Journey women: a narrative inquiry exploring the employability experiences of newly qualified midwives

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Journey women: A narrative inquiry exploring the employability experiences of newly qualified midwives.

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty of Business and Law Ethics Committee on 13/11/20.

I declare that the Word Count of this Thesis is 54,940 words.

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Abstract

This thesis presents a narrative inquiry that explores the experiences of newly qualified midwives [NQM] as they enter employment within the NHS in England at a time when retention of midwives within the workforce is of critical concern (RCM, 2022). Policy and professional standards for midwives focus on the acquisition of skills and the development of personal attributes as the means to best prepare students to enter the workforce (HEE, 2022; NMC, 2019). I argue, however, that becoming a midwife comprises more than the possession of certain skills and attributes. This argument draws on the wider literature that explores graduate employability (Holmes, 2013, 2015) and, in doing so, provides a new lens through which to approach the education and employment of midwives.

I have used narrative inquiry (Wang & Geale, 2015) to capture the stories told by five participants about their experiences of becoming a midwife as a student, and in the two years following graduation. Findings illustrate a shared temporal storyline which reflects the genre of a quest narrative featuring a challenge or an ordeal that must be faced to enable completion of the journey to become a midwife once qualified. The individual stories of each participant were 're-told' (McCormack, 2004), to illustrate the quest through five stages: the call, the threshold, the crossroads, the road of trials and the return. Detailed analysis of the participants' stories draws attention to the employability perspectives of graduate skills, social position, and the process of identity development illustrated through the plot elements of the quest.

The study concludes that, in order to address the retention of NQM in the NHS workforce, employability theory can provide a useful and comprehensive understanding of what it means to 'become a midwife'. A story archetype is proposed which reflects the journey to becoming a midwife and offers additional perspective on the experiences of Newly Qualified Midwives.

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Acronyms

AA: Alumni Association

A&E: Accident and Emergency

COP: Communities of Practice

HE: Higher Education

HEE: Health Education England

HESA: Higher Education Statistics Agency

LOP: Landscapes of Practice

NHS: National Health Service

NMC: Nursing and Midwifery Council.

NQM: Newly qualified midwife

NQN: Newly qualified nurse

OfS: Office for Students

TEF: Teaching Excellence Framework

RCM: Royal College of Midwives

RCN: Royal College of Nursing

RCOG: Royal College of Obstetricians and Gynaecologists

UCAS: University and College Admissions Service

UKCC: United Kingdom Central Council

Glossary

Active Cooling : An intervention to reduce brain damage in babies who have been starved of oxygen at birth

Band Five, Six & Seven : Roles within the NHS that apply to all non-medical staff and reflect salary and organisational responsibilities. Band Five is the minimum grade and applies to all new registrants. Midwives can expect to be in a band six role within a year of registration reflecting the additional responsibility of providing midwifery care unsupervised. Band Seven roles reflect organisational leadership and management in addition to professional practice.

Bank Shifts: As required casual employment, often used to cover for sickness etc

Blues: Relates to the blue uniform (or scrubs) of a registered midwife as opposed to the white uniform worn by students.

Cannulation: Insertion of a narrow plastic tube (cannula) into a vein to administer drugs or fluids intravenously

Case loading: Following a small group of women through their pregnancy and birth experience providing midwifery care in preparation for taking on a 'case load' of women once qualified.

Consultant Obstetrician: RCOG definition available at https://www.rcog.org.uk/media/igqfguvs/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

Defensive Practice: Fear of litigation in midwives and obstetricians driving clinical decision making

Doula: A person who will support the whole family to have a positive experience of pregnancy, birth and the early weeks with a new baby https://doula.org.uk/what-doulas-do/

Forceps: Use of metal instruments applied by a doctor to assist with the birth of the baby's head

Health Education England: The NHS organisation which supports the preparation and education of the NHS workforce in England.

Induction: Use of artificial hormones to start labour via an intra venous infusion (IV) or drip

Nursing and Midwifery Council: The UK regulator for the midwifery profession. The regulatory function includes holding the register of midwives, ensuring standards of professional behaviour via The Code (NMC, 2018a), and prescribing the standards for education that lead to professional registration.

Mentor : An NMC registrant who, under the 2008 Standards for Learning and Assessment in Practice, supported and assessed students whilst on placement.

Midwifery Supervisor: A previously NMC regulated function to manage the quality of midwifery practice

Obstetric Emergencies: Life threating medical situations for woman and or fetus such as massive haemorrhage or shoulder dystocia for which there are practised drills and team responses

One Born Every Minute: A television documentary on Channel Four illustrating the work of midwives and the experiences of the women and families they care for.

Primiparous: The term used for those who are pregnant for the first time.

Pre-Eclampsia: High blood pressure caused by pregnancy

Post-Partum Haemorrhage: Excessive blood loss following birth.

Royal College of Midwives: The RCM is the professional voice of midwifery as an organisation and trade union which represents midwifery and midwifery support workers.
https://www.rcm.org.uk/about-us/

Shoulder Dystocia: The baby's shoulders become wedged in the mother's pelvis after the head has been born. This is classed as an obstetric emergency as the oxygen supply to the newborn is compromised whilst the head is born and the body is not.

Epigraph: Daughters of Time

I am a daughter of time

My mother walked these hills in years gone by.

Her mother too once watched these trees

In blossom, bearing fruit and losing leaves.

We are the daughters, the daughters of time.

…

Last night I held a woman giving who was giving birth

She brought another daughter here to earth.

I feel happy with my man and with our son

But I wonder if a little girl will ever come to me

To join the daughters, the daughters of time.

Mary Offermann 1975

Chapter One: Introduction and Background

1.1 Introduction

The epigraph, a poem suggesting the origins of midwifery and the passing down of knowledge from one generation to the next, is included to both establish the value of story to my professional thesis and also, importantly to reference my practice: preparing the next generation of midwives. Indeed, my practice, as a midwifery educator is the primary motivator for this professional doctoral thesis. I chose a professional doctorate rather than a traditional PhD as, by doing so, I sought to locate my research within the story of my practice as a pragmatic way to explore and address a professional problem (Bourner et al., 2001; Fenge, 2009). Although I recognise that the traditional PhD has evolved to explore practice issues also (Jones, 2018), it is the centrality of practice to a professional doctorate that spoke to me. In addition, the scope within a professional doctorate to span different disciplines, and in this case as a doctorate in business administration[DBA], draw on the canon of management and employment literature would enhance the breadth and scope of the exploration of the education and experiences of Newly Qualified Midwives [NQM] (Jones, 2018).

The experience of NQM as they journey from student to employee has been at the centre of my practice as a midwifery educator and academic for most of my professional career. As I move towards the end of this career, the opportunity to reflect upon and capture that experience in this thesis is both a personal achievement and also a timely contribution to the current narrative concerning the midwifery workforce. The narrative I refer to in this way is the broad story or presentation of the situation in the midwifery workforce that policymakers, the media, midwives, and others construct to explain the challenges faced in ensuring sufficient midwives are employed by the NHS to meet service demands (Larson, 2017; Lovegrove, 2018; Royal College of Midwives, 2016). In the time since I started my doctorate journey in 2017, what was a narrative of increasing concern has become one constructed by many as a full-blown crisis, driven by factors such as the pandemic, political inertia, widening social inequalities and staff attrition (Royal College of Midwives, 2021b;

Summers, 2021). The NQM has thus become a concept of significance to the profession, policymakers, the National Health Service [NHS], and the universities that provide the education which enables qualification. I use the term concept deliberately because there is no agreed definition of an NQM and, as this thesis will discuss, that may be desirable if attrition of NQM from the workforce is to be addressed.

Having re-set the scenery from my original starting point of an awareness of employability as an important concept for midwifery to the present and the amplification of the narrative surrounding the attrition of NQM from the workforce, the remainder of this chapter introduces the thesis and research questions. This commences with a reflection on my practice as a midwife educator working within Higher Education [HE] and, as such, introduces my narrative or story to the context of the thesis. That story highlights the challenges of managing the dynamic between the professional requirements of the Nursing and Midwifery Council [NMC][1], the delivery of effective programmes of education for students and the organisational requirements of the National Health Service [NHS], as the students' future employers. The chapter illustrates how these challenges shaped the research problem within the wider UK employability agenda and concludes with my approach to understanding the research problem within this thesis.

1.2 Future Midwives

The word 'midwife' derives from old English and translates as 'with woman' or the person, [usually a woman], with the mother at the time of birth (Hoad, 1996). The definition of a midwife as someone who supports and cares for women around the time of birth, is enshrined in UK Law (The Nursing and Midwifery Order Article 45, 2001). The law is enacted via regulation and reflected in the policies and debates about the role and function of midwives in the 21st century (Begley, 2001; Bradfield et al., 2019; NMC, 2021a; Pollard, 2011). Globally, the International Confederation of Midwives [ICM],

[1] The NMC are the UK regulator for the midwifery profession.

augment national regulation by providing a definition of midwifery and a supporting philosophy which describes the women centred, and relationship based, values of midwifery practice (ICM, 2014).

Within the UK, in 2019 the NMC completed its 'Future Midwife' consultation and published new standards which aim to both define and transform midwifery care and:

> '*equip midwives of the future with the knowledge, skills, values, and behaviours to meet women's changing and often complex, individual needs and choices*'
>
> (NMC, 2019).

The standards were developed following consultation with stakeholders including women, students, and employers, and were also set against the context of concern over the quality of professional practice as highlighted in investigations into NHS care provision (Kirkup, 2015; Ockenden, 2020).

The quality of the professional practice of midwives is a concern both for the profession and the NHS which employs the majority of registered midwives in the UK. As employers, the NHS in England requires a sustainable workforce of midwives to meet the needs of maternity services. The UK Government's aim for maternity services is articulated in 'Better Births' (NHS England, 2016) and, although subsequently updated (May et al., 2022), the recommendations include the provision of personalised care to women and their families delivered by midwives who are working in community-based teams. This personalised approach to care requires an increase in the number of midwives employed in the NHS and is tempered by a report from the Royal College of Midwives [RCM][2] which highlights a shortfall in midwives in both employment and training, thus hampering the Governments aspirations (RCM, 2021b).

[2] The RCM is the professional voice of midwifery as an organisation and trade union which represents midwifery and midwifery support workers. https://www.rcm.org.uk/about-us/

The NHS Long Term Plan (NHS England, 2019) also aspires to provide maternity services which are safer and more responsive to the needs of families and includes the recognition of the need to recruit more student midwives. The drive to increase student numbers to meet future workforce needs is challenged by the RCM who argue that of equal significance to an increase in student numbers is the number of midwives who leave employment in the NHS each year (RCM, 2022). Attrition from the NHS workforce does not just impact the maternity services and the practice of midwives, there is concern about staffing numbers in other healthcare professions too and this has been magnified over time since I commenced my doctoral study (Castro-Ayla et al., 2022; Darbyshire et al., 2021; Lovegrove, 2018). My experience as an educator, however, was of large numbers of women [and the occasional man] expressing a deep motivation to become a midwife and applying in two or even three subsequent years to succeed. That the aspirations of so many are thwarted by the working environment of the NHS is an increasing challenge for all stakeholders.

Therefore, what happens to the women who apply to university to become midwives and the extent to which they are prepared not just for registration, but for employment in the NHS workforce, is of significance to my practice as an educator and the wider professional community. Employability in midwifery is the professional problem to be explored within the thesis and in the next section I present the story of my practice as a midwife educator and the contextual factors that have shaped my story as an educator. Story, as part of narrative inquiry is explored more fully in Chapter Three; however, I have chosen to describe my account as a story to capture the epistemological origins of midwifery knowledge, which has been described as the spoken passing down of knowledge between mother and daughter midwives (Casey et al., 2016; Davis-Floyd et al., 2001; Lave & Wenger, 1991).

1.3 Personal & Professional Context

My practice as a midwifery educator and academic has evolved over the 30 years I have been involved in HE. I began in 1992 as a midwife teacher; someone who used their clinical knowledge and expertise to teach students the skills required to become a midwife whilst also modelling

appropriate professional behaviour and values (Avis et al., 2013). At that time, I was employed by the NHS in a 'college of midwifery'. The students were both employees *and* trainees who contributed directly to service delivery, albeit under the supervision of a registered midwife (Le Var, 1997). However, this employer-led model of training for midwifery [and nursing] had been under scrutiny due to high attrition rates and concern for the future workforce at a time when 30% of students failed to complete their training programmes (Royal College of Nursing, 1985). It was also recognised that nurse and midwifery education was expensive with an estimated annual cost of £770m to the NHS in 1990. The then-UK regulator for midwives and nurses 'The United Kingdom Central Council for Nursing and Midwifery and Health Visiting' [UKCC] responded to these concerns with the introduction of 'Project 2000'. This was a new approach to the education of nurses and midwives, and it set the scene for the transfer of nursing and midwifery training into HE (Le Var, 1997; Ousey, 2011). There then followed a period of transition in the mid-1990s as midwifery teaching staff, including myself, migrated into roles within HE and students were no longer employees of maternity units but university-based learners who required a supernumerary placement there.

I was promoted to principal lecturer in 1992 and undertook academic leadership responsibilities ensuring that the standards for the education of midwives set out by the NMC, [who replaced the UKCC in 2002], were met by the university. Those standards described a set of skills and attributes that students needed to possess to enter the professional register and be able to practice as a midwife (NMC, 2009). The NMC also required universities to work in partnership with the NHS, as placement providers and future employers, when planning and delivering programmes of education. It was at about this time that I became increasingly aware of a divergence between the regulatory education requirements of the profession and the expectations of employers; this was also noted in the midwifery literature (Bower, 2002). For example, the NMC viewed tasks such as cannulation[3] as

[3] Insertion of a narrow plastic tube (cannula) into a vein to administer drugs or fluids intravenously.

outside the initial set of skills required by graduate midwives at a time when social and political pressure to relieve the workload of junior doctors meant that this was a task that the NHS, as an employer, expected graduate midwives to be able to perform (Raynor, 2010).

The social and political narrative of the late 20th and early 21st century was also shaping conversations in the nursing and midwifery press. Childbirth was becoming increasingly medicalised and centralised in large obstetric units despite the recommendations of reports such as Changing Childbirth (Department of Health, 1993). This, and the pressure to reduce junior doctor hours occurring alongside the implementation of Project 2000, set the scene for criticism that HE was not preparing students adequately enough for either their shifting professional role or employment in the NHS (Scott, 2004). In response, the NMC revised the standards for Midwifery Education in 2009 to include a comprehensive set of 'Essential Skills' that were designed to refocus the education of midwives on areas such as infant feeding and care in labour (NMC, 2009). Despite this rigorous approach, the narrative continued that NQM lacked the knowledge, skill, and confidence to practice and therefore function as NHS employees when they graduated (Cummins et al., 2016; Phillips & Inkster, 2016; Tracey & McGowan, 2015).

I continued leading midwifery education at my employing institution and contributing as an expert panel member for approvals and review at other universities. In 2017, I was a consultant for the NMC whilst developing the Standards Framework for Nursing and Midwifery Education (NMC, 2018b). I was also employed by Mott Macdonald to undertake quality assurance events on behalf of the NMC at other HE providers. These opportunities gave me insight into the experience of providing midwifery education and the challenges faced by students and new graduates across the UK. I was aware too that research into the experiences of students and the working life of midwives revealed that those wishing to enter the profession faced a maelstrom of challenges, in an often unsupportive, and sometimes explicitly hostile environment, characterised by poor professional relationships (Capper et al., 2020, 2021; Primanzon & Hogan, 2015). There was, in addition, a steady

stream of work published in the nursing literature which explored transition theory and the 'reality shock' of newly registered nurses (Arrowsmith et al., 2016; della Ratta, 2016; Duchscher, 2009; Edward et al., 2017; Stacey & Hardy, 2011). The picture for midwifery was less clear since up until the start of the 21st century most student midwives had been nurses previously. Consequently, the professional conversation tended to reflect the respective benefits and disadvantages of either the direct entry route or the short route to midwifery qualification for those already registered as nurses (Curtis, Ball, et al., 2006; Fleming et al., 2001).

In 2018 I moved into a role which included leading a review of employability across all of the programmes provided by the university and almost simultaneously was appointed as a subject reviewer for nursing and midwifery by the Office for Students [OFS]. I became fully immersed in the metrics [which included employment data] and quality assurance outcomes being applied to HE in England. I attended the university teaching and learning committee, and, at one meeting, we were presented with 'career readiness' data drawn from student surveys and presented by the university careers team. I was surprised to see that although scores were higher than for many non-vocational subjects, nursing and midwifery students did not unanimously feel 'career ready'. Although the concept of career readiness differs from employability, with a focus on planning and managing a career, there are also similarities in terms of transferable skills and confidence (Jackson, 2018). The data presented at the committee illuminated students' thoughts on where they would be employed and how ready they felt for that employment. This snapshot of the student voice as feeling unready, despite a vocational degree with many hours of clinical placement, needed to be heard and my attempts to understand what was being said inspired my doctoral journey.

As an experienced academic I was aware of the HE narrative surrounding employability and graduate skills and attributes, but I had not considered the concept of employability fully before. On reflection, I recognised that I, as many others, mistook *employment* for employability. Since the employment rates for the midwifery programmes that I had been responsible for were exemplary, I

had not seen the need to take any action. The narrative of 'unprepared' NQM in the NHS workforce of which I was aware was, I thought, either due to the challenge of role transition as articulated in the nursing literature; for example, Duchscher, (2009) or due to the challenge of ensuring consistency in the practice-based assessment of students (Fisher et al., 2017). However, as I delved deeper into the employability agenda within HE, concepts such as career and social capital informing identity development gave me a different theoretical lens through which to view the situation in midwifery (Brown & Wond, 2018) . The graduate employability perspective was largely neglected in the research which presented the challenges facing NQM. This was similar to the policy documents informing NHS workforce recruitment and retention which had taken a turn toward the concept of differing generational attributes (Jones et al., 2015; Lovegrove, 2018). Much of the professional narrative surrounding the readiness of student midwives for practice was also concentrated on personal attributes giving primacy to appropriate skills and knowledge (Avis et al., 2013; Clements et al., 2012; Phillips & Inkster, 2016; Skirton et al., 2012). There was a body of literature that addressed identity development and social capital (Hobbs, 2012; Parsons & Griffiths, 2007; Reynolds et al., 2014), however, the potential value of using an explicit employability framework to shape further understanding of the education, policy and NHS workforce landscape, was something to which I felt I could contribute. The next section, therefore, explores the concept of graduate employability and how this can be applied to the employment of midwives.

1.4 Employability: A Contested Concept

Graduate employability and the role of universities within society as a force for economic growth has been a UK Government priority since the late 1980s when 'employability' replaced 'employment' in the HE conversation (Clarke, 2018). The growth in the HE sectors across all disciplines and vocations was envisioned by policymakers to increase the employability of graduates by repositioning HE as an instrumental process to ensure a skilled workforce (Clarke, 2017). It can also be argued that the intent to move the education of nurses and midwives into HE, as I described previously, also

reflected the agenda to increase access to, and participation in, university education (Tomlinson, 2012). Student nurses and midwives currently make up a substantial proportion of undergraduate and, to a lesser extent, postgraduate student numbers in many universities. Most recently the introduction by the OFS of the Teaching Excellence Framework [TEF] in 2017, has reinforced the political focus on employability as a student outcome in England and Wales. Within an environment of high initial *employmen*t rates nursing and midwifery programmes benefited from good ratings (OFS, 2021) without the necessary consideration of sustained employability.

Employability is a broad and diffuse concept in HE that requires definition and awareness of that what constitutes employability will change through time and within social contexts (Artess et al., 2017; Stoten, 2018). The government, employers, education institutions, regulatory bodies, and graduates will each understand employability differently and place varying values on the concept of graduate employability. Nonetheless, there is a dominant narrative within HE in the UK and many other industrialised nations that graduate employability can be defined as a set of skills and attributes that graduates should possess (Holmes, 2015; Succi & Canovi, 2020). This approach can be illustrated with the following often cited definition from the Higher Education Academy [now Advance HE] concerning employability:

> *'A set of achievements – skills, understandings and personal attributes – that make individuals more likely to gain employment and be successful in their chosen occupations, which benefits themselves, the workforce, the community and the economy*.'
>
> (Yorke & Knight, 2006 p8)

Within a definition of employability which refers to skills and attributes, there is some consensus about what those skills should be but not always agreement on which are the most important. For example, the importance of subject knowledge and expertise varies within arguments about the increasingly short lifespan of technical knowledge versus equipping graduates with 'skills' to deal with the uncertainty of future developments. Similarly, reports frequently reference 'soft' skills such

as team working and managing conflict as being a prerequisite for employers and therefore contributing to employability (Succi & Canovi, 2020; Universities UK, 2018).

My initial exploration of the concept of employability led me to the increasing body of literature that challenges the skills and attributes approach to employability which is dominant in HE and instead offers alternative perspectives. These include the application of critical theory and the concepts of habitus and cultural capital [explained in Chapter Two], alongside work which argues that identity development is key to understanding employability (Clarke, 2018; Holmes, 2013; Tomlinson, 2012; van der Klink et al., 2016). Holmes (2013), in particular, identifies three competing perspectives on employability which he describes as:

1. possession [of skills and attributes]
2. position [social capital]
3. process [identity development]

There is resonance between the perspectives presented by Holmes (2013), and the narrative within midwifery; that is a political focus on the skills that graduate midwives should possess [and these varied depending on which stakeholder was describing them] and relatively scant consideration of the social context of employment in the NHS. There was also, for students in vocational programmes such as midwifery, the potential conflict between developing a professional identity as a midwife whilst assimilating an identity as an employee of an organisation such as the NHS (Kalfa & Taska, 2015; Kenny et al., 2011; Roscoe & Pithouse, 2018).

Holmes, (2013) articulates the challenge of a clear definition further when describing the differing understandings of employability by the stakeholders who use the term. Macro-level stakeholders such as governments and national agencies understand employability in terms of the economic and social benefits and this is reflected for example, in the work of the OFS, described above. A macro-level definition of employability is also evident in the narrative of concern which surrounds the challenge of securing a sustainable NHS workforce (NHS England, 2020). For individuals who are first

students and then NQM, there is a micro perception of employability (Holmes, 2013), where the focus is on finding suitable employment that will reflect personal career aspirations. Furthermore, van der Klink et al., (2016) argue that individual aspirations increasingly seek alignment of personal values with employment and the vocational nature of midwifery serves to illustrate this. Thus, a macro definition of employability which aims to achieve a sustainable workforce must also consider the micro definitions of the people so employed.

As I engaged with the employability agenda, I reflected that my assumptions about midwifery graduates being prepared for employment by virtue of their professional skills and attributes required reconsideration. The student voice captured by the career readiness survey remained a signpost, as did the drive to recruit and retain more midwives within the NHS workforce. Health Education England[4] [HEE] was focused on increasing student numbers to bolster the midwifery workforce whilst the RCM was arguing that the challenge was the retention of experienced midwives not the employment of new ones (RCM, 2016).

1.5 Employment of Midwives

The employment of sufficient midwives is of current concern to the NHS, the profession, and the users of maternity services (Care Quality Commission, 2022; NHS England, 2021; RCM, 2018). The aspiration to provide personalised care during childbirth by increasing access to small community-based midwifery teams articulated in 'Better Births' (NHS England, 2016) has, to some extent, been overtaken by safety concerns following the publication of two reviews into the standards of maternity care in England (Kirkup, 2022; Ockenden, 2022). The personalised care agenda reflects wider NHS policy and a strong evidence base (National Institute for Health and Care Excellence, 2021; NHS England, 2019; Renfrew et al., 2014; Sandall et al., 2013). However, this agenda is set against a backdrop of service-led approaches to care which are implicit within current maternity

[4] Health Education England | Health Education England (hee.nhs.uk) The NHS organisation which supports the preparation and education of the NHS workforce in England

services in the UK (Crowther et al., 2016; Divall, 2015; Newnham & Kirkham, 2019), and which are highlighted as having impacted on poor service outcomes (Ockenden, 2022).

Employment is a term used by the Higher Education Statistics Agency [HESA] to 'indicate that the graduate is working for pay, whether paid by an employer or self-employed' (HESA, 2021). This definition excludes those who are volunteering or in unpaid caring roles, although these can be defined as 'work' they are not classed as employment. Tax records are used to collect employment data and thus the transactional relationship between the Government, HE and employee is explicit (Artess et al., 2017; Clarke, 2018).

The NHS workforce shortfall means that graduate midwives within the UK can expect to find employment readily. This is reflected in recognition that the current NHS requires at least a further 3000 midwives to maintain the current midwifery workforce (Department of Health and Social Care, 2018; HEE, 2023). The programmes that student midwives' study and that prepare them for employment have been approved by the UK Regulator for Nursing and Midwifery, the NMC, ensuring that graduates are equipped with the skills and attributes needed to join the professional register and seek employment as a midwife. Additionally, the data collected by HESA confirm that employment rates are high amongst midwifery graduates ensuring that the academic subject of nursing, within which midwifery is subsumed, performs well on many HE employment metrics.

The NMC, which holds the register for midwives in the UK, identify that the total number of midwife registrants is 39,664 which has increased slightly by 1.5% [n594] between April and September 2021. However, this shows a year-on-year reduction when compared to the previous year's data when the number increased by 2.5% [n937] (NMC, 2021b). NHS data identify that clinical staff numbers have increased by 18,961 between May 2020 and 2021 which includes an increase of 210 midwives (NHS Digital, 2021). However, an examination of the data shows that while the net number of midwives has increased, there has been a substantial loss of 486 midwives since November 2020. Considering that independent self-employed practice by midwives is unusual in the UK, with the estimated

numbers being around 150 (National Childbirth Trust, 2022), there are 15000 registered midwives in the UK who are not currently employed by the NHS; five times the 3000-shortfall identified by the government. The reasons why registered midwives do not remain in the NHS workforce is explored in Chapter Two; however, within this context, these numbers shine further light on a need to understand employability from several perspectives.

1.5.1 Workforce attrition and retention

It is challenging to fully understand the difficulty in maintaining and increasing the midwifery workforce without robust attrition data from NHS Trusts. Taylor et al., (2019) identified that in the Northwest of England, for example, NHS Trusts were often unable to provide data on the number of newly qualified practitioners they employed or the numbers who left and why. In 2014, HEE reported that newly qualified nurses were most likely to leave employment in the first two years following registration (HEE, 2014). However, those numbers did not include midwives and the picture is not clear about why the increase in graduate numbers cannot keep pace with the demand for midwives.

The challenge for the NHS in retaining some groups of registered staff led HEE to commission a project to review the nursing, midwifery, and radiography workforce in England (Lovegrove, 2018). The Project 'R**e**ducing Pre-registration Attrition and Improving Retention' [RePAIR] identified concerns in the number of applicants to programmes; the number of students who leave their studies before completion; a reduction in the number of professionals per head of population and, of most significance to this thesis, the numbers who then leave the workforce having initially gained employment.

The RePAIR project reported that the number of applications to study midwifery had dropped by 35% between 2013 and 2017 and that the number of midwives per 1000 live births had dropped from 41.29 in 2009 to 40.39 in 2015. More recent 2022 data from the University and Colleges Admissions Service [UCAS] demonstrate an increase of 38% in applications to the subject group of

nursing, within which midwifery is placed. UCAS attribute the increase in applications to the Covid 19 pandemic which has inspired individuals to enter healthcare professions (UCAS, 2022). Concomitantly, there is evidence from the RCM that the pressures of working through the Covid-19 pandemic mean that 57% of midwives are considering leaving employment in the NHS. Furthermore, dissatisfaction is highest in those who have spent five years or less working in the NHS who report that they do not feel valued by their employer (RCM, 2021b).

The RePAIR project findings predate the Covid-19 pandemic and are based on evidence drawn from existing HESA data, the National Student Survey, and stakeholder focus groups including students across several case study sites. The report produced 14 recommendations aimed at improving the recruitment and retention of newly qualified staff. The first two recommendations were to develop a definition and a metric which would accurately account for the attrition of health care professionals from the NHS and then secondly, to develop cost-effective interventions to address attrition. Recommendations three to nine outline means to improve the student journey, leading to recommendation 11 which articulates the need for a greater understanding of factors that impact confidence in the transition from student to a newly qualified practitioner. The final three recommendations present the case for unified approaches to preceptorship, recruitment and improving workplace culture. The report also refers to the recent cohorts of students entering the workforce and the argument that those born into newer generations, [generation X,Y, & Z] have differing values and attributes which are then expressed in the workplace. The concept of generational difference, described in the RePAIR report, reflects earlier work also commissioned by HEE: (Jones et al., 2015); both describe the generational difference in individual attributes as a challenge for the NHS. Transition, generational differences, and workplace culture are discussed further in Chapter Two and applied to the different perspectives of employability. Preceptorship, however, as a means to address retention is next.

1.5.2 Preceptorship

Preceptorship is a concept that was introduced by the UKCC following the move of midwifery and nurse training from an employer-led model into HE (Irwin et al., 2018). The original purpose of a period of preceptorship was to address concerns that a theoretical education based in a university would result in students who were not fit for practice (Ousey, 2011). Preceptorship would provide new graduates with a supported period of transition where they could learn to apply graduate knowledge and skills in the workplace. However, despite its relative longevity as a concept, there is not an agreed standard for preceptorship between the NMC, employers and the NHS. Preceptorship periods vary significantly, as does the approach to providing support and the content of any structured activities if, indeed, they are provided (Edward et al., 2017; Foster & Ashwin, 2014; Irwin et al., 2018).

Both the NMC and HEE argue that preceptorship improves the retention of newly qualified staff (HEE, 2022; NMC, 2020), but there is limited data to support this claim and a recent systematic review added to those doubts concluding that the impact of preceptorship is an area for further research and evaluation (Irwin et al., 2018). The NMC has produced preceptorship principles for nurses, midwives, and nursing associates but national guidance for employers from HEE is less inclusive and focuses primarily on the nursing workforce (HEE, 2022; NMC, 2020). The NMC principles holistically articulate preceptorship with reference to organisational culture, quality assurance, and integration of the new registrant into the workplace. However, a review of preceptorship programmes in the Northwest of England found that where programmes exist, the dominant approach is that of reassessment of competence that had been achieved as an undergraduate, reflecting the narrative that NQM are not quite work-ready (Edward et al., 2017). The focus on the achievement of objectives and competencies alongside mandatory training was also noted in an earlier study (Foster & Ashwin, 2014) which concluded that more time and support were needed to enable the completion of preceptorship outcomes.

Thus, it can be argued that the early employment experiences of midwives are considered important by the profession and the NHS who have both attempted to understand and improve retention within the workforce. However, despite this, and the attempts at support via preceptorship programmes, retention of NQM in the workforce remains a concern, as does the education which should prepare them for employment.

1.6 Research Aim and Questions

The broad problem for analysis within my DBA, is therefore to understand the factors which influence the education and initial employment of midwives. The analysis is set within a context where the education of midwives is highly regulated, and where graduates are in demand yet there is a narrative of a lack of readiness for the role. The three perspectives of employability as stated by Holmes, (2013) could offer a differing lens through which to view the experiences of NQM. The aim of this thesis is therefore to contribute to the understanding of becoming a midwife through the lens of employability and address the following questions:

1. What do the stories of newly qualified midwives working in the NHS in England illustrate about the employability perspectives of possession, position, and process?
2. How are the stories constructed and does this add to an understanding of the process of becoming a midwife?
3. What can be learned from the stories to support the future education and employment of midwives in the UK?

1.7 Thesis Structure

The thesis has developed with further engagement with the literature and appreciation of narrative inquiry as a methodology. The thesis is structured to present the inquiry in the following Chapters.

Chapter Two, the literature review, considers a selection of relevant research, policy and other documents which have shaped the study and the orientation towards narrative Inquiry. Attention is

given to the literature which discusses the education and experience of newly qualified midwives within the context of employability, alongside theoretical perspectives including communities of practice [COP] as a means to understand the development of identity.

