives, unlike the HOMs, LME and midwifery lecturers, raised the increasing social challenges as also responsible for the changing profile of women being cared for. Whereas the student midwives felt aware of the possible medical and mental health complexities the social conditions stood out as an area that had taken them by surprise.

'I encountered lots of social problems it's difficult to grasp them until faced with them I was really shocked by what I was hearing and dealing with.' (STMC)

4.15 Summary

This chapter has provided an account of the findings from the data analysis of the programme documentation, HOMs, LME, midwifery lecturers and student midwives . The chapter has presented a largely descriptive account of the findings organised using the pre-determined variables linked to the theoretical propositions. This approach also enabled Yin's (2014) pattern matching technique to be employed. As part of the pattern matching technique findings were also examined according to any specific demographic characteristics. For example, differentiation of findings between the third year and second year student midwives. This was completed not only through the coding in NVivo but also through the application of comparison diagrams enabling different nodes to be compared. This part of the analysis did not reveal any differentiation in the findings related to specific characteristics of the source of data.

Chapter 5 :Discussion

5.1 Introduction

In the previous chapter the findings were presented against the identified variables. The findings were arrived at through following Yin's pattern matching data analysis process inclusive of the identification of rival propositions (Yin, 2014). In this chapter a discussion of the findings, with identification of possible explanations, is presented. The discussion includes incorporation of relevant theories and literature. Theoretical propositions are used as headings to continue the adherence to Yins' (2014) overall case study methodology. The discussion of the findings is managed by addressing where most of the data coded to the variable and the theoretical proposition was found.

5.2 Woman centred care as a guiding philosophy in pre-registration midwifery education

Theoretical propositions
P1) Woman centred care is likely to be linked to the theoretical concepts of choice, control, continuity of care, mutual collaboration and individualised care.
P2) Evidence of these concepts will illustrate woman centred care as a guiding philosophy in the pre-registration programme.

The findings support the theoretical proposition of core well known theoretical concepts of choice, control, continuity of care, mutual collaboration and individualised care being associated with woman centred care in pre-registration midwifery education. Many of the theoretical concepts depicted in theoretical proposition one had closely entwined findings also present in theoretical proposition two. Therefore, both theoretical propositions, in relation to the findings, are collectively discussed.

Choice as part of woman centred care in the pre-registration programme was frequently framed as a positive objective to be achieved. This finding may be explained by an on-going policy drive promoting choice as an indicator of high quality, effective midwifery care and paramount to achieving woman centred care (Thompson and Lewis, 2013; NHS England, 2016; RCM, 2018). Mander and Melender (2009) and Kirkham (2000; 2004) suggest that choice forms a central role in woman centred care as it empowers a woman through enhancing their autonomy. A causative relationship between choice and control is often prevalent in midwifery literature assuming when a woman has choice she will feel in control. Choice and control are frequently linked with improved health outcomes and levels of maternal satisfaction (Mander and Melender, 2009; Jomeen, 2012). Outside of maternity care, choice has also been reported as a guiding aspiration of modern western health care (Armstrong and Kenyon, 2017). Noseworthy *et a*l.(2012) report that the shift to theories of choice and control in western health care assumes people desire and can take responsibility of their care needs. An emphasis of choice may also reflect an

increasing consumer driven health care movement where people seek empowerment and control (Constand and MacDermid, 2014).

Evidence of a link between woman centred care and an aspirational model of choice and control was found in this case study. The pre-registration programme portrayed a causative relationship between choice and control, both of which were deemed necessary for woman centred care. However, choice was found to have variances in terms of its definition, and application, between the university and clinical practice. Choice for the LME, student midwives and midwifery lecturers, was defined as a process of informed choice whereby, a woman was presented with all the available options of which she was able to then select . Broda *et a*l.(2018) debate choice has been informed by two core theories of rational choice and habitus. In rational choice, individuals act to assess the benefits and risks of the presented options and select what they believe to be the best option. There is also an assumption of rational choice leading to a positive outcome and consequently, is something to be desired. In contrast, habitus theories of choice are based on social determinants of an individual's ability to make decisions considering social, political and cultural influences. Habitus choice is increasingly focused on the context the person is part of and how the context influences their relationship with choice (Broda. *et al.,* 2018).

It may be argued that the model of choice in the pre-registration programme for the LME, midwifery lecturers and student midwives aligned to a rational decision-making model. The participants discussed the programme advocating a theory of a woman being presented with information and then deciding the best course of action. The role of the midwife in the rational decision-making model was to empower the woman in making rational decisions and gaining autonomy. The process of choice was perceived as a desirable objective bringing brought about woman centred care. There was limited discussion on a woman's ability to engage in the process of choice due to their individual social context. This is of note as in a later theoretical proposition student midwives reported that the social circumstances related to woman centred care was often missing from their pre-registration programme.

Winch and Gingell (2004) propose that autonomy, when linked to empowerment and rational choice, has become an objective of modern western liberal education and policy. For a person to participate in an informed choice process it assumes they can act in a rational manner by evaluating and selecting options. It also assumes that a person is fully informed about all the available choices. It is through the rational process a person becomes increasingly self-governing and autonomous. Therefore, the student midwives, midwifery lecturers and LME were focused on promoting the theory of choice with the objective to enhance a woman's autonomy. The intent for autonomy also crafted choice as synonymous with providing enhanced control for the woman.

The causative relationship found between choice and control infers without offering choice the woman would be increasingly subjected to prohibitive, top down power. Lawler (2014) claims that prohibitive power is frequently located opposite to autonomy. The relationship between rational choice and autonomy may also explain the shared belief between the LME, midwifery lecturers and student midwives of

high-risk clinical environments limiting a woman's possibility of choice where they had to 'battle' for their choices. Indeed, although choice and control were prevalent as theoretical concepts of woman centred care the LME, midwifery lecturers and student midwives perceived the concepts were less visible in clinical practice. Consequently, clinical examples were provided as evidence of where choice and control had not been possible and subsequently, understood as constraining woman centred care.

The rational informed choice model assumes choice is both available, and desired, by the woman being cared for. Jomeen (2012) argues that choice cannot be an equitable concept and it has become an 'idealised norm' that both the woman and midwife want to achieve, but rarely do so. Jomeen (2010; 2012) further contends that experts continue to direct most choices which often discounts the voice of the woman. Consequently, the locus of control remains with the experts. It may be contested in an expert- led model of choice, if a woman decides against the experts the choice may be deemed as incorrect and the woman left with the blame. Indeed, Kirkham and Stapleton (2004), in a study exploring informed choice in maternity services, found choice was mainly formed from a professional perspective. Therefore, the 'right' choices were those aligning to professional expectations and advice. Expert-led choice has been subsequently corroborated with other studies which suggest choice largely serves the interests of the health professionals. In result, theories of choice are rarely found to benefit the person being cared for but used to perpetuate professional control (Lemire *et al.*, 2008; Powell and Boden, 2012).

Comparisons have also been made between a midwife's and a woman's autonomy in maternity services. The relationship asserts the more empowered a midwife the more empowered a woman is likely to feel (Green and Baston, 2003; Kirkham and Stapleton, 2004; Hunter *et al.,*2017). When both the midwife and woman are autonomous the greater the chances are of woman centred care being achieved. The predominant influence on a midwife's autonomy is the clinical context they are part of. Therefore, without a supportive working environment able to empower midwives, it is claimed to be unlikely that a woman will experience any difference in her level of choice or autonomy (Green and Baston, 2003; Mander and Melender, 2009).

To further explore the findings in relation to the theory of choice and control it is helpful to appreciate the rival propositions found in the case study. Although choice and control were identified as concepts associated with woman centred care, a large part of the data identified constraints preventing both concepts being actualised in clinical practice. Student midwives and midwifery lecturers identified an over reliance on guidelines and policies challenging the application of choice and control. The over reliance was exercised by midwives and other clinicians who privileged the professional voice over the woman being cared for. This finding is supported by other studies that have found health professionals, inclusive of midwives, bias woman's choice by deciding who gets to choose their care and what choice is available (Kirkham and Stapleton, 2004; Jomeen, 2012; Ahmed and Bryant, 2013). Indeed, feminist accounts have argued that the bias in choice is more acutely

obvious when caring for vulnerable women or those judged as possessing less power attributed to a socio or cultural background (Noseworthy *et al.*, 2012).

In addition, UK based modern maternity services have been increasingly governed by a risk management culture. As part of this culture clinical guidelines and policies are promoted as a method to ensure safety in childbirth and consistency of care (Lupton, 1999; Scammell, 2016). Kirkham (2004) states that as choice is located through a 'lens of risk' in maternity services, ultimately offering choice is more about preventing risk than autonomy of choice in woman centred care. In this case study, choice and control were found to have two different interpretations. One interpretation lay with choice and control as a positive process leading to empowerment. The other interpretation with choice as a risk discourse leading to the objective of safety .These interpretations did not easily reside with each other as part of woman centred care. Indeed, for student midwives and midwifery lecturer's, choice and control were viewed as necessary for empowerment whereas risk was viewed as limiting choice and control thus constraining woman centred care .

The HOMs also identified choice and control as theoretical concepts of woman centred care in the pre-registration midwifery programme. However, they did not understand or perceive choice and control in the same way as the student midwives, LME and midwifery lecturers. They did not perceive offering choice included providing all options as part of a rational informed choice model based on achieving autonomy . Instead the HOMs were increasingly concerned with offering a level of choice able to be achieved in the clinical services they were leading. As HOM2 stated, 'not offering everything in the sweetie shop' was based on them being mindful of the many constraints they were operating within as part of the clinical service context. Therefore, the HOMs were focused on choice providing a woman with options tangibly available as part of their care offering. Availability of what was available underpinning choice was seen to offer a realistic option more readily accessible for all women. Instead of an idealised concept only available to a limited number of women. In comparison, to student midwives and midwifery lecturers, the HOMs were less focused on control either inhibiting or enabling a woman's autonomy. In contrast , they were looking for choice and control emphasising what was realistically available. Consequently, the HOMs talked about being able to negotiate with the woman as a condition of choice and control for woman centred care.

Beech and Connolly (2005) state that assumptions of choice and decision-making based on processes of negotiation uphold a belief that compromise can be achieved. This may seem an obvious point, but in relation to this case it illustrates the HOMs were seeking a mutual process of mediation between the woman, the midwife and the service provision. Indeed, Stacey *et al*.(2010) report negotiation, and shared decision-making as hallmarks of the move to patient centred care initiatives and enable both the involvement of the family and other health professionals.

These findings suggest that although the concepts of choice and control in the pre-registration programme were identified, there was variation in the perceptions and understandings of how these should be related to woman centred care through pre-

registration midwifery education. Two opposing frameworks were presented which had created incongruencies. Discourses of risk were articulated by the midwifery lecturers and student midwives as oppressive forces actualised through policies and guidelines. The discourses of risk were largely seen as preventing woman centred care .In result, the midwifery lectures and student midwives sought to enable woman centred care through choice and control leading to empowerment . In contrast, HOMs were largely preoccupied with choice and control as a process of mediation aligned to what was available from within their services. As part of their clinical services risk was more readily accommodated as influencing choice and control . Therefore, risk was not perceived by the HOMs as inhibiting choice and control; rather it mediated the application of what was available within their clinical services as part of woman centred care. In the pre-registration programme the two different interpretations of choice and control were perceived as incompatible. Therefore, this finding is a rival proposition as it illustrates ,whilst choice and control were associated with woman centred care, there was variance in understanding primarily influenced by the clinical context.

In terms of mutual collaboration and individualised care, both concepts were evident as components of the pre-registration midwifery programme and perceived as enabling woman centred care. Individualised care was increasingly interpreted as personalised care by the HOMs and holistic care by the midwifery lecturers. Personalised care was understood as encompassing the family context of the women being cared for. Holistic care as a term increasingly reflective of the spiritual and social factors involved in woman centred care. Indeed, the emphasis on personalised care may be explained due to the shifting policy landscape through the duration of this study, which found an enhanced emphasis on personalised care as a pillar of implementing NHS England's Better Births Policy (NHS England, 2016).

Over recent years it could be contested that personalised care has become a more frequently quoted concept associated with woman centred and has replaced individualised care and mutual collaboration as used in this case study. Better Births (NHS England, 2016), and its subsequent action reports and implementation plans taken forward by NHS England's Maternity Transformation Programme, has endorsed personalised care as a necessary component for the future of maternity services (NHS England, 2016; NHS England 2018). The concept of personalised care has been shown to improve health outcomes and women's satisfaction by facilitating enhanced choice and shared decision making (Renfrew *et al*., 2014). In turn, the focus of personalised care has introduced numerous national and local initiatives aimed at improving personalisation in maternity services. An example of such initiatives are the launch of choice and personalisation pioneers and personal maternity care budgets (NHS, England, 2017). These initiatives directly relate to the concept of individualised care .

Therefore, after review of related maternity policy, personalised care was interpreted as aligning to the pre-ordained theoretical concepts of individualised care and mutual collaboration. With such close synergy to the overall concept of woman centred care this decision did not appear to detract from the overall case study intent. Indeed, personalised care was frequently explained through the case study data as enabling

individualised care and mutual collaboration. Collectively the two theoretical concepts of individualised care and mutual collaboration were mutually dependent and used to explain the significance of midwives developing meaningful relationships with a woman which captured a woman's social context and network. A meaningful relationship between a woman and a midwife was found to be a necessary part of woman centred care in the pre-registration programme.

In the case study the pre-registration programme was understood as a method able to advocate the importance of developing meaningful relationships with the woman being care for. A meaningful relationship through mutual collaboration was viewed as a vital step in achieving woman centred care. In result, statements from the data suggested student midwives needed to build trusting relationships with a woman. Perriman *et al.*(2018) also found that effective relationships shared between a woman and midwife was paramount for creating personalised care and empowerment of the woman. The student midwives were well versed in the concepts of individualised care and mutual collaboration as proponents of woman centred care. Like the midwifery lecturers, the student midwives predominately expressed these concepts in terms of the midwife-woman relationship. The HOMs further upheld concepts of mutual collaboration and individualised care and they also expressed these as part of developing relationships with a woman. However, the HOMs suggested developing meaningful relationships necessary for woman centred care needed to be extended to include multi-disciplinary team members, rather than being only centred on a relationship between the woman and midwife . Although, the HOMs also considered if the inclusion of more clinicians in the relationship could potentially weaken the overall role of the midwife.

Continuity of care was also presented as a theoretical concept of woman centred care in the pre-registration programme. Primarily, continuity of care was portrayed as a concept enabling woman centred care by further promoting mutual collaboration, or partnership, between the midwife and the woman. Consequently, the variable of continuity of care was not a standalone concept but interconnected as a method to enhance mutual collaboration. Continuity of care models in maternity services have been associated with improved health outcomes and maternal satisfaction (Hodnett, 2002; Sandall *et al.*, 2016) supporting its positive affirmation in this case study . The endorsed model for promoting continuity of care through the pre-registration programme was case loading, whereby students were expected to care for a caseload of women in each year of their programme. This model is recognised as an appropriate model for delivering continuity of care (RCM, 2018a).

Although there was consensus of continuity of care being necessary as part of the pre-registration programme for providing woman centre care, the ability to support this through clinical placements was less evident. The midwifery lecturers particularly reported student midwives unable to apply continuity of care in clinical practice. This was due to continuity of care models not existing in clinical practice and instead student midwives were part of fragmented maternity care services seen as also constraining woman centred care. Although, student midwives endorsed continuity of care as part of woman centred care in the pre-registration programme, none talked about their personal clinical experiences of the continuity of care model. This

omission provides further evidence that although continuity of care was evident as a necessary concept of woman centred care, its clinical application remained inconsistent and not in the forefront of the student midwives' clinical practice experiences.

It could be contested that with recent advancements in UK maternity policy advocating continuity of care as a model of choice for women (RCM, 2018a; NHS England, 2018), awareness of continuity of care models may be more apparent if this case study were repeated . For example, the draft NMC future midwife standards of proficiency have a domain entirely devoted for promoting continuity of care and carer (NMC, 2019). However, at the point of data collection, the results found continuity of care was largely portrayed as a theory of woman centred care advocated within the university environment and not well translated to the clinical practice environments .

In summary, the identified theoretical concepts (variables) of choice, control, mutual collaboration, individualised care and continuity of care were found in the pre-registration midwifery programme and linked to woman centred care. This finding supports the theoretical proposition of the identified variables being desirable concepts of woman centred care in pre-registration midwifery education. However, a rival proposition found that there was differentiation in many of the theoretical concepts interpretation and understanding between the university and clinical practice context. The differentiation was especially apparent with choice and control where HOMs were increasingly concerned on negotiating woman centred care as part of what was available within their services rather than a rational availability of all options as promoted through the theory of the pre-registration programme.

5.3 The Pre-Registration Programme and Knowledge and Understanding

Theoretical Proposition
P3) If woman centred care is effectively taught and understood, HOMs, the LME, student midwives and midwifery lecturers will be able to articulate how the associated theoretical concepts are contextually applied to the woman and her family in clinical practice.

This theoretical proposition proposed that the theoretical concepts of woman centred care in the pre-registration programme were conveyed through methods such as teaching which formed related knowledge and understanding pertaining to woman centred care. It was anticipated that investigating this process would uncover a contextual application of woman centred care.

In relation to this theoretical proposition most of the findings resided with the LME, midwifery lecturers , student midwives and programme documentation. The methods of education reported as enhancing contextual application of woman centred care were simulation, reflection, critical debates and using women's stories. This finding was further supported by the student midwives who especially highlighted the use of reflection as a positive tool for providing them with the opportunity in classroom-

based sessions to apply, and make sense of, the clinical application of woman centred care. Reflection has been previously reported as a teaching method able to integrate education with clinical practice as it enables professionals to make sense of their learning (Schon 1987; Boud, 1999). In addition, simulation is a well-recognised teaching method found to assist in integrating education into clinical practice (Cook *et al.,* 2011; Henriksen *et al.,* 2018;). In support of these assertions, this case study found that specific methods of education, such as simulation and reflection, had a greater potential to provide integration between education and clinical practice for woman centred care.

These findings may also be considered in terms of theoretical education literature. Hall *et a*l. (2008) suggest that many education theories perceive the learner as an agent to whom knowledge needs to be imparted. Imparting knowledge implies education organisations make decisions on the types of knowledge needing to be taught and learnt. In contrast, other education theories have suggested education should abandon its claim on academic knowledge as it is disconnected . Instead, education should promote knowledge as engrained with the context of practice (Roth *et al.,* 2014). The findings of simulation, reflection, debate and women's stories enabling a contextual understanding of woman centred care may be seen to endorse the value of knowledge engrained as part of practice. Other types of teaching methods were not conveyed as facilitating the same level of contextual application. Simulation and reflection were the two teaching methods with the highest amount of data . However, although these two teaching methods were prevalent for the endorsement of contextual understanding there did not appear to be any structured plan for their use in furthering woman centred care as part of the pre-registration programme. Cook *et al*. (2011) also suggest that although methods such as simulation have been shown to improve integration of knowledge with clinical practice, there is a limited evidence as to the best ways they can be operationalised into education programmes.

The use of enquiry-based learning (EBL) as a method of education was also widely reported by the LME, midwifery lecturers and noted in the programme documentation. The programme documents , interviews and focus group implied EBL had a direct role in improving the teaching, understanding and contextual application of woman centred care. Byrne *et al.* (2018) promote EBL as an education method able to enhance learning through the integration of theory and education as it develops student praxis. In other words, students become increasingly self-aware and able to focus and analyse their practise. However, despite the evidence of EBL from the midwifery lecturers and programme documentation, neither the student midwives or HOMs specifically referred to EBL as a method enhancing the development or clinical application of woman centred care. It may be contested that the HOMs and student midwives were less familiar with academic terminology such as EBL. Rather the stated methods of reflection and simulation were more familiar terms, and these may still be synonymous with EBL. It does indicate though that the LME and midwifery lecturers ascribed more value to EBL as a teaching method. Indeed, it may be argued that using terms such as EBL only brings benefit to those with an education background. Consequently, although EBL is an espoused method

for integrating theory and practice (Byrne *et al.,*2018) it may risk making education ever more inaccessible to clinical practice.

Although, the study found specific teaching methods such as simulation and reflection enabled a level of knowledge assisting with a contextual application of woman centred care this finding was not apparent in the rest of the data sources. The midwifery lecturers predominately associated their role as transforming the student midwife's knowledge and understanding in relation to the theoretical concepts associated with woman centred care. Therefore, the midwifery lecturers were concerned with changing student behaviours, so they could become 'braver' and 'confident'. The behaviour transformation was deemed necessary so student midwives would be able to challenge clinical practice. Challenging clinical practice was perceived, by the midwifery lecturers and LME, as the main action necessary for woman centred care. This finding substantiates behaviourism learning theories that look to the attainment of education objectives through the learner's ability to adopt necessary behaviours (Nestel *et al.*, 2018). Consequently, the midwifery lecturers and LME were focused on developing a behavioural knowledge and understanding of woman centred care that precluded its contextual application.

Sarid (2018) suggests that all education has two ultimate aims; to prepare learners to be part of a social context, and for learners to change reality according to an ideological claim. It may be argued that in the case study the midwifery lecturers and LME were focused on an ideological concept of woman centred care. This ideology was largely based on woman centred care being grounded in normality; an ideology highlighted by many authors such as Downe, 2008; Bryar and Sinclair 2011; Renfrew *et al.,* 2014; Scammell 2016. Renfrew *et* al,.(2014) state that normality provides midwifery with a unique impact as it enables a maternity service focused on keeping a woman healthy. Furthermore, the midwifery profession's focus on low-risk normality is a core feature of professional status as it positions midwives as the lead professional care provider for low-risk woman (Ridley and Byrom, 2018). However, there was a disconnect between the midwifery lecturers and LME's ideology of woman centred care and the reality of woman centred care experienced and understood by the HOMs and student midwives.

The midwifery lecturers and LME were aware of the disconnect between the knowledge and understanding related to the ideology of woman centred care between the university and clinical practice. However, they viewed their primary aim not to bridge the difference but to change and transform clinical practice to adhere to their woman centred care ideology. The need to transform clinical practice was based on a perception it would lead to a consistent clinical adoption of the theoretical concepts of woman centred care as found in the pre-registration programme. As indicated, the mechanism to bring about the change was through the agency of the student midwives. In result, the midwifery lecturers were almost zealous in their desire to transform students, so they became the change agents for taking forward woman centred care. This objective had not gone unnoticed by the student midwives and they were acutely aware of the midwifery lecturers drive for them to be the ambassadors of woman centred care as espoused in the theoretical concepts of the programme. Indeed, many students believed that to achieve high marks in their

theoretical assessments they were required to demonstrate knowledge and understanding as ascribed to the university's ideological model of woman centred care.

Winch and Gingell (2004) propose that in liberal modern education there is an emphasis on the learner being equipped to become an autonomous learner. Therefore, a core purpose is for education to bring about independence and autonomy. Furthermore, Winch and Gingell (2004) state that the benchmark for what constitutes 'good' or 'bad' education is its accordance to an ideology or a norm. Therefore, it may be construed that the apparent ideological woman centred care found from the midwifery lecturers and LME endorsed their role as educators by creating a 'norm'. The norm of woman centred care provided a framework, or set of criteria, to which the pre-registration programme needed to abide. The normative framework thereby, created the rules for which certain behaviours or activities were accepted or rejected. It may explain why student midwives appeared to imply they were assigned higher marks for assessments when their work adhered to the accepted norm of woman centred care.

However, the 'norm' for woman centred care reported by the LME and midwifery lecturers was not evident in the clinical context. Indeed, the ideology of woman centred care was not consistently experienced in clinical practice. The disparity meant student midwives struggled to always contextually apply the university's ideological norm in clinical practice. The case study found students were only able to contextualise woman centred care in certain clinical environments. For the majority the clinical environments enabling a contextual application were low-risk clinical areas. In the low-risk clinical environments students witnessed the espoused, normative ideology of woman centred care. The witnessed events perceived as evidence of the ideology of woman centred care was where the student midwives observed midwives spending time talking to women or facilitating choice. These events were reported as only being witnessed in low-risk clinical environments. This result supports previous work where the clinical context has been found to influence the type of maternity care with low-risk environments more able to support woman centred care (Kirkham, 2004; Brady *et al*., 2019). Outside of the low-risk clinical environments the student midwives had limited understanding of a contextual application of woman centred care.

The limited ability to consistently apply, and understand, woman centred care across all clinical environments resulted in student midwives feeling unprepared. The lack of preparation was more pronounced outside of low-risk clinical placements. Therefore, the case study found that there was not a contextual understanding of woman centred care in the pre-registration programme. To feel more prepared, student midwives sought enhanced teaching reflective of the full diversity of woman centred care across the range of clinical environments. As without this teaching student midwives felt there was a gap in their knowledge and understanding of woman centred care. When asked for specific examples of how the gap could have been addressed many of the student midwives talked about having teaching equipping them to manage woman centred care as part of busy clinical environments with competing priorities. Therefore, although the student midwives were well versed with

the LME and midwifery lecturer's woman centred care ideology this did not reflect their clinical practice experiences. The lack of teaching able to reflect different clinical scenarios for understanding and applying woman centred care left the student midwives unable to demonstrate its contextual application.

The absence of contextual understanding was also reflected by the HOMs. The HOMs perceived methods of education, and associated knowledge and understanding of woman centred care in the pre-registration programme , as not effectively applied to their clinical services. The HOMs were less concerned with an ideological norm of woman centred care. Instead their primary concern was being able to prepare student midwives for the workplace. Consequently, the HOMs wanted a 'work ready' model of education that was not apparent to them in the pre-registration programme. This differentiation may also explain why the HOMs reported student midwives not being well versed with perceived basic tasks necessary for woman centred care. Without an emphasis on workplace preparation the HOMs were concerned that student midwives would leave the pre-registration programme unprepared for the reality of woman centred care in clinical practice and leading to potential overall dissatisfaction in the workplace.

As with the student midwives, the HOMs were less concerned with a fixed ideological norm of woman centred care. Rather the HOMs sought increasingly flexible knowledge and understanding of woman centred care able to be contextualised across the full spectrum of their clinical services. Pring (1999) proposes that liberal models of education only focus on an aspirational, personal ambition and not on the social context to which people work. Consequently, Pring (1999) suggests that liberal education requires rethinking, so it encompasses the social and economic contexts it is preparing people for. Interview data from the HOMs may be seen to support this debate as they were seeking woman centred care as being evident in both theory and clinical practice. Eraut (2009) also argues that learning is influenced by the social context to which it is part and if learners are well prepared for the workplace context their confidence improves. Although, Carr (2006) argues that it is impossible to accurately make assumptions on the purpose of education and, in result, all educational theories should be abandoned. Instead Carr (2006; 2010) states that learners only understand themselves as part of their contextual situation and consequently, the only part of education that makes sense is its practice application as part of this context. As a result, it could be implied, without a full application of woman centred care in clinical practice, the student midwives were not only unprepared but unable to make sense of their own role as part of the clinical context.

In summary, the theoretical proposition preordained if woman centred care was effectively taught and understood a contextual knowledge and understanding of woman centred care would be found. The teaching methods appearing to facilitate contextual understanding were reflection, simulation, critical debates and womens stories. EBL was reported by the LME , midwifery lecturers and in the programme documentation as a teaching method enhancing contextual understanding. However, the same level of significance for EBL was not reflected by the HOMs or student midwives . It may therefore, be questioned if terms such as EBL are only pertinent

for academic settings and possibly may further separate university and clinical practice. Instead, it may be construed that pre-registration programmes should give greater attention to the 'how' knowledge and understanding of woman centred care can be achieved. As in this case study most of the emphasis of the pre-registration programme lay with promoting an ideological claim and not on how woman centred care could be contextualised.

Furthermore, the actual ideology of woman centred care reinforced by the LME, midwifery lecturers and documentation were more readily associated with a low-risk, normal aspirational ideology. This ideology was different to the requirements of clinical practice as both the student midwives and HOMs were seeking flexibility and enhanced application. This is a potential important finding as there are current ever-growing concerns with future workforce supply. A diminishing workforce supply introduces an accentuation on retention of the workforce (NHS, England, 2019). Therefore, it may be contested that the stark difference between the proposed contextualisation of woman centred care risks students not being fully socialised into the workplace and contributing to future retention challenges.

5.4 Woman centred care, the clinical context, power and professional identity.

Theoretical Proposition
P4) Understanding perceptions and experiences will help identify a contextual, practice-based concept of woman centred care for pre-registration midwifery education.

This proposition predisposed that a contextual practice-based model of woman centred care would be further gained by uncovering perceptions and experiences related to woman centred care in the pre-registration programme. The proposition related to pre-identified variables of power, professional identity and clinical context experiences.

An aspect already briefly mentioned in the previous theoretical proposition was the differentiation between the perceptions and experiences according to the clinical placement context. The impact of the clinical context became highly evident during this part of the data analysis. It confirmed that for the student midwives, LME and midwifery lecturers' low-risk clinical environments were perceived to be where woman centred care, in accordance with the programme's ideology, was experienced. The results also suggested that being able to provide the contextual implementation of woman centred care was dependent on the perceived level midwives were able to be autonomous leaders and decision makers. For the LME and midwifery lectures, autonomous decision making was understood as when midwives were able to make decisions independent of polices and guidelines. This finding also explains why low-risk clinical environments in the pre-registration programme, with less emphasis on risk, policies and guidelines, were more readily associated with a woman centred care ideology.

The midwifery profession has a long history of midwives acting as the protectors of normality where they have an integral role in ensuring normality of birth against a backdrop of increasing medicalisation and intervention (Downe, 2008; Scammel and Alaszewski, 2012; Ferguson *et al.,* 2015; Bharjk, 2016). The focus on normality has provided the midwifery profession with credibility and autonomy; forming its own professional scope of practice and preventing midwifery from its documented historical subordination from medicine (Donnsion, 1998; Mander and Reid, 2013). Furthermore; studies have shown that midwifery led care, where the midwife is the main carer for low-risk .normal women, results in improved health outcomes, higher levels of patient satisfaction and comparable safety to equivalent medical models of care (Hatemet *et al.*, 2008; Sandall *et al.,* 2016). Consequently, woman centred care is frequently predicated on low-risk normal midwifery led care. It could be argued that the relationship forged between low-risk midwifery led care and woman centred care has become mutually dependent. Indeed, midwifery education programmes have been reported to reflect this dependency with the philosophy of woman centred care grounded in a normal ideology (O'Connell and Bradshaw , 2016; Bharjk, 2016).

The relationship between midwifery, woman centred care and a low-risk normal ideology may also be understood as part of midwifery's professional identity. Professional identity is often associated with the possession of a domain of knowledge, expertise and autonomy (Clouder, 2003). Therefore, the focus on low-risk normality has provided midwifery with professional identity and status. Lawler (2014) claims that identity becomes established over time and provides a person with an understanding of their existence. The LME and midwifery lecturer's emphasis on an ideology of woman centred care need also be understood as part of their assurance of professional identity. Many of the midwifery lecturers reported concerns of possible professional erosion due to increasing medicalisation and diminished emphasis of low-risk, midwifery led care. These concerns may also explain the passionate responses of the midwifery lecturers imploring student midwives to uphold the woman centred care ideology as found in theoretical proposition three, as it was as much about midwifery status and identity as it was about woman centred care.

Hildingsson *et al.*(2016) in a study exploring midwifery empowerment across three countries found professional empowerment in midwifery was based on midwives being able to practise midwifery led care and having a work environment supporting them to be autonomous professionals. In this case study autonomous decision-making was seen to be experienced when the needs of the woman had been met above the needs of the organisation. Bradfield *et al.*(2018) also report that midwives are often faced with the choice of either being with a woman as synonymous with woman centred care or being with organisation and not woman centred. Therefore, it is unsurprising that the low-risk clinical environments were more synonymous with woman centred care. It may be argued that the ideology of woman centred care in the pre-registration programme was as much about protecting midwifery professional identity. Hence the ideology of woman centred care provided a norm for professional status. The relationship with professional identity may explain the LME and midwifery lecturers desire for the student midwives to mirror, and take forward, their desired

woman centred care ideology. It became part of setting expected behaviours and values as necessary for the midwifery profession status. Other studies have also reported that to be a ‘good midwife’ requires students to act and behave within established norms that consolidates professional self-regulation (Halldorsdottir and Karlsdottir, 2011; Carolan, 2013).

However, outside of the low-risk clinical placements student midwives, LME and midwifery lecturers were unable to provide extensive experiences and perceptions of woman centred care in the pre-registration programme. That is not to say the midwifery lecturers and LME did not recognise high-risk midwifery care still required a woman centred care focus; this sentiment was evident. Two of the midwifery lecturers did acknowledge that woman centred care was just as vital in high-risk clinical environments, but they were unable to fully articulate a contextual application of this without reference to low-risk contexts. Across all the midwifery lecturers and LME findings, a contextual model, or application of woman centred care, was not evident outside of low-risk areas. A relationship had been built that may be argued to have limited woman centred care application. Its synergy with professional autonomy and low-risk midwifery care had created a dilemma whereby, to move from this position risked professional erosion, whilst to not widen the remit of woman centred care threatened woman centred care models being contextually relevant for all clinical environments.

The reported experiences of the clinical context also highlighted perceived obstacles to applying and implementing woman centred care. Policies , guidelines and the focus of risk have already been presented . However, a further finding impacting on woman centred care delivery was the clinical constraint of time. Many of the student midwives talked about the busyness of the clinical environments perceived as diametrically opposed to enabling the theoretical concepts of woman centred care as identified in this study of mutual collaboration, choice, individualised care, control and continuity of care. From the case study it became apparent that the high and low-risk clinical environments created separate entities of woman centred care which could not be reconciled. Hunter’s work (Hunter, 2004) supports this finding. Hunter (2004) investigated emotional work in midwifery and found that midwives work in two conflicting ideologies shaped by the clinical context. Hunter (2004) found hospital, high-risk contexts represented medicalisation of birth with an overreliance on guidelines to the benefit of the organisation rather than the woman. The low-risk, community clinical contexts privileged low-risk, normal ideology more synonymous with the midwifery profession. Hunter (2004) claimed that when student midwives and midwives found themselves working in high-risk hospital contexts, perceived as unfocused on the needs of the woman, they experienced anger and frustration. Hunter (2004) calls this the ‘co-existence of competing ideologies’ and it is the competing ideologies, not the pressure or challenges of caring for women, that causes the negative emotional impact on midwives. Kirkham and Stapleton (2004) also provided similar findings with accounts of midwives being caught between trying to support woman centred care in clinical contexts that are focused on the needs of organisations and not the woman. The results from this case study corroborates the differentiation of ideologies between high and low-risk clinical environments.