Chapter Three explores the philosophical origins of narrative inquiry and discusses the ontological and epistemological perspectives which shape this approach to research, thus supporting its use in understanding my practice as an educator. As data collection took place in late 2020 and early 2021 during the Covid-19 pandemic, there is reference to modifications needed for data collection. The methods used to analyse the data are presented and discussed, alongside consideration of ethical principles applied to narrative inquiry and this study. Chapter Four presents the analysis and re-storying of the data into a temporal sequence of five stages and which reflects the journey to becoming a midwife for each participant. This is followed in Chapter Five with the stories analysed and presented as an archetypal quest identifying plot elements which illustrate the journey made and further address the research questions.

A discussion of the findings will take place in Chapter Six, reflecting on the research questions and considering the degree to which the dynamic between the employability perspectives outlined in the background to this study are supported, drawing on previous research and literature to explore the extent to which my findings relate to earlier work. The discussion will conclude recommendations for educators, employers and future research. The limitations of the study will also be articulated before drawing the thesis to a close in Chapter Seven, where my final thoughts and reflection on the narrative informing the education and employment of midwives will be concluded.

1.8 Conclusion

Chapter One has provided the context and background to the thesis and the narrative inquiry approach that is developed and applied in subsequent chapters. The chapter has reflected on the nature of my professional practice in developing an argument for the award of DBA and set out the

policy, regulatory, and education challenges which I've used as rationales for the importance of this work. The next chapter further develops the rationale for the inquiry through a review of the literature.

Chapter Two: Literature Review

2.1 Introduction

The purpose of this chapter is to explore the literature and summarise the existing evidence and theoretical arguments which underpin the narratives surrounding NQM outlined in Chapter One. The concept of employability is explored within the education and practice of midwives using a narrative overview of policy, professional standards, and research. In doing so, the literature shapes and informs understanding of employability as applied to the experiences of NQM and also identifies the areas where further investigation would contribute to these narratives. Drawing on the employability perspectives described by Holmes, (2013) and others (Clark & Zukas, 2013; Stoten, 2018; Tomlinson, 2012) provides an innovative and cross disciplinary exploration of a problem that is of significance to my practice (Drake & Heath, 2010).

A narrative overview approach to exploring the literature is described by Green et al., (2006) as having the flexibility to reflect the needs of the author, especially when drawing together various sources of information in order to provide a broad understanding on the development of a topic. Approaches to narrative reviews vary from the broad overview presented here to a structured and systematic approach to synthesis of information (Paré & Kitsiou, 2017). Providing a structure to this review adds to the clarity of the arguments and conclusions and thus the review is presented as three sets of activity: identifying the practice problem, the process of searching and selecting the literature, and the presentation of the literature summary within a professional discussion which informs the inquiry.

To commence the chapter however, I introduce an account of the place of the literature review in narrative inquiry and how this has shaped the narrative overview approach I used to inform the development of the thesis.

2.2 The Literature Review in Narrative Inquiry

The traditional approach to constructing a PhD thesis often requires a systematic or structured literature review which aims to identify the current state of knowledge in relation to the topic under investigation (Steen, 2011). This aim reflects the positivist epistemological viewpoint that knowledge or truth exist externally and independently to those who seek it and so can, in some way, be captured and presented. Following that argument, once a review of the literature is completed the researcher is then in a good position to identify a 'gap' in knowledge and use the literature to shape the research question which will address this (Jones, 2018; Saunders & Lewis, 2018).

In contrast, qualitative research has been presented as requiring less of a structured approach to reviewing the literature (Holloway & Freshwater, 2007). It is argued for example that extensive literature reviews do not reflect the inductive nature of qualitative research or the complexities of the relationship between the researcher, the literature and the researched (Wolcott, 2009). For students of professional doctorates, there is the further argument that the starting place for thesis development is rooted in a practice problem rather than a knowledge gap. Thus, literature review methodologies tend to be broader, interdisciplinary, and pragmatic (Jones, 2018).

The place of the literature review in narrative inquiry is also debated, with authors arguing that there may be no requirement for a traditional literature review or that the linear sequencing of research methodology should be challenged, with the literature as an integrated part of the whole (Byrne, 2017; Clandinin & Connelly, 2000). Similarly, there are authors who present a coherent argument about the benefits of literature review within narrative inquiry, arguing that a review of the literature prepares the researcher orientating them to the field of investigation and, if appropriate, selecting a theoretical perspective or lens through which to view the research (Kerr & Macaskill, 2020; Kim, 2020). Indeed, this thesis makes use of the 'lens' of employability and the perspectives described in Chapter One, as part of the background understanding that led to the

development of the thesis. Thus, it can be argued the orientation is already in place and that a review of the literature enhances this inquiry by strengthening its theoretical underpinning.

2.2.1 Practice problem

As articulated in Chapter One, the practice problem that informs the research questions is one of the education and employment of midwives. I argued that the work of Holmes (2013), in conceptualising employability via three differing perspectives offers a new lens through which to explore the experiences of NQM. Thus, the literature review aims to explore primarily the perspectives of 'possession' [of skills], 'position' [within the society and the workplace] and 'process' [reflecting the development of identity as an employee and a professional]. The narrative overview also considers the existing literature on the experience of newly qualified midwives *and nurses* using the more familiar theoretical arguments of transition and generational difference. Both nurses and midwives are included due to the paucity of literature which focuses on midwives as a separate profession and to enable a discussion of the relationship between nursing and midwifery and the extent to which their professional journeys as NHS employees are shared.

2.2.2 Searching and selection.

My engagement with the literature began co-incidentally as I was researching employability for a project I was leading as part of my practice as an educator. I had been asked to review the university employability plan and that led me to a set of publications that addressed the difficulty in defining and describing employability. I have included a summary of those as part of the discussion of employability in the first chapter. The work of Holmes was accessible and felt relevant to my practice and experience in the way employability was framed (Holmes, 2013, 2015). Therefore, the three perspectives on employability of possession, position, and process informed the search and selection of the literature which aimed to summarise the ways in which the identified employability perspectives were represented in the midwifery literature (Paré & Kitsiou, 2017).

My initial search of the available library data bases combined midwives/midwife or midwifery with employability and employability skills. This generated 11 papers that I had already accessed as part of my professional research project [described above] or which reappeared in searches using other key words. There was just one paper that appeared in relation to employability skills, and this was not relevant to the experience of NQM. I then used the search terms 'possession' of skills, competence, or knowledge' with midwives/midwife or midwifery and the return was 245 papers. This number supports the assertion by (Holmes, 2013), that there is a preoccupation with what graduates, and in this case NQM, can 'do' in terms of the possession of desirable skills. Of these papers, 40 referenced the experience of NQMs and further appraisal considered the relevance to the inquiry and the development of midwifery [education and practice] in the time frame of my practice.

The terms cultural, and social capital were then used as key words to search for papers which reflected 'position' as articulated for example by Bourdieu, (1990). These terms generated 41 further returns but fewer were relevant to the inquiry as they often referenced nursing, clinical care and social or cultural needs of clients. However, there were some exceptions (Blaka, 2006; Hobbs, 2012) which are included in the review below. Graduate/novice identity and identity development in midwifery identified 22 articles. The majority of these referenced nursing rather than midwifery. There were three which were relevant to the context of the inquiry and two had been identified in the previous searches. The third was excluded as it drew on the experience of midwives in China. I also undertook a search relating to generational attributes later in the inquiry development and this is accounted for in section 2.3.2.

Whilst appraising the literature, I included evidence from other countries which face similar concerns about securing a sustainable workforce in particular Australia and New Zealand, and also some nursing literature which reflected employment experiences in the NHS. There is a recognised challenge for midwifery researchers when selecting nursing literature (Atchan et al., 2016). Although nursing and midwifery share common values and are complementary in their work to

improve the health of individuals and the community, there are differences in professional identity which may need to be acknowledged when examining nursing research to inform midwifery practice and the work of midwives as employees. I have included nursing research, which I argue represent the employability perspectives of this study, as the employer [the NHS], is the same for nurses and midwives so some comparisons can be justified.

2.2.3 Summary and presentation of literature.

The literature summarised throughout the following sections includes those identified through the search and selection strategies described above, alongside policy and other documents which inform my practice. The broad overview is not intended to be inclusive of the papers identified by the search strategy, but rather, to present an analysis of the research, policy and standards which inform midwifery through the lens of the three employability perspectives.

In the second part of this chapter, I reflect on the literature describing transition and professional socialisation for new practitioners as the lens often utilised to explore and explain their experiences. This was not included in the initial overview search but as I was completing the inquiry, it seemed relevant to reference and draw upon the more frequently quoted literature informing the experiences of NQMs. The perspective of the macro stakeholders on employability is also discussed, and finally, a brief consideration of the literature which has used narrative inquiry to explore aspects of professional practice is presented to inform the inquiry.

2.3 Employability Perspectives

The following sections are structured to present a summary of the literature reflecting the three perspectives of employability: beginning with the possession of skills and attributes. This first section is prefaced with a discussion of the broader professional perspectives and definitions relating to skills in midwifery and nursing such as competence and proficiency. This then informs the review of policy standards and selected literature.

2.3.1 The Possession of skills and attributes

As I discussed in Chapter One, the narrative presented about the preparation of midwives for practice reflects the wider nursing and graduate employability agenda with a focus on knowledge, skills and attributes as key to successful employment (HEE, 2022; Jones et al., 2015; NMC, 2019; Universities UK, 2018). It was argued further in Chapter One, that the professional regulators, the UKCC followed by the NMC, were at the forefront of the skills and attributes agenda driven by criticism that newly qualified nurses and midwives were not 'fit for practice' (Bradshaw & Merriman, 2008; Ousey, 2011). As a macro-stakeholder, when using an employability lens, the regulators were keen to establish a sustainable workforce that was fit for purpose and there was a move towards competency-based education programmes. The concept of proficiency has, however, replaced the concept of competence within nurse and midwifery education in the UK. Both concepts present challenges in terms of definition and application to professional education with recognition that assessment of observable skills fits more easily into training as a mode of preparation for practice than it does into HE. However, HE too has adopted the 'skills' development approach within its practices as identified by Holmes and others (Holmes, 2013; Stoten, 2018; Tomlinson, 2012; Yorke & Knight, 2006) in the drive to demonstrate how graduates are prepared for employment.

The seminal work of Benner, who describes the development of nurses from novice to expert is useful to reflect upon at this point (Benner, 1982). Benner defines competence as a combination of knowledge, skills, and professional behaviours essential to the practice of the profession (Fullerton & Ghérissi, 2015). Proficiency in turn is described by Benner as progression beyond competence to a more holistic but not yet intuitive approach to practice. Importantly, Benner recognises there is both fluidity between the stages and that competent and proficient individuals will behave differently in the same situation as they draw on personal knowledge and past experience to influence their actions. The differentiation between competence and proficiency is therefore dynamic and, outside of the work of Benner, debate continues about the definitions and values of

each concept (Valloze, 2009). Nonetheless, the notion of the 'performance of a skill' as part of a proficiency approach to the preparation of student midwives and nurses for practice and their induction once employed, is deeply embedded in the professional narrative.

As identified in the introduction to this chapter, although there are commonalities between the professions of nursing and midwifery and they are often considered together (Jones et al., 2015; Lovegrove, 2018; NHS England, 2020; UCAS, 2022), the relationship between nursing and midwifery can be viewed as both interdependent and a source of tension (Cameron & Taylor, 2007; RCM, 2014). Interdependence arises from a shared epistemological framework with nurses and midwives drawing on the same theoretical perspectives and sharing common research approaches (Atchan et al., 2016; Bryar & Sinclair, 2011). Tensions arise from the perception that the voice and unique identity of midwifery have been increasingly marginalised within the NMC (Kirkham, 1999; Way, 2015). Of relevance to the employability perspectives, when the legislative difference between the two is articulated, it is at the level of proficiency: the values and standards expected by the professional code of conduct are the same for nurses and midwives (NMC, 2018a, 2019).

The focus on skills and attributes is illustrated within the Standards of Proficiency for Midwives (NMC, 2019) where the outcomes of midwifery education are described in an extensive list of proficiency statements. The Future Midwife list of proficiencies is longer and more detailed than the 2009 standards of competence they replaced, and are presented as setting out:

> "*what we expect a new midwife to know, understand and be capable of doing*"
>
> (NMC, 2021a).

Recent reviews into the standards of maternity care in the UK have called for enhanced 'training' of midwives to enable 'development of skills, application of policies, and demonstration of emergency drills (Kirkup, 2022; Ockenden, 2022). The skills identified accumulate around care in labour and assessment of fetal and maternal wellbeing. These are important skills for midwives and contribute

significantly to the safety of women and their babies. However, whilst the cultural context in which individual midwives are expected to apply those skills is part of both the Ockendon (2022) and Kirkup (2022) reports, the professional narrative continues to prioritise skills. Consequentially, a recent integrative review exploring the mental health and wellbeing of student midwives, which included 24 papers from the UK and elsewhere spanning the past 20 years, concluded that students approach their first years in practice fearful that they are not competent, whilst very aware of the accountability expected of them (Oates et al., 2019).

Furthermore, with a critical lens it is possible to see that Benner's work reflects the construction of nursing in the United States in the 1970s at a time when the nursing profession was first emerging as an academic subject. The practice of midwives in the UK in the 21st century is constructed differently and, although midwives may still need to progress from novice to expert, equal consideration needs to be given to what it means to be a midwife and the values that underpin that, as much as what it is that midwives should be able to do, know and understand.

The Future Midwife Standards (NMC, 2019) may also reflect the ongoing narrative that students are not ready to practice when they qualify and need a period of preceptorship with a further set of 'workplace' competencies or proficiencies to be completed. Consequently, there is a significant amount of time and resource invested in developing an extensive list of skills and abilities in students and newly qualified midwives (Kitson-Reynolds et al., 2015; O'Driscoll et al., 2022). In part response to these criticisms the NMC commissioned a three-part evaluation of midwifery education which aimed to establish the value of midwifery educators and the impact that their contribution could have on health outcomes (Fraser et al., 2010). The final part of the research explored the experiences of NQM which subsequently reflected the professional narrative about the preparedness of students to enter the midwifery workforce. The study focuses particularly on the

preceptorship experience of the NQM by including data from midwifery supervisors[5] and preceptors together with prospective diary accounts from the NQM. The research concludes that NQM do possess the skills required to provide care but lack the attribute of confidence to apply them in complex situations. There is recognition, too, of the role of the employer in creating a suitable environment in which these attributes can be developed (Avis et al., 2013).

The extent to which a lack of confidence can be assumed to be part of starting any new employment is worth considering at this point. Literature from the wider HE sectors is diverse but suggests that women may be more likely to suffer low confidence by underestimating their abilities (Baker, 2010; Carlin et al., 2018; Cech et al., 2011; Kidd, 2006, p. 37). In vocational professions such as social work and teaching where there are also concerns about attrition during the 'newly qualified' period, there are similar studies to those in nursing and midwifery that explore both lack of confidence and support from peers as factors in early career decisions (Pfitzner-Eden, 2016; Roscoe & Pithouse, 2018). In addition to confidence and support, literature drawing on career theory also references the role of alignment of personal values and identity as a factor impacting on successful employment which illustrates the complexities inherent in the differing employability perspectives (Kidd, 2006; van der Klink et al., 2016).

Returning to midwifery knowledge and skills, the practice of midwifery in New Zealand differs from that in the UK as many midwives enter self-employed practice and face the challenges of running a business alongside the transition to a new role as a midwife. The attribute of 'confidence' may have a different meaning in these circumstances; however, in the New Zealand based study 'Becoming a Midwife' (Patterson et al., 2019), the authors expand on this theme, describing confidence as improving clinical performance and promoting acceptance into the culture of the workplace. The research draws on survey data from 42 recently qualified midwives and also identifies the impact of

[5] Midwifery Supervisor: A previously NMC regulated function to manage the quality of midwifery practice.

negative experiences on confidence and the example given was a poor or bullying type workplace culture. The study concludes with the representation of the thematic findings in a 'Becoming a Midwife' model which incorporates knowledge and practice skills, management skills [business, time, people, processes] and confidence. The model clearly illustrates a possession of skills perspective on employability, albeit within the context of differing employment practices.

A lack of confidence in ability, despite clinical competence was a finding of a UK based qualitative study exploring how prepared NQM were to deliver care (Skirton et al., 2012). The research used diaries to collect data from 35 NQM who had studied either a three year or a shortened programme at one of six universities across the UK. The findings reflect other similar studies where students approaching qualification have unnecessarily high expectations of their abilities. Skirton et al., (2012) relates these expectations to the work of Benner, [as highlighted earlier in this section], and the aspirations of the NQM to move quickly from novice to expert. The study identified the significant role of mentors[6] in supporting the development of confidence, with the data indicating that good mentors not only enabled skill development but also role modelled effective problem-solving skills. Learning was further supported by relationships with experienced midwives within a positive working environment.

The place of workplace culture and environment and the impact this has on personal attributes of NQM such as confidence and resilience has also been explored in the UK and elsewhere (Fenwick et al., 2012; Hunter & Warren, 2014; Irwin et al., 2018). Fenwick et al.'s, (2012) Australian study, draws on qualitative data from a longitudinal project exploring retention of graduate midwives. The literature review which informs the study presents research findings across a time frame of 50 years [1974, 1999, 2009], providing evidence that the narrative of concern at retaining staff in the workforce is not new and could be used to challenge the generational explanations for poor

[6] Mentor: An NMC registrant who, under the NMC 2008 Standards for Learning and Assessment in Practice, supported and assessed students whilst on placement.

retention which occur in current literature (Jones et al., 2015; Lovegrove, 2018). Fenwick et al (2012) conclude that a supportive environment enhances confidence and also reference the position NQM find themselves in which is described as 'sinking in a toxic pond'. These findings highlight the challenges in delineating between possession of skill and social position (Holmes, 2013), in professional practice. Similar complexities are found in Hunter & Warren's, (2014) UK based exploratory descriptive study, where the individual attribute of resilience is argued to reflect personal qualities such as self-awareness, alongside both a supportive environment and a strong professional identity. The sample in this study were 11 midwives who had been qualified for 15 years or more, but the experiences resonate with those recounted by NQM and, in a follow up online survey of 1997 RCM members (Hunter et al., 2019), which aimed to explore emotional wellbeing, NQM were identified as being particularly vulnerable to burnout and stress.

Fleming et al.'s, (2001) UK based study is older but worth some consideration since it observed the narrative of the time in which it was undertaken about the introduction of three-year direct entry programmes to midwifery and the employment of NQM who lacked nursing skills. The research aimed to compare the competence of midwives with single or dual qualifications via a self-completed survey using a skills inventory at the point of registration. Semi structured interviews were also undertaken with experienced midwives. The findings concluded that it was the nurses' organisational and management skills which were most valued by employers. The midwifery specific skills were not highlighted as being of concern; however, the findings reported the perception that those who are nurses first have a greater degree of dexterity and are able to learn and perform manual skills more rapidly.

Being prepared with the appropriate level of knowledge about midwifery was confirmed in a study set in one maternity hospital in Ireland (van der Putten, 2008). The study collected interview data from six NQM and the findings indicated that students would prefer longer placements and more opportunity to put their knowledge into practice before qualifying. The findings make a further

observation about the gap between theory and practice; articulating this as the difference in ideologies between, for example the woman-centred, and evidence-based care taught in the classroom and the reality of the way care was manged in clinical practice. Lacking confidence as a NQM to speak up and challenge the practice of other midwives was reported as leading to feelings of guilt.

In summary, the possession of knowledge and skills as a perspective on employability for NQM presents a picture where individuals enter employment equipped with the necessary midwifery skills but are lacking in confidence to apply these. The culture and social environment of the workplace is frequently explained as contributing to the development of knowledge and skills, and this perspective on employability will be explored later in this chapter; firstly however, a consideration of generational attributes which reflect much of the current professional narrative identified in Chapter One.

2.3.2 Generational attributes

Chapter One identified the concept of generational difference as contributing to the professional narrative about the suitability of graduate midwives for the workforce. It is possible, within the literature selected for inclusion in this review, to challenge that narrative through consideration of generation within the discussion; comparing, for example, the similarities in why midwives choose to leave the profession across the decades which reflect the era of my practice.

The role of generational attributes in the work of nurses and midwives is explored by Jones et al., (2015), who produced the 'Mind the Gap' report for HEE. This multimethod research project was commissioned to respond to the high turnover in newly qualified nurses and midwives within the UK. The report uses data from surveys and focus groups to describe an early career period which is defined as being from the final year of study until the end of the period of preceptorship. The authors asserted that the NHS currently employs a unique generational mix and applied the work of Arsenault & Patrick, (2008) who present the case for differing generational attitudes and behaviours,

drawing on data generated in the field of consumer choice and behaviour. However, the theoretical and evidence base for application to values and attitudes in the workplace is weak and many authors consequentially urge caution in applying generational concepts to understand or predict behaviour (Costanza et al., 2012; Lyons & Kuron, 2014; Parry & Urwin, 2011; Rudolph et al., 2018).

The Mind the Gap report (Jones et al., 2015) sets the policy background for the retention of Newly Qualified Nurses [NQN] and NQM and the conclusion of the report lists eight recommendations based on its findings, the first two of which reference raising awareness of different generational needs and including alignment of personal values with employment.

As the Mind the Gap report has had influence on NHS policy (NHS England, 2019), it is worthy of further critique from the perspective of drawing conclusions about the experiences of both nurses and midwives, despite the lack of midwives in the focus group sample and the difference in mean age [and therefore generation] between the nurses and midwives who were included in the survey. The authors present the findings as applying to both professional groups equally in a narrative that illustrates the difficulties in untangling the experience of nurses and midwives. The professional identity of midwifery draws on a history which operated with a degree of autonomy outside of NHS hospital environments until the early 1980s (Kirkham, 1999). Currently, too, the practice of NQM is ascribed a greater level of accountability and responsibility. This is recognised by the NHS Agenda for Change pay scales which places the work of midwives at band six on completion of a preceptorship period; there is not a similar statement for NQN, (Department of Health, 2004).

To place the critique of the generational approach presented in the Mind the Gap report within the narrative which surrounds NQM, it is useful to consider the experience of older nurses and midwives within the NHS workforce. Wray et al., (2009) undertook semi structured telephone interviews with 27 older nurses and midwives to explore their employment experiences at a time when they were being made redundant due to financial pressures in the NHS. The study identifies the age profile of nurses and midwives amid concerns about discrimination and disadvantage for older staff. The

language of discrimination and disadvantage is different to that which is used by Jones et al., (2015) when describing the younger generation of nurses and midwives who are identified as having different 'needs' when struggling to work within the NHS. The challenges described for the older staff are very similar to those for the younger generation. Both studies (Jones et al., 2015; Wray et al., 2009) conclude that positive experiences related to the relationship with, and caring for, patients; and that excessive workload and stress contribute to a desire to leave employment. Within the final summary of the older study, the authors argue that nurses and midwives who feel their work is valued are much less likely to leave (Wray et al., 2009). This is a sentiment that is also observed in the younger generations described by the 'Mind the Gap' report (Jones et al., 2015), and repeated elsewhere (Griffiths et al., 2019; Reynolds et al., 2014; RCM, 2016).

When reviewing the literature initially, it was clear that the discussion about the 'employability' of newly qualified nurses and midwives is far from new. In 1987 a study of employment decisions by midwives in Scotland included the statement:

> *'it has long been recognised that the retention of midwives in midwifery practice presents a problem'.*
>
> (Mander, 1987, p. 62)

The study occurred at a time when the midwifery students in Scotland [as elsewhere in the UK] were registered nurses undertaking a 12 or 18-month work-based programme. The research utilised a longitudinal design with a survey questionnaire completed by students at the start and then on completion, of their midwifery education. The rationale for the study reflected the concern that as many as 50% of those completing their midwifery programmes, chose not to work as midwives but returned to nursing practice. This number had remained fairly constant since the 1940s, when an editorial in The Lancet had identified then, as now, a shortage of midwives impacting maternity care (Mander, 1987; Summers, 2021). In 1979 the RCM reiterated the problem of not retaining midwives on completion of their programmes and suggested that this was due to poor career prospects,

although by this time, the percentage remaining in midwifery had increased to 60% across the UK (Mander, 1987).

The concept of career prospects and paths fits well into the generational narratives that are currently being applied in retrospect to those post-war 'baby boomers' who started work in the 1970s and 1980s (Jones et al., 2015). The 'baby boomer' expectation of a period of education or training followed by employment and then a long career defined by loyalty, dedication and hard work, has been compared to the newer millennial generation and their desire for a supportive work environment and a willingness to leave, if that is not forthcoming (Keith et al., 2021). The comparison encourages the profession to change their approach to leadership and management to facilitate the education and retention of the new generation of healthcare professionals (Evans et al., 2016; Ulep, 2018).

Much of the literature surrounding generational differences describes the profession of nursing and may or may not include midwifery as a subset. For example, a search on CINHAL using nurse/nurses/nursing and millennials resulted in 151 papers. The same search using midwife/midwives or midwifery produced only one paper from the United States (US). Interestingly, this article reviewing strategies to increase the midwifery workforce, presented the characteristics of new generation millennials such as independence and a desire for autonomy, as an opportunity to support the future aspirations of midwifery in the US creating a positive narrative of the future midwife (Larson, 2017).

Examination of the careers of previous generation 'baby boomer' nurses in the UK (Bendall & Pembrey, 1972) identified the existence of ideal career paths versus actual career routes. This quantitative survey of 325 nurse graduates identified the role conflict felt by graduate nurses as they negotiate between their ideal careers and the reality they faced in the workplace. In a description that speaks across the decades, they illustrate this by describing the 'moralistic' nurse who can either withdraw from employment when their ideals are not met or, with a degree of personal

strength, choose to rebel against the aspects of the system that they perceive as unsatisfactory. In contrast, the less moralistic nurse may perceive the same lack of satisfaction but choose to accommodate the system within what becomes increasingly ritualistic practice. It should be noted that this study examined the experiences of graduate nurses, and at the time, few nurses entered the profession via this route. As one of the aspirations for a graduate nursing workforce was to enable a move from ritualistic practice to a more critical use of theory creating the 'knowledgeable doer' (Bradshaw & Merriman, 2008; Harden, 1996), it is disappointing to see those aspirations failing.

The study into employment choices of midwives conducted by Mander, (1987) described previously, also demonstrated the challenge of organisational structures, in particular the existence of hierarchies and unfriendly midwives who had little tolerance for students or NQM. Consequently, newly qualified staff felt unsupported at a time when they were very aware of the additional responsibility of practising as a midwife. The data also indicated that the participants were dissatisfied with the way women were treated by some midwives and medical staff. The findings concluded that participants changed their employment plans for reasons associated with their perception of the working environment.

A later view on employment experience is presented in the study 'Why do Midwives leave' (Curtis, Bally, et al., 2006); a mixed methods study which explored the experience of UK midwives who left employment in the NHS between 1999-2000. The findings concluded that midwives were dissatisfied with the quality of care that they were able to provide, often due to poor staffing levels and unsupportive management. The RCM (2016) undertook a follow up survey on these findings which used a sample of those who had [30.8%], or intended to [69.2%], leave the profession. The survey identified that staffing levels and dissatisfaction with the quality of care continued to be a concern for midwives, as were managerial support and working conditions (RCM, 2016).

Thus, the literature suggests that dissatisfaction with the working environment is not unique to the new generations entering the NHS as employees, nor is the need to align personal values with the care practitioners are able to provide. The next part of the literature review considers the working environment through the employability perspective of social position.

2.3.3 The Position within social structures.

Within the literature described above, the environment or culture within which NQM are employed is often difficult to delineate from the development of the skills and attributes they need to possess as midwives. Taking the three perspectives on employability, as described by Holmes (2013), into consideration provides an opportunity to explore notions of social position in more detail using the selected literature. The social theorist and philosopher Bourdieu, (1990), for example, approaches social position through the interactions between social structures and individuals arguing that resultant 'habitus,' or way of being, ensures cultural reproduction. The degree of agency that individuals have to shape that culture is debated by Bourdieu and others, including Wenger, (1998), whose work on communities of practice [COP] is also included in this review.

A Bourdieusian approach to employability is applied to the work of nurses and midwives by Hobbs, (2012) and Read, (2014). Hobbs undertook a qualitative ethnographic study in the UK, to ascribe meaning to the everyday experiences of seven midwives in their first year of practice. Findings are presented as a model of 'cultural re-creation for midwifery,' with the habitus defined as new ways of thinking, shared dispositions, and entrenched viewpoints. Hobbs concludes the midwifery habitus can be influenced positively by NQM, noting that the NQM remain influenced by the professional ideals presented at university.

Social capital is a concept also developed by Bourdieu, (1986) defined as the 'social energy' or 'fuel' gained from an individual's position in the social world. Exploring social capital within nursing, the work of Read (2013), who undertook a concept analysis of the subject reflects similar findings to

those of Hobbs (2012) above. Read uses a theoretical model to analyse the concept of workplace social capital in nursing and is thus defined as;

'*Nurses shared assets and ways of being and knowing that are evident in and available through, nurses' networks and social relationships at work'* (Read, 2014, p. 1004)

This definition reflects the value of positive social relationships within the work environment of the NHS and, how these relationships create the knowledge required for practice; further illustrating the complex relationship between knowledge, social position and being a professional.

Building social capital through effective relationships is explored in a longitudinal study evaluating a quality improvement intervention to improve the practice experience of student nurses in Australia (Materne et al., 2017). The intervention aimed to improve the way in which the nursing staff welcomed and related to students while on placement. There was targeted leadership development for middle managers, along with a focus on enabling student learning and providing good quality feedback in the ward setting. The approach of focussing on leadership as central to a positive environment for midwives and students has been reported by others in a UK context (Divall, 2015; Tweedie et al., 2019), and helps to contextualise the findings of the Australian study where it was reported that, following '*continuous and relentless engagement*' with the improvement process over five years, students reported greater degrees of social inclusion and satisfaction with their experience. Furthermore, with relevance to the employability agenda, recruitment rates improved threefold as students sought employment in the areas where they had been made to feel welcome. The UK based paper (Tweedie et al., 2019), exploring coaching models for student midwives within practice, reported improved confidence amongst those taking part thus, it can be argued that investments in relationships and strategies to enhance social capital, however resource intensive, may be worth further consideration. In addition, Materne et al., (2017), note the association between effective social networks and service outcomes, adding to the argument of Read, (2014)

above, that the knowledge needed to practice nursing develops within relationships with other nurses.

Lave & Wenger, (1991) describe knowledge that is created by relationships in communities as 'situated learning'. A term that was later developed by Wenger, (1998) into COP, drawing on the concept of 'legitimate peripheral participation' which describes the means by which COP are sustained. Situated learning is described as a social, rather than a cognitive process, with a sense of shared enterprise, and also reflects the traditional concept of the journey from apprentice to master (Emms, 2005; Lave & Wenger, 1991). The work of traditional midwives in the Yucatan region of Mexico is a case study used by Lave & Wenger, (1991) to illustrate legitimate peripheral participation. The community is, as described in the epigraph for this thesis, one of mothers and daughters where, rather than being taught the skills of a midwife in a structured way, younger women and girls are described as 'absorbing' tacit practice-based knowledge as part of their relationships with older women and midwives. This contrasts with the more formal arrangements described for other groups, such as apprentice quartermasters entering the Navy. However, the explanation of how newcomers are enabled to legitimately participate in the practice of experienced practitioners, or masters, within COP has been both explored, and critiqued, by other authors and applied in a variety of education settings (Amin & Roberts, 2008; Buckley & Du Toit, 2010; Duguid, 2005). More recently, Wenger and colleagues have revisited COP (Wenger-Trayner et al., 2015) and developed the concept of Landscapes of Practice [LOP] in order to reflect the challenge inherent in the multiple communities to which, if applied to this example, student midwives may aspire to belong to or move through.

There has been scant explicit application of COP to midwifery education and practice in the published literature, however there are examples from nursing and other health professions (Andrew et al., 2008; Andrew & Ferguson, 2008; Fenton-O'Creevy et al., 2015; Terry et al., 2020), which emphasise the social relationships required to develop knowledge. A qualitative case study

exploring the experiences of 30 student midwives from one graduating class in Norway, does draw explicitly on COP and legitimate participation (Blaka, 2006), and the findings reflect the work of Materne et al., (2017), discussed above; that is in relation to students feeling welcomed and having space for learning to take place. However, the findings also suggest that that students are perceived by placement teams as not having 'legitimate' access to the community as students, and therefore, participation and subsequent identity development is limited (Blaka, 2006).

Legitimate peripheral participation and situated learning are, as described earlier, social processes requiring the negotiation of relationships within communities. However, COP are presented by Wenger, (1998) as a means to understanding identity development; how individuals become who they are. As previously discussed, the process of identity development is argued by Holmes, (2013) as being central to understanding employability, thus the next section will consider identity development within the context of midwifery employability.

2.3.4 The Process of identity development

Identity can be described as an understanding of who an individual thinks they are, and how they construct and make sense of themselves both individually, and as a group (Kenny et al., 2011, p. 13). Developing a strong professional identity has been linked to workplace satisfaction and retention and is viewed as part of the professional socialisation process that takes place within education programmes (Best & Williams, 2019; Walker et al., 2014). LaPointe (2010) discusses identity theory further arguing that identities are constituted from the cultural and political discourse which surround individuals as they enter a field of work. Thus, NQM emerge with an evolving professional identity acquired as a student and a need to assimilate that into the identity required of an employee in a large organisation (Kenny et al., 2011, p. 134).

The acquisition of professional identity can be described as the internalising professional values and norms into a sense of self, building from the relationships and social positions that individuals find themselves engaged with (Roscoe & Pithouse, 2018). This approach to understanding professional

identity reflects that explained by COP with a focus on social participation but it is also important to consider the role of personal values in identity development, and the degree to which these may, or may not, be compromised in seeking a professional identity (MacLellan, 2014; Newnham & Kirkham, 2019). Within midwifery practice, the conflict between the professional values of women-centred care and the increasingly medicalised care provided by the NHS as an organisation, can create dilemmas for midwives, and as discussed previously, may lead to disillusionment and attrition form the profession.

In terms of employability as a process, LaPointe, (2010) presents career identity as differing to both professional and organisational identity. A career identity is not tied to a role or a place [a midwife at Trust A for example] but represents a sequence of work-related experiences. LaPointe, (2010) presents a theoretical and methodological explanation of identity and the way in which individual narratives can capture and present its development. The use of narrative in identity development speaks well to the narrative inquiry approach taken by this thesis and explored further in Chapter Three. It also reflects the debate, within midwifery in the UK, as the profession faces the challenges outlined in Chapter One, and articulated also by, for example, (Divall, 2015; Kuipers, 2022; Pollard, 2011). Challenges that may be summarised as an identity crisis for midwives who have to negotiate both professional and organisational values within their sense of self.

The literature on professional identity development is vast; however, as identified in Section 2.2.2 above, explicit exploration of midwifery identity is elusive, thus the arguments above are shaped by my professional knowledge of relevant texts and professional debates. In addition, the relative lack of explicit attendance to identity development in NQM supports the assertions of Holmes (2013) that this is an area worthy of exploration when considering employability. However, within the narrative overview presented this far, it is apparent that employability perspectives on identity, social position and the possession of knowledge and attributes are complex and interconnected.

2.4 Beyond Employability

My initial review of the literature did not include a search for publications which investigated the transition process for NQM. My intention had been to step away from that well-trodden path and use the employability agenda to map out a new route to explore experiences of the early days of employment. However, when I returned to the literature review chapter as I was writing up my thesis and reconsidered the purpose of the literature review in narrative inquiry, I felt I should revisit this decision. The story of becoming a midwife in the UK has shaped, and is shaped, by the 'transition' literature despite recognition that there is limited evidence to describe the process in midwives (Bradshaw et al., 2018). References to transition from student to registrant appear in the documents and research which speak to the context of this inquiry, thus consideration of the features of the transition literature will add value to an understanding of employability within midwifery.

2.4.1 Transition and organisational socialisation

The seminal work by Kramer, (1974) which describes the experience of newly qualified nurses and why they choose to leave the profession, situates the debate around newly qualified practitioners historically and to some extent represents how little has changed, inviting further research into the 'problem.' The study was also undertaken within the same decade and country that shaped the work described earlier in relation to competence and proficiency (Benner, 1982) and contributes to the emerging professional narrative at that time. Kramer describes 'reality shock' as a phenomenon experienced by newly qualified nurses when they enter the world of work and suddenly find they are not prepared, notwithstanding three or four years of focussed preparation (Stacey & Hardy, 2011). This phenomenon is presented as an inevitable part of professional socialisation, despite the continued recognition that the dissonance created serves to reduce the quality of care provided (Bendall & Pembrey, 1972; Mackintosh, 2006). Mackintosh, who undertook a longitudinal qualitative study exploring the socialisation of student nurses in the UK, further argues that a caring

and personalised approach to nursing care is discouraged within the workplace to enable the completion of organisational priorities and tasks. Those nurses who adopt a critical stance and challenge practice can find themselves excluded from the social networks that should sustain them and potentially fall victim to horizontal violence and bullying (Brookfield, 1993; RCM, 1996). Unfortunately, bullying is a current and ongoing issue in maternity services and here the literature specific to midwifery is plentiful (Capper et al., 2020; Gould, 2004; Primanzon & Hogan, 2015; Royal College of Obstetricians and Gynaecologists, 2021) and adds to the argument of focussing attention on the working environment to improve retention of NQM.

2.4.2 Institutional perspectives on employability

In Chapter One, when discussing employability, I outlined the arguments regarding the perspectives and definitions held by different stakeholders (Holmes, 2013). In relation to the profession of Midwifery, the NMC whose primary aim is to protect the public, can be argued to be a macro stakeholder defining employability in terms of its benefits to society (NMC, 2018a). The NMC however have a secondary purpose in prescribing the education and practice of midwives in the UK via the regulation and monitoring of education programmes. There has though, been concern that this function contributes to a theory practice gap between what students learn in university and what they are able to experience in practice (Hall & Way, 2018).

The NMC standards describe a set of proficiencies which students must demonstrate to enter the register which could be presented as a macro perspective on employability. Dictionary definitions of proficiency indicate a focus on the doing of a skill reflecting further the dominant discourse in employability;

> '*having the skill and experience for doing something'*
>
> (Cambridge Dictionary Online 2020)

The NMC proficiencies identified in the 2019 standards (NMC, 2019) include some very specific skills, such as:

> 6.37 *recognise and respond to oedema, varicosities, and signs of thromboembolism,*

alongside statements which reflect a more complex notion of proficiency:

> 1.9 *provide and promote non-discriminatory, respectful, compassionate, and kind care, and take account of any need for adjustments.*

The later may have more in common with the concept of capability, described as a combination of personal resources [including skills]; material resources [the right equipment]; physical resources [the space] and a facilitative social environment (van der Klink et al., 2016). Proficiency 1.9 above illustrates this requiring, for example, personal knowledge of anti-discriminatory practice, communication skills, and an organisational culture which supports such behaviour.

A second macro stakeholder can be argued to be the NHS as the organisation who employs the majority of registered midwives in the UK. The NHS Interim People Plan (NHS England, 2020) describes a workforce agenda to recruit and retain more nurses [midwives are included as nurses within this document] in order to deliver the NHS long term goals. The Interim People Plan recognises the need for effective leaders to drive the transformation required in the NHS, and there is a discourse of creating positive environments which enable employees to thrive. This discourse within the NHS, which is where most midwives will be employed, includes a broader macro perspective on employability that is beyond the 'doing of skills' and reflects opportunities to develop a career as an employee. The focus on the environment, which is recognised in this argument, is not however, as evident in the skills development approach adopted by many NHS Preceptorship programmes as discussed in Chapter One (Foster & Ashwin, 2014; HEE, 2022; O'Driscoll et al., 2022).

There is, in addition to the varying perspectives on employability described above, the challenge that arises when the standards required to educate midwives are not able to be reflected in the workplace. Hall & Way, (2018), argue that midwifery curricula are used as a driver for change in midwifery practice, for example in relation to differing models of care provision. The recent decision by NHS England to suspend targets for the implementation of continuity of carer within the maternity services in England (May et al., 2022), reflects the challenges faced by all stakeholders, and supports the argument for a better and broader understanding of employability.

2.5 Narrative and Midwifery

Much of the literature reviewed and presented above is qualitative research which reflects the dominant paradigm in midwifery and the experiential nature of midwifery knowledge (Newnham & Rothman, 2022). The selection of narrative inquiry as an appropriate research approach for my study will be explored in further detail in the next chapter. However, in terms of a review of narrative inquiry as a method to explore the practice of midwifery there are examples of studies which draw on narrative to explore professional identity (Feeley et al., 2022; Kerr & Macaskill, 2020; Weston, 2011), and equally those where the focus is the relationships with women or women's experience (Nolan et al., 2018; Reed et al., 2016). The use of narrative inquiry to explore and understand identity formation is supported, both as an emerging acceptance of the narrative 'turn' in nursing and midwifery (Riessman, 2008; Wang & Geale, 2015) and as an appropriate means to understand the development of identity (Bamberg, 2011). The application of narrative inquiry to the research problem may contribute to the literature by offering a differing approach.

2.6 Conclusion

The narrative review of the literature has provided a view on the experiences of NQM through the lens of employability and the perspectives of possession, position and process. As identified in the introduction to this chapter, the concept of a knowledge gap to be filled does not sit easily within the epistemology of narrative inquiry. However, I argued that for this study it was appropriate to

use the literature to shape the orientation of the inquiry and to strengthen theoretical perspectives. The literature presents a view of employability where the knowledge and attributes expected of NQM's are explicit in professional proficiency statements and preceptorship frameworks. NQM report a lack of confidence in their practice and identify the value of supportive working relationships in addressing this. The attributes and concerns of the newer generations entering the NHS workforce are presented as differing from previous cohorts. The literature, which explored the experiences of previous cohorts, however, identified similar concerns relating to not feeling valued nor being able to practice as they wished. The social position perspective on employability is captured by literature reflecting social capital and COP and, although these are less explicitly linked to midwifery, both provide additional insight into employability and identity development. The development of professional identity in midwifery draws on both personal and organisational values and may present a conflict for NQM to address.

The concept of employability, as defined in Chapter One, was not explicitly evident in the midwifery literature. However, the perspectives presented by Holmes, (2013) are visible and the complexity of the relationship between them justify further exploration. To reiterate, the aim of this thesis is therefore, to contribute to the understanding of becoming a midwife through the lens of employability and answer the following questions.

1. What do the stories of newly qualified midwives working in the NHS in England illustrate about the employability perspectives of possession, position, and process?
2. How are the stories constructed and does this add to an understanding of the process of becoming a midwife?
3. What can be learned from the stories to support the future education and employment of midwives in the UK?

The methodology for addressing these questions is discussed in the next Chapter which presents the rationale for the selection of narrative inquiry, and the methods selected to collect and analyse the data.

Chapter Three: Methodology

3.1 Introduction

Chapter One articulated the background of the study within the context of my practice as a midwifery educator and the challenges arising from the education and employment of midwives in England. I told a story; constructing my experiences to explain my view of the world, drawing on the policy and professional narratives that I understood to contribute to the debate. Using stories to communicate ideas and construct understanding is a common practice among humans (Casey et al., 2016; Clandinin, 2006). More recently however, the interest in stories has intensified as narrative inquiry has emerged as a research methodology (Clandinin, 2006; Wang & Geale, 2015). I referenced narrative inquiry as a methodology in Chapter Two when introducing the literature review, acknowledging the epistemological debates about sources of knowledge and the place of the literature review in reflecting these. This chapter, therefore, explains and justifies the methodology chosen to address the research questions, presenting the rationale for the use of narrative inquiry and the methods used. The context of the study set within my practice as an experienced midwifery educator illuminates the steps taken, thereby considering reflexivity and credibility within the thesis development.

3.2 Research Questions and Overview

As identified in Chapter One, the broad aim of this study was to contribute to the knowledge of the processes involved in becoming a midwife. The literature review illustrated the professional narrative that surrounds the practice of newly qualified midwives and further developed the research questions:

1. What do the stories of newly qualified midwives working in the NHS in England illustrate about employability conceptualised as possession, position, and process?

2. How are the stories constructed and does this add to an understanding of the process of becoming a midwife?

3. What can be learned from the stories to support the future education and employment of midwives in the UK?

Following ethical approval, five newly qualified midwives were recruited to participate and were interviewed between December 2020 - January 2021. The interviews were transcribed and analysed in a three-stage re-storying process to produce the findings articulated in Chapters Four and Five.

3.3 Research Philosophy and Approaches

Research philosophy refers to the assumptions and beliefs made about the development of knowledge (Saunders et al., 2019). Understanding my philosophy about the development of knowledge is fundamental to the design process since the nature of taught doctorate studies draws on the experience of the practitioner as part of knowledge development (Drake & Heath, 2010). As an educator with many years of experience in the practice of leading and managing education, I am aware of the appeal of the philosophy of pragmatism where knowledge is viewed in terms of its usefulness rather than as part of a search for a single truth (Cornish & Gillespie, 2009). Equally the philosophical arguments which underpin interpretivism speak to me as they emphasise the complexities created as humans construct meanings from their social experiences (Saunders et al., 2019). Indeed, I could argue that the larger social and professional narratives that surround the work of midwives reflect postmodern critical theorists and considerations of power and subordination in society (Ryan, 2018) and that these assumptions should guide the research design. Accepting that these assumptions may not be exclusive in the muddy waters of practice, I was content to move forward in my design with a focus on understanding the experiences of newly qualified midwives through the lens of employability. The literature review had highlighted the personal experiences that contributed to employability through, for example, participation in

communities of practice (Blaka, 2006) and the process of identity development (LaPointe, 2010). Focusing on the experience of becoming a midwife, rather than the outcomes of education and preceptorship, would also address the research questions and it was therefore appropriate to consider a qualitative design.

Inquiry focussed on the experiences of people, and which views the perspectives and accounts of individuals as the source of illumination on the world, most often requires a qualitative research design (Nolan et al., 2018; Ormston et al., 2013). Qualitative research can challenge the traditional academic design process since it does not fit neatly into the logical sequences which are more familiar in quantitative and experimental research (Ryan, 2018). Instead, qualitative approaches can be characterised by a mutual interdependence of stages, which require the researcher to develop reflexivity and flexibility in the design process (Flick, 2009,). A research study of any type, however, needs to have a clear plan for the design of the research to enable coherence between the research objectives and the methods or approaches used (Saunders et al., 2019).

The areas of interest which informed the thesis were my experiences engaging with the narratives that surrounded the retention of NQM's and those that informed the wider employability agenda in HE. Since I cannot separate my own experiences from the area of inquiry, qualitative design which enabled me to negotiate the challenges of data collection and analysis effectively and ethically within a structured framework was desirable and would add to the credibility of my work. Selection of a qualitative methodology which enabled the most effective means of addressing the research question was important along with considerations such as the practicalities of collecting data, in this case during a pandemic, and the burden of work for a novice lone researcher (Taylor & Hicks, 2009).

I was familiar with grounded theory as described by Strauss & Corbin, (1998) from a previous study I had undertaken (Derbyshire et al., 2014). Grounded theory is often presented as a means to inductively construct 'new' theories rather than the application of existing theory, although more recent constructivist approaches do reflect the role of the researcher and the social environment in

which the research takes place (Charmaz & Bryant, 2011). Grounded theory is widely used in nursing and midwifery research and provides a means to analyse processes and actions that arise across a data set. However, as described above, and even allowing for the constructivist turn in grounded theory, I felt that my professional doctorate based on many years of practice would require an alternate methodology which would better reflect the emphasis on story as knowledge that was emerging from my thinking.

My supervisor suggested that I consider phenomenological approaches as a means to explore the 'lived experiences' of NQM. Phenomenology is also an approach which situates itself inductively; traditionally asking the researcher to 'bracket' [put aside] prior experience and knowledge and recognising that the knowledge sought lies in the experiences of others (Miles et al., 2013). Phenomenology and grounded theory share the qualitative research characteristic of creating categories or themes from participants' experiences which are then argued to illustrate the experience of all (Riessman, 2011). However, in reading about methodology, I became aware of narrative inquiry and the attention paid to the detail of individual stories. This spoke to me of my own story as an educator, the motivation for the professional doctorate, and also the use of story as a means to communicate knowledge within communities (Wenger, 1998; Weston, 2012). Thus, I felt that narrative inquiry was the most appropriate methodology and additionally, narrative inquiry presented a relatively new approach to answering the research questions and provided, as explored in more depth below, a meaningful way to illustrate the process of becoming a midwife through the construction of identity that is present within stories (Frank, 1995; Riessman, 2008).

The sections below aim to address the challenges of undertaking research during the Covid-19 pandemic by reflecting on narrative inquiry as a philosophical approach, methodology and method. The narrative approach taken is identified whilst accounting for the limitations and, importantly, the opportunities created by the pandemic. Ethical considerations within the narrative inquiry and

reflexive analysis of my position are described, with particular reference to data collection and analysis.

3.3.1 Narrative ontology and epistemology

The ontological and epistemological underpinnings of narrative inquiry are contested, as are the definitions of narrative as inquiry, method, and data (Wang & Geale, 2015). The descriptions and terminology used for narrative approaches, narrative research and narrative inquiry can appear interchangeable, but each reflects a differing set of assumptions and beliefs (Caine et al., 2013). It was therefore important to be clear about my ontological and epistemological standpoint in relation to narrative inquiry and this was then able to shape the research study and influence its design and trustworthiness.

Ontology is described as the assumptions about what can be known and what exists as a truth (Ryan, 2018). Realist ontology argues that 'facts' exist in the world waiting to be discovered, independent of the researcher or the social context of the object of study (Polit & Beck, 2018). In contrast, relativist ontological assumptions suggest what can be 'known' is dependent upon the views and experiences of the researcher and the lives of the individuals they are researching (Ryan, 2018). Caine et al., (2013), present narrative inquiry as not fitting with either of these ontological positions; arguing that what can be known is generated within the process of inquiry itself. Narrative ontology implies that experiences are 'continuously interactive' as the process of telling a story enables individuals to make sense of their world within the inquiry process. Additionally, Caine et al, (2013) are clear about the role of the researchers' story and the experiences which have created the orientation towards the field of inquiry and how this contributes to the co-construction of knowledge. Recognising my story and demonstrating conscientious evaluation of the impact of such on the design, process and outcomes of the research demonstrates reflexive practice (Goldstein, 2017). Furthermore, reflexivity within narrative inquiry informs both ontological and epistemological assumptions (Savin-Baden & Van Niekerk, 2007) and is explored in more detail later in this chapter.

Epistemology or *how* to access knowledge can be defined as being either objective or subjective (Ryan, 2018). Objective epistemology seeks a single version of reality via credible and often measurable data. Subjective approaches find knowledge in the experiences and perceptions of individuals. If narrative inquiry locates knowledge ontologically within the research process, then it follows that the epistemology is one of the experiences of the researcher and those providing the narratives (Caine et al., 2013). Wang & Geale, (2015) expand upon this assumption drawing on Dewey's 1938 theory that 'experience is knowledge' and that narratives seek to identify and create meaning rather than truth. Thus, the stories within narrative inquiry are jointly constructed, first by the participants during the interview and then by me in data analysis, illuminating the meanings each has of the experiences of NQM and the implications for employability. It can also be argued that the stories generated within the inquiry process are situated within larger cultural, social, and institutional narratives (Caine et al., 2013; Clandinin & Connelly, 2000) Assumptions of larger narratives are evident within the orientation of the study drawn from the literature explored in the previous chapter. Larger narratives are also of significance if the worldview of midwives and the structures which enable or inhibit their identity development is to be explored and challenged (Pitre et al., 2013).

3.3.2 Narrative methodology

Narratives have traditionally been used by those studying subjects such as psychology, literary theory, and history. However, since the 1980s, social science and healthcare researchers have increasingly turned to narrative to better understand lived experiences through the meanings constructed within stories (Caine et al., 2013; Wang & Geale, 2015). Indeed, McCance et al., (2001) present a case for the use of narrative inquiry in providing insight into complex concepts found in health care such as caring. Employability, as argued within Chapter One, is also a complex concept with many potential definitions, and perspectives to consider (Holmes, 2013; Römgens et al., 2019). Negotiating those complexities by applying them to midwifery is the overarching aim of this inquiry.

Furthermore, within the literature review in Chapter Two, the challenges faced by NQM can be seen to arise from a degree of separation between expectations and reality. Narrative inquiry is well placed to explore this gap; Reissman, (2008 p53) referring to narrative inquiry argues that:

> '*respondents narrativize particular experiences in their lives, often where there has been a breach between the ideal and real, self and society'.*

Thus, narrative inquiry is a suitable means to address the research questions by exploring the stories told by NQM to understand the employability perspectives of possession, position, and process. As identified in Chapter Two, although much of the research surrounding the experiences of NQM is qualitative in nature, the use of narrative inquiry is novel and as a methodology may offer some further insights. In addition, analysing the way in which the stories are constructed, illuminates aspects of the process of becoming a midwife and provides opportunities to contribute to their future preparation and support.

3.3.3 Narrative and story

Narrative inquiry seeks to both understand and then present the world of the participants through their stories (Wang & Geale, 2015). Engaging with the narratives of people's lives is an effective means to access their perceptions and how they make sense of their experiences (Holloway & Galvin, 2017). Polkinghorne, (1995) defines the most inclusive meaning of narrative as that which refers to any spoken or written presentation. This definition can be expanded to reflect the role of a story in positioning the speaker in relation to the other characters, the time, and the place in which the story occurred (Riessman, 2006). The plot within the spoken story can be emphasised and used to craft or 're-story' a recognisable and temporal sequence of events, using a definition of plot as the action or 'doing' both within a story and as its purpose (Daiute, 2011). Thus, the plot of becoming a midwife is recounted by participants and presented by me, as the inquirer, as a journey or quest to find meaning (Ollerenshaw & Creswell, 2002; Polkinghorne, 1995). Stories as narrative are also able to illustrate how individuals craft themselves and their identity through the construction of each story and how it is told to which audience (Phoenix, 2017). The dynamic nature of stories and how

they illustrate lives not as a standalone experience, but as an expression of identity and meaning are why stories are so valuable within qualitative research (Wang & Geale, 2015).

3.3.4 Narrative and reflexivity

The value and trustworthiness of qualitative research, [discussed in section 3.6.2 below] reflect the concept of reflexivity which is much discussed in research texts and particularly in relation to narrative inquiry (Berger, 2015; Goldstein, 2017; Lambert et al., 2010). Reflexivity represents the need for continuous reflection on the part of the researcher and an awareness of how their values and biases impact on the research process (Berger, 2015). The nature of this narrative inquiry which reflects my practice as a midwife educator has placed my experience explicitly as part of the rationale for undertaking the inquiry. My reflections on the nature of employability and consideration of how these may contribute to an understanding about attrition from the midwifery workforce remain, however, just reflections. Reflexivity requires examination of my identity and thoughtful expression about how this impacted on the inquiry.

The description of insider-outsider research positions can be helpful when thinking about, and expressing, reflexivity (Toy-Cronin, 2019). Exploring my place in this inquiry I can be seen as an insider on several levels. Firstly, holding a shared professional identity as a midwife with the participants and, possibly more significantly, as the person accountable for designing and providing their midwifery education. That role also created a position of authority or power which I had to consider as part of the consent process. Equally being a known insider, someone who would understand '*what it was like to be a midwife*' [the words of one of the participants, see section 4.3.5] may have placed me in a good position to recruit an appropriate sample. My previous relationship with each of the participants was a positive one, there had not been any difficulties in their progress as a student, and I believe they viewed me at least benignly, and, at best, as a friendly and supportive educator. My previous relationship with potential participants may also have limited the sample to those who felt able to talk to me. It is possible that those who *did* participate shared

some elements of midwifery identity with me, making it more straightforward for me to re- story a familiar narrative; thus, there is the scope for some stories to remain unheard. My insider status may also reflect the approach to data analysis as I was familiar with, for example, the plot line of the competition for midwifery places at university, and the impact of mentors, practice supervisors and assessors on student experience. It is possible that a researcher with no knowledge of these may have created a different plot line. However, reflecting again on the epistemology underpinning the inquiry it is important to recognise the contribution my insider knowledge adds to the analysis and creation of each story.

Bringing knowledge back into to the discussion returns reflexivity to the concern about the value of qualitative methods, their trustworthiness, and the separation of researcher from the researched (Goldstein, 2017). Within narrative inquiry, as described above, what is 'known' is generated within the inquiry and reflects the experiences of both the researcher and the researched (Caine et al., 2013). The value of narrative inquiry reflects the relationships within it and, although some may resist the move to create a story of objectivity (Goldstein, 2017), transparency in those relationships is an important part of this inquiry and is explored further in the sections below.

Narrative inquiry is reflective of other qualitative methodologies where the focus is subjective experience and the role of the researcher can be criticised for lacking objectivity (Casey et al., 2016). The previous discussion of reflexivity within narrative inquiry goes some way to addressing this limitation and will also be addressed in Section 6.6 when considering the limitations of the inquiry. There is also the consideration, although not explicitly relevant to this study, that narrative inquiry is dependent on the ability of the participants to construct a narrative response which may be challenged by literacy or language barriers (Nolan et al., 2018).

A further potential limitation of narrative inquiry is the core nature of the methodology in facilitating the telling of stories; a term more often associated with fiction than academic endeavour. Elliot, (2005 p145) contends that researchers should be aware that narratives 'never communicate raw

experience' and are always constructed within a social context to give a particular meaning. Seeking raw experience or 'truth' is not, as discussed in section 3.3.1, a rationale for engaging with narrative inquiry.

3.4 Methods

The next section describes the methods used to collect, manage, and analyse the data. This includes a discussion of ethics, confidentiality, and the trustworthiness of the research.

3.4.1 Sample

The rationale for undertaking the research was a desire to explore differing perspectives on employability that might aid an understanding of the experiences of midwives, and the challenges within the maternity services workforce. The research questions remained broad whilst I reviewed the literature and began to consider theoretical perspectives and appropriate research design. This less structured approach is not unusual in qualitative research and often leads to a purposive approach to sampling as described by Flick, (2007). Flick argues further however, that sampling is a term drawn from quantitative methodologies referencing a population to which findings can then be generalised. It is not the intent of narrative inquiry, as a qualitative methodology, to replicate this process; rather sampling should enable the research question to be addressed through selection of suitable participants. Identifying the rationale for sample selection in qualitative research is also an important part of the transparency and authenticity required of any study. As I adopted the position of a narrative inquirer, it became clear that the experiences and stories of each NQM are unique and it is the strength of narrative inquiry that individual experience is heard. I needed to include those individuals who were about to, or had just, entered the workforce as midwives and had the experience of being employed. Flick, (2007) goes on to describe how sample choice can also be shaped by issues of access, and for me as a university-based academic, that was students and alumni of the midwifery programme.

3.4.2 Sampling approach

Making decisions about sampling is ongoing throughout a research project and includes more than identifying who the participants should be and why (Flick, 2007). Within narrative inquiry, an appropriate sample enables the aims of the research to be achieved by purposively identifying those who have knowledge of the phenomenon under study (Holloway & Freshwater, 2007). Therefore, I intended to gather a small purposive sample of six-ten participants using the criteria of midwives who had graduated from Northumbria University. The decision to seek participants who were graduates of the programmes I was responsible for, reflects the epistemological stance of narrative inquiry explored earlier in Section 3.3.1. Recognising the relationship between the researcher and the participants as the source of knowledge in narrative inquiry, it follows that building on an existing relationship and shared experience, augments the orientation to my professional practice within the thesis (Caine et al., 2013). Accessing graduates of other universities may have added breadth to the data set but there were practical and ethical considerations given the Covid 19 pandemic and pressures on academic and clinical staff time. Equally, I was confident that the graduates I wished to sample were employed in many areas beyond the Trusts where I was located. Indeed, two of the sample of five who came forward were employed in Trusts beyond the Northeast of England, so the stories were able to illustrate breadth that way as explored in Chapters Four and Five.

A small sample size within narrative inquiry reflects the methodological commitment to depth rather than breadth, and where the detail of individual experiences is of interest, rather than common insights gained from across a larger sample (Caine et al., 2013; Holloway & Freshwater, 2007). Debates within qualitative research as to the appropriate sample size continue to be shaped by realist ontology and ideas of representativeness and generalisability (Vasileiou et al., 2018). Authors may argue the need to have larger sample sizes to justify the authenticity and trustworthiness of their analysis (Guetterman, 2015) and narrative inquiry is not immune to those arguments. However, the reality for many narrative inquirers, including myself, is that a smaller sample is

sufficient as narratives generate rich depth of data, see for example (Haydon & Riet, 2014; Schwind et al., 2015; Weston, 2012) and this is supported by authors such as Caine et al., (2013) and others (Frank, 1995; Wang & Geale, 2015).

The purposive sample chosen excluded midwives who had graduated from other universities; this enabled a valuable insider perspective when constructing the stories for analysis. Those who had graduated more than three years ago were also excluded, since it was the NQM experiences which would be most valuable in addressing the study aims and questions. I had hoped to include those who had experiences working in different employing organisations and this was a key rationale for using the alumni to access the study population. However, I did not make this an explicit criterion because my knowledge of the population led me to rationalise that I might not gain a sufficient number of participants (Mthuli et al., 2021). By chance, rather than strategy, the sample included midwives working at five different organisations. The sample had elements of convenience, defined as those who are most easily accessible (Steen, 2011), as I interviewed all five midwives who responded to the invitation.

The experiences of those no longer employed as midwives was also considered relevant to the study aims and this was explicit in the participant information [appendix one]. However, there were no responses to the email invitation from this group [appendix one]. The use of a snowballing sampling approach had been included within my ethics submission and two of the participants identified peers who had left the profession and were working in other roles. Although I asked them to pass on my contact details and the participant information sheet verbally at the end of the interview, and in the follow-up email after each interview, no further participants were recruited.

A sample of five participants is acceptable within narrative inquiry when the aim is often to collect detailed personal stories for analysis (Holloway & Freshwater, 2007). Narrative inquiry can also contain larger samples if that will better reflect the research question, for example, a narrative inquiry exploring the experiences of both health professionals and patients used a sample of 24

(Durkin et al., 2022) . The use of smaller samples, or a single individual, is also a feature of narrative inquiry and participants may be interviewed on more than one occasion to enable deeper reflection on experiences and the developing story (Chan et al., 2013; McCormack, 2004). In this inquiry, the participant information [appendix two] did express the intent to undertake a second interview if necessary, however, all of the participants concluded their story in the first interview, and this was not necessary.

Five participants agreed to participate and, whilst a similar inquiry examining the professional identity of advanced nurse practitioners had a sample of 10 (Kerr & Macaskill, 2020), I was confident that the number I recruited would provide sufficient data to address the research questions. My confidence was informed primarily by the epistemological underpinnings of narrative inquiry where meaning is sought in the construction of personal stories and attention is paid to depth rather than breadth (Savin-Baden & Van Niekerk, 2007). There was also the additional consideration that as the sample was relatively homogenous [female, white, NQM, graduates of one university] fewer than ten is acceptable (Polit & Beck, 2018).

3.4.3 Recruitment and access

The sample was recruited via the University Alumni Association [AA]. The decision to recruit via the AA was because it increased access to the study population since it included those who had moved away from the area and had the potential of including those no longer employed as midwives in the NHS. If I had looked for volunteers within the local NHS Trusts with whom I had connections and therefore potential access, the study population may have been smaller. Additionally, contacting midwives via their employing NHS Trust may have created concern that they could be identified from their narratives and thus limit those willing to participate.

The Alumni office indicated that there were over 100 midwifery graduates registered as alumni who met the inclusion criteria and that they were willing to email the individuals with an invitation to volunteer to participate in the research. The first email was sent in early December 2020 and

resulted in three volunteers [appendix one]. To secure a larger sample, the invitation email was sent again in early January 2021 and two more participants contacted me.