However, it adds knowledge to the overall debates of Hunter (2014) and Kirkham and Stapleton (2004) by illustrating how pre-registration midwifery programmes endorse these ideologies early on in a student midwife's education. In this case study the early socialisation of ideological claims appeared to directly influence the contextualisation of woman centred care.

To fully appreciate this line of enquiry the theory of risk and high-risk versus low-risk care requires further elaboration. Lupton (1999) writes that to be high-risk a woman must be classified as outside of a norm criterion leading to additional monitoring, professional expertise and scrutiny . This theory implies that the classification process of low and high-risk is a rational process whereby, a woman is classified according to comparisons to other women (Lupton, 1999). It forms part of risk society theory with claims that late modern societies have become increasingly exposed to discourses of risk. In this discourse, individualisation, rather than collectivism, is accentuated and the individual is understood according to their coalescence to established norms. If an individual 'deviates' from these norms they become high-risk (Beck, 1999; 2009). Scammel and Alaszewski (2012) also report midwifery has become increasingly defined according to high-risk or low-risk definitions that demarcate the type of care a woman receives. With high-risk care there is an accentuation of risk and surveillance and Scammel (2016) contends that midwives negatively experience high-risk care due to it preventing normal midwifery care.

When applied to this case study it may explain why reports of time constraints and guidelines were viewed as negatively impacting on the ability of the pre-registration programme to contextualise woman centred care. Furthermore, there were no apparent solutions to overcoming these perceived obstacles or how woman centred care could be located within both discourses of high-risk and low-risk care. Primary locating woman centred care as part of low-risk environments also meant risk could only be managed through its detection and elimination. Not accommodating risk as part of woman centred care thereby, excluded any option of woman centred care able to embrace high-risk care. In result, the pre-registration programme had made it ever more difficult for woman centred care to be contextualised outside of low-risk environments. It may also be argued that most of the policy and research investigating discourses of low and high-risk midwifery care are based on social constructionist methodologies looking to uncover social meanings and relations (Moule *et al.,* 2018). An enhanced focus on how organisational structures potentially influence the context, and understanding, of low and high-risk ideologies provides new understanding of woman centred care. On this basis the following paragraph discusses frameworks of power and critical realism.

The perceptions and experiences of woman centred care can also be understood according to power dynamics. Instead of risk viewed as part of a social constructionist theory, critical realism offers a new understanding for low and high-risk care and its impact on woman centred care in the pre-registration midwifery programme. Critical realism frames risk as a known structure; a reality with causative powers (Rigakos and Law 2009). When applied to this case study it may be suggested that the causative powers for actualising woman centred care were mainly focused on low-risk, normal ideologies and contexts. These powers were able

to be actualised in low-risk clinical areas due to structures enabling the application of concepts such as mutual collaboration. Sayer (2012) terms this power dynamic as the contingency of power. Likewise, the contingency of power was not evident outside of low-risk clinical environments due to the structure of risk inhibiting the actualisation of woman centred care.

This analysis supports Nash (2005) who claims that critical realism enables understanding of powerful objects where causality may be investigated through the relationship between structure and agency. Sayer (2012) also contends that causality of power is frequently missing from power theories and the focus should not be on the how of power; rather why power does, or does not, get actualised. Applied to this case study it illustrates the importance of structures in the differing experiences of woman centred care that either enabled or constrained its actualisation. If, as critical realism contends, structure pre-exist agency (Rigakos and Law, 2009; Sayer, 2012) then implementing woman centred care became dependent on a midwife's and student midwife's agency being enabled through the structures such as time and policies. The structures causing the power difference varied according to the type of clinical context.

The ideologies of low and high-risk care, or social versus medical models of midwifery care (Kirkham, 2004;Walsh, 2007), may also be situated within Foucault's perspective of power. Foucault (1980; 1989; 2007) situates power as 'ways of knowing' where knowledge and power are interlinked as knowledge creates the discourses of truth. Foucault creates this as a relativist version of truth as discourses, or rather versions of the truth, are found everywhere that, in turn, produces power as a relational force. Foucault (2007) proposes that discourses of truth invent the norms to which individuals conform and this results in people becoming self-governing against the rules of the established norm. In this theory, becoming self-aware of the discourses enables transformation, a shift in power dynamics. Foucault (1980) and Rose (1998) suggest that the growing calls for individual autonomy signify the increasing influence of power. Applied to this case study it may explain how both the ideologies of medical and social models of care have created their own discourses to which there is an established norm for expected conformity. It is contested that low and high-risk clinical environments were operating under distinctive discourses resulting in different norms and expectations. These discourses had created the ideologies associated with woman centre care and the 'truth' for woman centred care was largely only associated with low-risk clinical areas.

Therefore, the norms created of woman centred care, as part of the theoretical part of the pre-registration programme, were more readily associated with midwifery professional identity and social, low-risk midwifery models. Student midwives were aware of this discourse and its associated expectations. The discourse of truth for woman centred care as low-risk care also meant when the norm was not evident, as reported in many clinical contexts, student midwives were left with a dilemma. The possibility of either challenging for the promoted norm of the pre-registration programme or conversely being isolated due to not conforming to these powerful discourses of woman centred care. Ball (2013), who has applied Foucault's theories

of power in education, claims that discourses found in education serve to professionalise education. Therefore, it is contested that woman centred care in the pre-registration programme served to operate the power of education through professionalising midwifery education. Overall the discourse of woman centred care created a power dynamic that permeated the programme .

This normative discourse of woman centred care also operated as a power dynamic to which the LME and midwifery lecturers abided, and it may explain their passionate calls for certain ways of behaving. However, although the power dynamic sought conformity and professionalisation it equally left some student midwives feeling unable to achieve the expected norm of woman centred care. The experienced power of perceived expectations shaped by the norms of woman centred care may explain why many of the students felt disheartened when their clinical practice experiences did not match the expected norms. However, student midwives were also mindful that to adhere to the norm resulted in the reward for certain aligned behaviours. Whilst the discourse of woman centred care has been discussed as part of critical realism and Foucault the finding of reward for certain behaviours conveys dominance over power theories. As Laverack (2016) states, power-over models may be understood as bringing about certain consequences such as reward where there are positive consequences if individuals comply.

The identification of the relationship between compliance and power leads to understanding power as a sovereignty, meaning power is a process of domination (Popkewitz, 1999). This power dynamic was especially apparent between the student midwives and midwifery clinical mentors. Whilst the student midwives were aware of the power to conform to the programme ideology of woman centred care in their clinical placements, they were also part of a power dynamic with their clinical mentor. Students talked about not ‘wanting to step on toes’ of their clinical mentors as they were caught between aspiring to take forward woman centred care whilst, simultaneously, seeking clinical mentor’s approval to sign-off their clinical competencies. Student midwives were also mindful of their long-term employment opportunities and there was a question that nonconformity in the clinical environments could lead to less chances of successful employment. Clouder (2003) describes these dynamics as the ‘learning to play the game’ where learners understand both the explicit and hidden rules they need to comply to and gain entry to a profession. Bourdieu (1990) has also written of students learning how to ‘play the game’ to secure future success. Therefore, student midwives found themselves as part of a web of power where they were trying to understand the rules of the game for woman centred care both to succeed in passing their pre-registration programme and gaining employment. It may also be suggested that the midwifery lecturers, outside of the university setting, were privy to power over dynamics. Despite the midwifery lecturers having well established visiting, partnership roles with clinical organisations, their sphere of influence in the clinical context was experienced as limited. Consequently, they perceived themselves as ‘visitors’ where they felt powerless to change the clinical context for woman centred care. This may also account for their perceptions of communication from the university not always cascading through the necessary channels.

From the midwifery lecturers and student midwives' perspective, woman centred care in the pre-registration programme was frequently in opposition to the organisation. Adversarial language such as a woman 'battling' against the organisation was a consensus for many of their experiences of hospital clinical contexts. Deery *et al.*(2010) undertook a study investigating tensions and barriers involved in the development of a birthing centre which found hospital environments were based on conformity and protocols. Deery *et al.*(2010) argued that this culture had produced hospital care as the mainstream and standardised type of care and low-risk birthing centres as niche models of care. In addition, Deery *et al.*(2010) found midwifery managers often faced discord due to the differentiation of care environments as they tried to conform to the mainstream organisation whilst also the more woman centred, low-risk models of care. The latter was usually more reflective of their midwifery professional identity. This finding has been substantiated by Bradfield *et al.*(2018) who also claims that midwives often feel they can either work with originations and systems or with the woman being cared for. However, unlike Deery *et al.*(2010) this case study did not reflect the same interpretation of discord associated with woman centred care and organisations from the HOMs. The discord was only reported by the student midwives, LME and midwifery lecturers. Instead, the HOMs dispute was centred on the pre-registration programme itself, as they wanted a mediated understanding of woman centred and not a powerful absolute. This finding from the HOMs appeared to suggest that they did not seek power as a dominance or absolute truth of woman centred care. The HOMs were looking for a dispersed power able to accommodate multiple professional roles and plurality of understanding of woman centred care able to be applied across their organisations.

This theoretical proposition has found woman centred care in the pre-registration midwifery programme was understood and perceived by the LME, midwifery lecturers and student midwives as mainly contextualised when part of a low-risk clinical environments. This finding was despite programme documentation indicating otherwise. It is contested that a low-risk contextual model of woman centred care induced midwifery professional conformity and identity. However, there was a growing perception of increasing risk, surveillance and medicalisation perceived as constraining the ideology of woman centred care as espoused by the theoretical component of the pre-registration programme. Therefore, there was an emphasis on student midwives having to battle, or be brave, to drive forward woman centred care in the clinical environments. Student midwives perceived that if they complied with the powerful norms of woman centred care they would be rewarded with higher assessment marks and accepted into the prevalent professional identity discourse from the midwifery lecturers and LME. However, student midwives remained aware of competing tensions created due to contrasting dominant discourses between their clinical practice environment and university experiences. For example, whilst aware of needing to comply with strong low-risk autonomous models of woman centred care they also needed to comply with the clinical environments for assurance of achieving their clinical competencies and possible employment opportunities.

The dissonance in experiences and perceptions of woman centred care was less evident from the HOMs. The HOMs did not present findings identifying any discord

between their professional discourse for woman centred care and their organisation. Instead the HOMs expected the pre-registration programme to provide woman centred care in a mediated way enabling a contextual application across all clinical environments. Whilst this theoretical proposition has resulted in differing experiences and perceptions of woman centred care in the pre-registration programme these have all, as predisposed, helped identify a contextual, practice-based model of woman centred care.

5.5 Theory practice gap, points of synergy and the profile of the woman in maternity services

Theoretical Proposition
P5) Identifying the broader clinical context of woman centred care will help expose any associated theory practice gaps and points of synergy between midwifery education and clinical practice.

This section aims to explore in much greater detail the theory practice gap and points of synergy found with woman centred care and the pre-registration midwifery programme. The theory practice gap has been well reported in health care literature depicting predominately negative consequences of education not readily accepted or translatable to practice (Roth *et al.*, 2014;). Rolfe (1996) claims that the theory practice gap is partly due to theory being placed opposite to practice, which infers a subordination of practice to theory. Instead Rolfe (1996) recommends a non-hierarchical relationship, a 'praxis', should be formed between theory and practice where practice helps generate the necessary theory. In contrast, other authors such as Haigh (2008) argue that there has been an over thinking of the theory practice gap resulting in an academic distraction. Instead, Haigh (2008) argues that the theory practice gap is inevitable and not a negative component of education. Rather Haigh (2008) contends that the theory practice gap should be celebrated as the existence of a gap provides the catalyst for change and transformation between education and practice.

This case study found that the broader clinical application of woman centred care in clinical practice exposed a theory practice gap. Student midwives perceived the university offering an 'idealised' model of woman centred care differing from the reality of their clinical practice experiences. Previous studies exploring the theory practice gap have also found healthcare students experience their educational programme as idealised and divorced from the reality of practice (Corlett, 2000; Monaghan, 2015). However, student midwives did not respond to the theory practice gap with a desire to lead and change practice. Instead they felt unprepared and disillusioned.

The midwifery lecturers and LME were aware of the student midwives' experiences of the theory practice gap surrounding the broader clinical application of woman centred care. However, they did not anticipate having to bridge the gap as they

understood their roles as providing the ‘gold standard’, aspirational model of woman centred care. A model they perceived as not evident in its broader clinical application. The midwifery lecturers did look to employ teaching methods, as already reported, of reflection and simulation aimed at integrating theory and practice. Although the use of these teaching methods was toward integrating theory and practice, the aim was biased toward the integration of clinical practice with the gold standard, aspirational woman centred care. Thereby, the midwifery lecturers framed the woman centred care of the theoretical university concept as the correct concept and clinical environment as the incorrect. This finding would appear to substantiate claims of education frequently privileging theory over practice (Rolfe, 1996).

In contrast to the midwifery lecturers, student midwives had different experiences of the theory practice gap. Student midwives predominately experienced the theory practice gap as a reality shock as their experiences in clinical practice fell short of their anticipated woman centred care. Attributed to the theory practice gap, the midwifery lecturers perceived students as becoming dismissive of the pre-registration programme, as they increasingly privileged clinical practice over the taught theoretical components of woman centred care. Lange *et al*.(2006) also found that students were more likely to be influenced by practice than the theoretical domain of education. It could also be argued that the midwifery lecturers were solely focused on aspirational models of eduaction that served to accentuate theory practice gaps. As Pring (1999) identifies, aspirational models of eduaction fail to recognise the social and economic context of the learner or of knowledge.

The HOMs also identified a perceived theory practice gap in the broader clinical application of woman centred care. The gap was attributed to the pre-registration programme’s woman centred care concept being idealised and not reflective of the reality of the clinical services they were leading or managing. Unlike the midwifery lecturers and LME, the HOMs did not perceive value in a theory practice gap. Instead, akin to the student midwives, they felt this was a negative consequence and left them feeling more detached from the pre-registration programme.

The profile of the woman was frequently seen to contribute toward the discussed theory practice gap. This finding was due to the recognition of the rapidly changing profile of women being cared for in maternity services. This change had brought with it increasing complexity and as one HOM stated, women in maternity services were no longer ‘healthy, young fit people’. This reported changing profile of women substantiates recent maternity policy depicting maternity services caring for women with increasing medical conditions, giving birth at an older maternal age, along with increasing psychological and social complexity (RCM, 2016; 2018). It also helps explain the theory practice gap in this case study. The HOMs, and student midwives, perceived the pre-registration programme was not keeping pace with the changing profile of women in maternity services and hence responsible for an ever-growing theory practice gap. Student midwives felt especially unprepared for woman centred care in complex social cases illustrating the importance of care not only based on psychological and physiological components, but the social context of the women being cared for. Therefore, the theory practice gap was not only based on tensions

between different ideologies but also on the changing clinical experiences shaped by the women being care for.

The programme documentation and midwifery lecturers stated that the pre-registration programme was well versed with the changing profile of the woman being cared for. This changing profile was also verified as due to increasing levels of complexity of the woman being cared for in maternity services. Some of the midwifery lecturers discussed opportunities for the pre-registration programme to respond to these changes and woman centred care needing to encompass high-risk women with known complexities. However, the HOMs suggested much more than an application of woman centred care to high-risk women. Their data appeared to indicate they wanted woman centred care to alter its fundamental definition and interpretation so able to incorporate medical and midwifery models of care. This assertion is a subtle nuance but demonstrates the different worldviews of the midwifery lecturers, LME and HOMs, accounting for an even greater accentuation of the theory practice gap.

Despite the theory practice gap, the case study simultaneously found that the LME, midwifery lecturers and HOMs were all seeking closer collaboration between the university and the clinical environments as part of woman centred care. This objective was also apparent in the programme documentation. Specific methods employed to forge synergy between the university and clinical practice were clinical mentor updates, link lecturer roles and attending meetings in the clinical services. These were presented as methods able to further unite woman centred care as a part of the pre-registration programme. However, despite these links there was limited evidence of sustained curriculum planning and implementation between the university and clinical practice that may have offered enhanced opportunities for synergy of woman centred care. Instead the synergy was sporadic and often based on a certain activity galvanising the need for collaboration, such as the approval of a new pre-registration programme or a focused meeting. Therefore, although the broader clinical context of woman centred care did identify points of synergy these ironically further accentuated the need for yet closer collaboration. Risjord (2010) also reports that theory requires contextualisation and therefore, education should seek integration of its theories through both education and the practice arena.