3.4.4 Motivation to participate

The decision to participate in a research study should be an informed one and the process of consent is described and critiqued later in this chapter. As identified in the literature review, working as a NQM is often stressful and potentially a threat to individual well-being (Clements et al., 2012; Hobbs, 2012). All the participants had a previous, although increasingly historical, relationship with me [as one of their university educators] and it may be that those who volunteered to participate did so because the interview provided an opportunity to discuss their experiences with someone with whom they felt safe. Giving voice to experience is a presented as strength of narrative inquiry (Nolan et al., 2018), the ethical issues this may raise are discussed later in this chapter.

3.4.5 Data collection

Narrative inquiry can present opportunities for differing types of data to be collected such as diaries or letters (Holloway & Freshwater, 2007). However, since NQM experiences were sought, interviews enabling the oral construction of their experiences as stories were an appropriate method for data collection (Caine et al., 2013). Narrative interviews provide an opportunity for individuals to present their stories, following a generative rather than structured or semi-structured question pre-set by the interviewer. The interviewer takes on the role of an active listener and aims to avoid interruptions or making evaluative statements in response to what is being said. It can be argued that there are similarities between coaching conversations and narrative interviews. The role of the coach is very much to be an active listener and to create the space for the 'coachee' to recount their situation and then to reflect on key observations to enable and co-construct actions towards goals (Marson, 2019). My experience in active listening as a coach and a midwife supported the narrative process and ensured an ethically sound approach to the participants (Wang & Geale, 2015).

Narrative inquiry requires a commitment to the participants and their story and therefore one or more face-to-face in-person interviews are the best means to establish this type of relationship. The venue for the interview should be agreed upon in advance and this could be in the researcher's place of work or somewhere the participant feels comfortable (Savin-Baden & Van Niekerk, 2007). However, due to the Covid-19 pandemic, all the interviews were undertaken virtually via Microsoft Teams and recorded on a separate device. I had experience with qualitative interviews from two previous small research studies; however, this was the first time I had used a narrative approach and undertaken interviews online. In preparation, I revisited resources I had reviewed about narrative interviews (Lupton, 2020), and contacted a colleague with expertise in narrative interview who suggested undertaking a 'pilot' and subsequently, I undertook a narrative interview with my daughter who qualified as a midwife in 2015. This allowed me to check that the recording equipment would work and to test the narrative approach to the interview and my opening question [below], which I adapted from Kerr & Macaskill, (2020, p. 1203).

> '*Can you tell me about how you came to be a midwife? The best way is to start from when you first thought of becoming a midwife through being a student and right up until today. Take your time, give examples – everything is of interest*'.

The pilot helped in terms of recording an online interview and the use of the opening question and I proceeded to organise the interviews with the participants.

My aim for the interview was for the participants to tell their story with little interruption or prompting from me other than the opening question. I anticipated that I may have needed to clarify some points in response to each participant [and as can be seen from the stories this did occur], but I did not have any further fixed questions planned. The first participant was a concise storyteller and completed her story quickly. Since I had from my reading notions of plot and character in mind (Daiute, 2011), I introduced a question about the significance of others to encourage further reflection and elaboration on the story. Had I interviewed the first participant after one of the others, I would also have asked about a particular crisis or event as through listening to the other

stories, [phase one of analysis described below], this seemed important. For the remaining four participants, I felt less need to ask further questions as they provided detail without much prompting. For example, when I was interviewing one participant she spoke at length about her story as a midwife until the time she changed jobs. At that point I asked for clarification about the nature of her new job and if it required a midwifery qualification. When I interviewed participant three, her story contained detailed description of why she wanted to be a midwife and then moved quickly onto her current situation. I therefore asked her to add more detail about when she was a student. This had been part of the previous two narratives and reflected the focus on education in the research questions. All of the participants told me about personal and professional challenges during their interviews and it was necessary for me to respond appropriately to those; acknowledging their emotional responses and giving time to pause and gather thoughts before proceeding.

Narrative interviews vary in length reflecting the diversity of approaches that may be used (Creswell & Poth, 2018; Kerr & Macaskill, 2020). The five interviews conducted for this study lasted between 40 and 58 minutes. I had envisaged that a second interview might be necessary to capture each participant's story, but all completed the story within the interview time slot we initially agreed. I knew that short single interviews, although acceptable, are not usually a feature of narrative inquiry so it was important that I reflected on the depth of the data I had recorded. The opening question which I used was adapted from a similar study exploring professional identity, and using data collected from single interviews with the participants (Kerr & Macaskill, 2020). It is possible that the question suggested that the whole story needed to be completed in the time allocated for the first interview and this resulted in a second interview not being required. The question too, was focused on a fixed period of time that had passed, the three years as a student and two years since qualification. The part of the story before becoming a student varied in length, and four of the five participants did reflect on their childhood. However, it was not the aim of the research to explore

the motivation to become a midwife per se, so I was satisfied with the depth of the data provided about that part of each story.

For the remainder of the stories my feeling was, that on completion of each interview, I had the depth I was anticipating for a the time span indicated. Narrative inquiry can have a biographical approach aiming to elicit rich data which depicts an individual's life or progress through a life stage (Frank, 1995; McCormack, 2004). Alternatively rich data can be gained from the construction of stories exploring a topic over a specified time, during which both researcher and participant are able to reflect and develop meaning (Chan et al., 2013). Reflecting this approach, I completed the initial analysis of the interview, re-storying the data as described below, and emailed each participant a copy [appendix four]. The email invited the participants to comment on the story but was also clear that this was optional given the ongoing work pressures in the NHS. Two participants replied, this may reflect the challenges in maintaining ongoing engagement with research participants (Saunders & Lewis, 2018), but also an indication that the participants had told their story and my data were complete.

All interviews were recorded, transcribed, and stored according to NU Governance requirements (Northumbria University, 2017).

3.5 Ethical Considerations

Hammersley, (2019) recognises the focus on gaining ethical approval from research committees as being a part of the research journey and a requirement before contact with participants and data collection. This study was therefore submitted for approval to the Faculty of Business and Law Research Ethics Committee in November 2020. The approval process required submission of the proposed research design, details of data collection methods and evidence of how informed consent and confidentiality would be assured. The participant information sheets, consent forms and debriefing information are provided in appendix one to three of this thesis. The study was approved without any amendments being requested and subsequent recruitment of participants

commenced. Ongoing ethical oversight was provided via reflective discussions which formed part of the supervision process and by adherence to my professional code of conduct as a registered midwife (NMC, 2018a). The participant information [appendix one], highlights the possibility that the interview may include recounting difficult experiences and also the measures in place to mitigate the risk of causing distress to participants. During data collection difficult topics did come up, either in relation to personal experiences of childbirth, or in relation to what is identified in the analysis as the 'ordeal;' a clinical event which led the participants to question their practice and future as midwives. One participant, although not overtly emotional, left me feeling that she was struggling to deal with being a midwife: so much so that I felt professionally obligated to contact her the next day and check that she was okay. Another participant managed their emotions differently and it was only when she read her story later, after I had sent it to her, that she recognised how poor her mental health had been at the time. Two further participants did become tearful during the interview, and we paused, and I responded to recognise their emotions thus aiming to reduce harm through the data collection process.

3.5.1 Informed consent

The five participants who responded to the invitation to take part in the study were emailed the information sheet with the offer of a telephone conversation if they had any questions. Following receipt of the information sheet all five responded via email agreeing to participate and an online interview was arranged at a date and time convenient for them. Since the interviews were online, obtaining live written consent was not possible but all participants confirmed verbally [which was recorded], that they understood and had signed the consent form, and all had emailed me a copy which I stored securely within the university secure cloud storage. Each interview was followed with a further email containing the debrief information which made clear the options for withdrawing their data.

The voluntary and informed consent of participants is a fundamental aspect of an ethical approach to study design. Ensuring informed consent demonstrates the ethical principle of respect for the

autonomy of the participants and within qualitative research, this is an ongoing process (Holloway & Galvin, 2017). Informed consent at the outset of a study traditionally engages the researcher and participants in a conversation about the broad aims and outputs of the research. However, the iterative nature of qualitative approaches such as narrative inquiry means that how the research will develop and the outcomes which will be produced may not be fully known at the point of requesting consent from participants. Indeed, Miller & Bell, (2012) argue that the exact nature of what is being consented to may only be apparent at the end of the study. Consent should not, therefore, be seen as a one-off event that occurs at the start of the study but rather as an ongoing part of the relationship between the researcher and the participants (Miller & Bell, 2012; Savin-Baden & Van Niekerk, 2007).

As described above, the ongoing relationship with the participants in this study was briefer than I anticipated. When I emailed each a copy of the first analysis of their stories only two replied to comment. Both confirmed that the story was an accurate reflection of how they had felt at the time of the interview, both added briefly in their email response how things had changed since then. Neither asked me to remove or delete any information.

3.5.2 Confidentiality

An agreement between the researcher and participants about what may be done with data includes conversations about confidentiality and anonymity. The power of narrative inquiry is in the use of the whole, rather than coding and categorising data into themes and de personalised quotes. However, other qualitative approaches to data analysis, which do just that, are more easily able to protect the confidentiality of the participants. Narrative Inquiry studies that are published in peer-reviewed journals within the health arena tend to present an analysis of Narrative Inquiry 'findings' in a way which is recognisable to the professions i.e., with themes and implications for practice; see for example (Chan et al., 2013; Durkin et al., 2022; Kerr & Macaskill, 2020; Palese et al., 2014). By so presenting segments of stories as elements of a recognised plot [as I have done in Chapter Five] anonymity and confidentiality can be enhanced. However, in order to reflect the approach to

narrative inquiry used, Chapter Four contains the experiences of each participant 're storied' to present the rich detail and depth of their experiences. Since the thesis will be published and available in full via the British Library ETHOS catalogue further consideration of confidentiality is required.

Anonymity differs to confidentiality. Confidentiality can be argued to be the means by which information collected during a study is protected and only available to those in the research team (Saunders et al., 2015). Anonymity is part of that process, but also includes consideration of privacy and the decisions that researchers make about which data to include and recognition of how this may, or may not, identify an individual. Saunders et al., (2015) suggest several ways in which the anonymity of data can be enhanced whilst also recognising that, within 'in depth' qualitative interviews, complete privacy many not be possible. The first way to assure anonymity is to create a pseudonym, which I did using the top names for female children in 2021. The second involves location; I did not name the participants employing organisation other than to locate them in England. However, my story locates me at Northumbria University [NU] and the participants as graduates of the same. Within the analysis I have included that three participants chose to seek employment where they had been students. This, within the 'small world' of midwifery (Saunders et al., 2015), effectively narrows the employing organisations down to four possible locations. However, as the decision to stay or move was a significant part of the plot, I decided to keep this within each story and take further steps as identified by Saunders et al., (2015) to enhance anonymity. I changed the detail of health conditions for two participants as the impact of an absence was relevant; the detail was not. I was also careful to exclude unnecessary personal detail when analysing the data, for example, in relation to previous birth experiences. Finally, when identifying previous occupations, I used generalised terms such as 'science' degree or 'design' in place of the more detailed descriptions shared during the interviews. However, one participant had

a very relevant previous occupation as a doula[7] and there was not a more general term I could use which would not dilute its meaning and impact on the participant's story. Within the interview data, the participant states that she does not hide her previous occupation from the midwives she works with; I included this detail in the analysis also, as it reflects on the relationships the participant felt she had as a student. The inclusion of previous employment as Doula may compromise anonymity but as Saunders., et al (2015) discuss, this can be justified to maintain the integrity of the data when other reasonable steps have been taken. This included sharing the story constructed from the data with the participant when the analysis was complete, offering the opportunity to comment, and also indicating that I would continue with the analysis if there was no response [appendix four].

3.6 Data analysis

I identified earlier in this chapter the differing definitions and approaches to narrative and narrative inquiry and how these reflect the assumptions and beliefs of the researcher or inquirer (Caine et al., 2013; Riessman, 2006). This, in turn, creates a flexible and creative space in which there is no singular or correct way to analyse narrative data (Holloway & Freshwater, 2007). It is, however, important to align the method with the aims and assumptions of the inquiry and by doing so, an appropriate analysis can be undertaken.

The typology of methods for narrative analysis 'sketched' by Riessman, (2006, p2) is not intended to be conclusive but presents a useful summary of the methods discussed elsewhere (Byrne, 2017; Clandinin & Connelly, 2000; McCance et al., 2001; Wang & Geale, 2015). Thematic analysis of narrative is presented with an emphasis on the content of narratives, *what* is being said rather than *how.* In this way, the language used within the narrative is judged to be a direct route to meaning and thus enables inductive approaches to grouping concepts or generating themes from the data (Riessman, 2006). However, the underlying assumption that language and words carry the same

[7] A person who will support the whole family to have a positive experience of pregnancy, birth and the early weeks with a new baby https://doula.org.uk/what-doulas-do/

meaning regardless of context, is a criticism of the thematic approach. Recognising the context from which narrative data arises is more evident in structural approaches to narrative analysis. This draws on the work of Labov & Waletzky, (1997), who viewed *how* narratives are structured as being of prime significance. They argue that narratives as stories are temporally ordered and consist of an abstract; an orientation to time, place and people; the action or plot often with a crisis or turning point; evaluation where the narrator reflects on meaning; resolution or outcome of the story; and the coda or ending (Riessman, 2006). Viewing narratives in this way can enable the development of theory, if that is part of the approach taken (Riessman, 2006) however, this too may fail to contextualize the stories within the wider social and cultural narratives surrounding the storytellers (Elliott, 2011).

The interactional approach to narrative analysis emphasizes the setting of the story and the dialogue between the storyteller and the person to whom the story is told. Riessman (2006), notes that there may still be attention to content and structure, but the emphasis is on the co-construction of the story; the *who*, *when* and *why* (Riessman, 2008). This brings reflexive attention again to the relationship between the participants and the researcher, with recognition that stories are told for a reason and constructed for a particular audience (Josselson, 2012).

Returning to the aims and objectives of the inquiry I was undertaking, there was a strong rationale to emphasize the content and the *what* of the participant's stories. What were their experiences of becoming midwives and what can be learned from these? Developing themes from the data was also a familiar strategy from my previous engagement with qualitative research and indeed, several authors argue that this approach is justifiable to provide practical or clinical value (Kim, 2020; Overcash, 2003). However, the *how* and the *why* of the stories I had heard were hard to put aside. I had chosen narrative inquiry because of how stories can illustrate the construction of professional identity in midwives which the literature review had suggested was poorly accounted for. Analysing the content of the stories would reveal insights into *what* the experiences of the participants were

and enable theorising across cases as described by Riessman, (2006), in this case, the application of employability perspectives to the experiences of NQM. Nevertheless, I felt that content alone would not answer the research question, so I modified the phased approach described by Fraser, (2004) and explained in the next section.

3.6.1 Engaging with the data

It is a challenge to pinpoint where engagement with data in narrative inquiry commences. It could be argued that it commences during the interview process since the meaning of each story I heard, started to take form as I reflected on my knowledge and experience or the situations the participants were describing. Fraser, (2004) identifies this as 'phase one' and encourages the use of a reflexive notes during and after the interviews. My notes included consideration of the start and the end of the interview; the re-establishment of rapport; my genuine interest in the participants lives and noting parts of the interview where emotions were visible.

Phase two is the transcription of the interviews, and although Fraser (2004), describes the benefits of the researcher undertaking this activity, there is also recognition of the time and skill required to complete transcriptions efficiently. I was in a position to use some university funding to secure the services of a transcriber and, given the time pressures created in my work by the Covid-19 pandemic, I decided to use that option and did not undertake the transcribing myself. The person who did was a post graduate student who had experience with qualitative interviews and data management. Within narrative inquiry, approaches to transcription may focus on the structure and construction of language as described by Elliott, (2011). However, in this study I requested a verbatim transcription which was provided with the speaker marked as 'P' for participant or 'I' for interviewer. When I received the transcriptions, I listened to the recordings again as I re-read the text and annotated reflections from my diary.

I further familiarised myself with the data and entered phase three, as described by Fraser (2004), with interpretation of the individual transcripts. I identified 'small stories' as described by Bamberg

& Georgakopoulou, (2008) within each transcript that represented an abstract, orientation to time and place, character etc [appendix five A]. I gave each small story a title and reorganised them when necessary to create temporality for each participant. In this way I was able to analyse and 're story' each participant's experience (McCormack, 2004) into a journey from 'starting out' to 'becoming a midwife'. This analysis as a temporal journey, which is presented in Chapter Four, reflects a common genre of storytelling. The concept of a genre as summarised by Elliot, (2005 & 2011) is described as a recognisable pattern within a story that provides a shared cultural framework which enhances communication and understanding; in this analysis addressing the aim of my thesis.

The fourth and fifth phase of analysis seeks to '*scan across different domains of experience'* and '*link the personal with the political*' (Fraser, 2004 p183). These phases are evident in my reflexive notes from the analysis activities [appendix five B] and influenced the interpretation and framing of the stories. Thus, as an academic narrative, the stories represent the experiences of the participants as 'journey women' through the final seventh phase of analysis (Fraser, 2004) and are presented in Chapter Four.

There is a phase six in the approach described by Fraser (2004) where the data is analysed looking for commonalities and differences. However, in this analysis that phase came after the writing of the individual stories. Using the stories in Chapter Four which represented *how* the stories were told and constructed [addressing question two], I examined *what* the stories contained; [appendix five B]. Furthermore, following, for example, the work of Frank, (1995) and Steiner, (2015) I considered *what* type of a journey story they represented. In doing so, I was able to generate archetypal plot elements which illustrated the features of the 'quest' narrative within the stages of the journey previously identified (Riessman, 2006; Sanders & van Krieken, 2018). The elements were not intended to be representative themes extracted from the data to generalise the participant's experiences. Rather, they served to illustrate recognisable experiences, symbols or patterns within

the plot of the quest story that could be discussed further (Sanders & van Krieken, 2018). These findings are presented in Chapter Five.

3.6.2 Trustworthiness and authenticity

In any study, there is a requirement to consider the quality of the research undertaken and concepts such as validity, reliability and generalisability appear within texts and publications on the subject (Loh, 2013). These concepts arise from within the natural sciences and there are challenges in applying these to qualitative methodologies (Creswell, 2014; Lewis & Ritchie, 2003; Riessman, 2008). However, Holloway & Freshwater, (2007) remind qualitative researchers that it is not possible to sidestep these challenges. Addressing issues of quality and how they align with the epistemological assumptions of qualitative studies can be a strength of research design and one that enhances the utility of the findings (Creswell, 2014, p. 201).

As identified above, validity and credibility are the traditional criteria used to assess the quality of research studies (Holloway & Freshwater, 2007), and, as argued by Loh, (2013) failing to address these will prevent the acceptance of the findings into '*the pantheon of knowledge.'* This inquiry aims to contribute to the understanding of how best to educate and support newly qualified midwives, so navigation through the challenges must be presented.

Validity is defined as representing an assessment of the 'truth' or trustworthiness of research findings and for qualitative researchers, this is translated into procedures for confirming accuracy (Creswell, 2014). I n narrative inquiry it is suggested that this can occur at two levels; firstly, at the level of the story told and secondly, at the level of the analysis and how the story is then re-told by the researcher (Riessman, 2008). I have addressed these in Table 1 overleaf.

Table 1: Quality Criteria for Narrative inquiry

Validity of the story	**Explanation**	**Action**
Authenticity (Holloway & Freshwater, 2007)	Ensure the authentic voice of participants can be heard presenting their reality.	The re-storying of each narrative to present a whole story. Inviting each participant to read and comment on the story once complete
Authenticity (Flick, 2018)	Ethical principles of justice applied to research	My relationship with the participants, my concern for their wellbeing and confidentiality. The participants expressed desire to contribute to practice through their stories.
Validity of the analysis	**Explanation**	**Action**
Reflexivity (Holloway & Freshwater, 2007)	Surfacing of researchers beliefs, values and assumptions and through self-reflection and reflexivity	Research memos, discussions with supervisors, reflexivity within the thesis.
Verisimilitude (Loh, 2013)	The quality of appearing real and believable, creating congruence with the readers own experiences.	Re-storying into temporal stages which reflect a sequential plot. The use of participants words throughout the text of each story. Careful and detailed transcripts and documentation of the process used to analyse the data. The development of plot elements to compare and individualise stories.
Debriefing (Creswell, 2014; Holloway & Freshwater, 2007)	Use peer de briefing to enhance the accuracy of the account and seeking interpretation beyond the researcher adds validity.	I shared the first draft of the re- storied data with a colleague who has extensive experience of narrative inquiry. This provided opportunity for further

		discussion and reflection on the construction of the stories.
Utility (Riessman, 2008)	The presentation of context specific knowledge via study of in-depth cases.	Rich description of each participant's story. The nature of the inquiry arising from my practice as an educator.

Reliability in research terms is understood to mean the replicability of the study and the extent to which the findings would be repeated in a similar study (Lewis & Ritchie, 2003). The challenge for qualitative researchers is in arguing that findings that are constructed by individuals do not represent a single truth. This is despite the sometimes opposing epistemological and ontological assumptions that underpin differing research methodologies which, in turn, will challenge the assertion that a single truth can be found and generalised to a wider population. The underpinnings of narrative inquiry can vary too and therefore account must be taken of this when arguing for the validity or truthfulness of inquiry findings. Confirmability may be a more appropriate term for narrative inquiry reflecting the authentic link between the data and findings (Stenfors et al., 2020).

3.7 Conclusion

Narrative inquiry is an appropriate methodology to explore the experiences of NQM and address the research questions. Using the stories of the participants to illustrate the detail of their experience enables a rich and authentic analysis which is presented in the next chapter. Further analysis with identification of the plot elements of a quest archetype, is presented in Chapter Five.

Chapter Four: The Stories

4.1 Introduction

The findings are presented in this chapter as an interpretative re-storying of the narrative interviews which illustrate the process of becoming a midwife. The presentation of the whole story of the journey to becoming a midwife reflects this inquiry's epistemological stance, which is to faithfully portray the subjective experience of the midwives in the study (Holloway & Freshwater, 2007). The stories were crafted to reflect the participants voices from the accounts of their experiences as constructed during the moments of the interview (Riessman, 2008, p. 22). The process of re-storying resulted in five stories presented using the language from the interview transcripts and my reflective notes. The stories include, when appropriate, embedded quotes from the interviews to illustrate each experience and to represent the participants voice directly in the telling of each story. Participant's words are italicised to illustrate the differing voices in the construction of the stories.

4.2 Introducing the Midwives

Because of the value that narrative inquiry places on appreciating individual experiences and providing a more complete picture of each midwife's journey, this chapter begins with an overview of each participant. Table 2, overleaf, identifies the age and date of graduation for each along with a summary of their employment history. Names have been changed to maintain confidentiality and anonymity and each participant has been given a pseudonym.

Table 2: Summary of participants

Participant	Date of interview	Graduation	Age	Employment History	Pseudonym.
1	11/12/20	2018	43	Band six midwife[8]. Always worked part-time at a large NHS Maternity Unit	Olivia
2	18/12/20	2018	40	Band six midwife. Now part-time at a smaller NHS Maternity Unit	Emma
3	6/1/21	2017	24	Band six midwife. Previously employed full-time at a large NHS Maternity unit. Later employed full-time by a charity.	Ava
4	26/1/21	2018	35	Band five midwife. Now part-time in a large NHS Maternity Unit	Sophia
5	29/1/21	2017	24	Band six midwife. Full-time at a large NHS Maternity unit	Mia

4.2.1 Pen portraits

To further set the context for the analysis of the participants' stories within this chapter, a short pen portrait of each is provided.

Olivia:

Olivia is a science graduate who came into midwifery with experience working as a project manager. She has two children and delayed starting her midwifery education until they were both at school. Olivia took studying to be a midwife in her stride and was actively encouraged and supported to seek employment in the NHS Trust where she was placed. She is content in her work as a hospital-based midwife and feels that part-time hours give a good work-life balance. She feels supported and able

[8] Band Five, six and seven are roles within the NHS that apply to all non-medical staff and reflect salary and organisational responsibilities. Band Five is the minimum grade for a registered Health Professional and all new registrants begin at this grade. Midwives are usually promoted to a Band Six role within a year of registration which reflects the additional responsibility and skill required to provide midwifery care unsupervised. Band Seven roles reflect organisational leadership and management in addition to professional practice.

to ask for help when she needs it and is happy to support and supervise students in turn. She sums up her experience as *'I still feel that complete privilege and honour of doing what I do every single day*.'

Emma:

Emma is a social science graduate with three children who worked as a doula before deciding to become a midwife. Emma found being a student a challenge but negotiated the relationships successfully and sought employment in the Trust where she had been a student. She describes the environment there as supportive with examples of senior midwives taking an interest in her well-being following a challenging incident. She currently works in the community as a continuity of care midwife and she says, '*I don't see myself as doing anything else for the rest of my working life*.'

Ava:

Ava came into midwifery straight from school and midwifery was not what she thought it would be. She found being a student hard but with the support of her friends and the midwives she met, she rose to the challenge. Ava sought employment in a different Trust than where she had been placed as a student and was supported through a preceptorship period and into a band six role. However, she left her employment as a midwife in the NHS following a period when she felt unsupported in dealing with some difficult situations. Ava now works for a pregnancy charity which she concludes has '*made me a bit of a different kind of midwife*.'

Sophia:

Sophia is a mature student with a background in design. She has two children, one born before and one after she became a midwife. She had clear aspirations about what she could bring to midwifery. She found being a student challenging and the care provided for women was not what she hoped it would be. Sophia is still a band five midwife as her preceptorship period has been extended by ill health and her second pregnancy although she still aspires to become a band six and to work in the

community. However, she currently summarises that '*I don't really feel like I'm the midwife that I want to be*.'

Mia:

Mia researched the role of the midwife at school after considering other health professions and left home to go to university immediately after her A levels. When she graduated, she moved back to her hometown and worked as a midwife in the local maternity unit. She started there in the community, as all new midwives in that Trust did, and then moved back into the hospital where she became a band six midwife in the midwifery-led care team. She likes to feel part of a team and finds the support of other midwives to help deal with challenges. She describes working in the continuity team where she is now as '*this is what my idea of being a midwife was… you feel like you're sort of completing the full circle*.'

4.3 Journey Women: The Stories

The stories told by the midwives were analysed and 're-storied' into the five stages below, which, as described in Chapter Three, reflect the story genre of a journey. The stories illustrate *how* the participants' narratives were constructed as they made sense of their experiences when asked about becoming a midwife.

Stage one: Starting out.

Stage two: The student journey.

Stage three: Choosing where to work.

Stage four: Working as a midwife.

Stage five: Being a midwife.

The participants' stories are presented in the order in which they were interviewed, each is given a title.

- Olivia's story: 'It's exactly what I thought it would be'.
- Emma's story: 'I'll take all of it'.
- Ava's story: 'I'm a better midwife now'.
- Sophie's story: 'I've just got to keep going'.
- Mia's Story: 'Completing the circle'.

4.3.1 Olivia's story. 'It's exactly what I thought it would be'

Stage One: Starting out.

Olivia begins her story by saying that she went to university to study a science subject straight from school and that she had no idea what she wanted to do for a career. Upon graduation, she ended up working for a large business organisation and very quickly realised it was not what she wanted to do. When pregnant with her first child, Olivia thought, *'wow, I'm actually really interested in this, and not just because it was happening to me, but I'd spent ten years being bored at work and suddenly there was something really interesting that I thought, I could do this.'* Olivia goes on to recall that she did not have a great experience giving birth to her first child, despite having an '*on paper'* normal birth, '*I didn't feel listened to, I didn't feel part of the process, and thought, I could do that better.'*

Olivia went on to have another baby and had a very different experience with a midwife she later describes as the hero in the story of her journey to becoming a midwife. This second midwife did listen and share decision-making, even though the birth this time was the kind Olivia *did not* want. This experience confirmed Olivia's decision '*she's just made such a difference to me and my life and my experience, that's what I want to do for other people*.'

Stage Two: The student journey

Olivia does not dwell on the process of applying to university as part of her story, summarising it as waiting until her youngest child was at school and then describing securing a place at university as '*lucky'*. She moves quickly on to describe her experience as a student, recalling that her previous career as a manager was valuable; she goes on to describe a set of transferable skills such as time management and task organisation which meant that '*Doing that degree was a hell of a lot easier than my old job, just in terms of pressure and stress and just sheer workloads, so, I was always a bit bemused by how difficult everyone else was finding it.'*

Olivia continues relating a positive story about when she started placement experience as a student within the NHS Maternity Unit where she now works. She tells me, '*I sort of almost felt like walking onto the placement from the very first shift, and I don't know whether it's just the mentor that I had, or I don't know, I just felt like, yeah, this is where I'm meant to be, this is what I'm here to do.* I*t's always felt like more than a job*.'

I ask Olivia to tell me more about her mentor because I know from experience and the literature that mentors significantly impact the student experience. In later interviews, I do not interrupt in this way, but, Olivia gives a detailed description, *'She was a nurse, she was an A&E*[9] *nurse, and then did the 18-month course to become a midwife, similar age to me, also had two kids, so we were kind of quite similar in that respect, and probably quite a similar personality in that she was, you know, very well-organised and manages her time really well and stuff and was just actually a pretty good teacher.'*

However, Olivia tells me that there were some issues relating to organisational roles and the relationships that operate between band six and band seven midwives which her mentor did not prepare her for; *'[it] was really difficult as a student, to be in that position, where [you're seen as]*

[9] A&E Accident and Emergency Department

almost like putting up against the band sevens, just simply through ignorance of how the whole thing is working together and what the co-ordinator's role was.' Olivia expresses frustration that she had a problem because her mentor '*shielded' her* from some of the '*politics'* within the organisation. She expands on this saying that she had thought band sevens were *'there to help'* the more junior band sixes in a professional capacity. In reality, she found that they would overrule their junior colleagues on organisational issues such as managing student placement hours. Subsequently, when Olivia was seen to be leaving before the end of the shift, she recalls that the band seven '*was not best pleased.'*

Overall, Olivia's student experience led her to reflect that *'I've worked with mentors that I got on really well with and I've worked with mentors that I really didn't.* She to explains that *'they just didn't practice in the way that I wanted to practice, and that's difficult as a student, very difficult. It really reinforces that idea of, I will not do this, I will not practise like this.'* Olivia also says that while she recognises it is a good thing to see different practices*, 'observing examples of how you don't want to be…. has also helped to define me as a midwife in terms of I always make sure that I'm never straying into that territory*.'

Stage Three. Choosing where to work.

Once qualified, Olivia knew she wanted to work at the same NHS Trust where she had trained. She was asked to apply for a job and was made an offer a month before she was due to complete her studies. She recalls that the Trust was good at preparing students for the selection process and that the interview '*just felt like a chat*'. When she heard about the job offer, she was in the delivery suite and someone said there was a call for her, '*and I was like, "oh no, what have I done," and it was actually the Head of Midwifery saying, "yeah, we're going to offer you the job," so it was brilliant*'.

The staff on duty that day congratulated Olivia and made a fuss of her which she recalls as '*really supportive and welcoming, I would say that's when I felt I was a fully-fledged member of the team, even though I still had my student uniform on*.' When Olivia went back a couple of weeks later as a final elective placement, the staff said, *'we're going to treat you as a midwife, because you're*

qualified in two weeks' time.' Olivia described this validation from others as a defining moment of becoming a midwife.

Later in the narrative, I ask Olivia about how helpful she thought it was to choose to work somewhere that was familiar, with established relationships, and where she was known. I ask this because Olivia had told me that on her first shift, she did not work supernumerary with a preceptor as expected, *'I got about an hour's supernumerary because I remember the band seven coming in and saying, "[Olivia] you know what you're doing, it's fine, I've got another woman for you" so I left the midwife I was working with and that was it.'* Olivia tells me she felt it was *a 'massive advantage finding my feet as a qualified midwife in a place that I was familiar with.'* She continues*, 'I think I would have found it really hard to work out, you know, a new hospital, a new set of faces, as well as you know, finding my feet for the first time as a qualified midwife.'* Olivia also highlights the welcome that she and her fellow new starters received from staff. '*I remember everybody going, "oh look at you in your scrubs," and making like a real fuss of us all, you know, who'd started at the same time and just actually feeling really special and really almost like people were celebrating the fact that you were there.'* She articulates a subtle difference in visibility within the team, '*I felt more seen once I was qualified than I did as a student because I think when you've got that student uniform on a lot of people just see a student, I'm not saying that they're not pleasant, but I definitely think there's a difference between how a lot of people see you from wearing the white to wearing the scrubs.'*

Stage Four. Working as a midwife.