The same points of identified synergy between the university and clinical practice of mentor updates, link lecturer roles and attending clinical meetings were not reflected in the findings from the student midwives. Student midwives did not specifically identify any activities, or roles, perceived as supporting synergy between the university and clinical practice pertaining to woman centred care. It may be these were interpreted as roles largely supported by the university and therefore, an assumed expectation of the university linking with clinical practice. However, it is worth considering that no actual reported university role or activity was specifically highlighted as greatly enhancing points of synergy in their pre-registration programme. Instead, as Hughes and Fraser (2011) found, the clinical mentor had a high level of influence on the student midwives' experiences of woman centred care. In result, the only aspect reported as representing synergy between theory and practice was when a clinical mentor enabled student midwives to practise woman

centred care as espoused by the pre-registration programme. However, the synergy of practising woman centred care with a mentor was not a regular occurrence in the student midwives' clinical experiences. When it was experienced the students ascribed the clinical mentors with almost saintly virtues. Carolan (2013) found that a risk with esteemed , exemplary practice is it is highly likely to disappoint, as few will be able to match these expectations. In result, although the 'saintly' clinical mentors were described by the student midwives as points of synergy it may equally be contended this fuelled an idealisation of maternity services and the midwifery profession. The risk of this exemplarily, idealisation is that few will be able to reach such a saintly status or to achieve this desired status may come at a personal or professional cost.

Although the HOMs expressed feeling detached from the pre-registration programme there was a collective desire to be increasing involved in curriculum planning and part of the programme. Likewise, there was a genuine passion and commitment from the LME and midwifery lecturers to be more involved in clinical practice. Programme reapprovals were seen to provide a model for the level of desired engagement from the HOMs and there was a clear appetite for this to be a sustainable model of working together. This finding illustrates possible opportunities for further models able to maximise points of synergy between the university, clinical practice and woman centred care.

This section has confirmed that identifying the broader clinical context of woman centred care did expose theory practice gaps and points of synergy related to woman centred care in the pre-registration programme. The theory practice gap may be partly accounted to competing ideologies of woman centred care held between the university and clinical practice environments. These differences resulted in the HOMs, and student midwives ,experiencing a highly idealised concept of woman centred care. The midwifery lecturers and LME were aware of the idealisation but perceived this as providing an aspirational, gold standard of woman centred care to ultimately change clinical practice. Therefore, the HOMs saw woman centred care in the pre-registration programme as divorced from clinical reality and the student midwives sought a programme increasingly able to prepare them for managing the realities of clinical practice. The changing profile of the woman was found to be a core variable and strongly associated with the theory practice gap. Whilst the HOMs, LME and midwifery lecturers acknowledged the changing profile of woman due to medical and psychological complexities, student midwives perceived the social complexity of woman being cared care for was often overlooked as part of woman centred care. Unlike the midwifery lecturers and LME, the HOMs were seeking woman centred care to be interpreted, and applied, as part of multi-disciplinary models of care . Whilst there was evidence of synergy, by large, this was not systematic or a method enabling close integration or discussion of what woman centred care should constitute as a concept in the pre-registration programme.

Chapter 6: Reflections and recommendations

6.1 Introduction

This chapter will respond to the case study research questions encompassing overall reflections on the research. The latter part of the chapter identifies recommendations for future practice, policy and pre-registration midwifery education. Although, the overall research question is stated below, this chapter addresses each of the sub questions and the overall question is fully answered in the concluding chapter.

6.2 How do student midwives, HOMs, the LME and midwifery lecturers understand, and experience, woman centred care in a pre-registration midwifery programme?

The case study confirmed that the theoretical concepts of choice, control, continuity of care, mutual collaboration and individualised care were associated with the overall concept of woman centred care. Therefore, exploring these concepts revealed how woman centred care was understood and experienced in the selected case study. Whilst the concepts were evident as part of woman centred care it also found there was variation in the understanding and experiences attributed to the concepts.

In the main, the HOMs had different understanding and experiences of woman centred care to the midwifery lecturers, LME and student midwives. In terms of choice and control the LME, midwifery lecturers and student midwives ascribed to a rational model of choice based on a woman being offered all available options and empowered to make an informed decision. A causative relationship between choice and control was found, whereby if a woman was offered choice it was believed to lead to an enhanced level of control for the woman being cared for. This causative relationship supports previous findings that have reported causation between choice and control in midwifery practice (Jormeen, 2012; Brady *et al.,*2019). However, examining the relationship between choice and control, as part of a pre-registration midwifery programme, has provided new understanding of the relationship. Especially in how this relationship influenced understanding and experiences of woman centred care.

The case study found that understanding and experiences of the relationship between choice and control varied according to the context of either the university theoretical component of the programme or the clinical practice environments. In clinical environments student midwives, LME and midwifery lecturers perceived choice as negatively constrained by an over reliance on guidelines and policies. In turn, the constraints on choice were seen to explain diminished control for the woman being cared for. An assumption that further adheres to the reported causation found between choice and control. The perceived constraints of policies and guidelines may be understood as evidence of clinical practice being increasingly influenced by a risk management culture with a focus of promoting a safe service and eliminating risk (Healy *et al.,*2017). It was also apparent student midwives, LME and midwifery lecturers understood choice as a largely rational process where a woman was offered all available choices on which to base their desired care options. A rational model of choice further explains why policies and

guidelines were perceived as constraints as privileging the choices of the organisation over a woman having all available choice.

However, this case study found that the HOMs had a different understanding and experience of choice and control as part of woman centred care in the pre-registration programme. They did not align, or aspire, to a model of rational choice with a woman offered all available choices. Instead, the HOMs understood choice having to be located as part of what was available within the services they were leading. Consequently, the HOMs were concerned woman centred care in the pre-registration programme promoted unattainable options of choice neither available in their services nor equitable for all women. This led to the HOMs looking to the pre-registration programme to increasingly frame choice and control as part of the context of their clinical services. A contextually applied model of choice and control was thereby, perceived as mediating what was realistically available in clinical practice. It may also be debated that the student midwives, LME and midwifery lecturers' understanding of choice and control assumed all women would want , or be able, to have access to choices and the desire for control as part of woman centred care. It is highly questionable if all women have equal access of choice in maternity services. Therefore, choice and control, as part of woman centred care, requires not only enhanced clinical contextualisation but recognition of the women themselves in maternity services.

The concept of individualised care was also evident in the case study as part of woman centred care. Although, the term more often used than individualised care was personalised care. Irrespective of the terminology, individualised care and personalised care were associated with the same underlying experiences and understanding of developing meaningful relationships focused on the specific needs of the woman. The underlying understanding of individualised care also became interchangeable with the concept of mutual collaboration. To the LME, student midwives and midwifery lecturers enabling individualised care required a mutual collaboration between the midwife, student midwife and the woman. In this way mutual collaboration and individualised care was very much about a relationship shared between the woman and the midwife. The HOMs also verified individualised care and mutual collaboration as part of woman centred care in the pre-registration programme. Although, a different interpretation in terms of the relationship emerged. Unlike the LME, student midwives and midwifery lecturers, the HOMs were more inclined to interpret meaningful relationships built with student midwives and midwives as part of multi-disciplinary teams encompassing a much wider remit than only that of a woman and midwife.

The final concept of continuity of care was also found to be part of woman centred care in the pre-registration programme. The concept was predominately understood as a case-loading model promoted through the theory of the programme and applied in clinical practice. All the participants of the case study agreed case-loading was a method able to further embed woman centred care in pre-registration midwifery education. However, despite this commitment, case loading was inconsistently reflected in clinical practice. The midwifery lecturers perceived that the lack of case loading in clinical practice was due to fragmented clinical placement organisation.

Student midwives also reported limited exposure to continuity of care through case loading models in clinical practice that would appear to endorse the midwifery lecturers' perceptions and experiences.

As part of a critical realist framework the verification of the pre-ordained concepts of choice, control, continuity of care, individualised care and mutual collaboration for woman centred care in the pre-registration programme support their existence as part of a real domain where theoretical constructs are known to reside (William *et al.*,2017). In other words, whilst there were variances in perceptions and understanding their existence as constructs was a real existence outside of subjective perceptions. For example, the concept of choice is a known objective part of reality in woman centred care. However, the variances in experiences and understanding was due to the theoretical concepts acting as structures with powerful tendencies, Whilst, the theoretical concepts existed outside of subjective perceptions they were influenced by structures with the tendencies, the power as to whether the concepts were able to be fully actualised or not. In result, policies, guidelines and professional roles had causative tendencies influencing the concepts associated with woman centred care in the pre-registration programme.

6.3 How do the student midwives, HOMs, the LME and midwifery lecturers perceive that the theoretical concepts of woman centred care from the pre-registration programme are applied to the woman and her family in clinical practice?

Having identified the theoretical concepts of woman centred care in the pre-registration programme, this question sought to uncover how they were applied as part of the clinical context .The intent of the question pre-disposed that if the programme provided effective knowledge and understanding of the theories through successful teaching methods, woman centred care would be evident not only as a theoretical construct but as part of the clinical context.

The case study found that certain teaching methods were perceived to be more effective in facilitating a contextual understanding of woman centred care. These were the specific teaching methods of reflection, simulation, debates and women's stories. From the student midwives' perspective, reflection and simulation were the most effective teaching methods. Their effectiveness was explained by them enabling direct application between the taught concepts of woman centred care and the clinical context. Indeed, as reported by the student midwives, reflection especially helped students make sense of how they could apply woman centred care as part of a challenging and complex clinical context.

Whilst the student midwives were focused on the actual methods of teaching, the LME and midwifery lecturers were inclined to place the teaching methods as part of an overall teaching methodology that in this case study was EBL. The emphasis on EBL was also found in programme documentation where it was stated as offering enhanced contextual application of woman centred care. However, the HOMs and student midwives were unable to support this claim and neither reported EBL as a known teaching methodology of the pre-registration programme. It could be suggested that the quoted discrete teaching methods of reflection and simulation are

more likely to be found in an EBL methodology and therefore, the emphasis of these teaching methods supports the value of EBL in the clinical application of the identified theoretical concepts. Nevertheless, it is a tenuous connection and this case study purports that the use of terms such as EBL may only be meaningful to those from an academic background and obscure its purpose for those outside of academia. Instead, pre-registration programmes should spend greater attention considering a structured plan for the use of teaching methods known to enhance contextual understanding, whilst also using terminology that is accessible and understood by all stakeholders.

Although specific teaching methods were identified as assisting the application of the theoretical concepts of woman centred care this did not correlate with expansive contextual knowledge and understanding. This finding was different to the pre-disposed theoretical proposition that indicated if there was effective teaching of woman centred care the theoretical concepts would be contextually applied. The lack of contextual application of woman centred care may be partly explained due to variation in the perceived knowledge and understanding necessary for its clinical application. The midwifery lecturers and LME were focused on a normative ideology of woman centred care where the concept was ascribed to midwifery led care of low-risk, normal women. Indeed, optimising normality has been, and continues to be, a hallmark of the midwifery profession (Renfrew *et al.,* 2014). Therefore, in many ways it was unsurprising to find that the midwifery lecturers, LME, student midwives and the programme documentation, accentuated normal low-risk women as part of understanding woman centred care in the pre-registration programme. The adherence to normal low-risk midwifery led care was clearly perceived as the underlying philosophy of the pre-registration programme and promoted as a highly aspirational ideology. The ideology was also relatively fixed in what it could, or could not, be. Such an alignment automatically led to dilemmas for the contextualisation of woman centred care. Embracing a low-risk, aspirational midwifery led philosophy potentially meant care outside of this definition, such as high-risk care, challenged the very essence of midwifery.

The fixed, constructed ideology served to accentuate a demarcation where anything not reflective of the ideology was perceived to constrain woman centred care as part of the pre-registration programme. Although, there was some recognition of woman centred care as an important component of high-risk care this still sat uncomfortably with the core midwifery led ideology. The aspirational ideology ascribed to woman centred care may also explain why low-risk clinical environments were more easily described as a context for woman centred care. Indeed, outside of the low-risk clinical environments there was limited contextual application of woman centred care. It may also be debated that the ideology of woman centred care resonates with a Western liberal education construct where the objective of education is to transform and change (Winch and Gingell, 2004). Therefore, the midwifery lecturers and LME aimed to empower student midwives as able to transform clinical practice toward the application of the aspirational ideology of woman centred care.

Although, student midwives were aware of the intent for them to apply an aspirational ideology, they were seeking a less fixed ideology of woman centred care

able to be applied across the full range of clinical environments. Likewise, the case study found that the HOMs perceived the pre-registration programme as not fully contextualising woman centred care as the ideology did not reflect the clinical services they were managing. Instead, the HOMs were less concerned with the ideological claims of woman centred care and more inclined to understand woman centred care as part of preparing students for the workplace.

This case study contends that in pre-registration midwifery education woman centred care is largely perceived, and understood, as a theoretical construct entwined with the role it plays in ameliorating a midwifery professional philosophy . Although teaching methods, such as reflection and simulation, have an important role in contextualising woman centred care, enhanced synergy with the clinical environments could potentially further support a much wider contextualisation. It may also be suggested that the ideological construct of woman centred care found from the LME, midwifery lecturers, programme documentation and student midwives acted as a further causal structure to either actualising, or inhibiting, its clinical application.

6.4 Why do student midwives, the HOMs, the LME and midwifery lecturers understand, and experience woman centred care in this way?

The last question found that there was a limited understanding of an application of woman centred care in the pre-registration programme. This question aimed to build on these findings and help identify a possible contextual model. Overall the question found that clinical context, professional identity and power all influenced the identification of a contextual, practice-based concept of woman centred care in pre-registration midwifery education.

As presented in previous sections, this question further validated low-risk clinical contexts perceived by the LME, midwifery lecturers and student midwives as the primary location for woman centred care. This understanding was based on low-risk clinical environments being synonymous with the theoretical aspirational ideology of woman centred care. It became increasingly apparent that the aspirational ideology of woman centred care was equally about safeguarding midwifery professional identity. Professional identity in the case study was understood as midwives able to act as autonomous professionals. In turn, autonomous midwifery professional practice was perceived as where the midwife was able to be the core decision maker with less visibility of other professional groups. With this held belief, autonomous working was perceived to predominately exist in the low-risk clinical environments. Consequently, low-risk clinical environments had also become the location of epitomising woman centred care and part of upholding midwifery professional identity. The aspirational ideology, as ascribed to low-risk clinical environments, became a causative factor for both the application of woman centred care and midwifery professional identity. Midwifery has a long-standing history of its assertion for professional status (Donnisson, 1988; Witz, 1992) that may explain the found focus of professional identity and woman centred care. As a result, for the LME, midwifery lecturers and student midwives abandoning low-risk midwifery led care as

the guiding ideology for woman centred care was equally about abandoning the historical hard gained midwifery professional status.

Furthermore, ascribing to a low-risk, professionally affirming ideology of woman centred care automatically construed clinical environments as often unable to meet the same expectations. In this way, according to the LME, midwifery lecturers and student midwives, clinical practice became responsible for woman centred care not being effectively evident in all clinical contexts. Clinical guidelines, policies and busy time demands were the most highly quoted reasons for preventing a contextual application of woman centred care. Endorsing certain clinical environments as synonymous with woman centred care and the midwifery profession not only created a demarcation but a deviancy for anything outside of these areas. The low-risk, aspirational ideology associated with midwifery professional identity also accentuated discourses of risk and safety as not easily accommodated as part of woman centred care in the pre-registration programme. Risk and safety are frequently reported as prevalent discourses in the midwifery profession (Scammel, 2016). In the case study, risk and safety for the LME, midwifery lecturers and student midwives were understood as separate discourses constraining rather than enabling woman centred care.

Power was inherent through the entirety of this case study and part of shaping experiences, understanding and perceptions of woman centred care. Therefore, investigating power provided a new level of understanding to the study and for pre-registration midwifery education. Applied to a critical realist interpretation, and already noted, woman centred care only possessed causative powers when part of low-risk clinical environments. The mechanisms in these areas that enabled, or the causation, for the clinical application of woman centred care were less time constraints, high midwifery visibility and professional autonomy. The mechanisms perceived as inhibiting the causation of woman centred care was through structures of surveillance, risk and low levels of midwifery decision making. Applied to Foucault (Foucault,1980; 1982; 1989) these power dynamics resulted in two discourses of truth, or norms, associated with woman centred care. A normative discourse of low-risk normal ideology and a discourse of risk and safety. Both discourses were perceived to be incompatible. This tension may explain why the midwifery lecturers saw themselves as having to battle against perceived negative, prohibitive power that prevented woman centred care.

Student midwives were also aware of the competing discourses of woman centred care. They sought opportunities to conform to the woman centred discourse associated with the theoretical part of the programme as they believed this often resulted in them being rewarded. For example, the acquisition of higher assessment marks. When students experienced clinical environments outside of this power dynamic, or discourse of truth, they were left feeling disheartened or anxious.

However, student midwives were not immune to the competing discourses with woman centred care also constructed through the identification of risk and safety. Consequently, students were equally trying to conform to a clinical practice environment that largely did not align to the pre-registration programme’s power

dynamics for actualising woman centred care. In the clinical practice context, student midwives were also aware of the role of the clinical mentor and the power they possessed over their attainment of clinical competencies and possible future employment prospects. This finding highlights the causative properties of the role of the clinical mentor in a practice-based model of woman centred care. In addition, the HOMs were less concerned with an absolute discourse of truth for woman centred care and conformity to a set professional identity. This is a different finding to previous studies that have found midwifery managers competing with two ideologies of midwifery care; one based on the midwifery aspirational profession and the other on the needs of the service (Hunter, 2004; Fontein-Kuipers *et al.,* 2018). Rather the HOMs perceived woman centred care to be a mediated concept not limited to the causative actions brought about by the relationship between a midwife and a woman. The HOMs were increasingly aware of the role of the multi-disciplinary team and how midwives needed to have the causation to bring about woman centred care as part of a team. Therefore, the HOMs did not perceive being caught between two competing ideologies; there was a desire for enhanced harmonisation between them.

In exploring this question, the case study has identified new perceptions and experiences of woman centred care as part of a pre-registration midwifery programme. These findings have shown that to accurately develop a contextual practice-based model, pre-registration midwifery programmes need to consider how clinical contexts directly influence the interpretation and definition of woman centred care. The power dynamics that either enable, or inhibit, woman centred care or more importantly if the discourses of truth acting as powerful dynamics remain fitting discourses for a practice-based model to be secured. The later points of the HOMs seeking woman centred care as part of a multi-disciplinary teams against a largely individual, midwifery led model of woman centred care, starts to question if for professions to remain relevant to clinical practice they need to increasingly construct concepts such as woman centred care as part of a collective, shared discourse.

6.5 How do student midwives, HOMs, the LME and midwifery lecturers perceive the concept of woman centred care from the midwifery pre-registration programme is more broadly applied in clinical practice?

Addressing this final question helped synthesis many of the reported perceptions, understandings and experiences of woman centred care as part of the pre-registration midwifery programme. To support the question the theory practice gap related to woman centred care was investigated. Student midwives and HOMs perceived that woman centred care in the pre-registration programme was highly idealised and not reflective of the reality of clinical practice and therefore, unable to be broadly applied. Student midwives and HOMs did not respond to the idealisation of woman centred care as a possibility for them to aspire. Instead, it had a negative impact as the student midwives were left disillusioned and the HOMs detached from the programme.

The LME and midwifery lecturers were aware of the theory practice gap although, it was not perceived as negative but necessary to create the change for optimising

woman centred care in clinical practice. Therefore, they perceived a broader application of woman centred care was through promoting a gold standard, aspirational model acting as a guiding light for practice to follow. Anything less than this was excluded, and it may be contested it ironically accentuated the theory practice gap.

The HOMs were especially focused on the changing profile of the woman being cared for as no longer being low risk, healthy women but women with known complexity. The changing profile of women also accentuated the theory practice gap as student midwives and HOMs perceived that the pre-registration programme lacked relevancy in its application of woman centred care. This finding may be related to higher eduaction being based on a liberal, transformational model of education where the objective of education is to provide the direction of best practice (Hall *et al.,* 2008). However, this case study found that education aligning to best practice objectives, rather than clinical contexts , may defeat the very objectives of the growing policy agenda. This policy agenda calls for education to be focused on enhancing the economy by equipping people with the necessary skills and competencies to succeed in the workplace (Department for Business Innovation and Skills, 2016).

Points of synergy between the university and clinical practice were also evident as part of the perceptions of the broader application of woman centred care. Given the extent of the theory practice gap this may seem an expected finding. However, it also highlighted that due to the differentiation of woman centred care between the university and clinical practice, student midwives only reported points of synergy when their clinical mentors endorsed the boarder application of the concept as fitting with that espoused by the university. The clinical mentors perceived by the student midwives as able to practise according to the ideological woman centred care model were those who went above and beyond the normal expectations. Consequently, these clinical mentors were given a virtuous standing from the student midwives. The challenge here is that students have yet another aspirational model of woman centred care and it is questionable if many of the students will ever be able to live up to these virtuous models.

Whilst points of synergy were not as frequently reported as the theory practice gap, it nonetheless did provide insight into how closer working between the university and clinical practice was perceived as enhancing the broader application of woman centred care. The HOMs memories of involvement in the reapproval of programmes, though sporadic, was a desired model for future collaboration. The LME and midwifery lecturers were also actively seeking increased collaboration. Therefore, despite the many reported differences, there was an underlying commitment for meaningful collaboration assisting in the broader application of woman centred care able to support both the university and clinical practice. Indeed, the quest for enhanced synergy may be seen to reflect calls for the LME role and midwifery education to be increasingly focused on enabling high levels of consistency and quality in the education of midwives (Way, 2016).

6.6 Application of critical realism to woman centred care in the midwifery pre-registration programme

To enhance new understanding from this case study a model has been created that outlines the application of critical realism to woman centred care in midwifery pre-registration education. The model represents the stratified world where structures have causal powers. The stratified world is an important aspect of critical realism and suggests research cannot only focus on the empirical world where events are experienced and observed. Instead, research should explore the deeper parts of reality to expose the structures as having the causal tendencies for events to be activated or not (Bhasker, 2008 ; Scott, 2016). The real domain signifies the deeper level of reality where the events at the actual level are created and critical realists argue that the real, deeper domain is rarely accessed in research (Wright, 2010). In the stratified world structures pre-date agency meaning agents do not actually create the events but respond in a certain manner due to the set of pre-existing structures. Structures do not pre-determine events they either enable or prevent them. Therefore, structure can produce different outcomes according to the context (Tsang, 2014; Bygstad *et al.*, 2016). In the critical realist stratified world knowledge remains socially constructed, whilst the world is an independent objective realty (Bhasker, 2010; Sayer,2012).

In terms of the newly developed model the real, deeper level illustrates the structures with pre-determined tendencies that were found in the case study. These structures explain why certain behaviours were enabled ,or constrained, leading to the actual events being created and then finally observed in the empirical domain. For example, the structures identified as existing at the deeper level were structures such as ideologies, clinical guidelines , professional identity and the clinical context. All these structures were independent and pre-existed the clinical broader application of woman centred care of which was more reliant on individual agency. Structures at the deep level can represent embodied physical structures, collectively held discursive narratives and systematic structures such as identity (Lukes and Bates, 2014). The structures as identified in model 6.1 on page 126 directly influenced the ability of the HOMs, LME, midwifery lecturers and student midwives to contextualise, or not ,woman centred care in the pre-registration programme. These explain why actual events were generated such as the theory practice gap and variable application of related theoretical concepts such as choice and control. Furthermore, the deeper structures influenced individual behaviours and experiences as these were attributed to certain events triggered by the structures associated with woman centred care. One such instance was in the empirical domain the student midwives being disillusioned and unprepared for clinical practice when they were unable to create the event, the application, of the woman centred care ideology as affirmed by the theoretical component of the pre-registration programme.

Identifying the deeper level of structures offers important new understanding for woman centred care as these possess the powerful tendency as part of pre-registration programmes. By becoming aware of the structures and their powerful tendencies offers the potential to all those involved in pre-registration midwifery

education to increasingly consider how these structures can be mediated for the future requirements of woman centred care.

Figure 6.1 Critical realism woman centred care and pre-registration midwifery education

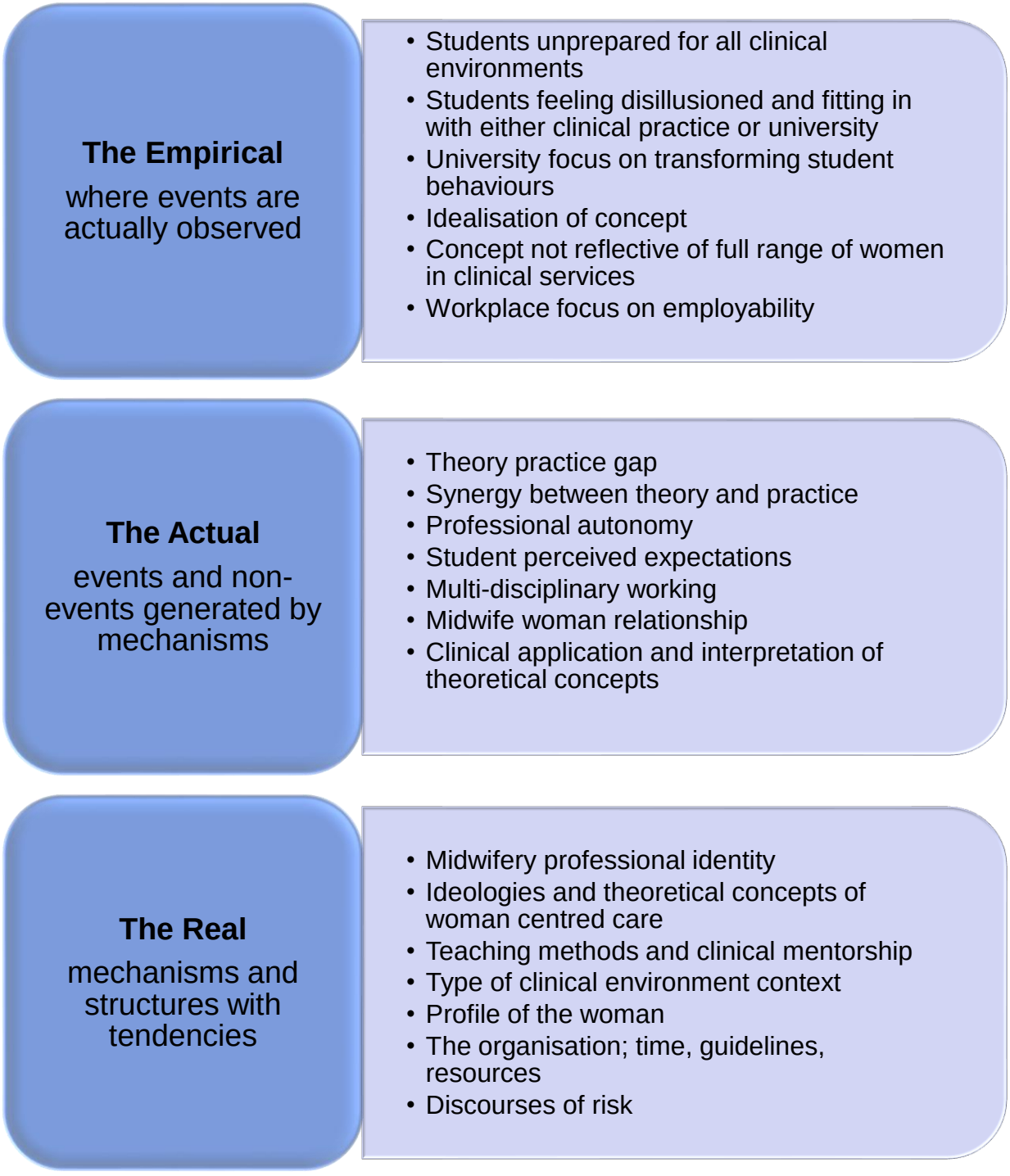


Figure 6.2 A model of woman centred care for pre-registration midwifery education

Having developed from the findings of the case study a critical realist application of woman centred care in pre-registration midwifery education further application to education was sought. Consequently, informed by the critical realist application shown in figure 6.1, a new programme model for pre-registration midwifery education was developed. It is anticipated that the model provides a new framework for designing and developing programmes able to effectively embed a contextual practice focused woman centred care concept.

6.2 Programme model for contextual woman centred care in pre-registration midwifery education

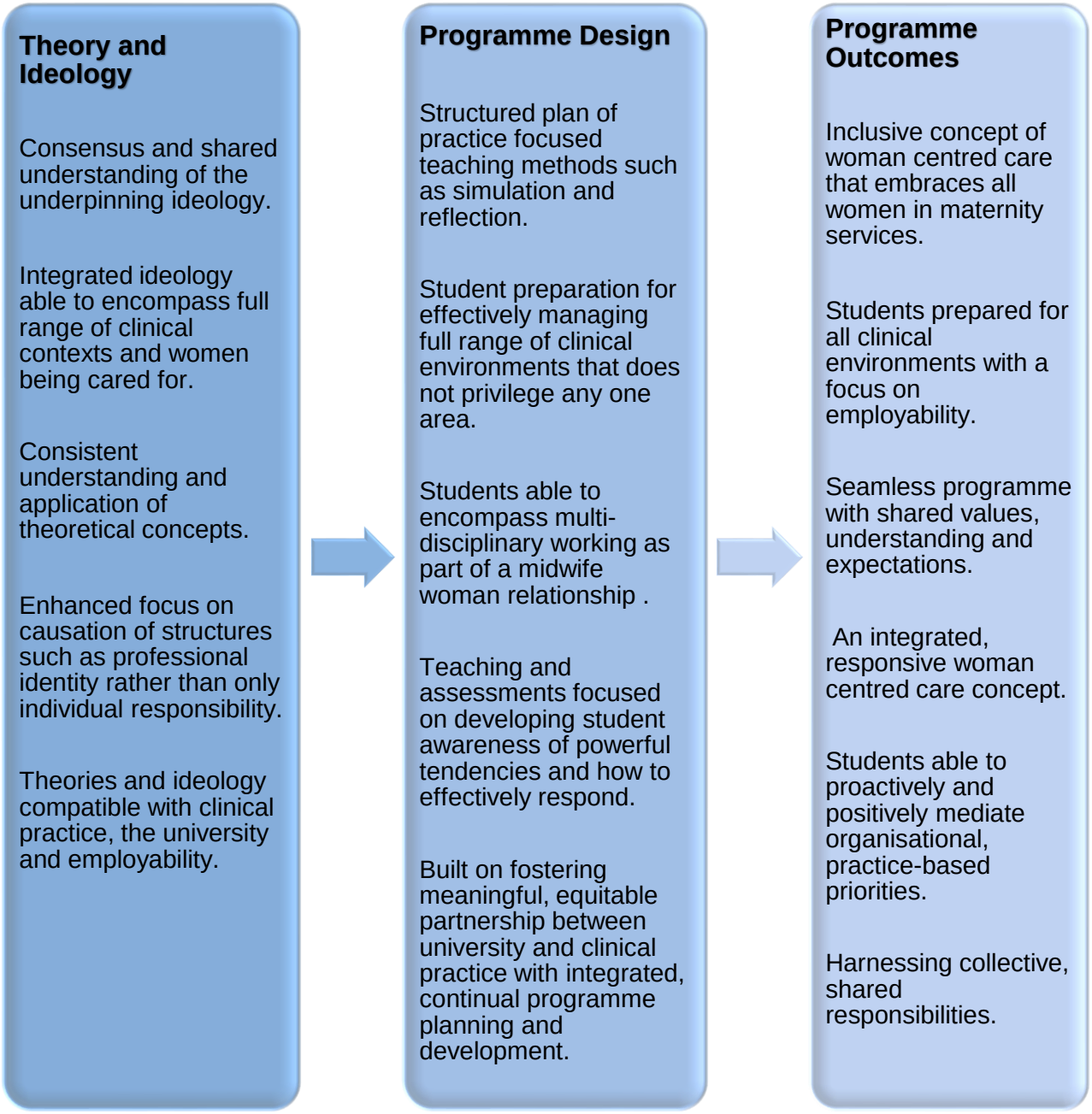


Figure 6.2 on page 127aims to provide a set of processes to help guide future pre-registration midwifery programmes toward a contextual concept for woman centred care. It postulates that before any actual planning of a programme, focus must be given to the foundations on which the programme intends to be positioned. It requires open discussion and shared consensus with all stakeholders on the intended theoretical concepts and resultant ideology of woman centred care. Indeed, this consensus should also encompass use of terminology and definition such as woman centred care or personalised care. As part of the discussion ensuring the identified ideology and theories are those suited for the full scope of midwifery practice and clinical contexts would potentially lead to less fragmented understanding and a shared vision. It is argued that the ideology should not have to choose between the organisation and university or aspirational and risk focused. Continuing to endorse such perspectives only serves to accentuate difference. Instead the figure depicts integrated approaches with a focus on collective understanding. Furthermore, early awareness of the powerful tendencies such as professional identity would ensure consideration may be given through the programme design of how these may be positively addressed as part of woman centred care in pre-registration midwifery programmes .

The programme design may then proceed with the theoretical foundations to which all stakeholders agree and uphold. Certain aspects of programme design have been highlighted as able to privilege a contextual concept of woman centred care. These methods include teaching of simulation and reflection as helping facilitate student midwives to make sense of the clinical application of theory into clinical practice. However, simulation and practice focused teaching methods need to be committed to a structured plan throughout the programme that is increasingly focused on what way they enable contextualisation of woman centred care. Focused reflection may also offer further opportunities for student self-awareness and discussion of the powerful tendencies such as professional identity and policies as identified in this case study. As part of a structured plan for teaching, enhanced opportunities may then be sought for students to consider the choices they are able to make in relation to the powerful tendencies that influence their own individual agency and ability to apply woman centred care.

The programme design section also depicts unified clinical environments where not one area is privileged over another. Preparation is necessary for the full range of clinical environments in an equitable manner where student midwives can be proactively prepared, and supported, so that knowledge becomes ingrained as part of clinical contexts. For example, providing student midwives with specific methods for how they can manage a busy clinical environment caring for a woman with complex care needs that still embodies woman centred care. Therefore, the developed model contends programme design and assessments need to focus not on student agency testing individual aspirational knowledge base. Instead, an engrained application of knowledge which supports students becoming socialised into how they can proactively respond and influence the powerful influences of woman centred care. Finally, ongoing partnership between the university and clinical

practice must run through every part of the design and not limited to sporadic involvement.