Despite the welcome and support, Olivia describes the first few weeks of working as a midwife as *'terrifying*'. She provides the context for this: *'the way our degree was structured in the third year it was mainly community, hadn't had the [*labour ward*] experience at all in third year, apart from the*

case loading[10] *bit, so it felt like, I mean I always felt like a fish out of water the first week or two back on a placement anyway, but then suddenly you're not a student anymore. It's on you, you know?*' However, she recalls that everyone was supportive and happy to help so, '*I think the pressure I felt was pressure I put on myself, rather than the pressure anyone else put on me. So, yeah, it wasn't awful, it was scary, but it wasn't awful.'*

I ask Olivia to tell me what she means by pressure, and she replies that it was the pressure to make the correct decision and recalls how she would find herself 'say*ing to one of the more senior midwives, "can I just run this past you, is this what you would do?"'* Olivia says that she was never afraid to speak up and ask for help and that is still part of her practice now, reflecting that *'I always think two brains are better than one, so if I'm not quite sure of an action I'll still run it past people…. I don't want to miss anything, but I was never, ever afraid to speak up and say, "I need a bit of help here"; I probably spoke up a bit too much, to be honest.'*

Olivia tells me that as work-life balance is important to her, she started work as a band five midwife for 30 hours per week. She had never wanted to work full-time after having her children and had found full-time placement as a student hard with the competing demands of a family. When she became a band six, she reduced her hours further and describes her current role as '*absolutely perfect';* clarifying that she does not resent her shifts in the way she sees other staff who are full-time and juggling their work and home life resent theirs. She summarises*, 'for me it's perfect, this was kind of always where I wanted to be, to be honest: a band six midwife, hospital-based, working 24 hours.'*

Stage Five. Being a midwife.

Olivia does not tell me about a significant crisis in her practice; a feature which does appear in the stories of the other participants. If there is a challenge within Olivia's journey, it comes from her own

[10] Case loading: following a small group of women through their pregnancy and birth experience providing midwifery care in preparation for taking on a 'case load of women' once qualified.

experience of childbirth and the two different midwives who motivated her original decision to become a midwife. When I asked about this again and how becoming a mother may have influenced her to become a midwife, it was clear that these memories still arose strong emotions in Olivia. However, she reflects that '*in terms of my journey into motherhood, I think to a certain extent [her personal experience] but it wasn't so much about that, but about how I felt as a woman in relationship to another woman who was caring for me, if you like.'* Olivia explains that she still felt it was more than her own unique experiences which were impacting her practice as a midwife; remaining '*fascinated by childbirth'*, reading and looking up new evidence that she feels others possibly lack. '*I can see in other people who have maybe qualified around the same time as me that it has maybe just become a bit of, it's more of a job to them.'*

Midwifery as a job rather than a relationship with women is further illustrated by what Olivia identifies as the '*very real practice/ theory gap*' which she illustrates as being driven by the task focus of the organisation. '*You've got a list in your head that you've got to tick off, and the pressure's on, because, once that baby's out you've got two hours to get them down to the ward, and I just think it's so easy to forget everything that uni' tried to teach us.'* She reflects that she has colleagues who started with wonderful intentions, but now she can see *'they're just going through the motions because all they've got to do is tick off the tasks that they need to do to get to the end of their shift*.'

Olivia does not think that the system - as it currently stands - allows for midwives to practice in the way they may choose; instead, there is a focus on organisational tasks. However, she feels that the implementation of continuity of care teams seems to be having an impact, '*The midwives who join the continuity teams are absolutely loving what they do, and I think feel very differently about their jobs as midwives now, so it's quite an interesting one to watch.'*

Olivia describes her commitment to supporting others on their journey to becoming a midwife. In her previous employment, she had set-up female-to-female mentoring in an otherwise very male-

orientated environment, so she was keen to contribute to student learning once she became a midwife. She tells me that even when she was a student, she observed her mentors and thought '*is this how I want to mentor, you know, how would I do it differently*?' Olivia says she does not see working with as '*just part of the job'*. She feels that it is much more than that; it is about nurturing and encouraging the passion she can see in students.

Finally, reflecting on being a midwife Olivia has a very positive story. *'I can honestly say it has been what I expected, I haven't been surprised by any of it, and I don't think at any point have I thought, "this isn't what I want," the passion has just been there right from the start, and I've never lost it, and I still haven't lost it now. So, I still feel that complete privilege and honour of doing what I do every single day. '*

4.3.2 Emma's story: 'I'll take all of it'

Stage One: Starting out.

Emma tells me that she does not recall ever consciously setting out to become a midwife. She used to live next door to a midwife as a child and wonders if that '*sowed a seed*.' Explaining further, she says that as the daughter of a single mother, 'I *suppose I was quite interested in women's experiences of life and how being a woman could be different to being a man, and a lot of that was probably shaped by the fact that I was brought up in a one-person household by just my Mum, at a time when that wasn't especially common.'* Emma completed a degree in social sciences at university and when she graduated planned to become a librarian. However, her mum became ill and Emma moved home to care for her. She got a job in the area with social services and then joined their graduate programme to become a social worker. '*At this point I still hadn't thought of being a midwife even though I was interested in lots of things about it, when I really think about it, I think I just hadn't really joined up the dots. I think I saw midwifery as more of a science job than maybe it is and I was never into the sciences, so I just don't think it really occurred to me.'*

Emma's mother died not long before Emma had her first child, so she found becoming a mother quite difficult and felt she did not handle it well, *'I remember I had a little kind of brain of a thought, this is actually a really important job, people are being affected quite badly, and I can't be the only one, why aren't they doing this better?'*

Emma had a second child and met with a different consultant[11] than that involved with her first birth and she thought '*oh, there is another side to this, people can be doing this really well and they're actually listening to women and caring what we think about the services being offered*.' Following this more positive experience and a subsequent third child, Emma still did not consider becoming a midwife. However, when a friend asked her to be present at her birth to support her, she agreed, '*and that was maybe the beginning of a noticeable thought, that maybe I could do something related to this as a job*.' Other women started to ask Emma to be with them too and, eventually, she decided that if she was paying for childcare to enable her to do this then, *'I would actually be better doing it as a job.' S*o, she started to work as a doula.

When working as a doula, in the beginning, Emma did not think of becoming a midwife, *'I thought this is the best path for me because I've got autonomy and I don't have to make any decisions, I just support the woman with whatever she decides, even if it makes me nervous, even if I think she's doing the wrong thing, I don't have that responsibility that midwives do.'*

Emma recalls that she worked as a doula for several years, attending over 100 births and that she enjoyed it; her children were at school by then and she felt everything had worked out well. Then she started to think about her degree and what she had learned about social and gender inequalities. Emma tells me that, '*almost every single woman that I had supported* [as a doula] *had been someone who was in a position to pay me, who could speak English, who knew how to navigate*

[11] Consultant Obstetrician: RCOG definition available at https://www.rcog.org.uk/media/igqfguvs/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

the system, … I just kind of felt like, is this a good use of my time?' Consequently, Emma recalls deciding to apply to study midwifery and discovering it was the closing date for applications that day, so she felt as if it was '*now or never*'. She applied, was interviewed, and offered a place. Emma reflects that she thought, '*Okay, well let's do it, let's go,'* and goes on to confirm, *'I didn't really think of doing anything else, I don't see myself as doing anything else for the rest of my working life really, all my interests have come together, in one role.'*

Stage Two: The student journey.

Being a student was a '*mixed bag'* for Emma. She tells me that her experience as a doula meant she had already gained some experience of childbirth, albeit with women who were '*pushing the boundaries*' of what was acceptable to the local maternity services. So initially, being a student was quite frustrating, '*I kind of kept thinking, "when are we going to get to the bits that I think are important."' So, it was kind of odd I guess in the uni' context because I kind of felt I already know some of this, but also kind of, oh no, I don't know anything about that, help.'*

On placement, as a student, Emma was guarded about the parts of her story that had led her to become a midwife, '*I knew from experience of working as a doula that it was a very mixed bag, who was doing the work* [as a doula] *at that time, and how* [un] *ethically some people were behaving. If I was to tell my mentors that that's what I'd been doing then that it would initially set them against me, almost being wary of me and I didn't want that to happen.'* If ever directly asked Emma never lied about her background but thinks that because she has three children, people just assumed her motivation to become a midwife was related to her own experiences of childbirth. She tells me she thinks this is only '*partly true'* for her, but her motivation to become a midwife was not raised very often on placement. She recalls; '*that was one of the other difficult things about being a student midwife, not wanting to be seen as an individual really. I think the amount of stuff you do that you're just seen as one of the students, and ideally, people don't even know who you are.'* She describes

feeling anonymous for the first two years of her degree and she goes on to recall the few occasions where '*I sort of stuck my head up a little bit and it went really badly.'*

Emma tells me the story of one of the occasions when she questioned the practice of a midwife with whom she was working. It followed her observing a woman receiving conflicting feeding advice from several midwives, one of whom then made an inappropriate comment about the family's cultural background. Emma had challenged the assumptions that lay behind the cultural stereotype and did not think any more of it at the time, but then her tutor came the next day and the midwife involved made a point of finding the tutor and reporting Emma for challenging a member of staff. '*And I was kind of like, "wow," I thought all my intentions previously to say as little as possible and stay under the radar were all just quite correct really, because it was quite stressful in itself, so I think I just tried to stay safe as a student*.'

When she reached the third year Emma had the confidence to be herself more; arguing that she could not simply become an advocate for women overnight on the day she qualified, '*those skills [of advocacy] don't just magically descend*.' Emma also recalls that carrying her own caseload of women helped develop that confidence and how she was able to support one particular woman who did not want to have her labour induced, despite medical advice to do so. 'So *yeah, by the third year I think I had come to a feeling that it was okay to be yourself, you didn't have to shove who you were down everybody's throats, but there was going to have to come to a point where I was going to have to be honest about feeling maybe less happy with some of the stuff that goes on at work.'* She feels that it takes time to get to the point where it is okay to speak up; reflecting that sometimes, first-year students get it wrong when they start to challenge the status quo before they have built up the relationships needed to do so. *'It's not that they're wrong, it's just not a good way to start to build a relationship with anybody, is it, and there's obviously a whole heap of context that goes in circumstances that are happening in maternity care that, you don't really know about*.'

Stage Three: Choosing where to work.

Once qualified, Emma stayed at the same hospital where she had trained because she knew the dynamics, personalities, and policies. She was aware of the possible benefits of moving to another unit but felt that staying where she was '*chops out a lengthy period where you have to try and work out who you can go to for support, who's always going to always be against everything, it doesn't matter what it is, you know, where the kind of wriggle room is.'* She remembers a conversation with another midwife who thought she would start '*toeing the line*' once qualified using the threat of 'if *something happens, you'll regret it.'* Emma does not think that she did change and took deliberate steps to ensure this did not happen. She chose a preceptor who was an experienced midwife who had worked in many different settings and whom Emma viewed as practising defensively[12], avoiding risk. This midwife had been '*difficult*' with Emma when she was a student and had been surprised when Emma chose her. Emma recalls she wanted to understand her preceptor's approach to care because she was worried that as an NQM, she was '*slow on the uptake with some of the practical stuff*' and did not want to be closed to the risk factors that some women may have. She concludes; '*When we came to the end of the preceptor period, we had reached an understanding, she could step back and leave me- she knew I was safe, not the midwife for her, but a safe midwife.'*

Stage Four: Working as a midwife.

Starting her first year as a qualified midwife, Emma felt she was becoming the midwife she hoped to be, '*So, you know,* [the first year] *wasn't easy, but it also wasn't really, really difficult, I don't know if that is just because I was already immersed in the culture of that place and those people …. these environments can be quite manipulative, and I think sometimes it's difficult to know who's truly an ally and who's not, and where the support comes from.'*

About halfway through her first year as a midwife, however, Emma tells me '*Something did happen*,' as foretold by the midwife who predicted she would have to fall in line once qualified. Emma

[12] Defensive practice: fear of litigation in midwives and obstetricians driving clinical decision-making.

reflects that this has had a big impact on her practice going forward. She recalls that she was working a night shift on the maternity assessment unit and volunteered to go to the labour ward to care for a woman who was having her labour induced. '*So, I went to go and do that and the long and the short of it was this was a primip*[13] *being induced at 37 weeks with pre-eclampsia*[14]*, who had previously been low risk, and she had a shoulder dystocia*[15] *that was really significant, and the baby was born without a heartbeat, it took about 20 minutes to get the baby's heart to start beating again.'*

Because the woman had laboured quickly, Emma had been the only midwife looking after her. Emma tells me that she felt '*very responsible*,' and even more so when it transpired that the baby would have life-limiting brain damage. She recalls '*you know, we responded very promptly to what happened, but ultimately, it was my service user that night and I felt like, was there something I could have done better if I had more experience, did I miss a sign, that things were going to be difficult, and you know I obviously had to do a lot of kind of soul searching at that point.'*

Emma tells me that she went home in the morning and '*cried for hours*' and that the labour ward coordinator telephoned later to see how she was feeling and to say that she did not have to return for her shift the following night. Emma though felt that if she '*didn't go back then she never would*.' That night, Emma cared for another woman in labour and was supported by the coordinator who again checked on how Emma was; she recalls, '*It was really nice actually, I mean I had a lovely normal birth with this woman, and it was one of those babies that's all pink and trying to cry before it's even been born and everything was lovely and the woman thought it was just lovely because it was lovely, but she had no idea what it meant to me*.' Emma explains that the meaning for her '*was*

[13] Primiparous is the term used for those who are pregnant for the first time.

[14] High blood pressure caused by pregnancy.

[15] The baby's shoulders become wedged in the mother's pelvis after the head has been born. This is classed as an obstetric emergency as the oxygen supply to the newborn is compromised whilst the head is born and the body is not.

not about healing because the other baby and family were still hurt' but rather a reinforcement that she could '*make good decisions*.' Emma is tearful and still clearly upset at the memories that this event creates.

There was an investigation following the incident and Emma is aware that at that point it would have been easy to become more defensive in her practise because '*everyone's looking at it and discussing it, nearly everything they're talking about is about you.'* However, she tells me of an experience that she thinks helped her deal with the situation. When the baby was about six months old, the family returned to the maternity unit to discuss what had occurred during their baby's birth. A senior midwife who knew that Emma had been affected by the experience, asked Emma if she would like to be there, confirming that the parents had always spoken very highly of her. Emma tells me, '*I saw them with the baby and the baby was actually meeting some of her milestones, but more than that they were just happy that she had lived, they weren't actually putting any value on that she was going to have a learning disability…. So, you kind of think, well, we put a real judgment on something that it's a good thing or a bad thing* [if the baby survives]*, but you know, all those kinds of conversations really contribute to you feeling quite judged and pressured into behaving in certain ways and analysing your own practice and probably in an unhelpful way.'*

The outcome of the investigation did not find fault in Emma's practice; she was reassured to have the confirmation that she had done everything she should have done. Emma reflects, however, that the investigation '*doesn't change the fact that you know there's a family who've got a baby that's damaged.'*

Emma considers that her first year as a midwife was probably easier than some of her cohort but feels that the incident with the shoulder dystocia stood out. She summarises her feelings, '*I felt like I had to really think about who I was as a midwife and what I was going to do going forward and I decided that I was consciously choosing not to practice defensively'… In a way I think that* [the incident] *was a good thing for me, because it really like confirms to me that yes, I'll take all of it, we*

don't want any of these things to happen to people, but they will always sometimes happen and I'm making like an informed choice that this is what I'll do.'

Stage Five: Being a midwife.

Emma concludes the interview by telling me that she is now working on the continuity team providing care to women whom she can get to know in more depth. She describes challenging the organisational status quo as being much easier in the continuity team. She gives the example of a situation with a woman who was refusing to have the standard care offered, with no interventions or tests of any kind, and who wanted to give birth at home. The situation generated a great deal of debate within the organisation, and it was decided to ask for volunteers to provide midwifery care for this woman and her family. Emma recalls a conversation with a doctor at the time who had said '*God help whichever lunatic who agrees to support this woman'.* Emma tells me she replied, *'I'm covering the on-call for that woman and at the end of the day if it has a bad outcome, you know she's taken personal responsibility for that, we don't magically make things for the mum and the baby okay by being present…if this is the safest thing for her, then we have to respect that, you don't have to be comfortable with it, but you do have to respect it.'*

Working on the continuity team has made being a midwife easier for Emma because she has more autonomy to meet women's needs without the organisational scrutiny that comes with working in the hospital. She concludes that being a newly qualified midwife is stressful and from those in her cohort she knows the experience has been varied and left some wondering if they have made the right career choice. Emma however is confident this is what she will do for the rest of her working life.

4.3.3 Ava's story: 'I'm a better midwife now'

Stage One: Starting out.

Ava describes having had an interest in maternity from a young age and apologises for watching TV programmes such as 'One Born Every Minute'[16] when she was in year ten or eleven at school. She goes on to say that she thinks it was exposure to the role of the midwife in this way that made her explore it as a career path with her teachers. Ava recalls, '*I ended up getting the grades that I needed by probably some miracle, to get into Uni and then started in September 2014 as a little 18-year-old, thinking, "this will be great," and really had my eyes opened…It just wasn't what I expected it to be I think no matter what you think it's going to be when you actually get into it, it's not what you think it's going to be at all.'*

She continues by reflecting that the role of the midwife is different from that presented in the media and found in commonly held beliefs – she spent more time feeling she was a social worker or mental health nurse than she did a midwife '*which isn't a bad thing in an ideal world, but when you're actually out there as a midwife it makes it really hard work*.'

Stage Two: The student journey.

Ava describes the first year of being a student as '*not too bad,'* even though she had a difficult mentor during her first placement in the labour ward. Ava describes her mentor as a '*band seven*' and reflects that she did not really have the time to work with Ava as a first-year student. She goes on to say, '*but I feel that probably made me a much stronger midwife at the end of that than I would have been if I'd had someone who just let me, potter around… and it didn't feel very pleasant at the time, but I think that it probably did toughen me up a little bit and I probably did need that.'* Ava found the second year much harder as students have practice experience in non-midwifery settings, she spent two weeks in intensive care, '*and I still tell the story now, that every patient that I touched*

[16] A television documentary on Channel Four illustrating the work of midwives and the experiences of the women and families they care for.

on intensive care died. It was just really awful, one died while I was rolling him, it was horrible.' Reflecting again on those experiences, Ava felt that they helped to prepare her for dealing with death as a midwife [which occurs much less frequently than may be expected when working in an intensive care unit], and also to confirm that midwifery and working with healthy women was where she wanted to be.

Ava tells me that she '*loved the third year*' of being a student and the case-loading experience. '*I just found it so rewarding to have picked up those women and being able to look after them as families right throughout until they brought their babies home… that was probably the best part of my training, being able to do that, I absolutely loved it*.' She goes on to describe that she took on a large caseload of women and that it was challenging managing the demands of that '*but it was great, I wouldn't have changed that at all, it was absolutely fab.'*

For Ava, an important part of being a student was the long-lasting friendships that she formed with other students; relationships, she argues, based on the shared experience of being a student midwife and then a qualified midwife. She still talks with these friends almost every day, '*no one else understands what it is to be a midwife, and in some ways, I'd never want them to, because quite a lot of it is difficult and not very nice and I wouldn't want anyone else to have to feel with that about their day-to-day job'.* She summarises *'it's nice to have those people… who you know that they know exactly how you feel.'*

Stage Three: Choosing where to work.

Ava decided to move away from the northeast of England for her first job as a qualified midwife. The Trust where she moved to has an '*excellent preceptorship package'* which influenced her choice. She explains that her choice was also influenced by her fears about the responsibility of working as a midwife reflecting, *'where I trained* [the NHS Trust providing the student placements]*, they only offered me a six-month contract, which I just thought was just, that's no time, you're not going to have learned anything about being a midwife by then.'* She adds*, 'I would have constantly been*

worrying if I do something wrong am I going to lose my contract, and you're bound to do things wrong when you're a brand-new band five. So, I didn't want that fear hanging over me, so I went for the permanent contract.' Ava reflects that looking back, she thinks this was the right decision since the move took her out of her '*comfort zone*'. She was not known in the new maternity unit; there was no history as a student *'you were just a band five and you had to get on with it, that was probably quite good.'*

Stage Four: Working as a midwife.

Ava describes qualifying as a midwife as the '*biggest anti-climax ever,'* realising that she would not be going to university anymore. She recalls waiting for registration to be completed with the NMC so she could wear her *'blues*[17]*.'* Ava had moved 120 miles away from her home to a new job in a new maternity unit and says, '*that's when I suppose you really learn to be a midwife.'* Ava reflects that '*nothing prepares you for that first day when it's your name and just your name next to someone on a board, and it's all on you… you know that everyone that you're on shift with is there to help and you can ask questions, but you're the one in the room making that decision at the end of the day so those first few months were probably quite horrific.'*

Ava tells me that the preceptorship package was as good as was promised. She describes a broad range of experiences and that she got to do '*lots of different things that I probably wouldn't have done otherwise.'* The package lasted *'about a year'* which Ava feels was the right amount of time it takes to learn how to work as a midwife in an organisation. On completion, she was placed in the community for three months. However due to staffing problems, she was asked to stay and *'during that time I just decided that I didn't really want to go back in the unit full-time, I was band six by this point, so I did three days community and one long day on delivery suite a week, and it was a lovely mix, really nice mix.'*

[17] Blues here relates to the blue uniform (or scrubs) of a registered midwife as opposed to the white uniform worn by students.

Ava thought it was important not to be seen to be losing any hospital-based skills but also that she saw the community as an opportunity to learn new skills, for example safeguarding and managing a caseload which she was keen to get back to. Unfortunately, this period only lasted three months before Ava injured her back and had to go off sick for two months. When she returned, she was still using crutches so she '*was not allowed to be patient-facing.'* Consequently, she was given a range of alternate tasks to do, including risk management, audit, and training packages for new staff. She reflects, '*I already had my fingers in a lot of pies, I was organising Christmas parties, I was RCM secretary, did all sorts of different things, but I think being able to do that sort of broad spectrum of bits and bobs made me realise that you don't have to be clinical to be a midwife.'* Ava also comments on how these jobs are seen as '*cushy little office jobs*' and that she felt that there was a hierarchy in place about who would be next to get a job like that.

When Ava recovered enough to return to clinical work, it was to the community job she had before her injury. There, she worked with the person she describes as her '*work mum*' who looked after her and ensured she knew what she was doing. This person was very experienced and '*just the most wonderful human and I think if it wasn't for her, I would have left a long time ago.'* The supportive relationship was mutual; Ava describes how she undertook some of the activities that she was better at and how they shared the caseload well between them, '*she definitely made me a better midwife*.'

Ava is the first participant to raise the impact of the Covid-19 pandemic. When the pandemic started, her job as a community midwife *'was just like a wildly different job to what I'd left in the June before I'd done my back, in the space of eight months it had just totally changed*.' Ava explains that she found this hard, as working in the community meant drastically reduced contact with the women and many appointments were moved to video calls. Ava recalls that this was '*another step away from what it really should be*.' She says she became nervous that she would miss something and there were now long gaps between appointments when anything missed could be picked up. She describes an increase in workload too. '*We had a nice little baby boom as well, so we went from*

picking up two or three women a week to 15 women a week for a lockdown baby boom, and that teaches you how to be a midwife in terms of juggling your time when you're spending an hour doing a video call with each one of them, …. that was hard work.'

Following that, a run of '*really difficult things*' occurred one after the other and Ava recalls she '*didn't really have the chance to get over one before the next happened*.' The first involved a communication error with the IT system used by the community maternity service. Consequently, a home visit was missed, and a baby was readmitted to the hospital due to weight loss. An internal investigation was instigated. *'I put my statement and my reflection in on the Monday morning when I went back into work, no thank you for doing it quickly or over annual leave, or anything like that, and then never heard anything again.'* The baby was discharged without any further treatment, but Ava did not receive any feedback from the investigation, which she found difficult. Then a woman made a complaint about Ava following a telephone consultation in which Ava had had to involve social services in the woman's care. The complaint was not taken further; Ava concluded, '*it still doesn't feel great that someone's putting in a complaint and saying those things about you, you never want as a midwife someone to make someone feel that way*.'

Ava goes on to describe the final event in the series of difficulties. *'Two weeks later in my clinic, a woman told me she was suicidal, and she was on her way to buy rope on her way home to go and hang herself and I didn't get the appropriate support with that, and that was what tipped me over the edge into not being able to be an NHS midwife anymore.'* She tells me later in the interview that she had asked for help in the correct way for safeguarding crises such as these, but that the person she spoke with was inexperienced and provided the wrong advice. As a result, the woman absconded. She goes on to say, '*it became a massive incident, an issue, that carried on for days, and was a big ordeal and I just thought, I'm getting dragged through the coals, for trying my very best to get advice in something that I didn't know what to do*, *and I'm being made to look like the bad person.'*

The woman was found eventually and was safe, but the incident had a lasting impact on Ava who decided she needed to work somewhere else, where there was good support available. By this time, she had already applied for a non-NHS job and was interviewed to work as a midwife at a charity a few days later. She was offered the job immediately, but it still took a little time to work out what to do, *'I was worried I was going to be jumping out the frying pan into the fire, that it was going to be just as bad, no support, that I was going to feel just as stressed, and that all my days off would be consumed with worrying about what I'd done at work for the previous days.'* After discussing it with her partner, who was concerned about her mental well-being, she accepted the job and had been doing it for a few weeks at the time of our research interview.

Stage Five: Being a midwife.

Ava's new job is providing pregnancy advice and, although most of these appointments are also over the phone due to the Covid-19 pandemic, Ava does not feel scared by this in the way she did when providing maternity care over the phone. She feels much calmer now and she assigns this to '*being a different kind of midwife*.' Ava also tells me that she feels much more supported in this new job, knowing there is always someone at the end of the phone who can give her the appropriate advice.

Ava tells me that leaving the NHS '*felt like a massive failure. '* She explains*, 'I'd spent a really long-time training to be a midwife and then a really long time getting to be a band six midwife, it felt like I knew what I was doing in some respects, to then think, 'well it's only been three years and I've had enough.*' She adds that her ex-colleagues told her that she would miss her job as a midwife in the NHS and she agrees that they may be right adding, *'I'm not saying it's the ideal job, I'm not saying I'm going to stay with it forever*.' She still does work bank[18] shifts at the maternity unit but adds that for now 'I *just needed a break from that level of stress.'*

[18] Bank shifts are as required casual employment, often used to cover for sickness etc.

Working as a '*different kind of midwife,*' Ava tells me she is sometimes mistaken for a nurse since nurses make up 50% of the staff in her new job, *'I do get confused for a nurse quite a lot of time, which bothers me a bit, I didn't train to be a nurse.'* She enjoys working with her nurse colleagues however, and sees the strength of the different professional perspectives, '*it does feel like it's definitely broadened my midwifery spectrum quite a lot, probably a lot more things that I didn't realise were going to be so midwifery related that really are, and I think that's really quite interesting.'* She also feels that if she does return to the NHS as a midwife, she will have *'a whole different branch of skills that I could bring.'*

Ava concludes her story by saying that she still feels like a midwife and, in some ways even more so, *'I don't think I probably ever felt as much of an advocate for women as I do now. I'm able to be a non-judgemental, hopefully, friendly half face, with a mask on, that they come into the clinic and not feel like someone is judging them for a decision that they need or want to make*.' She also reflects that she wasn't able to provide the midwifery care to women that she thought she should within the NHS conditions she experienced, '*I think being able to recognise that made me a better midwife than I'd been…I wasn't in the right place for me or for them.'*

4.3.4 Sophia's story: 'I've just got to keep going.'

Stage One: Starting out.

Sophia begins by recalling a discussion about midwifery with her school friends when they were aged about 12. At the time she thought a 12-year-old wanting to be a midwife was *'a really weird thing to want to be*.' However, she describes how she always found pregnancy and childbirth fascinating '*I just found it quite magical… what an amazing thing to be part of.'* Sophia tells me that later she did consider becoming a midwife but that she '*never thought I was clever enough…. and was put off a couple of times at school*.' Instead, she made use of her artistic skills and went into design. When Sophia became pregnant with her first child, she attended a parentcraft class run by two midwives and she recalls, 't*hey were so animated, they were so knowledgeable, and they were*

so passionate, and I thought, 'wow, that's amazing.' She thinks this class '*sparked the light*' in her for midwifery but also that '*I kind of just parked it to one side and thought, I'm not good enough, you know, I'm not clever enough to do that, I'm not academic.'*

Sophia's experience of the maternity services as a pregnant woman was '*quite frustrating*;' she saw different midwives at each visit and did not feel she was being listened to. She describes the birth of her daughter as '*a really quite horrible experience*'. She reflects that it was not, she now realises, an unusual birth, an induction[19] followed by poor pain control, a forceps delivery,[20] and a postpartum haemorrhage[21]. But experiencing it, she '*found it really traumatising and I didn't feel supported, my concerns and feelings weren't acknowledged, I was left alone quite a lot of the time, I was quite frightened, and we just weren't informed of what was happening.'* Sophia shared more of her personal story with me, and how she felt the lack of care and support she received had impacted her relationship with her daughter. She was disappointed that the '*amazing event*' depicted by that the midwives in her parentcraft class had not happened and reflects, '*I kind of felt then, it was ridiculous, I had a duty to make sure other women didn't go through what I went through, and I wanted to be that midwife who gave that care that I didn't get*.'

Once back at work following maternity leave, Sophia thought, *'you know what, I'm done, [with her job as a graphic designer]. I thought "I'm going to make a difference"*.' She enrolled in a Higher Education Foundation Course [HEFC] at college and applied to study midwifery at university. Her first application was unsuccessful, and she recalls that the teachers at the college told her, '*you'll never get on, it's very rare, you've got to be a saint to get on that course, why are you even bothering trying*?' Sophia's HEFC class was full of other students whom she describes as, '*midwife wannabes*' all also wanting to make a difference. She continues, '*I thought, how can I stand out amongst all*

[19] Use of artificial hormones to start labour via an intra venous infusion (IV) or drip.

[20] Use of metal instruments applied by a doctor to assist with the birth of the baby's head.

[21] Excessive blood loss following birth.

these other applicants? So, I went back and re-looked at my skills and looked at other things I could do to help me get on the course. That drive and that determination never left me.' Sophia recalls, that as part of her effort to improve her application, she was able to organise some work experience with a midwife whom she describes as a role model even though they advised her against a career in midwifery. This advice did not put Sophia off; she thought she knew from her own experiences what the reality could be, so she applied again to study midwifery and was successful the second time.

Stage Two: The student journey.

When I ask her to clarify her time as a student, Sophia recalls that the experience was very dependent on what kind of mentor she had. Some, whom she describes as nourishing her aspirations, were *'brilliant'*; 'I *was able to grow and to learn around them*.' Others, made her fearful of midwifery; such as the mentor who on Sophia's first day in a new placement area said, '*why do you want to be a midwife, why are you doing this, do you know that you're putting your health at risk, you're putting your livelihood at risk, you're putting your house at risk, you can get sued and lose everything.'* Sophia did not find that attitude helpful but tells me that she came across it frequently. Nevertheless, by the end of the first year, she tells me, '*the first year ended on a high, it was like everything I was expecting and then I felt really positive, and I still had that drive*.'

By the end of the second year, Sophia reflects that her enthusiasm '*was kind of starting to wane a little bit, I think because I'd just had a bad experience with a mentor*.' She recalls that as she continued into year three, she had hoped for things to improve with the case-loading experience. The reality of year three was different, '*I think I found the responsibility really hit me then and I had a couple of mentors who really focussed on defensive practising…. it put a bit of a downer on my experience in third year.'* Despite this, Sophia says that she remained determined; confident that once qualified, she would be able to '*be the midwife who I want to be, rather than trying to meet other people's expectations of what they feel a midwife is*.'