The last part of the model highlights desirable programme outcomes as ambitions based on the previous two stages. It proposes as an outcome, that the concept of woman centred would increasingly reflect the full range of clinical environments, involved health professionals and the women being cared for in maternity services. It is anticipated the model offers a dynamic woman centred care concept as over time the powerful tendencies will continue to change . However, the principles can remain the same for how these are increasingly acknowledged and then responded to proactively and collectively rather than an individualistic and reactionary manner. It is anticipated this focus could potentially lead to student midwives feeling increasingly prepared and ready for the full remit of the workplace. In addition, helping unite midwifery teaching teams and clinical practice leaders through shared common objectives .

6.7 Recommendations

To ensure professional application and learning from the case study key recommendations have been identified. These recommendations have implications for maternity policy and midwifery education.

- Woman centred care in pre-registration midwifery education should be based on a mutually agreed integrated ideology shared between the clinical practice environments and the university. The ideology should encompass the full range of clinical environments and profiles of women being cared for. An agreed ideology will potentially lead to consensus of the knowledge and understanding for the theoretical concepts of choice, control, individualised care, continuity of care and mutual collaboration. Agreed use of terms and definitions may enhance understanding and consistency for the clinical application of woman centred care.

- Woman centred care should abandon normative claims of low and high-risk or risk and surveillance. These normative claims bring with them powerful tendencies for either enabling or constraining woman centred care. This change could be achieved by pre-registration programmes no longer using programme designs or identifying clinical placements according to low and high-risk definitions. Instead, clinical placement environments need to be recognised as part of a range with an equal ability to enable woman centred care.

- Context practice focused teaching methods such as reflection and simulation need to be increasingly employed as part of pre-registration midwifery programmes. A structured plan for how these methods supports contextual understanding of woman centred care should be evident throughout all stages of the programme and the plan created and shared with student midwives and HOMs.

- Student midwives require practical integrated, skills and competencies focused on the ‘how’ of implementing an inclusive woman centred care concept. A change in focus would prepare students to mediate the range of clinical contexts and become increasingly aware of the powerful tendencies associated with woman centred care. For example, simulating busy clinical scenarios and what practical skills and competencies could be employed in order woman centred care may still be achieved. Assessments should increasingly emphasise practical, work placed methods for woman centred care rather than the formal acquisition of theoretical knowledge.

- Pre-registration midwifery programmes need to become increasingly concerned with preparing students for the workplace. The workplace should not be promoted as either adversarial or idealised but a location of relational power dynamics that influence the choices students must make for woman centred care. This recommendation could be initially achieved through simple changes such as programme documents illustrating the shared responsibilities of preparing students for a workplace.

- Pre-registration midwifery programmes should identify, and understand, the contexts and structures responsible for the powerful tendencies associated with woman centred care. Once aware, enhanced consideration may be provided for proactively addressing them for a dynamic, responsive contextual application of woman centred care. For example, midwifery professional identity was found to have a powerful tendency to bring about woman centred care when part of low-risk contexts. Instead, professional midwifery identity needs to increasingly accommodate a less delineated definition able to be used as a consistent powerful enabler of woman centred care. A reconceptualisation of professional identity would further enable midwives to influence woman centred care as part of multi-disciplinary teams. This would enable woman centred care to reside in relationships much broader than solely the midwife and the woman.

- The role of the clinical mentor/assessor has a pivotal influence on a student’s perception and understanding of woman centred care. The role should be effectively embraced and recognised as part of enhancing the contextual application of theory and knowledge into the workplace. Therefore, pre-registration programmes should develop enhanced opportunities for clinical mentors/assessors to be involved and communicated with as part of programme development and evaluation.

- Pre-registration midwifery programmes should further integrate educational theories with equal attention to individual autonomy and the workplace context. Therefore, leading to less emphasis on the individual student as solely responsible for woman centred care and moving to a collective responsibility shared with clinical practice. This different emphasis could potentially lessen

student midwives feeling they may never achieve such high, aspirational expectations surrounding woman centred care. This could possibly support the longer-term retention of midwives.

- Meaningful mutual collaboration between the university and clinical practice should be present throughout all stages of a pre-registration midwifery programme. Mutual collaboration could be achieved through joint roles; shared decision making and increased opportunities for midwifery lectures to be visible in clinical practice and likewise for clinical leads visible in the university. Professional body reapproval methods potentially offer a collaborative model able to be implemented as everyday practice. Furthermore, shared programme development would enable aspects such as continuity of care to be collectively planned leading to successful implementation. Student midwives may then experience pre-registration midwifery programmes as seamless, integrated experiences not defined by either a clinical or university context.

- Related policy should consider moving away from promoting idealised, unachievable concepts of woman centred care to a practical application of the concept resonating with the changing expectations and profiles of women being cared for in maternity services. This change would require policy to serve less attention to the aspirational and enhanced attention to the actual 'how' for achieving woman centred care as part of rapidly changing clinical environments .

- Maternity policy needs to pay greater value to the role of education as enabling strategy implementation. Pre-registration midwifery education is an important pathway into the profession and shaping future expectations and understanding of woman centred care. Therefore, maternity policy should involve education and student midwives in its development, implementation and evaluation. This enhanced involvement could be acknowledged through policy devoting separate, detailed sections to the value of midwifery education.

- Whilst this case study has focused on HOMs, LME, midwifery lecturers and student midwives, further research exploring women's experiences of woman centred care as part of pre-registration midwifery education may offer new insights. Future research is also recommended to encompass the experiences and understanding of clinically working midwives and other health professionals involved in supporting pre-registration midwifery programmes.

- Critical Realism is well suited to Yin's (2014) case study design methodology and offers new possibilities for future midwifery led research. Critical realism has the potential to build new levels of understanding well suited to complex and changing clinical contexts. Therefore, future opportunities should be sought for critical realism as part of woman centred care and midwifery education.

- Future research is suggested able to test and evaluate the newly developed models for woman centred care in pre-registration midwifery eduaction. This research would enable enhanced understanding of the newly reported application of critical realism to woman centred care and pre-registration midwifery education.

Chapter 7: Conclusions

7.1 Introduction

This chapter reflects on the research process and identifies learning points and limitations of the case study. It concludes with an overall response to the main research question of the case study.

7.2 Reflections on the research process.

The research process has been both challenging and rewarding. It started with a professional interest formed by experiences of working as a midwife and as part of a policy and higher education remit. As a midwife I increasingly found myself acutely aware of a strong woman centred care philosophy and how the philosophy did not always sit comfortably with the woman being cared for, or its application to clinical practice. These reflections continued when I was part of higher education and as part of this culture, I strived to lead practice orientated education able to readily advance the many policy initiatives for maternity services and the broader health and social care remit. It was also apparent that in much of the policy the importance of education was rarely valued for supporting, or understanding, the overall ambitions of service change. Although my current position as an Associate Director of Education, in a large NHS Foundation Trust, has been for a relative short time of my doctoral journey it has highlighted the often-tenuous relationships held between higher education and health and social care organisations.

In all these experiences I have consistently grappled with negotiating the requirements of higher education, policy and the workplace. The experiences have also nurtured a curiosity in the ability of policy to effectively influence either environment. Woman centred care was identified as the concept appeared to personify these complex relationships between policy, higher education and the workplace; whilst also part of a personal interest formed through my own professional development. Although woman centred care has, and continues to be, a strong ethos of midwifery practice, policy and education, its contextual application remains sporadic and rarely actualised.

As shown in the literature review chapter, woman centred care has been explored through other accounts from a policy perspective, clinical health outcomes and maternal satisfaction. Studies have explored woman centred care in pre-registration education. However, these are limited in number and largely focused on the theoretical constructs of woman centred care. In result, this case study explored , further critiqued and extended the knowledge base through an enhanced emphasis on the contextualisation of the concept. The focus of investigating a practice based , contextual woman centred care concept in pre-registration midwifery provided a unique contribution to existing knowledge of the subject area. The utilisation of Yin's (2014) case study framework enforced a structured methodology enabling focus and attention to detail. There were occasions where the pre-ordained, deductive process required a personal discipline not always the automatic response. For example, ensuring the pattern matching data analysis strategy remained focused on the findings of the case being matched to the predicted ones. During these times the

conceptual framework was extremely valuable as it ensured a return to the objectives of the selected methodology. Indeed, the conceptual framework was placed in a visible location throughout the case study process and its writing. This visibility created an on-going reference and helped develop a coherent thought process.

As my confidence grew in the research process, challenging or perplexing moments were also greeted with less anxiety. There was a growing understanding these periods required space, reflexivity and an open mind. Indeed, during these challenging moments notes, memos and visual maps were made that assisted the cognitive process. It became apparent that these periods usually resulted in enhanced knowledge and understanding that may have been otherwise easily missed or misconstrued.

The data collection process was a noteworthy learning point in the case study. Looking back there was an assumption data collection would be relatively straightforward and easily achievable within the overall timetable of activities. The reality soon revealed the data collection as extremely time consuming and often unpredictable. There was an underestimation of galvanising student participation, especially in the initial data collection method of focus groups. This assumption now seems naïve, especially given the then occupied position of Head of Department. On another occasion further attention would be given to this important part of the research process with both realistic timeframes, and detailed insight into the accessibility of participants. Some of the experienced challenges of data collection may have been overcome with a pilot of the data collection methods through engaging with a sample of students to collectively design the preferred model of data collection.

Overall the case study methodology did achieve its objectives of exploring and finding new understanding for the concept of woman centred care in pre-registration midwifery education. The application of critical realism also assisted in discovering associated power dynamics and possible causation for understanding and experiences related to woman centred care. Case study methodology and critical realism were found to be complementary and the dual application meant woman centred care and pre-registration midwifery education were explored from a novel perspective offering a unique contribution for policy makers and education.

7.3 Limitations of the case study

Whilst the case study was able to effectively answer the set research questions there were limitations. One of the core limitations was the occupied role as Head of Department at the university of the case study location. The limitation was managed through a process of reflexivity however; undoubtedly this role would have had an influence on the data collection process. It would be interesting to see if there were comparative findings with a researcher from a different professional position, or a less perceived figure of authority. Although, through the many times of listening to the audio recordings, dialogue was free flowing, and the voice of the participant was of a higher ratio to the researcher in the transcripts.

The use of a single case study was a further limitation as Yin (2014) claims that with single case studies it is harder to establish generalisation. The decision to use a single case study was discussed as part of the methodology chapter. The limitation was addressed through the case study providing a typical case and multi methods of data collection. However, it may be a multiple case study would have enabled further support for the theoretical generalisation of the findings from this research.

Finally, the case study was focused on the voices of the LME, midwifery lecturers, student midwives and HOMs. This focus was the intent of the case study however, as the study unfolded the impact of the clinical mentor working with the student midwives became apparent. It may be if the case study were to be repeated, including a sample of midwives working in the clinical areas would offer a different source of understanding not gained from the HOMs. Furthermore, testing these theories with the woman being cared for would also bring closer attention to the woman as part of the investigated woman centred care.

7.4 *How is woman centred care understood and experienced by student midwives, Heads of Midwifery ,the Lead Midwife for Education, and midwifery lecturers in a pre-registration midwifery programme*?

This case study found that there were theoretical concepts associated with woman centred care influencing understanding and experiences in pre-registration midwifery education. These concepts were confirmed as choice, control, continuity of care, individualised care and mutual collaboration. Evidence of these theoretical concepts is likely to be indicative of a pre-registration midwifery programme promoting woman centred care. Whilst there were variations in the use of terms, broadly applied, this finding supports the use of a theoretical framework as a means of promoting woman centred care. Although, recent policy published since the inception of this work are more likely to use the term personalised care than woman centred care, the same theoretical concepts remain suited. Consequently, identification and consideration of how these theoretical concepts are understood and experienced may assist both future policy makers and educationalists.

However, there was differentiation in the understanding and experiences of woman centred care. The variation may be explained due to the causative structures attributed to ascribed ideologies, clinical contexts ,the organisation, professional identity, teaching methods, the clinical mentor and the profile of the woman. Each influenced how woman centred care was understood and experienced and resulted in the variations of woman centred care in the pre-registration programme. In result, understandings, experiences and perceptions frequently varied between the HOMs, student midwives, LME, midwifery lecturers and programme documentation. Largely the HOMs were increasingly focused on experiences and understanding influenced by the clinical context with an aim of mediating a realistic expectation of what could be offered as part of woman centred care. In contrast, the LME, midwifery lecturers and student midwives aimed for an aspirational concept of woman centred care with anything outside of the construct being perceived as adversarial to achieving woman centred care. Consequently, woman centred care in the pre-registration programme was influenced by the competing ideologies personified through different clinical

environments. The low-risk clinical environments resonating with the aspirational ideology and the high-risk environments unable to accommodate the same aspirational ideology. The deep-seated ideologies also formed complex power dynamics where the aspirational midwifery led ideology was a structure for the on-going assertion of midwifery professional identity.

As part of this context, the midwifery lecturers and LME were focused on the necessity of student midwives being educated in an aspirational, gold standard of woman centred care aiming to support both the woman and the midwifery profession. Therefore, they focused on a student midwife's agency, so that they were able to possess the qualities and competencies to challenge and change practice for adopting the espoused model of woman centred care. Indeed, nearly all the attention in the theoretical components of the pre-registration programme was on the student's agency and limited attention was provided to the structures causing or preventing woman centred care. The overreliance on student agency placed considerable responsibility on the student and their expressed feelings of disillusionment suggest that many of the students perceived this responsibility as an additional pressure.

The aspirational ideology of woman centred care in the pre-registration programme was not without challenge. The LME and midwifery lecturers were aware of the rapidly changing profiles of women being cared for that did not align to low-risk healthy normal models of care. However, despite this awareness a stronger philosophy of low-risk aspirational ideology pervaded the pre-registration programme. The HOMs were also acutely aware of their clinical services being shaped by the changing profile of the women being cared for. Unlike the LME, student midwives and midwifery lecturers, the HOMs had a broader understanding of woman centred care encompassing the multi-disciplinary team and locating care as part of the available resources from within their services. This finding supports the importance of woman centred care in pre-registration midwifery education being equally mindful of the powerful tendencies of organisations such as policies and time demands. These competing perceptions and understanding of woman centred were largely responsible for a limited contextual application of the concept in the pre-registration programme.

This finding is not without acknowledging the many challenges facing the midwifery profession and pre-registration midwifery education. Indeed, with ever-increasing reports of medicalisation in midwifery it is unsurprising there was a strong desire of professional protection that supports recent calls for a physiological process of birth rather than pathology and surveillance (Williams *et al.,* 2019). The implications of the case study are more positioned toward revealing the consequences of a fixed concept of woman centred care being promoted by pre-registration midwifery education. Whilst the university pre-registration espoused model of woman centred care was promoted with passion and good intent, ironically it accentuated the differences between clinical practice and the university. Exposing differences risks student midwives becoming ever more disillusioned or feeling unprepared for clinical practice. Or at the other extreme suggesting that to effectively apply woman centred care students need to go 'above and beyond' normal working practises. It is

questionable if this is a sustainable model of working. Furthermore, although not included in this case study, a fixed approach may also risk midwifery education becoming isolated from the women themselves and unable to dynamically respond to the fast-changing clinical context.

This study contends that pre-registration education is an important first step of a journey into the expectations and socialisation of the midwifery profession and, in turn, the understanding and related experiences of woman centred care. There is a fine balance between educating for aspiration and professional autonomy and educating for employability based on the demands of the workplace. In fact, from this case study these were mainly at odds when applied to woman centred care in the pre-registration midwifery programme. Indeed, midwives conforming to anything other than a midwifery led culture is often viewed as being obedient and detrimental to midwifery autonomy (Holing *et al.*, 2006). Despite these assertions it is proposed that rather than woman centred care being shaped by competing ideologies further integration is required. To achieve this integration less emphasis needs to be given in pre-registration programmes on endorsing fixed theoretical constructs which create powerful norms. Instead, flexibility and enhanced awareness of norms and their resultant powerful consequences would allow new opportunities for pre-registration midwifery programmes. In turn, allowing the contextualisation of woman centred care irrespective of the type of clinical environment. Furthermore, preparing a flexible, contextual model of woman centred care would enable less adversarial responses to anything outside of the fixed powerful norms. Therefore, assisting student midwives to be fully prepared for how they can apply woman centred care as part of their experiences inclusive of when they are part of busy, clinical environments with women who may not be low-risk and healthy. Indeed, pre-registration midwifery education is well placed to work with its service colleagues to commence these discussions potentially releasing midwifery from what could be contested, outmoded concepts of woman centred care whilst still enabling autonomy of the midwife.

The employed critical realism framework offers new understanding and the developed models for pre-registration midwifery education aim to support future programme planning with an enhanced consideration of the powerful tendencies enabling or constraining woman centred care. By focusing on these areas new possibilities for woman centred care could be achieved supporting both the changing profile of women and the methods to effectively address student midwives being prepared and able to effectively respond to the full complexity of the concept.

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Appendix 1 Glossary of Terms

Term	
BERA	British Educational Research Association
Cisgender	An individual who identifies with their biological sex assigned at birth
CNO	Chief Nursing Officer
Continuity of Care	A continuous relationship in care between a patient/woman and their main care provider
DH	Department of Health
EBL	Enquiry Based Learning
Episiotomy	A surgical incision made in the perineum during birth, usually when the baby's head is being delivered
HOM	Head of Midwifery
ICM	International Confederation of Midwives
Instrumental Birth	An assisted vaginal birth with instruments, a ventouse or forceps.
LME	Lead Midwife for Education
Midwifery Led Care	Midwife as the named lead care provider during pregnancy and birth
MINT (study)	Midwives in Teaching
MBRRACE-UK	Mothers and babies ; reducing risk through audits and confidential enquiries across UK
NMC	Nursing and Midwifery Council
Non-binary	A gender that does not identify as male and /or female
Pedagogy	Methods of teaching and learning
Pre-Registration	Prior to qualification and entry to the professional register of midwifery
Pre-Term Birth	A baby born before 37 weeks
Programme Leader	Academic responsibility and leadership for an education programme
Reflexivity	Process of continual reflection
RCM	Royal College of Midwives
RCUK	Research Council UK
Simulation	Acting out a real-life event or condition to support training
STM	Student Midwife
Transgender	An individual who does not identify with their biological assigned sex at birth
UK	United Kingdom
WCC	Woman Centred Care

Appendix 2 Chronology of Midwifery Developments

Date	Development
1902	1st Midwives Act and CMB Central Board of Midwives. Midwifery became legally binding and a mandate for training. CMB set up as part of the Act.
1905	All midwives had to be on the register or could not be called or work as a midwife.
1938	Midwifery training split into two parts. 12 months for nurses and 24 months for direct entrants.
1948	Creation of the NHS. GP became paid for delivering maternity care.
1970	Peel report . Recommended availability of beds for birth in hospital.
1979	CMB abolished and the creation of the UKCC (UK Central Council for Nursing, Midwifery and Health Visiting). Creation of single professional register with separate parts for different qualifications.
1981	3-year training for direct entrants and 18 months for nurse entrants.
1990s	Midwifery education moved from an apprenticeship work-based learning model into higher education and formulation of an academic knowledge base.
2002	UKCC abolished and NMC (Nursing and Midwifery Council) established that took over the regulatory function.
2009	NMC recommended midwifery become an all degree profession.
2015	Kirkup Report recommended removal of supervision from regulatory NMC framework.
2018	New NMC quality assurance framework for nursing and midwifery education.
2019	NMC consultation on new midwifery pre-registration education standards.

Appendix 3 Literature Search Key words and Terms

Key words and terms employed in the Literature Review:

Woman centred care

Women's centred care

Wom* centred care and concept

Wom* centred care and midwifery

Wom* centred care and maternity services

Wom* centred care and pre-registration midwifery education

Wom*centred care and midwifery education

Wom* centred care and health policy

Wom* centred care and policy

With woman and midwifery education

With woman philosophy and midwifery

With woman philosophy and concept

Pre-registration midwifery education

Midwifery education

Midwife-mother relationship

Midwife-mother relationship and midwifery education

Literature Search

Searched Databases

MEDline

CINAHL

Science Direct

British Nursing Index

EMBASE

PsychoINFO

JSTOR

ASSIA

BMJ

Emerald

Maternity and Infant Care

PubMed

Wiley Online

Psychoinfo

NICE Evidence

Cochrane

Websites

RCM: https://www.rcm.org.uk

Gov.UK: https://www.gov.uk

Google Scholar https://scholar.google.co.uk

NMC https://www.nmc.org.uk/

ICM https://www.internationalmidwives.org/

BERA https://www.bera.ac.uk/

Appendix 4 Interview and focus group schedules

Title: A case study exploring the understanding, experiences and application of the concept of 'woman centred care' in a pre-registration midwifery education programme.

Heads of Midwifery Semi Structured interview questions (v4)

1) Name and grade

2) How long have you been qualified as a midwife?

3) How long have you been a Head of Midwifery?

4) Could you describe the type of maternity services that you lead?

5) How many qualified midwives and student midwives do you have in your maternity services?

6) What are your key roles and responsibilities in relation to pre-registration midwifery education?

7) How do you understand that woman centre care is experienced by the student midwives on the pre-registration midwifery programme at xxxx ? Can you provide specific examples?

8) How does the concept of woman centred care in the pre-registration midwifery programme relate to the women and their families that are part of your maternity services? Please provide examples

9) How do you perceive that these concepts of woman centred care are more broadly applied in clinical practice?

10) What do you see as the opportunities for woman centred care in midwifery pre-registration education?

11) What do you see as the challenges for woman centred care in midwifery pre-registration education?

12) Given your answers what do you think this means for the future of woman centred care within the pre-registration midwifery programme?

13) Is there anything else that you want to tell me about woman centred care and pre-registration midwifery education?

Semi Structured Interview LME

1) Name and grade

2) How long have you been qualified as a midwife?

3) How long have you been a Lead Midwife for Education?

4) Could you please describe the educational organisation that you are part of?

5) How many midwifery lecturers and student midwives do you have in total?

6) What are your roles and responsibilities in relation to the pre-registration midwifery programme?

7) As the LME, what does the concept woman centred care mean to you as part of the pre-registration midwifery programme?

8) How do you perceive and understand that the xxxx pre-registration midwifery programme addresses concepts of woman centred care?

9) How do you perceive that woman centred care is experienced and understood by student midwives on the pre-registration programme?

10) How do you perceive that the concept of woman centred care from the pre-registration midwifery programme is applied by student midwives in clinical practice? Can you provide examples

11) How do you perceive that woman centred care is more broadly applied in clinical practice?

12) What do you see as the opportunities for woman centred care in midwifery pre-registration education?

13) What do you see as the challenges for woman centred care in midwifery pre-registration education?

14) Given your answers what do you think this means for the future of woman centred care within the pre-registration midwifery programme?

15) Is there anything else that you want to tell me about woman centred care and midwifery education?

Midwifery Lecturers Focus group framework

- How long have you been in midwifery education and outline key responsibilities?

- How do you understand the concept of WCC as a part of midwifery education? Can you provide examples of how you apply this to midwifery education that you teach?

  - Link to aspects such as professional identity- why is it important?

- How do you think this links to the lived experiences of the student midwives on your programme?

  - -I.e. some lived experiences were different according to the clinical context - why?

- How do you overcome the links and constraints?
  - Do you think this is driven by differences or organisational needs , what is your understanding and role ?

- Can you explain how this impact on the education?

- How do HOMs want WCC provided?

- -Changing profile of women – what implications does this have and for WCC in education

- Opportunities and challenges going forward

- Anything else you want to tell me?

Appendix 5 Information Sheets and Consent Forms

Participant Information Sheet (V7)

1. **Study title**:

A case study exploring the definition and application of the concept of woman centred care in a pre-registration midwifery education programme

2. **Invitation**

You are being invited to take part in a research study that forms part of my professional doctorate in education at xxxx. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

3. **What is the purpose of the study**

This study aims to further examine the concepts and definitions of woman centred as applied in a pre-registration midwifery programme at xxxx with the following core objectives:

- Explore and understand what woman centred care means to Heads of Midwifery, Lead Midwife for Education , student midwives and the midwifery lecturers.

- To examine how the concept of woman centred care is applied and experienced in a current pre-registration midwifery programme from the Heads of Midwifery, LME , student midwives and midwifery lecturers' students' perspective and how this relates to the women and families they are working with in practice.

- Consider any future implications for a new concept of woman centred care in pre-registration midwifery education that will support the future role of the midwife

- Provide implications and recommendations for maternity policy and education.

- Develop a new 'woman centred' educational framework for under graduate midwifery education

It is anticipated that this study will be completed with my thesis submission by October 2019.

4. **Why have I been chosen?**

You have been selected to take part in this study as you fulfil one of the following criteria:

- A third year or second year student currently on the pre-registration midwifery programme at xxxx.
- A Head of Midwifery who is aligned to the pre-registration midwifery programme at xxxx.
- A Lead Midwife for Education in England
- A midwifery lecturer involved in the pre-registration midwifery programme

5**. Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form and contact me to agree with me a time for the focus group or interview. Prior to the focus group, or interview, verbal consent will be obtained and recorded. If you decide to take part, you are still free to withdraw and without giving a reason that can be facilitated up until October 2018. university. If you decide to withdraw all data relating to your participation will be destroyed.

You are free to withdraw from the study at any time without giving a reason. With your permission we would like to retain any data we have collected to the point of withdrawal, but you can request that your data be destroyed. All data will be anonymised prior to analysis that will be completed by December 2018, and after this point it will not be possible to withdraw your data.

6. **What will happen to me if I take part and what do I have to do?**

If you agree to take part the data collection will involve the following**:**

- If you are a third-year student midwife this will involve being either part of a focus group based at xxxx that will consist of 5-7 student midwives that will last one and a half hours or an individual recorded telephone interview lasting twenty to thirty minutes. The focus group will take place at the xxxx and will be filmed or digitally recorded with notes taken during the session. The telephone interview can be arranged at a mutually convenient time.
- If you are a second-year student midwife this will entail an individual telephone interview lasting twenty to thirty minutes arranged at your convenience that will be recorded and transcribed.
- If you are a Head of Midwifery this will involve a recorded Skype or telephone interview lasting 40 minutes and conducted at a mutually convenient time. The interview will be recorded and transcribed.
- If you are a Lead Midwife for Education, this will involve a recorded Skype or telephone interview lasting 40 minutes and conducted at a mutually convenient time. The interview will be recorded and transcribed.

- If you are a midwifery lecturer this will involve a focus group of midwifery lecturers of between 6- 8 participants or an individual recorded interview lasting 40 minutes. The focus group or interview will be recorded and transcribed

I will be undertaking the data collection and will ask you a number of set questions relating to woman centred care and the pre-registration midwifery programme.

7. **What are the possible disadvantages and risks of taking part?**

It is not anticipated that any harm will result from the study. However, if the reflection of your experiences cause upset counselling or support services are available through your organisation, especially directed through that of the Human Resources department or wellbeing student services. If any unsafe practice or professional misconduct is disclosed to the researcher this will be reported to the relevant manager.

8. **What are the possible benefits of taking part?**

There are no direct benefits from taking part in this study. However, it is hoped that the results will help inform future maternity policy and pre-registration midwifery programmes,

9. **What if something goes wrong or I am unhappy about something?**

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions**.**

If something goes wrong, you can contact my supervisor

If we are unable to resolve your concerns or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Please provide details of the name and description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

10. **Will my taking part in this study be kept confidential?**

All information which is collected about you will have your name and address removed so that you cannot be recognised from it. In all processes your identity will be kept confidential and subsequently, during data collection, transcription and data analysis you will be given a research code. Data will be anonymised after your interview has been transcribed i.e. within 1 month of interview. However direct quotes may be used in publications or presentation, but these will be anonymised. Any transcribed data will be kept for up to five years.

Access to the data will only be managed by me with a small sample shared with my supervisory team to ensure compliance with the research governance process. No one else will have access to the data from the study and personal data will only be accessed through a password protected computer.

11**. What will happen to the results of the research study?**

The research will be submitted as part of my professional doctorate in education that is anticipated to be completed by October 2019. The results will be published in peer reviewed articles, conferences and policy forums. The results will be made available to people who took part should they specifically request this information. The results will be published when the study is completed and will be available online free of charge in an open-access journal. Your information will remain totally confidential when any findings are published.

12**. Who is organising and funding the research?**

I am a student undertaking a professional doctorate education at xxxx. My professional background is a qualified nurse and midwife currently working as the head of department xxxx.

13. **Contact for Further Information**

You may contact me on xxxxx for any further information or my research supervisor

Many thanks for reading this and for taking the time to take part in this study.

As part of the study you will be provided with a copy of the information sheet and a signed consent form.

Consent form for Student Midwives

Title of Project: A case study exploring the definition and application of the concept of woman centred care in a pre-registration midwifery education programme

Researcher: : **Contact**

I confirm that I have read and understand the information sheet dated

12/06/2017 (v6) for the above study ☐

1. I understand that my participation is voluntary and that I am free to withdraw at any time up until December 2017. If I do I understand that any response will not be stored. ☐
2. I agree to take part in the above study ☐
3. I agree for the focus group/ telephone interview to be filmed or recorded ☐
4. I agree to the focus group/telephone interview to be digitally recorded ☐
5. I agree to keep confidential any information shared during the focus group ☐
6. I agree to the use of my anonymised data in publication of other outputs ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Consent form for Heads of Midwifery and Lead Midwives for Education

Title of Project: A case study exploring the definition and application of the concept of woman centred care in a pre-registration midwifery education programme

Researcher:: **Contact**

I confirm that I have read and understand the information sheet dated

12/06/2017 (v6) for the above study ☐

1. I understand that my participation is voluntary and that I am free to withdraw ☐

up until December 2017. If I do I understand that any response will not be stored.

2. I agree to take part in the above study ☐

3. I agree to be contacted for a Skype or telephone interview and ☐

for this to be digitally recorded

4. I agree to keep confidential any information shared during the interview ☐

5. I agree to the use of my anonymised data in publication of other outputs ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Consent form for Midwifery lecturers

Title of Project: A case study exploring the definition and application of the concept of woman centred care in a pre-registration midwifery education programme

		Please initial each box
1.	I confirm that I have read and understood the information sheet dated 19/04/2018 (v7)	
2.	I agree to take part in the study	
3.	I understand that I am free to withdraw at any time, without giving a reason and that any data collected from me up to the point of withdrawal will be retained. I can request that this data be destroyed up to the point of anonymization, one month after the interview	
4.	I understand that the focus group, or telephone interview, will be audio recorded and my identity will be kept confidential. I give my permission for either of these to be audio recorded.	
5.	I understand that my anonymised data will be used in publications and conference presentations (and this may include direct quotes) and may be retained for a period of five years. I give my permission for my data to be used in this way.	
6.	I understand that my participation is voluntary and that I am free to withdraw at any time	

Name of Participant Date Signature

Name of Researcher Date Signature

Name and contact of Researcher: : **Contact**

19/04/2018(v1)

Appendix 6- Sample of Interview Transcripts

Excerpt One

RES:	I love everyone's background. It's amazing. It's so interesting like when you put everybody's, you know dynamics together. It's fascinating.
INT:	Yes exactly. It is. So, um great. So, moving on then 'cause obviously one of the things I'm really interested about is this concept of woman centred care because we kind of use utilise the concept all the time interchangeably with lots of other terminology. Yes?
RES:	Yes.
INT:	But as a student, you know if you were to say the concept of woman centred care, what does it mean to you? You know if you were to kind of think about it or outline it. What's it means to you xxx?
RES:	Okay well I think initially what it means to me is that whatever we do should be for the benefit of the woman.
INT:	Um, um.
RES:	So um, you know they should be at the centre of everything, you know whether it's what's the decoration like in a birthing room or um you know, what's the trust policy on whatever. I think you know, we should always be thinking about what they want and need...
INT:	Um.
RES:	- And making sure that they really know about it, but I think for me, I find it's quite tricky when um, you know I think it gets quite blurred as to what, you know are women genuinely – is it genuinely women centred care or is it actually women centred care that fits in around policy/guidelines and trust guidelines and midwives working hours and...
INT:	Yes.
RES:	- You know, all that kind of thing but I think, you know ultimately what I think it is is you know women having – well for me I think the women centred care equates to continuity of care. I think that's you know, a massive bit of it but I think, yes it's just making sure that you know we're always considering the needs of the women, whether or not that's – and I think sometimes it's difficult because I think you know in other fields, you know if you've got cancer and you go and see your cancer doctor, you would expect your cancer doctor to tell you what they are going to do and you wouldn't necessarily – you would be a part of that conversation but you wouldn't be calling the shots.
INT:	Yes.
RES:	You know your doctor would be and I think, you know, the women centred care, I think you know when the women are at the centre of it and we

consider them, it's great. I think sometimes where it then becomes complicated is maybe when you've got women centred care but they're maybe suggesting that they want a care that you wouldn't necessarily feel is the best care for them.

INT: Okay. Yes. So just give me – 'cause we'll tease out some of those things that you've said xxx just in future challenges 'cause there's some really interesting stuff that you've said but just – can you kind of give me an example of woman centred care that you perhaps thought in your education, like where you think oh yes, that does capture to me woman centred care just as a, you know an example? Is there anything?

RES: Of what we're taught at University?

INT: Yes what you're taught at University or you may have come past in practice that you thought yes, as a student midwife that kind of illustrates to me what woman centred care is.

RES: Um I think it's – it's communicating with them.

INT: Um, um.

RES: Having the time to sit down and communicate with them and not communicate on your agenda but communicate on their agenda so you know, you can explain something to them – that's not women centred care because you're just explaining it but if they can understand it...

INT: Yes.