Reflecting on her time as a student, Sophia felt that the course had, '*bettered me in many ways that I am very thankful for and couldn't imagine*.' She adds later that '*it took me a long, long time, I don't know, to mend, to recover from the birth of my daughter, but I did find actually doing midwifery and becoming a midwife helped heal a lot of those wounds.'*

Stage Three. Choosing where to work.

Unlike the other participants, Sophia does not say why she chose where to work as a newly qualified midwife, although I know from the conversation at the start of the interview that she has stayed where she was placed as a student. Within her story, I can hear that, in many ways, she still considers herself a student on the periphery of her workplace and, in the next part of her story, she describes the challenges that brings.

Stage Four: Working as a midwife.

Sophia tells me that working as a midwife is '*bloody terrifying, really scary'*, and that she did not feel prepared. '*The unit that I'm working in is very high risk, and I don't feel that* [the midwifery programme*] it's prepared me for that high-risk side of things, the very fast pace of the environment, the responsibility, the ownership, the scary side of thing.'* She reflects that had she spent her first few months in the 'low risk' birth centre, she may have felt differently, as she feels the degree programme prepared her better for that approach to care: '*Maybe I was a bit naïve, but I didn't feel prepared enough for what I was being led into in some ways. I know a lot of newly qualified midwives feel totally out of their comfort zone, and you know, that's when you start to learn, you start to learn on that job*.'

Sophia completed her initial preceptorship but then had a period of sickness followed by maternity leave. She felt that the pregnancy, although planned, was not well timed for her development and confidence as a midwife; she tells me that the other midwives expected her to know more than she does. While she was on leave, no one from the Trust contacted her and when she arrived on shift for a 'keeping in touch' day, no one knew who she was or why she was there. '*I felt like I had to*

make people aware that I only did a few weeks before I went on maternity leave, and I've been off and then I've just come back, I really don't know what I'm doing, I had to justify my lack of confidence and skills.'

Sophia provides examples of the tasks or skills she lacks confidence in which she describes as '*the nursing side of things*.' She describes her experience when asking for help with a blood transfusion; recalling that the midwife involved, '*came out of the bay…. in front of everyone, you know, the midwife station and visitors and women and told me off publicly and said, "you know next time why you don't try and figure it out yourself before you come calling for help".'*

The hospital environment where Sophia works is high risk and the women and babies that she cares for often have medical problems. There is frequent input from the medical staff and sometimes, she feels she is just there to follow instructions and give out medicines which Sophia says feels more like a nursing role than a midwifery one. However, she can still identify moments when she feels like a midwife. These moments are when she can be 'with woman'; '*It's just you, and you know when they get really frightened and scared and you just try and comfort them, you know you're just there for them, even if you're just holding their hand*.'

Being with women and a shared female experience is also part of the relationship that Sophia describes as having with her work colleagues. Most of the medical and midwifery staff are female and Sophia finds that '*an empowering experience*.' She talks about listening to an all-female discussion at shift handover, where the focus is on getting the best outcomes for the women who are in labour that day. '*I'm just in awe of these people that I work with and that's I think another one of my drives that keeps me going because I want to be part of that, that culture in that environment and I want to be like that as well.'* Sophia describes how, unlike her previous example with the blood transfusion, these colleagues make her feel safe; they don't seem to be scared of anything and if she has a problem, they walk in quite calmly and fix it and she doesn't feel judged.

Stage Five: Being a midwife.

At the end of her story, Sophia reflects that she often doesn't feel like a midwife '*because I'm still transitioning*' and '*because I have had so much time off*.' She says '*I feel like I'm letting myself down, I'm letting the women down because there's just, it's just so hard, mental wise, very hard, very rushed.'* She tells me that can't give the care that she would like to; she tries, '*but then you've got a band seven on your back saying, "well this woman, she needs to get to postnatal, and why are you still here, why are you still giving her breastfeeding support? She delivered two hours ago".'*

She tells me that her experience as a newly qualified midwife did provide opportunities to '*be the midwife you wanted to be*,' without '*someone looking over her shoulder and questioning her practice*.' Sophia uses the example of pain relief in labour and explained how she aims to apply the evidence she learned about as a student, rather than comply with the organisational norms, which she describes as '*running straight for the anaesthetist*.' Sophia again reflects on her own experience and how pain relief for her own labour was poorly managed. Now she is qualified, she always takes time to talk to women about pain relief and how they are feeling, 'so *that's been good once I've been qualified because I've been able to, I don't know, find my own way.'*

Sophia explains that she still has not lost her drive to help other women avoid the experiences that she had giving birth and it was this drive which makes her go to work every day and face the challenges involved. I ask Sophia to tell me about people who have influenced her as a midwife, and she recalls the midwife with whom she did work experience with at the start of her journey, describing her as *'a bit of a role model*.' She compares herself with this midwife, explaining that, '*I think after the years went by, she realised that maybe the hospital environment wasn't for us, so she went to the community and is doing really, really well in the community*, *it's seeing other people like that, who may be found the hospital environment quite difficult, and they've gone onto other areas and are having better experiences, which is why it's kind of, I still feel like 'oh, I've just got to keep going, I've got to keep going.'*

Sophia tells me that she feels much more suited to community midwifery and feels that she would '*thrive in that environment*.' At the Trust where she works, however, only band six midwives can work in the community and achieving that has taken '*so much longer than anticipated*.' Sophia says she will keep trying and is hopeful that a move to the birth centre or the community will allow her to be the midwife she wants to be, '*I'm finding the reality of midwifery is kind of not what I expected, ... so yeah, I'm fine.'*

4.3.5 Mia's story: Completing the Circle

Stage One: Starting out.

Mia recalls that she was about 16 when she first thought about researching the role of the midwife. She liked the fact that '*you could get close with families and communities without having to care for sick people, I really liked that aspect of it.'* She knows some people experience '*a certain event*' or '*have children or something*' which inspires them,' but for Mia, 'i*t just sounded an interesting job.'* She tells me that she did not think she had the academic skills to study medicine, but she did study science 'A' levels which she felt helped her in becoming a midwife. School told her that midwifery was a difficult course to get onto, so she did not think she would be accepted the first time she applied, but she was so thought she would '*give it a go and see what happened*.'

Stage Two: The student journey.

Starting at university meant moving away from home aged 18; Mia found that hard and describes the experience as '*very up and down*' as she was homesick. She tells me, '*I had good support around me from my cohort, you know, I have a friendship group now that I still speak to on a daily basis, there's probably four of us that are still really close, and we support each other a lot*.' Mia found the academic work at university a challenge too and a '*big jump'* from school. She reflects, 'y*ou were still working the hours that your mentors would work, but also you were* [completing] *all your placement outcomes as well as assignments, exams.'* There were times when '*it came to a head and we just thought, 'well, why are we doing this*?'

Mia moved into a shared house with her friendship group in the third year and recalls, '*I think that helped us through as well because we were all in the same position, we were on night shifts, we understood what nights were like, and we could discuss things if we'd had a hard day, and it just made that last bit of it easier.'*

Mia describes approaching the first year positively as a fresh new student and the second year as being more difficult. *'There were positive parts to it that I really enjoyed, you know I liked the placements. I met some really good midwives who taught me lots of different skills.'* Mia describes the range of placements she experienced, telling me '*I'm grateful for that, it has stood me in good stead*.' She describes the second year as being '*stuck in the middle'* and the third year as hard, *'but actually, you've got something to work towards, and you know, you're thinking, "I've done two years of this now, come on, I can do it", and I think that's what got me through it really.'*

Stage Three: Choosing where to work.

Even though Mia *'loved'* the maternity unit where she had trained, she decided to move back home with her parents to save money as she planned to buy a house. She did an elective placement in the maternity unit which was closest to her parent's home and applied for a midwifery post there. She tells me that '*I did apply for the Trust that I trained in, just because, you know, I wanted to keep my options open just in case.'* She reflects *'I don't really know why I didn't apply for any more [jobs] because there were more around, but I just thought I'd start with them two and see how it went.'* She was offered the midwifery post near her home and accepted it.

Stage Four: Working as a midwife.

Mia started work in the October after she had graduated and was placed in the community for ten months, which she describes as being a make-or-break experience. 'I*t was quite hard, you know, you're on your own a lot, whereas in the unit you've always got people to ask questions you're never alone really.'* On reflection, Mia, says that it helped her decision-making skills and that she thinks that the Trust still places NQM in the community for that reason.

Following the first ten months in the community, Mia moved back into the hospital onto a post-natal ward expecting to be supernumerary for four weeks, but '*that didn't happen'* as the ward manager thought she had trained in that unit and '*knew how everything worked*.' She describes this as overwhelming, particularly since she had been comfortable in the community, *'I remember thinking after my first week on there, "oh, this is hard", and it was just a lot of pressure and because I was included in the staff numbers, I felt like I was letting other members of the team down, I couldn't be as independent, and I wanted to be.'* After another ten months on the ward, Mia was ready to move to the labour ward; she felt anxious about it but knew that this was the setting where she needed to develop skills. She tells me that she could not help but compare herself to her friends who had been qualified for the same length of time and had spent time on the labour ward since qualifying; '*I know I'd got different skills that they'd not had, but I was just waiting to go.'*

Mia cannot describe how it feels to work on the labour ward as a newly qualified midwife but gives some insight, telling me '*you sort of drive in and you think, "oh, my gosh, what am I going to have, you know, who am I going to care for" …I just remember that feeling and I think there's still a part of you that gets that now, even down the line, no matter how sort of experienced you are.'* She tells me that many of the women where she works have multiple complex medical health care needs which contribute to a feeling of '*the unknown*' when at work. After about seven months, Mia says that she did start to feel better about going to work and that by that time she had also been moved to the birth centre which cared for low-risk women with no complications or medical health needs. She reflects, '*looking back on it I really appreciated being on labour ward first, because I'd learned more about, complexities and high-risk inter-partum care, and so when I was caring for low-risk women I could easily identify when they were becoming high-risk and I had better relationships with the labour ward co-ordinators and the doctors. I sort of came into my own a bit and I thought, oh, you know, I like this.'*

There was more time to care for women in the birth centre and also more time to complete skills such as perineal suturing which Mia needed to complete her preceptorship and progress onto a band six grade; she reflects, *'I was seen [*by others] *to [*be*] becoming more of a midwife.'* She describes how she was already a midwife '*on paper*,' but now she was able to make her own decisions about care for low-risk women, she felt '*fully-fledged*' and she was enjoying being a midwife. She went back to the post-natal ward after that for a few months, then joined a continuity of care team based in the birth centre with the plan that she would not be moved again. Mia confirms *'I'd done quite a lot of rotations, and it's hard because even though the teams are nice, and you build some good relationships, you never fully feel part of the team, because you're always sort of waiting to move and I think that affects your confidence a bit …whereas if you're there long-term you can settle down a little bit more and I think that's what I was craving, feeling part of a team.'*

Mia tells me that when the Covid-19 pandemic happened, it impacted her and the other staff hugely. There was more unplanned movement between wards and units due to staff shortages and requests to work extra shifts were put out frequently on social media. Mia continues, '*so you're already building up this anxiety of, oh this is probably going be a difficult shift, I don't know who I'm working with, I don't know if I'm working with anyone, I don't know if I'm going to be moved*.' Mia recognises that this could not be helped and also that her experience since qualifying meant she was '*easily moved*' but it still left her feeling that she was '*just a number to them, and then they'll just put me where they need me - you just didn't really feel valued.'* Mia reflects further that as the initial pandemic wave settled down, she was moved less and that this enabled her to feel more part of the team at the birthing centre; '*I think this has helped actually, being part of a team because I know where I am now, I know where I'm based*.'

Mia tells me that '*there have definitely been some bumps along the way*.' I ask her say more about these, and the incident she provides the most detail about, happened not long before we conducted the interview, and involved a woman at the birth centre who was being cared for by another

midwife. At the time, Mia was the most senior midwife in the birth centre [still a band six but the longest qualified] and she went in to help at the time of birth. The baby unexpectedly required full resuscitation and then active cooling[22] and subsequently '*had a really, really bad outcome.'* Mia reflects that this most recent incident has had more of an impact on her because '*I was the midwife who had been qualified the longest, so I think that's why it hit me hard as well because I was like 'should I have done anything else to help that midwife, you know, could I have done anything different, could I have asked if she was okay.'* She remembers coming home from that shift feeling that being a midwife was '*just far too much responsibility*' and being unable to stop thinking about the family of the baby. Mia tells me that an investigation is ongoing and that it remains fresh in her mind: '*It's just crazy how much it does affect you, and no matter what level you're at, you know, the band seven that was working with me that evening* [on the labour ward next to the birthing centre] *is really affected by it as well*.' Mia reflects that it will take time to move on from the impact of the situation, *'I think I said to someone quite recently, it's almost like you're sort of waiting for it to happen again, and you just think, "well if happens again I think that'll tip me over the edge." It's trying to get out of that mindset because you can't think like that, … I think I've just started to accept that I can only do what I can do. Really, that's all you can do, isn't it?'*

Stage Five: Being a midwife.

Despite the above, Mia feels that working in the birthing centre though has made her a more rounded midwife. The continuity of care project means that she has a small caseload of women whom she gets to know, and she can manage her workload around their needs. On working with a smaller group of women, Mia reflects, that *'well I've seen this woman antenatally, I've been able to deliver her, I've been able to suture her if she needs it, and help with feeding and anything like that, and then I've seen her at home…you can see the outcome straight away*.' Equally, Mia is realistic about the future and recognises that due to the Covid-19 pandemic, things may get busier again, and

[22] An intervention to reduce brain damage in babies who have been starved of oxygen at birth.

'*there'll be more bumps along the road because it's a new team of continuity so it's sort of adjusting.*' Overall, her role currently is letting her be more of the midwife she wants to be; *'I'm able to practice how I want to practice.'* Mia says that '*some people flourish on the labour ward and you know, that's their environment*.' She reflects that her '*idea of being a midwife*' is not about moving women through the system quickly, as is called for on the labour ward. For Mia, being a midwife means spending time with women, giving them options, and providing all of the care they need, '*so you feel like you're sort of completing the full circle so it's, about that job satisfaction really.'*

4.4 Conclusion

The stories of the five participants in this narrative inquiry have been provided to capture the whole experience of each individual and to provide the audience with rich detail about the setting and context (Ollerenshaw & Creswell, 2002). Each story presents the complex and individual process of *how* each became a midwife. The use of the genre of a journey to structure the stories has highlighted the impact of a traumatic event (or series of events) on becoming a midwife and adds to the existing literature on transition into professional practice. The origin of identity as a midwife is illustrated in the motivation to start the journey with an idea of what the practice of midwifery entails [or should entail] and how that aligns with personal values and aspirations. Being a student shines a light on the possession of graduate skills (Holmes, 2013), when organisation and time management are evident in the stories. Acquisition of midwifery-specific skills is also evident but, as argued by Holmes (2013), these are dwarfed by the narratives describing relationships with other students and mentors. The stories break at the point each interview ended, and with the version of a midwife each participant described themselves as being at that time. The next chapter presents, as described in Chapter Three, an analysis which enables further consideration of the research questions in terms of the archetypal features of the stories, how they are constructed and what this illustrates about the employability perspectives of possession, position and process.

Chapter Five: The Quest.

5.1 Introduction

This chapter develops the analysis further drawing the stages from each individual story together within the plot framework of an archetypal 'quest' story as described by, for example Frank, (1995) and Steiner, (2015). I present the stories using the archetypal structure of a quest, taking the stages identified in Chapter Four, and creating a further analysis of the stories, identifying the plot elements which occurred within and across the individual stories. The use of the participant's pseudonym and the development of their stories through the stages is intended to allow the individuality of each participant to remain.

5.2 Story Archetypes

I framed the stories constructed and presented in Chapter Four as a journey from 'starting out' to 'becoming a midwife'. Pivotal within how the participants constructed the stories was the role of a traumatic event and this led me to consider what type of journey [or story] the five stages represented. The metaphor of a quest is used widely in literature and reflects the work of Joseph Campbell who, in 1949, described the 'universal journey of the hero' (Hambly, 2021). In an archetypal quest, the first stage of the journey is the departure which is characterised by 'the call' or recognition that something must change. The 'call' may not be heeded initially, but eventually the hero must respond and cross 'the threshold,' initiated into a new world (Frank, 1995). Initiation is described as a 'road of trials' facilitated or impeded by various characters until a final ordeal is faced and transforms the hero providing new insight or abilities which equip them to 'return' (Frank, 1995; Steiner, 2015). Using the archetypal characteristics and plot elements of a quest story, I mapped the stages described in Chapter Four as illustrated in Table 3 overleaf. The analysis of the 'what' within the stories, as described in Chapter Three, supported the development of the plot elements of this quest to become a midwife within and across the participants' stories. These elements are illustrated in Table 3 also.

Table 3: The journey as quest

The Journey	The Quest	Plot Elements
Stage one: Starting out	The call	Midwives Women Representation Access
Stage two: The student Journey	The threshold	Being Prepared Mentors and fitting in Companions
Stage three: Choosing where to work	The crossroads	Stepping out The welcome Being seen
Stage four: Working as a midwife	The road of trials	Initiation Working and Learning The ordeal Participation
Stage Five: Being a midwife	The return	Loss and acceptance A different kind of midwife Organisational tasks Role models With woman

When I was considering the journey to becoming a midwife as a quest, the point of threshold was a challenge. It could be argued that there are two 'callings'; one to become a midwife and the second where best to be employed. This stage of the journey was also the one I was less familiar with and, when listening to the stories, it was part of the analysis that led me to present the experiences as a journey with stages. Consequently, I added in the 'crossroads' as an archetypal feature of the quest to become a midwife.

5.2.1 Stage One: The Call

There was not a single shared experience that led to the start of the participants' journey to become a midwife. However, analysing the narratives from the perspective of the motivation to undertake a journey creates an opportunity to see some shared elements that contribute to the process of becoming a midwife. For the participants in this inquiry, the journey can be crafted to illustrate a set of inspirations and expectations that enabled the start of their journey. What is shared is a desire to make a change and find a way into a world that aligns with their values.

Midwives

Three of the participants were mothers themselves and had experienced the work of midwives and maternity services first-hand. For, Olivia and Sophia, these experiences influenced their intent to become a midwife and initially, midwifery was seen as a more interesting occupation than the one in which they had found themselves in. In her story, Sophia describes how she had always thought of pregnancy as '*quite magical'* and that the midwives she met during her first pregnancy '*sparked her interest;'* however, she did not feel she was academic enough to study midwifery, so she did not pursue the idea.

Olivia, too, was inspired initially by the midwives that she met when pregnant. She begins her story by saying that she went to university to study a science subject and that she had '*no idea*' about what she wanted to do for a career. Then, when pregnant with her first child, Olivia describes how interesting midwifery seemed when compared to her '*boring*' job as a project manager.

Olivia and Sophia shared the experience of being employed in a job that they did not enjoy, and midwifery presented itself as a way out of that world and into one that held more interest and meaning. For both women, what finally motivated them to step out on their journey to becoming a midwife was their shared personal experiences of midwifery care when giving birth. When reflecting on her first birth, Olivia recounts care that was not what she expected; she wasn't listened to and thought '*I could do that better.'* Olivia went on to have another baby and had a very different and more positive experience with a midwife she later describes as the hero in the story of her journey to becoming a midwife. This experience confirmed Olivia's decision and she decided that midwifery was '*what she wanted to do for other people*.'

Sophia describes the birth of her first baby as a '*quite horrible experience.*' Her story also reflects her acknowledgement that what happened to her was not that unusual or remarkable, illustrating her disappointment that the midwifery care she had been prepared to expect from the first midwives she met did not materialise. This contrast between expectation and reality then motivated Sophia,

as her story illustrates, from a sense of '*duty*' to prevent her experience from being repeated with other women.

Both Olivia and Sophia were inspired to become midwives because of their personal encounters with maternity services and the positives and negatives that they experienced. Olivia moves to position herself away from that narrative in explaining it was not just because it was happening to her but rather because it appeared as an interesting alternative to her '*boring'* job. There is also a desire to change jobs in Sophia's account, but both stories illustrate exposure to the role of the midwife as a pregnant woman and, in particular, exposure to care that did not meet their expectations as something which inspired a change in direction.

Women

Emma also told me that she is a mother and within her narrative, her personal experiences of maternity services led her to reflect on the value of midwifery and wonder '*why aren't they doing this better?*' However, unlike Sophia and Olivia, Emma viewed midwifery as something that other people did and so did not consider becoming a midwife as a result of her personal experience of maternity care. This remained the case when she found a more inspiring professional in the form of the consultant involved in the management of her second pregnancy. Her story reflects her recognition that care could be done well. For Emma, as for Olivia, that meant being listened to.

Even as a social sciences graduate working as a doula, Emma did not '*join the dots*' on her path to midwifery. Her story illustrates her rationale that being a doula was the '*best path*' since it delivered her the autonomy to meet women's needs without the professional responsibility of being a midwife. As she became more experienced as a doula, she began to question her own argument and asked herself *'is this a good use of my time*?'

Emma's story positions her 'with women' from the start and illustrates an awareness of the practice of midwives without any desire to become one until she finds her egalitarian values being

challenged. The challenge to personal values in Emma's story may be explicit but the expectations of care held by Olivia and Sophia that were [or were not] met, also reflect values about the care women should expect to receive. Both stories evidence an argument that women expect midwives to listen to them, provide support, keep them informed and be present to provide care that is safe and compassionate. Expectations that closely mirror the professional and organisational values expressed by the NMC and the NHS. In seeking employment as a midwives, Sophia, Olivia and Emma seek to align their personal values with suitable employment.

Representation

In contrast to the varying engagement with either pregnant women, the maternity services, or midwives that inspired Sophia, Olivia and Emma,' Ava and Mia share the experience of studying midwifery straight from school and, by their own accounts, had scant experience of the maternity services they could draw on. Ava's story illustrates the fascination with media representations of childbirth that many young women articulate; perhaps reflecting gender norms in a society where exposure to childbirth in the home or family setting is limited (Morris & McInerney, 2010). Ava describes herself as a '*little 18-year-old*' whose expectations of midwifery were '*not what you think it's going to be at all.'* She explains her realisation that the role of the midwife is broader than that portrayed by the media; for example, in TV documentaries, and highlights the skills required of social and mental health workers as being of relevance to the practice of midwives.

Mia's story reveals that she did not consider becoming a midwife until she was about 16, having dismissed medicine as too academic. Her school also warned her that midwifery was a difficult programme to secure a place on; Mia was not put off, motivated by the expectation of an interesting role where '*you could get close with families and communities.'*

Mia recognises that she does not have the personal experience of childbirth that people often expect of midwives. Nevertheless, her recognition that midwifery would enable her to work with women and families illustrates a shared value base with Olivia, Emma, and Sophia. Ava perhaps

stands out at this stage as being the least aligned with the woman centred and relationship-based values required for being a midwife (ICM, 2014). However, as the stories of all participants unfold, the frustrating dynamic between professional values and organisational reality becomes a shared experience for all.

Access

Within the participants' stories, the narrative of the difficulty of obtaining a place to study midwifery is a shared experience. For example, Ava is warned by her school of the challenges in doing so, and the way that Olivia describes her success at gaining a place as '*lucky,*' shows an awareness of the hurdles aspiring midwives need to negotiate. Mia was told that midwifery was a difficult course to get onto and she did not think she would be accepted the first time she applied, so when she was, she thought she would '*give it a go and see what happened*'. Emma also describes a 'now or never' fatalistic approach. Integrating luck and fate into the stories of their journey to becoming a midwife possibly illustrates an attempt to minimize their own achievement or maybe reflects a common plot line in stories about becoming a midwife when so many applications do not succeed.

Sophia does not share the experience of being successful on her first application to study midwifery; her story reflects the message from her college that '*you've got to be a saint*' to succeed. Sophia reflects on her peers, whom she describes as '*midwife wannabes,*' all also wanting to make a difference for other women. Sophia does not construct a story around luck or fate and is clear about how she actively moved away from the mass of 'wannabes' into someone who stood out and was accepted to study midwifery.

Summary

The participants' narratives illustrate 'the call' or start of their journey to becoming a midwife. The 'mother as midwife' narrative features in all of the stories as participants position themselves variously around that starting point. Expectations of the role of the midwife based on personal experience, media representations, and research, feature in decision-making about starting the

journey as does the recognition of a large number of '*midwifery wannabes'* versus the much smaller number of available places. Consequently, all except Sophia, play down their success, possibly reflecting some gendered constructions of self-confidence. The stories also, however, illustrate a quest to align personal values with paid employment, and with the identity of a midwife which is recognised as being 'with women'; thus, as Sophia describes, the start of the process to become '*the midwife I never had*.'

5.2.2 Stage Two: The Threshold

This stage of the participant's journey accounts for the time between their successful application to study midwifery until their graduation. This student journey represents 'the threshold' over which they must step but it is not a simple fit as this stage also holds trials to be overcome as students and features those who will facilitate or impede their onward journey.

The participants were now sharing the common experience of being a student, studying, and being on placement in one of three local maternity units. The younger participants, Ava and Mia shared the experience of stepping out into independent life away from the parental home. The stories in this stage reference the shared plot elements reflecting social position; the relationships with their mentors and the other staff they met and how this shaped their onward journey. There is little in the stories about the university-based experience of being a student and this possibly reflects the situated-in-practice nature of the 'learning' that occurs. Consequently, relationships with university academic staff do not feature in any of the stories.

Being prepared.

Within the stories, there are narratives that capture how prepared [or unprepared] each participant felt they were to study midwifery. Olivia's story illustrates the value of her previous graduate skills and employment experience, in particular, her ability to manage her time and organise herself effectively.

When describing one of her mentors, Olivia highlighted that the personal similarities that they had meant they worked well together. Time management and organisation made the list, illustrating the value that Olivia placed on these skills within midwifery practice and why they are included in the construction of her story.

Ava and Mia, who did not have any substantial employment skills to fall back on, found the course more of a challenge. Ava feels, however, that she rose to that, especially in the third year when she describes her case loading experience as '*probably the best part of my training.'* It was demanding but she learnt to manage her time and organise the care for the women in her caseload, developing skills that would prepare her for employment.

Mia found the academic work at university a challenge too and a '*big jump'* from school. Her story reflects the narrative of having to manage both a university degree and the hours on placement required for registration with the NMC. However, her experience of the final year as a positive one is shared with Ava, and she also describes rising to the challenge of the final year and focusing to complete her studies.

Within the narratives, the demands of studying to be a midwife and the need to manage time and self effectively are evident both in the skills that the participants brought with them and also in the ones that they developed through the programme. Having, or developing, the skills to manage 'self' in work situations may also have aided 'participation' in the placement 'communities' the students were placed in. Other transferable attributes, such as a knowledge of science, appear in the first stage of the journey as a consideration but do not reappear when the participants construct their experiences of being students.

Emma had the most relevant previous employment experience having attended over 100 births as a doula. Her story illustrates that as a doula, she often worked with women who were '*pushing the boundaries'* of what was acceptable to the local maternity services. She argues that her previous

experience is a source of knowledge she can bring with her whilst also recognizing how this needs to be situated within the new unknown context of midwifery.

Mentors and fitting in.

All of the participants shared the experience of working with mentors as this was a regulatory requirement for pre-registration midwifery programmes at the time. The relationship with mentors described within the stories varies, as does the impact that they have on each participant's journey. Sophia is clear in her story that her experience on placement was very dependent on her mentor. Describing some as *'brilliant,'* creating nourishing relationships, and some who made her fearful. She includes a narrative which describes a mentor challenging her aspiration to become a midwife, recalling the words, 'w*hy do you want to be a midwife, why are you doing this?'* The recollection and construction of this negative mentoring relationship within Sophia's journey may simply have reflected her state of mind at the time when the story was told. Or it may indicate her surprise at meeting midwives who expressed this view quite so explicitly to the students whom their organisation had asked them to mentor and support on their journey to becoming a midwife.

The other participants also had varied experiences with mentors, but they construct the experience differently in their stories. Mia describes her relationships with mentors as a helpful part of her student experience, '*I met some really good midwives who taught me lots of different skills.'* She confirms that the range of placements and skills she developed with her mentors '*stood me in good stead*' for her future journey as a midwife. Ava, too, recognizes that the experience that she had with her mentors, even those she describes as '*difficult,*' had a positive impact on her journey making her a '*stronger midwife'*.

Emma describes her relationships with her mentors differently, and her story illustrates her awareness of the need to fit into the practice of her mentors which she perceived to be '*set against*' her previous employment as a doula. The narrative in Emma's story describes the assumptions she thinks were made by her mentors that, as a mother of three, her motivation to become a midwife

was related to her own experiences of childbirth. In allowing her mentors to do this, Emma was protecting the relationships she knew she needed to establish if she was to succeed as a student midwife. Additionally, Emma describes the ideal situation of people '*not really knowing who you are'* and the consequences of challenging the practice of a mentor. Her narrative concludes by noting that in order to feel safe as a student it was necessary to '*say as little as possible and stay under the radar.'*

In Emma's story, the place of the student within the organisation becomes evident – to be *not* seen and not heard. Even with her previous experience of maternity services as a mother and a doula, Emma found this aspect of being a student surprising; the ability of the organisation to quell dissent and maintain the status quo. Emma does not give up completely though and when she makes it to the third year, as with Ava and Mia, her confidence increases as she takes on her own caseload. Her story illustrates her growing confidence to '*speak up*' and '*be honest*' with others about the values that had brought her to midwifery originally.

Olivia too, as an experienced manager in previous employment is surprised at the organisational '*politics'* that need to be negotiated and is frustrated that her mentor acted to '*shield'* her from the hierarchical dynamics that operate between 'band six' and 'band seven' midwives. The relationships of all the participants with their mentors demonstrate the challenge of negotiating a place within a complex social environment, made more so by the transient nature of practice placements.

Companions

For Mia, starting at university meant moving away from home aged 18. She found this difficult and describes the experience as '*very up and down.*' Her narrative reflects the value of the relationships she established with other students in her cohort, noting that they '*were all in the same position.'* Mia's experience is mirrored by Ava, who was also 18 when she started the midwifery degree. Ava describes her friendship group as being built on the shared experience of being first a student and then a qualified midwife. Her story articulates the uniqueness of being a midwife and her desire to

protect those who are not from some of its challenges. She relies instead on her friends because *'no one else understands what it is to be a midwife.'*

The older participants, Olivia, Emma, and Sophia did not include the role of friendship groups in their stories, either as students or later. Ava references her partner later in her story who supports her change of employment and while Emma's story included her experiences with her mother, the majority of the relationships described in the stories are those with midwives, women, and each other.

Summary.

The student stage of the story illustrates the importance of forging relationships with mentors, friends, and other midwives as the participants take their first steps into the world of midwifery practice. The stories describe their experiences of negotiating organisational social structures and within this, the language used by some of the participants now refers to midwives by their organisational title 'band six' or 'band seven'. This may indicate a growing awareness of the organisational values and the position of students within each practice area. The stories illustrate how the participants constructed their developing professional identity in the positive descriptions of the case-loading experience which emphasises continuity of care and relationships with women. There is also recognition of the midwives with whom they work as having similar values, or not, thus assisting their developing definition of midwifery practice and their identity as midwives . Emma's account of hiding her experience as a doula perhaps presents a clear illustration of the dynamic between the aspirational women-centred ethos of midwifery which should align with the work of doulas, but in reality, may not align so readily with service-led priorities and limited resources.

5.2.3 Stage Three: The Crossroads.

In a quest story, the decision to step out in a particular direction is taken at the start of the journey; in stage one described above. Stage two described the journey as a student. Within the stories of Ava, Mia, Emma and, to some extent Olivia, there is a second stepping-off point or crossroads in

considering where to seek employment as a midwife featuring in each of their stories. This is not evident in Sophia's story perhaps because, as she tells me, she still feels like a student and therefore has not yet completed this stage of her journey.