RES: - And comprehend it, then that's women centred and I think it's just individualised, you know what fits for one woman will not fit for another women so it's also having the time to sit down and really listen to what they're saying they would like or us explaining what really is best for them and having a chat about it but I think it's, for me it's you know, if you can communicate with them and build a relationship with them, you're going to definitely be much further ahead with their woman centred care if you've got that trust and relationship and I think that, you know that comes back again to the fact that you know, it's not – you know, if you're working with a woman and you're seeing her over nine months, that's women centred. She's at the centre of your practice. If it's the other way round and the woman sees nine midwives, then it's midwife centred care because they're at the centre of the practice so I think it's the fact that it's trying as much as possible to have her needs at the front so for me I think, you know seeing a woman and then seeing her again and remembering her and saying um I remember I saw you last week and we sent you up to the DAU so you know we had a woman who came into community, for example.

INT: Um.

Excerpt Two

RES:	Um, what was I thinking there. I was thinking um we've got in the maternity service, obviously we've got policies and we've got procedures and we've got standards and we're aiming to give women informed choice but obviously we've got guidelines around that, based on what I call the average woman [inaudible 8:32] 'cause they're based on statistics, they're based on, you know, all women over 35 this is the sort of general view but when you come to delivering care for an individual woman she's not really interested in, to a certain extent is she, in broad risks, she wants all that personalising to her as an individual. My risk, you know all risk, women over, let's take the age thing. All women over 35 are more at risk of this and that and if we looked at the stats it would all be very general, and I suppose you're teaching them about those risk factors and stuff in education aren't you. Then they come here but we've got to personalise [inaudible 9:11] individuals, so for you, this could potentially be a risk, this might a risk but in your situation you've got this, this and this that are counter balancing that, therefore you, when you're considering the risk, so to enable to information isn't it, meaningful individual woman, so she can make, we're not just giving her generic information then she makes an informed choice, we need to um adapt our information for her don't we so she understands what her choices are, what, you know what her informed choices are and what options we've got. I mean some of our options um, one might argue that some of those options could be unrealistic for that woman, although we give her all the options, I'm not trying to say we limit her options, but some options are more realistic than others aren't they.
INT:	Yeah, so xx
RES:	Take a most dramatic, to take a really dramatic example, if you're having your, I don't know, let's think of an example, um er say you're having a VBAC and you've got twins and you want to have a home birth in xxxx, that might be possible, that is something you know but that option for her, we're going to explain that option and we're going to talk through it aren't we and we're going to explain why we might be suggesting another option and hopefully with good, informed choice people are making really safe options but doesn't mean to say that some women you know, for the risks for that woman she's going to say well I don't want that, I want something else and we've got to be adaptable haven't we and all the time adapting and providing care which is hopefully is safest possible outcome for the mum but also in the baby but also meeting her needs of what she wants, her expectations of what she wants her care and everyone's got different expectations haven't they.
INT:	Yeah, absolutely.
RES:	From, someone, someone's expectation might be I absolutely don't want to experience pain in this birth that might be one expectation, compared to some other woman who, who I don't know, is taking a different choice, so yeah.
INT:	But how do you, no 'cause what you're describing, as you say, is those very real examples aren't they of how woman-centred care is applied in different ways, yes. As axxxx thinking about it with your services, is that the kind of approach that you take for woman-centred care then, more broadly to women, to women and their families, thinking about how you, because you, you've really nicely identified with all the principles of informed choice..

RES: Yeah.

INT: ...you know and things but, but as you say how, how do you think you apply it within your services. Just to be, so I'm, so I'm taking sure I'm hearing the correct information.

RES: How to we apply it. We try, we try to give all women, I hate that informed choice, keep seeing informed choice, it's so historical but we're trying to give information with women to make a decision...

INT: Mm.

RES: ...about their care so that they understand um the realities aren't we, so they're all really well informed. So the principle that we would apply is trying to make sure that all women get appropriate information up to date, you know, research based, all the most appropriate information but we're trying to deliver that information in the way that she can make sense of it aren't we.

Excerpt Three

I think if you've got – or even if you – even if you're limited on time to make sure the time you've got with them you really focus on them.

INT: Um okay.

RES: I think that would probably the other thing.

INT: Yes so thinking about – 'cause what you've talked about is some of those, as you say, the concept of what it means to you is great, I'll come back to the practice bit in a min but thinking about your programme that you're on…

RES: Yes.

INT: Yes so thinking about your midwifery programme, how do you know – just reflecting on it and what you've learnt on that journey, how do you think your programmes kind of addressed some of the things that you're talking about around woman centred care...

RES: I think the programme is very – well you could argue either the programme is either very ideological or you could argue the programme is teaching the gold standards depending on where you are.

INT: Um.

RES: So we are given, you know, in year you know you're talking about women and you're learning about bookings and antenatal care and all of this and you're really

saying about you know, you've gotta spend time with the woman and that's really sort of encouraged within the course that it is women centred and I think that's very good and it's great that you know, that they're doing that but I think sometimes you can go out into practice and I can remember you know, you're given your sort of case loading documents and they say you know, you're gonna be in community and you'll see a woman you know two or three times in her antenatal care and then you might get to see her birth if you put it in the notes and then you'll be able to visit her afterwards and I went out with this really fabulous idea that this was what I was going to do and this is what I want to do and then the reality came back that you know, you're working with one, two or three mentors or actually you're mentor only works part-time so all of her women already see more than one and then you might have to cover somebody else's clinic so I think the course definitely encourages woman centred care and it encourages the fact that you need to build those relationships with your woman and when you're doing a booking, you know don't look at the computer screen, make sure you're spending time with them, get your conversation going. All those really, really, really valuable things and then I think it's how do we take that out into practice and not feel deflated within the first week when you're told you've only got an hour to do a booking appointment and hurry up please because you've got 15 women then to see later and actually then the woman that you saw last week, you're not gonna see in two weeks because I'm on holiday or whatever and I think it's trying to cope with – in a way I was disappointed by it...

Excerpt Four

Right, I think sometimes actually they're – and it might depends upon where their placement is. I think in the community placements it strikes me that they get more experience of that, going to birth centres where that tends to be more of the underpinning philosophy and approach. I think sometimes talking to students when they're in places – sort of more acute placements like CDS and things that women sometimes it sort of – it can be quite task orientated or there can be quite a focus on the complexity of the woman or her condition and the treatment and management is very much structured around that or sometimes quite a lot of hostility. The students talk about from midwives who don't approve of women sort of want hypnobirthing or come in with sort of different needs or actually if they kind of don't want to conform to the recommended care pathway or clinical guidelines. So indicating that potentially the students experience in practice is not sort of seeing my kind of thoughts about what woman centred care should be.

INT: I mean just on that point, I mean we know this don't we. I don't know if you've thought about what makes those clinical contexts so different in that application of the things that you're teaching in your programme so different according to the clinical context they're part of?

RES: I think partly I don't know, and this is probably sort of from my experience with working in different practice areas. Potentially I feel it could be the midwives themselves and their perspectives. I don't know whether sort of – different types of people work in different types of area or whether it's the culture of working in that area then sort of make them adopt certain perspectives and kind of a world view around something. I mean I presume most of us have had similar education in terms of midwifery philosophy and care and more social models, so why then potentially people sort of end up maybe not practicing in that way or not challenging when they see that people aren't practicing in that way or whether it's because sort of the more acute environments are quite influenced by medical models and

	their quite stressful environments to work in where you are often dealing with sort of emergencies where priorities change. I don't know, so whether it's people are attracted to go into certain environments where they might not sort of take on such an ideal of woman centred care or whether working in those environments and cultures just kind of impact and creates that.
INT:	Yeah it's interesting isn't it?
RES:	Mm.
INT:	Where's that created I suppose is what you're saying?
RES:	Yeah and I think you know wherever a midwife is working I think they believe that they are doing the best for women but I think sometimes when they don't adopt the woman centred approach they believe that what they are adopting and arguably is the case that it's not a sort of bad or half full approach necessarily but obviously it's not necessarily in keeping with that philosophy of woman centred care.

Excerpt Five

RES:	Um in terms of the ability to assess risk and formulate plans um in terms of that how to be able to balance risk and probability and underpin that with with the evidence er to enable them to make that risk assessment I would say that's probably going to be a key critical skill. Um so I'm just thinking is as examples because when we look at woman centred care it is about meeting… it's about um it's about meeting mums needs but the others the other end of that scale is that I see woman centred care as being women's voices need to be heard and they need to be involved in designing and evaluating maternity services so one of the skills that they're going to need is the ability to be able to facilitate evaluation maybe. So things like co-design, so experience based co-designs some knowledge of those concepts of what's involved in that and how to you know how to talk to women about that and involve them. Er I mean obviously if they're progressing their career as a midwife you know just thinking about um even the concepts that underpin might be useful. Um so I'm just thinking about in terms of risk assessment for me is a big one.
INT:	Do you think it's in a particular area or across the board xxx risk assessment?
RES:	What risk assessment?
INT:	Yeah.
RES:	I would say it's the ability to take complex information um and and particularly if you're thinking about a midwife coming out into practice er that um they have um a woman who is I don't know somebody who has complex needs so if we say somebody who maybe is diabetic or um has a complex medical need that is then requesting to have a home birth the ability to work through that process so the ability to (a) facilitate discussions that don't alienate the mum but also the ability to give information er in a in a way that doesn't come across as being um er what's the word, er I'm just trying to think of the word I need, that that isn't frightening the mother or scaring her into making a decision based on fear but being able to convey

	the information in a way that er she can then assess that it's understood because that's one of the biggest challenges that I think midwives who've been quite a while in practice struggle with er the ability to to provide that information in a non-threatening way but that's still supportive and maintaining a relationship because that that seems to be the challenges as an obstetrician, an obstetrician has no problems in saying right well this is this is what the evidence said and so therefore I would say no you can't or yes you can, whereas midwives will take a very different approach so it's a very um appreciative enquiry approach from a perspective of asking questions seeking understanding you know of of um where these requests have come from I think is something that midwives do do um and and also when they're in a… if you are in a delivery suite environment um if we're looking at women centred care it's being able to support um advocate in multi-professional discussions to meet the mums needs as well I think and it's the same kind of skill isn't it really across the board.
INT:	Yeah. Mmm no that's really interesting.
RES:	Does that translate into a more professional speak, sorry I'm just thinking speaking
INT:	No no no just speak there isn't… literally just that's the point of it as things come into you know thinking about.
RES:	I mean it comes down to informed choice I suppose is what I'm saying to summarise it I mean it's about facilitation of informed choice in a way that that supports the woman and makes her feel supported and not pushed into making decisions because ultimately at the end of the day we're all trying to have the safe same outcome aren't we which is a safe a safe birth but also a safe pregnancy that… where a mother has a positive birth experience.
INT:	Absolutely.
RES:	Um you know and sometimes that's not always ultimately doesn't end up being what they initially started out thinking that it was going to happen in terms of where they give birth but it's about how um it's about her feeling supported um and safe really yeah.
INT:	Mmm okay definitely. Is there… I mean we've talked a lot about I mean thinking about again is there anything that you think you know that oh she's missing the point here in all of our questions, Is there anything that you think you know I've kind of missed the point or actually that's my [inaudible 23:03] I'm really...
RES:	Well I don't think so because I think for me there is a big focus already on women centred care I'm seeing you know what I'm seeing in practice is that the midwives are coming through and they are very focussed on meeting those needs of the of the mum and the family. Um I think the biggest challenge is is the time to do that. You know the time I mean it's the whole spectrum isn't it it's yeah I don't think you're not asking any questions. I think there is a big focus on it already. Um I think…
INT:	Mmm can I just ask about time when you picked up cos you have said about the time, just expand that a little bit for me xxx when you say about the time.

RES: Well one of the things that community midwives quite often say er is that um ante-natal appointments, when they're doing ante-natal appointments one of the things I've heard them say quite frequently is that that the time to have some of the discussions with people in order to facilitate informed choice feels very rushed um and you know the ability to to have the necessary conversations but do that in a succinct way um has been one of the issues I think.

INT: Um that's absolutely fine. Sorry you were…

RES: It's communications skills isn't it really.

INT: Yeah absolutely yeah that's right.

RES: Um and I guess it comes under prioritisation in terms of the ability to prioritise your workload because for some for some prioritising some more time with women to talk through their issues save time in the longer term. It's how you arrive at that place and understanding that isn't it really.

INT: Yeah. Yeah definitely. So is there anything else that you want to say that I haven't given you the opportunity to say, obviously relating to woman centred care and not what you're eating tonight. [laugh].

RES: Yeah yes yeah. Um no because inherently I do feel that the training is women centred I mean I think there is a strong focus on that already so and we've talked about informed choice, we've talked about risk assessment um prioritisation and that evaluation about and about how they involve women in in designing services and evaluating them um which for me is kind of women centred care is about looking at all the needs of the of the mum and the family isn't it…

Excerpt Six

Absolutely. Absolutely. I feel strongly with the times we're at the moment where midwifery feels like it's being eroded. We're working with high levels of complexity, we're working with challenging times and cases, we're working with a shortage of midwifery, and the removal of the provision, a lot of the bad publicity, I think it's even more important to try and re-grasp that identity as an individual group, rather than to be merged. I think if we don't talk about while they're in their education for becoming a midwife, when they become employed, it's difficult for them to see that that ever was the case. Practice has changed so much. Worryingly so. I'm ever hopeful that the Better Births work will transform and support the regrowth of that midwifery specific autonomy and identity, but that's a work in progress, and actually it's quite slow. I'd really like to see the continuity of carer element of that rolled out and come into play as it should, but I'm worried that we're not in a time where that's feasible.

INT: Just explain a bit more. We'll go back to some of the things about the profession, but one of the things that's come out really strongly, which you're going into now, from the student midwives, is the experiences that they're having in clinical practice.. What sort of things are you hearing, or what do you think those experiences are?

RES:	When they come back and they're sharing in the classroom and in the skills lab we talk very much about being women-centred, often about time and the advice and committing to her, but when they come back and they're sharing the experiences of practice, initially they can be quite deflated because the reality of the pressure in clinical practice doesn't enable the time to spend with women to offer that true woman-centred approach. I get the impression that it's become quite task-focused. I think the CNST did us no favours. We've had to put in so many stringent guidelines, so many sticks, bits of documentation at this point, now you offer this information at that point. There was no flexibility to be truly women-centred. It became more of a tick box approach. I don't think we've come away from that yet, despite the fact the CNSE hasn't been around for about five years, although it's creeping back. Again, it's going to worry me more. I think we've also become quite risk-averse, quite focused on the risk, and have put in place more stringent policies and guidelines that prevent that true women-centredness and the offer of choice. We're afraid to support a woman because of litigation. I think the students come back quite disheartened in that way.

Excerpt Seven

RES:	Um I've seen it really good in practice. For example, on the birth unit, so we'll have like a woman who, they've come in for whatever reason and we're caring for them and we will literally sit down. I've seen mentors for example, who will just sit down next to the woman and talk her through her options which I think is really good, it's not just like, you come in with this, this is what we do. It's kind of sitting down, discussing with her how she feels, telling what we can do for her, saying you know we can do this, we recommend this, we recommend that, these are your options and then having a proper discussion with her about what she wants 'cause then she can ask questions, she can you know find out more in depth about a certain thing and then she's happy with what's going on 'cause she knows what's going on.
INT:	Yes.
RES:	I think I've seen really good practice when the woman is in the know of what's happening. I think it gets – it gets further away from woman centred care when she doesn't know what's happening you know so if there are emergencies or things aren't explained very well, I think when we lose woman centred care, it's when we lose that – when they lose that understanding.
INT:	Okay.
RES:	So, I think when I've seen it, it's when – it's been best when the woman understands basically what's happening.
INT:	And do you think there's particular – just to – just to probe that a bit more xxx, that's interesting, do you think there's particular environments – placements or environments that's more likely to happen or is it different in different places?
RES:	Yes, I think it's more – it's more community and birth unit.
INT:	Um.

RES:	Because I've had experience in delivery as well and I think because – because there's a lot more going on delivery quite a lot, you know these things could be more complicated. It's harder to keep the woman in the know whereas on community 'cause you're seeing them quite often and on the birth unit when things are normally quite low risk, it's a lot easier for the woman to understand what's happening whereas I think on delivery, it's a lot harder perhaps to be woman centred because it's hard for her to understand everything that's happening. So, I think that's when it might kind of go further away from it in really high-risk situations 'cause it's hard for them to have that knowledge of what's happening.
INT:	Have you seen any examples of – um just made a funny noise then. I hope it's still recording [laughs]. Don't know what that was.
RES:	I didn't hear it.
INT:	No, obviously hopefully just my side then [laughs]. Can you think of any kind of – thinking about that so you're saying delivery suite for me to get it correct, ?
RES:	Yes.
INT:	Have you got any examples where you think you have seen it? Describe where perhaps you have seen what epitomises woman centred care in those environments.
RES:	Um one, yes, I think it's just – like I mentioned on the birth unit, like it's you do obviously see some midwives where they just try their best to explain everything that's happening and then the woman she is a lot happier from what I've seen with what's happening because it must be really scary if you haven't got a clue what's happening, and you get it in doctors as well. You know some people will come in and just be really good at explaining things and you know you might have an obstetrician come in and be really good at saying, okay this is what's happening, this is why, this is what we can do and if the woman understands it, from my experience – the more the woman understands, the kind of happier she is with what's happening because it might be as far from her birth plan as she wanted it to be but if she understands why it's all going on then obviously that's a lot better so I think woman centred care that I've seen, it's been best from people who have been really good at explaining what's happening to the woman.