Stepping out

The younger participants, Ava and Mia started university after school and left their homes, moving to a new city to study midwifery. They did not have roots in the locality or the established relationships that may have influenced decisions about where to seek employment. Mia, even though she *'loved'* the maternity unit where she was a student, sought employment elsewhere so she could live at home and save money. Mia's decision about where to seek employment as a midwife was shaped by factors external to her experience as a student and she constructs her story at this next stage with a similar '*give it a go'* state of mind as she did when starting out for university. Ava also decides to move on from where she trained but has a different rationale. She describes how the Trust where she moved to have an '*excellent preceptorship package*' which influenced her choice. She then adds that her fears about the responsibility of working as a midwife also influenced her decision; resulting in her accepting a permanent contract in a new environment rather than a temporary one where she was known because *'I would have constantly been worrying if I do something wrong am I going to lose my contract.'* Ava's story continues with the reflection that looking back, the move was the right one for her as it took her out of her '*comfort zone*'. She was not known in the new maternity unit, and she arrived as a '*band five'* and '*got on with it*.'

Ava and Mia moved on to new maternity units to start their employment as midwives. Both have rationales for their choice and the reference to the preceptorship package and seeking a permanent contract does not seem unreasonable for newly qualified staff. Ava's story adds the anticipation of the challenge on the road ahead and an awareness of the narrative around the lack of skills in newly qualified band five midwives. Mia's reflections illustrate a desire to keep options in place for

employment and also her future adult life, despite feeling an emotional attachment to the Trust where she had been a student.

The welcome

It is clear from the student journey part of her story that Olivia felt part of the Trust where she had trained as a student; thus, once qualified she knew she wanted to work there. She was asked to apply for a job and was made an offer a month before she was due to complete her studies. She describes how when she heard she had been successful, the other staff on duty celebrated her success which Olivia found '*really supportive and welcoming.'* Olivia uses this point in her story to illustrate when she started to feel part of the team and was treated '*like a midwife*' even though she was still a student. This validation from others is highlighted by Olivia as a defining moment of becoming a midwife. Later, once qualified, this early validation manifested itself in the absence of preceptorship as the 'band seven' asserted that Olivia '*knew what she was doing*' and could work unsupervised.

Being seen

Olivia describes in her story how she felt it was a *'massive advantage'* choosing to work in the Trust she knew and where she was known. She argues that moving to a new Trust would have meant having to build new relationships whilst trying to establish herself as a newly qualified midwife. Her narrative also reflects the invisibility of being a student, also highlighted by Emma. Olivia describes that compared to being a student, even in the same practice area, once qualified she feels '*more seen*' once wearing the blue scrubs of a midwife. Emma also stayed at the same hospital where she had trained, arguing the same advantage that Olivia did; by knowing the personalities and the policies you know where the '*wriggle room is*.'

Just prior to qualifying as a student, Emma's story recounts a conversation with another midwife who thought she would start '*toeing the line*' once qualified, that is, adopting the practice norms of the maternity unit. The conversation was a veiled threat, hinting at the anticipation of error that

had, for example, influenced Ava's decision about where to work. Emma describes, however, the means by which she actively addressed that threat. She chose a preceptor who did not practice in the same way that she did; someone with whom she had had a difficult relationship as a student but also someone whose risk-averse practice was deemed safe. Emma's rationale for this was to be sure that she too would be safe, referencing some of the '*practical stuff*' that she felt she had been slow to pick up as a student.

Summary

The stories in this stage describe the role of the organisation and an emerging professional identity in influencing employment choices. There may seem to be some organisational loyalty evident in the stories of Olivia and Emma, but as mature students with family commitments, they may have had less choice about where to seek employment. Olivia's story, however, is constructed to illustrate how welcome she was made to feel and the process of applying for and securing a post validated her identity both as a midwife and an employee. Emma's story constructs a more strategic approach which she argues enabled her to continue on her path within a known environment. As the participants approached the transition from student to qualified practitioner, they become more visible within the organisational social structures and in this position are more able to be heard. There is also recognition in the stories of the challenges or 'road of trials' ahead once employed as a midwife.

5.2.4 Stage Four: The Road of Trials.

The participants' stories included the shared experience of the initial few weeks or months of being a newly qualified midwife. All constructed their stories to capture the impact of this, and the individual stories illustrate the varying means by which each negotiated this part of their journey. The initiation phase is explained by all of the participants both in terms of the challenge of additional

responsibility and the notable difference between what they learned about being a midwife as a student and what the reality of midwifery practice in the NHS requires of them.

Dealing with the responsibility for the lives of others and the shifting organisational demands placed on them as midwives and NHS employees, the formal and informal social support provided for each participant can be theorised as being pivotal to their well-being and also to their success as midwives at this stage of their journey.

Initiation

Starting work as NQM, the participants constructed a similar story of the challenge of the responsibility that they faced. Ava describes the first few months as '*horrific*' and even though she knew there were others there to help her, found the responsibility of decision-making on her own a challenge. Sophia is also extreme in her use of language with her story reporting that starting work as a midwife is, '*bloody terrifying, really scary'.* This is also mirrored by Olivia who similarly describes her first few weeks as *'terrifying'* despite the warm welcome and known environment in which she had placed herself. Emma, who also stayed where she was known, describes the first year in a more measured way, reflecting that '*it wasn't easy, but it also wasn't really, really difficult.'*

Mia had a different experience in the new Trust where she went to work. Unlike the other participants, she was placed in the community setting for the first ten months as an NQM, which she describes as being '*make-or-break*' rather than fear-inducing. Working in the community meant Mia felt more on her own, with fewer opportunities to ask others for support. However, when constructing her journey to becoming a midwife, Mia recognises the value of this initial period of time in the community in developing her decision-making skills. When Mia did move back into the hospital environment, the incorrect assumption was that she had trained in the unit and '*knew how everything worked*.' At this point, 10 months into her employment, she describes the situation in the hospital as '*overwhelming;*' the preceptorship had ended, and she was included in workforce numbers. Mia struggled to regain the independence she had experienced in the community and felt

she was letting her team down. Mia's experience shows the impact of working without the supervision and support of a mentor or other midwives. Her recognition that this may bring benefits in developing confidence and being prepared for the autonomy of qualified practice is part of the construction of the story. What is noticeable too in the story, is that what is constructed as '*hard*' [but not terrifying or scary], is engagement with the organisation and knowing how things were 'done'.

Working as learning

Sophia and Olivia explained in their stories the differences between the midwifery they were taught at university and what was expected of them in practice and when they qualified. Sophia is clear that she feels her university degree did not prepare her for the '*very high risk'* working environment she entered as an NQM, even though this was the same environment she had engaged with as a student. Her story describes a sense of naivety about the reality of working as a midwife and what she was '*being led into*.' In the final year of the programme, which all of the participants had studied, students were placed primarily in the community with a small caseload of women to care for. This reflected the NMC education standards at the time and indeed the case-loading approach has been strengthened in the newer 2019 NMC standards. However, Olivia also describes in her story the impact of the community focus of the final year of the degree programme on her readiness for working as a midwife in a hospital setting. She argues that she always felt like a '*fish out of water*' on the labour ward but going back as a qualified midwife magnified this with the reality of *'it's on you, you know.'*

Ava says much less about the differences described above but perhaps in her short explanation, sums up the challenge succinctly. Having moved away to a different maternity unit, she started work as a NQM and her story illustrates her thoughts; '*that's when I suppose you really learn to be a midwife.'*

The Ordeal

Emma and Ava's stories included unprompted and detailed accounts of how they had faced difficult and traumatic situations at work and the impact that these had had on their development as a midwife. It may be that having the opportunity to share these challenging experiences with someone who they thought would listen and understand and who was not connected to their work, influenced their motivation to take part in the study.

Following her qualification, Emma's story moves quickly to describe an incident that happened about halfway through her first year. She constructs this as the incident foretold in the veiled threat about 'toeing the line' described in the previous stage, and also as having a significant impact on her practice as a midwife. The ordeal can be summarised as an unexpected obstetric emergency for which Emma was the only midwife in attendance and, perhaps as such, represents the anticipated fear of the other participants when approaching the end of their time as a student. Her story describes how she felt '*very responsible*' for the decisions she had made, and how she spent the day after wondering if there would have been a better outcome for the baby had she done something differently. Emma, however, describes being supported through this ordeal by the senior midwives she worked with who made deliberate attempts to seek Emma out and offer support, both immediately after the incident and at a later date. Emma's narrative is also clear about the benefit of being supported to return to work and the restorative nature of '*a lovely normal birth.'* Crucially, this restoration also rebuilt her faith in herself to '*make good decisions*.'

It is usual practice for there to be an investigation after unexpected incidents such as that described by Emma, and she describes how easy it would have been to change and adopt a more risk-averse approach to practice at this point. The incident and the outcomes were a topic of conversation for the staff she worked with, and she described feeling as if '*nearly everything they're talking about is about you.'* Through the deliberate support that was offered to Emma, including meeting the baby and family six months later, she was able to gain perspective on the value judgements made about

what is good and what is bad practice. Emma concludes that following this 'ordeal' she could make an informed choice to practice midwifery.

Emma's experience and adjustment to the reality of practice are also reflected in Mia's story when she reports that '*there have definitely been some bumps along the way*.' I asked her to clarify and she describes a recent and unexpected obstetric emergency with a baby that required full resuscitation followed by active cooling[23] with a subsequent poor outcome. Mia also felt responsible because, although the same grade (band six) as the midwife she had gone to assist, Mia had been qualified the longest. Like Emma, Mia spent time wondering if she had made the right decisions, what else she could have done and if she could or should have helped earlier. At this point, her story illustrates how Mia felt that being a midwife was '*just far too much responsibility*.' She concludes by reflecting on how she is waiting for something similar to happen again, something that will '*tip her over the edge*.' However, she does also express a degree of acceptance in that she '*can only do what I can do;'* reflecting possible progress towards the stage reached by Emma several months later.

Mia doesn't include in her story how much support she received following the incident, but she does reference the feelings of 'the band seven' which suggests she has had a conversation with them, and they have been able to reflect on the incident together. Mia and Emma have faced the peril which is, and always has been, an inevitable part of midwifery practice. Their stories indicate a resolution and a choice to carry on; this unfortunately was not the case for Ava.

The participants above described a single event, but for Ava it was a run of '*really difficult things*' which occurred consecutively. They differ from the experience of Emma and Mia in that the difficulties faced would not be classed as an 'obstetric emergency' or the type of event for which skills drills would be part of preceptorship and regular updating. The first was a communication error that resulted in a baby being readmitted to the hospital and an internal investigation. Ava's story

[23] An intervention to reduce brain damage in babies who have been starved of oxygen at birth.

illustrates her frustration that she did not hear anything more about the investigation which left her wondering about her practice. The second challenge was having a complaint made about her by a woman in her care. This was resolved quickly but it still left Ava in a situation where she didn't feel good about her practice because '*you never want as a midwife someone to make someone feel that way*.' Two weeks later a third, and a potentially more serious, event occurred when a woman attending the antenatal clinic told Ava about her plans for suicide. Ava's story describes how she asked for help and support in deciding how to respond but was pointed in the wrong direction and, even though the woman ultimately was safe and unharmed, it was an experience that led to her '*not being able to be an NHS midwife anymore.'* Ava describes how she felt she was being *'dragged through the coals,'* despite following procedure, and it was this experience that confirmed an already existing intent to look for work elsewhere. Ava constructs her narrative as one of having to deal with challenges unsupported and in an information vacuum despite a story which described a positive preceptorship period and good informal relationships at work.

A perceived lack of support and poor communication is also part of Sophia's story. Sophia's journey diverged more from the usual path due to personal circumstances. As a result, her period of preceptorship was prolonged and the staff with whom she later worked seemed to have little knowledge of her progress and therefore support needs. Sophia describes how she had to '*justify my lack of confidence and skills*.' Although not a crisis or ordeal in the ways described by the stories of Emma, Mia and Ava, Sophia does describe a challenge which she uses to illustrate how her confidence is undermined as she tackles '*the nursing side of things,*' for which she feels much less prepared for. Sophia describes how asking for help resulted in an interaction with a midwife colleague who '*told me off publicly,'* and further reduced her confidence in decision-making and managing tasks. Sophia reflected on this experience and related it to different mentors and their varying approaches to ensuring students develop the skills that they need. It can be argued that this may represent the differing professional identities of the midwifery mentors and, as such, highlights

the challenge of a proficiency-based assessment where all students should have had the same expected of them.

Feeling unable to ask for help for fear of being reprimanded, compounded Sophia's lack of experience and confidence and, as she identifies herself, it is important for public safety that registrants seek support when they are unsure. Having the skill to do this within an environment which will respond appropriately is demonstrated from a different perspective in Olivia's story. This is in response to my asking her to expand on the pressure she said she felt during her first year of practice. She tells me that it was the pressure to make the correct decision and recalls how she would find herself saying to one of the more senior midwives, *'can I just run this past you, is this what you would do?'* Olivia goes on to say that she was never afraid to speak up and ask for help and that is still part of her practice now.

Olivia does not include a similar crisis in her story of being a midwife but does become tearful when I ask her to identify a hero or role model as part of her story. Her description of her first experience of childbirth and how vulnerable the lack of care and compassion made her feel is clearly still impactful on her own practice. The hero in contrast, is the midwife who cared for Olivia when she was having her second baby, and her story illustrates the lasting impact of a personal crisis on the journey to becoming a midwife.

Participation

Within Ava's story, she tells me both about the formal preceptorship package offered by her new employer and the informal support she received from the midwife she refers to as her '*work mum*.' She describes her preceptorship period positively and tells me that she '*got to do lots of different things.'* Once the preceptorship period was over, Ava was moved into the community and decided that she preferred the community setting, eventually settling on a mix of community work and a weekly shift in the hospital. Ava's story demonstrates how she felt it was important not to be seen by other midwives to be losing any hospital-based skills even though she also saw the value of the

skills she was developing in the community. These included a return to case loading which she had enjoyed so much as a student and, as illustrated across the stories, her education had prepared her for.

Three months later, Ava had to take some time off sick and, on her return, '*was not allowed to be patient-facing.'* Consequently, her work changed to include organisational, rather than clinical tasks including risk management, audit, and training packages for new staff. This experience led Ava to the realisation that '*you don't have to be clinical to be a midwife.'* Once recovered, Ava returned to the community and her 'work mum' whom she describes as '*the most wonderful human and I think if it wasn't for her, I would have left a long time ago.'* Ava's story also illustrates the reciprocal nature of this relationship which is summarised by Ava as making her '*a better midwife.'*

Mia and Ava are the only participants who bring the Covid-19 pandemic into their story. This is interesting because all of the interviews occurred during the second winter lockdown period of 2020/2021 when NHS services were under significant strain. For Ava, the pandemic upset her relationship with her 'work mum;' as she had to start working from home and undertaking clinical assessments by phone. She tells me that she became '*anxious'* that she would miss something and that the nature of her job as a midwife '*had just totally changed*.' Mia, who was based in hospital tells me about the impact that the pandemic had on her and the other staff in the maternity unit. There was more unplanned movement between wards and units due to staff shortages, and Mia had already told me how unsettling she found being moved between departments before the pandemic. Mia describes the anxiety of driving into work with not only the anticipation of the complexity of care she may be expected to deliver but also the uncertainty of who she would be working with, and where. Mia recognises that this could not be helped and also that her experience since qualifying meant she was '*easily moved*' but it still left her feeling undervalued and being seen by the organisation as '*just a number.'* As the first pandemic wave receded, Mia describes how she was

moved much less often, which enabled her to feel part of the team in the birth centre; she concludes '*I know where I am now, I know where I'm based*.'

Summary

This stage of the journey is illustrated in the participants' stories by the initial shock of the responsibility of working as a midwife and the articulation of the difference between what has been expected of them as student midwives and what was expected as an employee. There is evidence in the stories that the difference is not just about the responsibility of decision-making, but about the difference between the woman-focused values that underpinned their degree and the task-focused nature of service delivery as an employee. How the participants constructed the story of their respective ordeals also illustrates the need for an ongoing mentoring and support system which can aid the learning and resolution that the ordeal brings.

Applying the analogy of the quest, this stage of the journey is described as the 'road of trials' where the midwives will meet their greatest challenge; a test or ordeal that requires them to face their fears alone and emerge stronger or become '*trapped in a world of unrealistic fantasy*' (Steiner, 2015, p. 698). Facing death is often cited as the type of ordeal faced by heroes in myths and fictional stories. For the participants, the threat of death for the women and babies in their care is not fictional and although none of the women or babies did, in the end, lose their lives, the peril was there and had to be faced. For the participants the analysis identifies these significant clinical events as an ordeal within the trials of newly qualified practice, a test of their practice.

5.2.5 Stage Five: The Return.

The participants had graduated as midwives and obtained employment as such within an 18-month period of each other and all had the experience of working as a midwife when I met them to hear their stories. The question that I asked to generate the stories prompted the participants to tell me how they had *become* midwives, from when they first thought of midwifery to the day that the interview occurred. The quest analogy would point towards the return of the protagonist from the

trials and ordeal renewed and with new skills and insights. For the participants, the journey as a midwife continues, and they know that there will be more challenges ahead, but they are able to articulate some of the essences of what being a midwife means.

Loss and acceptance

For all of the participants, there are varying degrees of recognition that the reality of practice as a midwife has required an adjustment to their expectations and values. Olivia perhaps stands out as the only participant who found midwifery '*exactly what I thought it would be*.' Even within that statement, the emotional response to recollections of her own care as a pregnant woman suggests a loss that resurfaces from time to time.

Within Ava's story, there is an explicit loss; after the incidents she described she felt she had no choice but to change jobs and resigns her role as an NHS midwife. She tells me that leaving the NHS '*felt like a massive failure,'* considering the length of time she had spent studying to become a midwife. Ava's story also described the reactions of her work colleagues who suggested she would miss being an NHS midwife and Ava still works occasional bank shifts, reflecting possibly the value still placed on 'hospital skills'. However, Ava's story makes it clear that she '*needed a break from that level of stress.'* It also illustrates the challenge of being unable to provide midwifery care to women in the way that she thought she should within the NHS conditions she experienced. She concludes that being able to accept that made her a better midwife: '*I wasn't in the right place for me or for them.'*

Within the story that Emma tells, the 'ordeal' is followed by a resolution, and she is able to construct acceptance and reality about what being a midwife entails. The story illustrates how she had the opportunity following the 'ordeal' to reflect and think about '*who I was as a midwife.'* Emma is able to view the experience as a positive learning episode that enabled her to conclude that she is making '*an informed choice that this is what I'll do.'*

In contrast, at the end of her story, Sophia reflects that she often does not feel like a midwife '*because I'm still transitioning*.' Her story illustrates the loss of her aspirations articulated so strongly at the start of her journey. She describes the environment she is working in as '*very hard, very rushed',* and consequently does not feel she can offer the care she would like to. Sophia's story concludes that '*I'm finding the reality of midwifery is kind of not what I expected.'*

A different kind of midwife.

Ava's story of becoming a midwife describes her new job working for a charity that provides pregnancy advice and abortion care. Ava is now less fearful of her job; she ascribes this to '*being a different kind of midwife.'* The difference is articulated as a new understanding of what being a midwife involves, and the story illustrates an awareness of the breadth of the role of the midwife. Ava argues that her current role will provide *'a whole different branch of skills'* if she were to return to an NHS role. Some of those skills she identifies as being shared with nursing and, although Ava's story describes her frustration at being mistaken for a nurse, she also sees the value of these nursing skills within midwifery. This differs from the frustration with '*the nursing tasks'* that challenge Sophia.

Ava's, and to some extent Sophia's, description of the skill set to be brought to midwifery is one of the few references to skills within any of the stories and it is interesting that this is presented in terms of what may be added, rather than what is deemed essential. That these skills are articulated within the context of a different profession, resonates back to the start of the participant's journeys and their expectations of what midwifery may involve.

Organisational tasks

Within the final part of Olivia's story, she describes the 'theory-practice gap' and constructs a rationale based on the task-focused nature of the reality of her work as a midwife. Her story illustrates how she has had to assimilate her motivation to provide the women-centred care that

initially inspired her journey and '*that uni' tried [to teach]',* alongside organisational priorities. She describes some of her colleagues as '*just going through the motions'* of being a midwife.

The use of the word 'tried' in relation to university teaching is telling and reflects the challenge for universities and regulators who wish to influence future midwifery practice. Olivia's story captures her thoughts that the '*current system*' does not permit midwives to practice in the way they may choose. However, she is hopeful for the future in terms of the continuity of care models that are being implemented in her employing Trust.

Sophia also constructs a picture of the challenge of working within organisational priorities. Her frustration with her experience of being a midwife permeates much of her story and she describes having '*a band seven on your back'* which prevents her from providing the care she would like. She uses the example of pain relief in labour and how she tries to use her university-based knowledge to challenge the organisational norms which she describes as '*running straight for the anaesthetist*.' Sophia's personal experience and motivation to become a midwife are evident in this narrative and her story does shine some light on how some experiences since she has been qualified have enabled her to '*find my own way.'*

Role Models

Olivia is the only participant to include in her story a commitment to supporting others on their journey to becoming a midwife. This may reflect the relatively comfortable position her story presents her as occupying in terms of acceptance of her role and her validation by others. Olivia constructs her story to reflect her previous experience in a different work environment where mentoring colleagues was an important role. Coming to a mentoring relationship with that previous experience meant that Olivia observed her mentors and used the experience to reflect, '*is this how I want to mentor, you know, how would I do it differently*?' Olivia's story also illustrates her thoughts about colleagues who have no interest in supporting students and who just do it because '*it's part of the job.'*

Within the quest analogy, becoming a mentor to the next generation would signify a successful journey, and the inclusion of this within Olivia's story suggests that the willingness to mentor, teach and share with others is part of her self-affirmation of her midwifery identity.

Sophia's story describes her answer to a question about role models which I introduced to generate a more positive narrative to her story. Sophia can identify a role model easily and compares herself to them, identifying how they too struggled in the hospital environment but are now much happier working in the community. This midwife is the inspiration that Sophia draws on when she says '*I've just got to keep going,' demonstrating* her aim to complete her preceptorship and move into the community as a band six midwife.

With Woman

Emma concludes her story by describing her current role in a continuity of care team providing care to women with whom she is able to form relationships. Her story illustrates how Emma finds challenging the task-focused status quo much easier in her current role. Emma describes a situation in which she was able to challenge a medical colleague on their value judgement about the care one woman had asked for. Her response referenced the expectation that midwives [and doctors] have to respect the choices that women make, even if that is professionally uncomfortable.

Speaking up for women in this way, being an advocate, is a core professional expectation of midwives and one which may be challenged by organisational demands. Emma is not the only participant who includes advocacy within her account of what it means to be a midwife. Ava is explicit about her role as an advocate, arguing that expressing this particular attribute has enabled her to still feel like a midwife, and in some ways even more so now she is employed outside of the NHS. She describes how she has never *'felt as much of an advocate for women as I do now*.'

Positive relationships with women are also part of Mia's story; illustrating the job satisfaction that comes from providing continuity of care. She describes how working in the continuity team based

in a birth centre she feels '*like a well-rounded midwife.'* Providing care in this way enables her to *'to practice how I want to practice',* which means for Mia, as with Olivia and Sophia, not processing women through a system as quickly as possible.

Being with women and a shared female experience is also part of the relationship that Sophia describes with her work colleagues. Most of the medical and midwifery staff where she works are female and Sophia finds that '*an empowering experience*.' She describes what she is able to learn from her colleagues and how they provide inspiration to her to continue as a midwife.

Relationships between women and midwives are important to Olivia too, and her story illustrates that her practice is shaped by more than her personal experiences. She describes the benefit of being in a professional caring relationship with another woman and also that she remains '*fascinated by childbirth;'* reflecting that this may not be the case in those midwives whom she identified earlier as '*going through the motions*'.

Olivia describes being a midwife in terms of her feelings, and the value she places on the role. Stating that being a midwife is what she expected presents an alternative narrative to that played out in the literature about the experiences of NQM. Reflecting on being a midwife, Olivia has a very positive story to tell and concludes her story by saying, '*I still feel that complete privilege and honour of doing what I do every single day.'*

Summary

The participants, Olivia, Emma, Ava, Sophia and Mia have shared their stories about the process of becoming a midwife and within this last stage, the narrative returns to their starting values, and aspiring identities as midwives; to meet the needs of women. However, their position as qualified midwives mean these values are now shaped by the journey they have taken and the knowledge they have acquired of midwifery practice and how that is bounded by the context of their employing institution.

5.3 Conclusion

In this chapter I have used the findings from the study to illustrate the journey to becoming a midwife as a quest by paying attention to the individual *and* the shared experience of the participants and presenting these as archetypal elements in the story of becoming a midwife. In doing so, the analysis addresses the first two research questions namely: considering *what* the stories of NQM illustrate about the employability perspectives; and how the stories are constructed and the understanding of the process of becoming a midwife. The student journey as a quest contains plot elements which reflect the 'situated in practice' and relational nature of learning for midwives which includes domains beyond the acquisition of technical skill. The view of the newly qualified period as a 'road of trials' with varying degrees of visibility and affirmation from others that leads to the archetypal 'ordeal' is central to the quest archetype. I have added a 'crossroads' to the journey to exemplify the complexities of being a student and then choosing *where* to be a midwife; both of which inform the development of identity.

The findings are discussed further in Chapter Six, with reference to the research questions, literature, policy and employability theory in order to lead to recommendations for the education and employment of midwives and areas for future research.

Chapter Six: Discussion and Conclusions

6.1 Introduction

In this chapter I discuss the findings of the inquiry and how they address the research questions and contribute to the understanding of employability in midwifery. The literature, theory and policy which inform the current debates surrounding both the experience of newly qualified midwives and graduate employability, are outlined. The discussion demonstrates how the study has added to the narrative, discussed in Chapter One, which surrounds the employment of newly qualified midwives through my analysis of the stories as a journey reflecting the structure and plot elements of an archetypal 'quest.' I argue that the findings have illustrated the value in viewing the experiences of NQMs through the lens of the wider employability literature (Clarke, 2018; Holmes, 2013; Tomlinson, 2012) and, in doing so, have highlighted the need to attend to the social structures, for example COP, which surround NQM and how these influence the development of identity as a professional in order to enhance employability. I will reflect on the archetype of a quest as a metaphor for the journey to becoming a midwife, along with the limitations of the inquiry and recommendations for both educators and employers of midwives and future research.

6.1.1 Summary of Findings

The participants in this narrative inquiry were asked to describe how they became a midwife in order to answer the following questions.

1. What do the stories of newly qualified midwives working in the NHS in England illustrate about the employability perspectives of possession, position, and process?

2. How are the stories constructed and does this add to an understanding of the process of becoming a midwife?

3. What can be learned from the stories to support the future education and employment of midwives in the UK?

The participants constructed their experiences in a way that I was able to analyse as a story of a journey divided into five temporal stages: 'starting out'; 'the student journey'; 'choosing where to work'; 'working as a midwife'; and 'being a midwife'. Chapter Four presented a 're-storied' analysis of each participant's journey using participants' voices and my analysis to illustrate the five stages whilst maintaining the integrity of each story. The title of each story illustrates my analysis of how participants understand their role and identity as a midwife at the point when data were collected.

Chapter Five developed the stories further, presenting archetypal plot elements to further address the research questions. In the beginning or starting out' as a midwife, describes the experiences leading up to the time the participants started their midwifery degree. The data suggest that this stage of the journey is motivated by 'the call'; a search for meaning, reflecting personal values illustrated as the elements of experiences as 'women' and encounters with both 'midwives' and media 'representations' of such. The 'student journey' is 'the threshold' and second stage, characterised by the plot elements of developing relationships; with each other as journey 'companions,' and with midwife 'mentors. Mentor is the language used by the participants and reflects both the NMC standards in place at the time and the more classic definition of a mentor as a guide on a journey (Bradford et al., 2022). Being 'prepared' through time management and organisation skills also featured as part of the archetypal elements and the data held a scant reference to the university-based aspects of the programme other than the challenge of assessed work.

The third stage of the journey creates a crossroads in 'choosing where to work,' reflecting a further threshold or 'stepping out' in the journey where participants constructed their motivations for choosing to stay on a familiar path or seek employment elsewhere. The 'welcome' and 'being seen' illustrate expectations of support and space to develop autonomy. The stories also suggest some degree of alignment with organisational values and belonging in identity development as an employee.

Stage four of the journey tells the story of the 'road of trials' when 'working as a midwife,' illustrated with the expected stress of 'initiation' into a professional role alongside 'working as learning' when an employee. A key finding was the role of the 'ordeal' or traumatic event as part of the process of becoming a midwife. This plot element illustrates the complexity of professional decision-making and the implications of retaining midwives in the workforce. The final stage of the journey is 'the return articulated as 'being a midwife' and the archetypal element of 'loss and acceptance' of personal values illustrates the challenges in forming an identity as both a midwife and an employee.

6.2 Becoming a Midwife.

In the summary of the research findings in the introduction and the analysis of the stories of newly qualified midwives presented in Chapters Four and Five, I have addressed the first research question by creating a lens through which to consider how the three employability perspectives, described by Holmes (2013) can be understood in a midwifery context. The identification of the process of becoming a midwife as the stages of a journey or a quest with archetypal plot elements addresses the second research question. As a narrative inquiry these findings augment the literature discussed in Chapter Two which views the NQM experience through a transitional and socialisation lens (Blaka, 2006; Reynolds et al., 2014; van der Putten, 2008). In doing, so the findings address the third research question in terms of the contribution to the education and employment of midwives. Throughout this thesis, I have created a practice-based inquiry in response to an identified problem and, as such, the answers to the questions are not always distinct but, as the discussion chapter will show, overlap to contribute to an understanding of becoming a midwife.

Within the stories and the plot elements created from the data, there is much that could be learned and discussed further. However, to address the research questions this discussion focuses on the findings which illustrate the differing perspectives of employability, as described by Holmes, (2013) and how the stories told by the participants inform understanding of becoming a midwife. The plot element of the 'ordeal' was constructed as central to the stories. The data illustrates both the

impact of support for midwives when making decisions during critical episodes of care and also how these episodes shape professional identity. Therefore, the context of professional decision-making is explored, arguing that this is an example of a concept that straddles the three employability perspectives of skill [possession], [social] position, and [the process of] identity development. The social position of participants and their relationships with others, was frequently evident in the stories and plot elements, thus the discussion considers what this means for students, new employees, and employers together with exploring how different levels of social participation contribute to the process of becoming a midwife. The development of identity is discussed to reflect the findings on the alignment of values as an employee and the original values that motivated the participants to become a midwife.

6.3 Employability Perspectives.

The introduction and literature review in Chapters One and Two, identified three perspectives on employability which, I argued, would provide an alternate lens through which to view the experience of NQM. Those perspectives of possession, position and process thus informed the first research question, and the following sections explore each of these, drawing on the arguments presented previously; for example, COP, whilst also introducing literature to aid discussion and consideration the findings. The second research question is also addressed through consideration of the way in which the stories are constructed around thearchetype of a quest. This is illustrated through the plot elements identified in Chapter Five, and referenced within the discussion below.

6.3.1 The possession of skills and attributes

Chapter One included an overview of the employability debate with reference to the dominance of employability skills within that agenda as argued by Holmes and others (Holmes, 2013; Römgens et al., 2019; Succi & Canovi, 2020). This was developed in Chapter Two to consider how the profession has constructed skill as a continuum encompassing proficiency (Fullerton & Ghérissi, 2015b; Valloze, 2009). The stories constructed within this study make few literal references to the midwifery

proficiencies listed in the NMC standards (NMC, 2019), and, as such, they are not an archetypal element of the journey to becoming a midwife in this analysis. That is not to say these are not of value and essential to maintain the safety of the public, but it does evidence that, as argued within the introduction to the inquiry in Chapter One, enabling individuals to become a midwife encompasses more than ensuring the achievement of a prescribed set of skills, knowledge, and attributes (Holmes, 2013). Recognising that the employability perspective of possession [of skills], is only part of the story the findings can, however, contribute to the skills narrative and thus address the research questions.

The student part of the journey is characterised by the challenge of managing the relationships with 'mentors' and each other as 'companions' on the journey to becoming a midwife. The stories illustrated that 'being prepared' for the journey by possessing the graduate skill of organisation and time management was valuable and that the development of these graduate skill developed through the caseload working in the final year of the programme.

Within the literature review, it was highlighted that the skills valued by the employers of NQM who had been nurses first were their ability to prioritise and manage themselves, and the tasks required of them (Fleming et al., 2001). The stories of the participants who entered midwifery with a strong set of graduate skills would seem to support that argument and reflect a perspective on employability which favours the development of graduate skills such as time management (Succi & Canovi, 2020). The ability of midwives to manage and organise their time, thus ensuring care needs are met, is an important part of the role of a midwife and it is of note that it emerged as an archetypal element of the journey to becoming a midwife. This element is articulated as the following proficiency statement by the NMC:

> *'safely and effectively lead and manage midwifery care, demonstrating appropriate prioritising, delegation, and assignment of care responsibilities to others involved in providing care'*
>
> (NMC, 2019, p. 29)

The stories also illustrated the development of this proficiency both as a function of undergraduate progression through the programme, and as a result of the caseload requirement in the final year of study. The case-loading experience which was designed to consolidate a range of midwifery skills and deliver continuity of care to a small group of women, served to both increase confidence and develop the organisational and management skills desired by employers. Continuity of care models have been identified as providing benefits to women and are a central feature of professional and policy expectations (NHS England, 2016; NMC, 2019; Renfrew et al., 2014). This inquiry adds to the argument identified elsewhere (Clements et al., 2013; Cummins et al., 2015; Evans et al., 2020), that models of care which promote relationships with women also have benefits for the midwives providing the care. For students, the benefit is not only in the reciprocity of the relationship with women but the development of valuable graduate skills for the employer. Currently, the provision of continuity of care in England is paused in many Trusts. This pause is in response to concerns about maternity service staffing levels that followed the publication of the Independent Review of Maternity Services at The Shrewsbury and Telford NHS Trust (Ockenden, 2022). Recognising the additional employability perspective of the skill development continuity of care may enable, could serve to support the re-commencement of continuity of care service provision. There may be long-term benefits to the workforce in addition to the benefits of continuity of care already published (NIHCE, 2021; NHS England, 2021; Renfrew et al., 2014).

Moving on from the plot element of 'being prepared' within the student part of the journey to 'working as a midwife,' the stories provide insight into the experience of NQM as the 'road of trials'. The use of the of a 'quest' archetype to structure the stories has highlighted the impact of an adverse event or ordeal on becoming a midwife and adds a different perspective to the existing literature on transition into professional practice (Duchscher, 2009; Kramer, 1974; Mackintosh, 2006). The findings of an 'ordeal,' as an archetypal plot element in the journey to becoming a midwife, reflects the traumatic events described elsewhere in the literature, (Hobbs, 2012; van der

Putten, 2008; Weston, 2011). Importantly, in relation to the findings of this inquiry, the ordeal element can be seen as playing an explicit role in the process of identity development and the construction of the journey to 'being a midwife'. Additionally, in relation to employability, this element can be used to argue that the midwifery-specific graduate skill of decision making is worthy of further discussion.

Decision-making is a complex skill and for the midwives within these stories, the decisions they made [or may need to make] during the 'ordeal' element of the story were constructed as critical to the outcomes for the women and families involved and to their developing sense of what it means to be a midwife. Emma, Mia and Ava recount challenging situations; Emma, for example, feels "very responsible" and wonders if there was anything else she could have done despite responding promptly to an obstetric emergency. Mia has a similar experience, highlighting that being a midwife is "far too much responsibility" and Ava, whose experience is outside of the recognised obstetric emergency,[24] is left feeling unsupported and "being dragged through the coals" after recognising that she didn't know what to do. Clinical decision making also features elsewhere in the stories; Olivia, for example, describes a self-inflicted pressure to make the right decisions "can I run this past you; is that what you would do?" This sense of identity arising from the accountability of decision making within midwifery practice has been reported by Newton et al., (2016) and also reflects the benefits of community-based case load working; discussed above and evident in the participants' stories.

There are several models of *clinical* decision-making which are described elsewhere (Jefford et al., 2010; Raynor et al., 2005), albeit with some recognition of limited application to midwifery. However, drawing on the lens of employability, authors within the field of occupational psychology describe 'decision latitude' as a tenet of employee wellbeing (Warr, 1990). Research within nursing

[24] Life threating medical situations for woman and or fetus such as massive haemorrhage or shoulder dystocia for which there are practised drills and team responses.

has identified that decision latitude informs job satisfaction and retention in the workplace (Ernst et al., 2004; Kotzer et al., 2006; Merrick et al., 2012). Decision latitude is described as:

> '*the possibilities within an organisation that enable practitioners to make decisions about their work and to have influence within the organisation'.*
>
> (Merrick et al., 2012, p. 616) .

Decision-making can also be viewed through the sociological lens of occupational control which identifies three models that can be applied to midwifery (Porter et al., 2007). Firstly, there is 'classical professional' where control lies with the professional, 'bureaucratic control' which lies within the organisational rules, and 'new professional', which reflects much of the rhetoric of professional and policy aspirations, where control is shared between professional and client. The plot element of 'organisational tasks' in the stories is supported by examples of bureaucratic control expressed by the 'Band Sevens,' and the pressure to move women through the system rapidly. Within the stories, the participants described those individuals impacting on their preferred practice, by their organisational function or pay band, rather than as other midwives. The language used in these descriptions reflects the relationship that midwives have with the organisation and how this may be expressed through their relationships with each other.

The occupational, psychological, and sociological understandings of decision-making described above, draw attention to the impact of the context within which decision-making skills are being applied. In doing so, they create an opportunity to consider that an employability perspective which describes a complex process such as decision-making as simply a 'graduate skill' will not reflect the reality of the experience of NQM. Decision-making involves not just knowledge of what to do, the correct procedure, or the policy to follow illustrated in the plot element of 'working as learning'. It involves professional judgement which is influenced by the social context and the degree of practice participation which the midwife experiences, alongside individual values, such as being 'with woman' which participants viewed their role as midwives to be (Daemers et al., 2017; Porter et al.,

2007). Thus, the employability perspective on the development of graduate skills cannot be seen in isolation from the perspectives on social position and identity development, and rather than viewing the perspectives as competing, they can be viewed as complimentary. This is a view on employability shared by Jackson, (2016 p925), who argues that graduate employability should embrace an understanding of the connection between the '*skills, qualities, conduct, culture and ideology'* of their intended profession. The paper draws on both communities and landscapes of practice to emphasise the social and situated nature of learning 'to be' for all graduates.

The social context of decision-making is evident in the participants journeys. Olivia articulates her ability to ask for help and support without hesitation and her story indicates that, within a positive environment, she has developed the decision-making 'skills' she needs to be a midwife. Olivia's story also illustrates the degree of trust she was held in from her very first shift as an NQM when it was confirmed that she '*knew what she was doing*.' Applying firstly an occupational lens on relationships as social exchanges, the leader-member exchange theory as described by Jokisaari, (2013), supports the argument that positive relationships with leaders contribute to employee performance. This has been demonstrated to reflect the relationships and degree of COP participation which act as a resource for learning about organisational roles and responsibilities. However, social networks which provide informal support can be equally important and this may be particularly so for newcomers, (Jokisaari, 2013; Sheer, 2015) and is illustrated in the findings through the archetypal plot elements of 'the welcome', 'being seen' and 'participation'. Drawing secondly on COP as a means to facilitate the possession of skills such as decision-making, Wenger, (1998) argues that it is the contextualisation of skills within the community that practices them which confirms the practitioner as not just being skilled, but being competent (Wenger, 1998). I explore COP further in Section 6.3.2, where perspectives on employability as a social position are addressed; however, in this argument, and reflecting the work of Zolkefli et al., (2020), it can be theorised that decision-making, as constructed around an 'ordeal' in practice, is central to becoming a midwife.

Furthermore, to support the development of NQMs, the occupational or employment environment in which that 'skill' is practised, and the development of effective and reciprocal relationships should be considered by those who wish to support NQM (Materne et al., 2017; Newton et al., 2016; Panda et al., 2021)

The data also identified decisions which were made at 'the crossroads' in relation to choosing where to work when 'stepping out' over the threshold into the next stage of the journey. This stage of the journey was represented by less data than the plot element of the 'ordeal' but is worthy of further consideration because of the role of career decisions in reflecting a sense of self and identity (LaPointe, 2010). Indeed, literature exploring career choices in graduates as well as both nurses and midwives illustrates an alignment with the employability perspectives of Holmes, (2013) and articulation of the place of identity, relationships, and appropriate skills in influencing career choice (Brown & Wond, 2018; McCall et al., 2009; Price, 2009). The participants in this inquiry made their decisions on where to work based on their expectations of themselves as NQM and the relationships within the work environment which are evident in the stories. This was true also for Ava when deciding to leave the NHS. However, the data mostly reflects the participants as students moving into employment. It can be argued that the decision to become a midwife was made earlier in each story [in response to 'the call'] and shaped by experiences as, and with, women and as a result of encounters with midwives. The movement of students through the work environment as a learning space and then a place of employment, is reflected in the discussion that develops in Section 6.3.2, and the experience and expectations of self will follow within the discussion on identity development in Section 6.3.3.

6.3.2 The position in social structures

The literature review identified that the workplace culture within the maternity services can be challenging for NQM who can feel unsupported in their transition from student to registrant and employee (Fenwick et al., 2012; Hobbs, 2012; Reynolds et al., 2014; van der Putten, 2008). There is

also evidence that for some it is more than a lack of support and this manifests as bullying and negative experiences which may lead NQMs to leave their employment within the NHS (Capper et al., 2020; RCM, 2016; Royal College of Obstetricians and Gynaecologists, 2021).

The journey of the midwives in this study did not describe a consistently unsupportive culture, nor was the word 'bullying' used. There were examples of lack of support following particular incidents but, in general, the participants felt supported by the informal network around them and, were able to find mentors, and companions to sustain them on their journey and who may have influenced decisions about where to work. However, the stories illustrate the impact of formal support, or the lack of it, with a focus on the 'ordeal' plot element explored in the previous section. NHS policy and workforce strategy identifies the need for formal support mechanisms for all employees but especially those who are newly qualified (HEE, 2022; NHS England, 2020). For nurses and midwives, this is the period of 'preceptorship' and the debates surrounding this were discussed in the introduction to this inquiry in Chapter One. The participants' stories illustrate that preceptorship offers may impact decisions about place of work but also that those offers reflected the reported inconsistencies in the delivery of preceptorship and also a predominant focus on the possession of skills (Foster & Ashwin, 2014; Irwin et al., 2018; O'Driscoll et al., 2022; Taylor et al., 2019).

The literature review considered COP (Wenger, 1998) to inform an understanding of employability as Wenger situates learning and identity development within the space where particular practices occur. The example given by Wenger in his analysis of situated learning is a workplace; however, in his previous text (Lave & Wenger, 1991), the spaces are not so defined and include, for example, the community of traditional midwives handing down knowledge through the generations [also illustrated in the epigraph to this thesis]. Within these spaces, situated in practice, and supported by participation in the community, learning 'to be a midwife' takes place. Participation is conceptualised as reflecting the traditional apprentice-to-master journey which is described as initial peripheral engagement moving towards full participation (Lave & Wenger, 1991, p. 29). There are

several archetypal elements within the stories which illustrate this social space of learning; 'mentors and fitting in;' 'the welcome' and 'being seen;' 'working as learning' and 'participation'. As such, these archetypes support the argument that an ability to negotiate and maintain social position is an important part of the journey to becoming a midwife. Holmes too, argues that negotiating position is a perspective often taken on employability, albeit not without the limitation of diminishing individual agency (Holmes, 2013).

Communities of practice are maintained by the legitimate peripheral participation in the practice by newcomers and, as will be argued in the final section below, this engagement requires a degree of compliance which can inhibit innovation and new working practices (Fox, 2000; Pollard, 2011). However, the extent to which it can be argued that practice-based students are in the social position of newcomers as they cross the boundaries between practice areas [COP] as students has been considered by Fenton-O'Creevy et al., (2015). This work argues that the trajectory which students take through the various communities they engage with depends upon where they consider their final destination to be. This in turn may be influenced by an emerging sense of identity as a midwife guiding decisions about where to work as discussed in the previous section and highlighted by McCall et al., (2009). The plot element of 'loss and acceptance' illustrates this in addressing the loss of the aspirations and expectations of the participants when they set out to become a midwife and the reality of being employed as one.

The journey that students take, and which emerged in the participants' stories, is also a metaphor used by Fenton-O'Creevy et al., (2015) to argue that the peripheral-to-centre trajectory proposed originally by COP requires further development to reflect the boundaries students encounter. It is argued instead that students move through *landscapes of practice and* may adopt different forms of participation as they do so. These are illustrated in Figure One, overleaf.

Figure one: Forms of peripheral participation

		Imagined trajectory	
		Inside COP	**Passing Through**
Participation	**Low**	Marginal	Tourist
	High	Apprentice	Sojourner

Adapted from Fenton-O'Creevy et al., 2015, p. 44

Applying the concept of landscapes of practice to the findings of this study adds an additional contribution to understanding the experience of the participants when students, when deciding where to work and as NQM. Students primarily pass through the communities they engage with giving them the role of either a low participant tourist, or a more engaged sojourner. Tourists are argued to have their identity located outside of the community they are passing through (Fenton-O'Creevy et al., 2015), and the findings within this study can support that argument if there is an understanding that there are 'different kinds of midwives'. This is not an argument reflecting the journey of Ava, who describes herself in that way when she is working outside of the NHS; but rather it reflects the participants stories where there is recognition of the difference between community and hospital-based midwifery practice; and even between different types of hospital-based care. Sophia, for example, describes how she feels she would 'thrive' in the community setting and Mia confirms that the midwife-led unit enables her to "practice how I want to practice". Previous literature has also highlighted these differences (Baird et al., 2022; Carter et al., 2022; Newton et al.,

2016), and therefore exploring these will assist students and those who facilitate their learning and early employment.

The sojourner has a higher level of participation; although still passing through they engage with the 'meaning of local practices' (Fenton-O'Creevy et al., 2015, p. 44) without full assimilation into the placement community. Indeed, Olivia's story illustrates her move from sojourner to the secure social position of a newcomer or apprentice once qualified and she described 'being seen' as more than "just a student". Even once qualified, Mia describes being "just a number" as she passes through on a sojourn [short stay], filling in gaps in the rota. Whilst acknowledging that much of this movement for Mia, was due to the unprecedented demands of the Covid-19 pandemic, it is common practice for NQM to 'rotate' or move through several areas as part of a preceptorship programme (Taylor et al., 2019). Recognising that the support offered by other midwives varies, as illustrated by the literature (Foster & Ashwin, 2014), the stories and the plot elements [mentors, the welcome, role models] within this inquiry, it may be beneficial to explicitly explore differing midwifery identities with NQM as part of preceptorship programmes.

The forms of participation described in Figure One, can also contribute to an understanding of the participants' experiences concerning the plot elements of 'being seen' and 'initiation' into the realities of practice. The practice areas and teams where students are placed may view the students as just 'passing through' and therefore they are not yet eligible to participate in the practice of the community. As tourists or sojourners from the 'uni' students are physically present and are learning the requisite skills. However, they must negotiate the boundaries within the landscapes of learning to be a midwife, boundaries which could be used as a means to address the recognised gap between theory and practice (Allan, 2022; Hatlevik, 2012; Landers, 2000; Rooks, 2006).

Communities of practice enable the social reproduction of the knowledge that is required to practice within a group or context. Lave & Wenger, (1991) argue that social learning in this way, is of much more significance than the cognitive explanations of learning which take place in the classroom or

lecture hall. It could be argued therefore, that if there is a desire in professional and policy narratives to change the practice of midwives (NHS England, 2016; NMC, 2019), consideration must be given to understanding the social participation dimension of learning that takes place within the practice of midwives. Such consideration would move the employability narrative in midwifery away from the current focus on the possession of skills. Additionally, the social structure of COP poses a dilemma for students who are passing through, described above, but also for NQM's who join as newcomers. To participate in the COP the newcomer must engage in existing practice whilst establishing their own identity in the future of the community. This creates power conflicts and the alliances that are formed between newcomers, the not so new [or journey folk] and masters may be crucial in creating sustainable change in practice (Fox,2000). Thus, understanding the social learning that constructs the identities of midwives as both professionals and employees, evidenced by the archetypal elements in the stories in this inquiry, can be argued as central to understanding the meaning of employability in midwifery.

The plot elements which highlight relationships with 'mentors'; 'the welcome' and 'initiation;' and the facilitation of 'participation' within the stories presented in Chapters Four and Five also provide an opportunity to further discuss the context within which the skill of decision-making takes place as described earlier. The literature on the concept of the 'second victim' in traumatic clinical situations highlights the position of the professional involved or witnessing the event (Stone, 2020; Wu & Steckelberg, 2012). The term is not without critique, reflecting the concerns of service users and patients who have been harmed by medical incidents (Clarkson et al., 2019). However, considering the place of 'the ordeal' in the stories presented in Chapters Four and Five more attention should be paid to providing support to midwives following adverse incidents. The findings suggest that any incident that results in practice being questioned could contribute to NQM's questioning their decision-making abilities and that appropriate support from colleagues can contribute to effective resolution (Christoffersen et al., 2020).

The social position perspective on employability highlighted the culture of the work environment as an important factor in the experience of NQM (Ashforth & Kitson-Reynolds, 2019; Fenwick et al., 2012; Reynolds et al., 2014). The stories presented in Chapters Four and Five, reflect the significance of further exploring the employability perspective of social position in terms of relationships with 'mentors', 'women', and other midwives as role models. The discussion of participation in communities and landscapes of practice, and the roles of both novice and expert, represent those relationships. I also highlighted earlier the role of positive relationships in the workplace as enhancing performance (Jokisaari, 2013). Thus, when considering how best to prepare students and NQM to engage and move through landscapes of practice the stories and plot elements highlight relationships as being of prime importance.

Building effective workplace relationships enabled the participants, as illustrated in the stories, to feel nurtured, to learn and to gain confidence from their relationships with women and each other. Within the stories, making career decisions about where to work was influenced by recognising the "wriggle room" and the development of identity as a midwife via the affirmations of others. Within the Future Midwife standards (NMC, 2019), domain five states the expectations of midwives as colleagues and leaders. There is a focus on safety and quality improvement and recognising vulnerability in self and others. Strategies to promote positive workplace relationships are implicit in the NMC standards, however they reflect a one-sided focus on the individual to achieve, rather than the reciprocal nature of effective relationships, where there is responsibility on behalf of qualified staff to foster positive relationships (Sahay & Willis, 2022). Reciprocity is captured in the Standards Framework for Nurse and Midwifery Education (NMC, 2018a),where there are statements about student empowerment and advocacy within organisations. There remains, however, concern about the limited impact of professional standards on the culture and practice within the NHS (Hall & Way, 2018; Kirkup, 2015), a concern which has surfaced again with the most recent review of poor maternity outcomes (Kirkup, 2022; Ockenden, 2020).

Considering the challenges inherent in the workplace for NQM and the impact these can have on developing effective relationships, the findings of this inquiry would support an explicit approach to educating and supporting students and NQM to negotiate the landscape of practice they cross on their journey. In terms of the detail of the stories and the plot elements of relationships with 'mentors' as role models, developing emotional intelligence as a tool to support participation and well-being can be argued as a valuable part of midwifery practice (Carragher & Gormley, 2017). In addition, there is evidence that those with well-developed emotional intelligence can recover more rapidly from adverse events reflecting the arguments earlier about 'the ordeal' event in the participant's journey (Nightingale et al., 2018). For employers of more experienced midwives who act as mentors and are required to demonstrate leadership, emotional intelligence is also recognised here as a valuable aspect of professional development (Bradford et al., 2022; Carragher & Gormley, 2017; Dooley et al., 2019).

The literature review identified the narrative of the needs of the newer generations who require more support than previous cohorts with an argument that personal resilience is an attribute to be developed to aid retention (Jones et al., 2015; Keith et al., 2021). The stories in this inquiry were told by midwives whose ages spanned three generations. Each story was unique but within the plot elements I did not construct a generational perspective or even differentiate between those who had children and those who had not. My analysis reflected my feminist conviction that all women share the experience of being positioned in relation to their reproductive status; categorising women as those who have, or have not given birth, can be argued as unhelpful in a midwifery context (Bewley, 2010, p. 191). The argument throughout this thesis, that employability is more than the possession of individual or generational attributes, also influenced my approach to understanding the stories. Identifying emotional intelligence as a potential area for development may seem to suggest a similar focus on individual skill deficits. However, as the stories in this inquiry have illustrated, the means to develop effective relationships with others and facilitate participation

in landscapes of practice are a tenet of the organisation, and its existing employees, as much as the NQM.

6.3.3 The process of identity development

The final employability perspective to consider in relation to the research questions is the process of identity development. In Chapter Two, the development of professional identity was defined as the internalisation and alignment of professional values with those already held (Roscoe & Pithouse, 2018). Taking values as a key component of identity development the findings illustrate the construction of identity through 'the call' to change, 'the return' and the plot elements within.

The stories illustrate that for those with personal experience of the maternity services and interaction with midwives it was both the potential, and absence, of women-centred values that raised the possibility of becoming a midwife. The role of personal experience in the developing identity of midwives has been explored by Bewley, (2010) and Fleming & Mander, (2009) with some reference to both positive and negative childbirth experiences influencing decisions and identities. There is also debate as to the extent to which personal experience should influence midwifery practice and the obvious challenges that brings when midwives are mostly women and many have direct experience of the maternity service themselves (Battersby, 2009). Nonetheless, the poor experiences of maternity care described by the participants and the recognition that it could, and should be done better, increasingly reflect the wider experience of maternity care in the UK. Recent surveys highlight that although most women remain satisfied with the quality of care provided by the maternity services in the UK that satisfaction is reducing (Care Quality Commission, 2023; Stacey et al., 2021). Along with the impact of the COVID-19 pandemic, reduced satisfaction also reflects the staffing pressures within the maternity services and the need to recruit and retain more midwives in the workforce (RCM, 2022). However, there is also the argument that poor care which does not meet women's needs arises from a culture that prioritises organisational requirements above the needs of women (Newnham & Kirkham, 2019; Pollard, 2011). The literature in Chapter Two

highlighted the mismatch between personal and organisational values as a factor in attrition from the midwifery workforce, (Griffiths et al., 2019; Pollard, 2011; Royal College of Midwives, 2016) despite the values espoused in women-centred care as being central to professional and policy documents (NHS England, 2016; NMC, 2019).

Identifying values, and expectations of the midwife in providing care for women, as a starting point for NQM may help to shift the narrative in terms of preparing midwives for employment and supporting their transition from student to employee. As identified in Chapter One and Two, the focus in that transition period tends to be on skills and attributes, what the NQM can do or how well they can respond to the challenges they face; how resilient or confident they are (Foster & Ashwin, 2014; Irwin et al., 2018; Taylor et al., 2019). Consequently, practical skills and organisational induction tasks predominate in preceptorship programmes contributing to the narrative that NQM are not prepared for employment.

Values-based recruitment is a narrative that is familiar to those who educate and employ midwives where selection processes are required to ensure that those recruited can demonstrate the NHS values (HEE, 2016). From an employability perspective, the NHS values represent a macro stakeholder view of what is expected from employees (Holmes, 2013), and indeed the NHS values sit comfortably with other policy and professional standards documents (NHS England, 2019; NMC, 2018a). The NHS is a large organisation, however, and the translation of policy into the reality of the practice of its employees is, as the stories in this study have illustrated, challenging.

Recognising the alignment of personal and professional values as part of an identity perspective on employability in both education and preceptorship programmes can increase employability and address retention (Holmes, 2015; van der Klink et al., 2016). Furthermore, a values-based approach to *retention* reflects the impact of the practice values of the employer and their employees rather than the skills deficit model as currently constructed in preceptorship programmes.

The findings of this narrative inquiry also highlight the place of identity in shaping employment choices at the crossroads stage of the journey. The processes captured in the plot elements of 'stepping out' and 'being seen', reflect the ideas of participation in COP as central to identity development as participants negotiate who they are becoming through the relationship with others and employing organisations. There is literature about the role that values play in career identity and how work and employment are used to express personal values (HakemZadeh et al., 2021; LaPointe, 2010; Tomlinson, 2012). The findings illustrate that personal values and aspirations to be 'with woman' remain through the journey to becoming a midwife. Reflecting other similar qualitative studies, (Griffiths et al., 2019; Hobbs, 2012), the elements of 'loss and acceptance' and 'organisational tasks' demonstrate how the NQM were able to express those values and accommodate them within the organisation where they are employed, by for example, locating themselves in continuity teams, or aspiring to meet individual needs.

The personal values expressed in the stories represent personalised care and, even though this reflects the narrative within NHS policy and professional expectations, (NHS England, 2016; NMC, 2019) the reality of organisational practice has been shown in the stories, and elsewhere (Divall, 2015; Kirkham, 2017; Newnham & Kirkham, 2019), to be task focused. Thus, NQM are judged not on their ability to provide personalised care, but on their ability to complete the task on time. To gain entry to the COP through legitimate peripheral participation, NQM must adopt the practices expected (Fox, 2000; Jokisaari, 2013; Wenger, 1998), thus professional aspirations for personalised care remain challenging to implement for policy makers.

The concept of moral distress is relevant to conflicting identities, and, as with the concept of employability, requires some definition and explanation when applied to the work of midwives. Moral distress is an example of a concept which arose from the ethical debates that surround nursing (Jameton, 1984) and which has been applied across healthcare settings and professions (Musto & Rodney, 2018). It is stated to arise when personal values and morals about the correct

course of action are impeded by institutional constraints (McCarthy & Deady, 2008; Musto & Rodney, 2018). Within midwifery, the challenge to personal morals by being unable to provide midwifery care that aligns with personal values has been shown to contribute to attrition, create dissatisfaction with employment, and negatively impact individual well-being (Griffiths et al., 2019; Hunter et al., 2019; Reynolds et al., 2014; RCM, 2016; Wray et al., 2009). Therefore, as illustrated by the findings of this study, graduate midwives need to develop both a professional identity and one as an employee that reflects, or at least accommodates, an organisational identity. This argument is supported further by discussions raised when considering professional socialisation literature and notions of agency, compliance and conformity (Clouder, 2003). Compliance is defined as bowing to pressure to behave in a particular way, particularly if that behaviour is visible to others. However, unlike conformity, compliance does not reflect a fundamental change in value base but rather an individual strategy to fit into the expectations of others (Abrams, 1992). This is visible in the participants stories, for example when complying with organisational time constraints, and equally when resisting pressure to conform with negative attitudes towards the women in their care.

6.4 The Journey Women's Story: An Archetype.

The previous section primarily addressed the first research question and the ways in which the stories of the participants illustrated the three differing employability perspectives:

1. What do the stories of newly qualified midwives working in the NHS in England illustrate about the employability perspectives of possession, position, and process?

Inherent in that discussion is also the analysis of the stories as a quest or a journey and the plot elements that can be identified to illustrate each stage. This goes some way to also addressing the second research question through the identity process of *becoming* a midwife:

2. How are the stories constructed and does this add to an understanding of the process of becoming a midwife?

However, in terms of adding to the understanding of becoming a midwife, the analysis of the participants' journeys to 'becoming', as an archetypal quest, creates a useful metaphor for further consideration. Additionally, such a consideration adds to the to the discussions above in addressing the final research question:

3. What can be learned from the stories to support the future education and employment of midwives in the UK?

As outlined in Chapter One, stories are a powerful means to communicate ideas and knowledge within communities and, it has been argued this is true also for the professional knowledge shared by midwives (Weston, 2011b). In my analysis of the stories as an archetypal quest journey I argue that I am both adding to the existing knowledge transition from student to practitioner outlined in Chapter Two (Clements et al., 2012; Griffiths et al., 2019; Hobbs, 2012; Kramer, 1974), and presenting that knowledge in a new way by creating recognisable plot elements in a story that can contribute to professional practice.

In Chapter Five, I introduce the quest as the journey archetype for analysis. There are, however, alternative story archetypes to that of the 'quest' such as restitution, where the journey returns to the same starting point, or one of chaos where the protagonist is overcome by events (Frank, 1995). The quest archetype is characterised by the voice it gives to the protagonist and the personal transformation that occurs following the 'ordeal'. For this inquiry where the focus was understanding 'becoming a midwife,' that transformational archetype was broadly reflected in the stories. Equally, it is important to recognise that none of the archetypes are idealised and that individuals select elements from each when describing their journey (Frank, 1995; Sanders & van Krieken, 2018). However, in the analysis of the journey as stages and the development of archetypal plot elements, I have constructed the findings to represent a 'quest to become a midwife'. Table 3 from Chapter Five is presented again below to inform the discussion.

Table 3 : The journey as quest archetype

The Journey	**The Quest**	**Plot Elements**
Stage one: Starting out	The call	Midwives Women Representation Access
Stage two: The student Journey	The threshold	Being Prepared Mentors and fitting in Companions
Stage three: Choosing where to work	The crossroads	Stepping out The welcome Being seen
Stage four: Working as a midwife	The road of trials	Initiation Working and Learning The ordeal Participation
Stage five: Being a midwife	The return	Loss and acceptance A different kind of midwife Organisational tasks Role models With woman

The archetypal journey to becoming a midwife broadly fits that of the classic quest journey as described by Joseph Campbell and cited by several authors (Frank, 1995; Sanders & van Krieken, 2018; Steiner, 2015). I outlined the characteristics of the classic quest in Section 5.2 in Chapter Five, and some further discussion on the applicability of this metaphor will, as discussed above, contribute to addressing the research questions.

The analysis of the narrative data as a quest which begins with 'the call' places identity and women-centred values at the start of the journey and reflects both the organisational and personal aspirations identified in Chapter One and Two, (HEE, 2016; Newnham & Kirkham, 2019; NMC, 2018b) alongside employability perspectives on the process of identity development (Holmes, 2015; Kenny et al., 2011; LaPointe, 2010). Crossing the 'threshold' as a student midwife, illustrates the second part of a classic quest plot, with reference to significant others who aid or impede progress at the start of the journey; identified in this inquiry, for example, as 'mentors' and 'companions.' The value of these characters is recognised in the literature describing the experience of student

midwives, (Bradshaw et al., 2018; Kuliukas et al., 2020; Oates et al., 2019). Classic quest mythology does not, however, reference pre-existing skills in the way that the plot elements in the quest proposed here suggest; rather, the skills needed for the hero's journey are developed along the way. From an educational and employability perspective the value being organised and prepared, reflects something of the complexity of the journey ahead; the challenges of being a student and negotiating practice and social position (Fenton-O'Creevy et al., 2015; Kuliukas et al., 2020; Oates et al., 2019). Furthermore, in my analysis there was a second threshold for the participants when choosing where to work. Thus, the relationship between the threshold and the crossroads is not a clear one in this quest, and the plot elements can be presented as fitting ether stage.

The 'road of trails' as the experience of NQM is recognisable from the literature (Blaka, 2006; Reynolds et al., 2014; van der Putten, 2008), is explicit in the stories told by the participants and represented by the plot elements of 'initiation' and the 'ordeal.' In the quest presented in Chapter Five, transition continues on the 'road' and the plot elements of 'participation' and 'working as learning' were argued previously in Section 6.3.2 to reflect the theoretical perspectives informing social position (Wenger, 1998; Wenger-Trayner et al., 2015). The social process of sustaining a profession through its practice, steps away from the lone hero model of the traditional quest story and resonates more with the apprentice to master journey identified in Chapter Two (Emms, 2005). The notion of a hero too, has been critiqued for being a simplistic overly gendered archetype that reflects the paternalism in post-war Western society that was the context of Joseph Campbell's writing (Hambly, 2021; Steiner, 2015). Presenting health care professionals as heroes or indeed heroines, can also have negative consequences for both the profession and those that they attend through unrealistic expectations of what, for example, being a midwife means (Smith, 2002; Stokes-Parish et al., 2020). Thus, in constructing the archetype as a quest narrative my purpose was to give the hero a voice, as described by Frank, (1995), rather than present the participants as a lone conqueror.

The final stage of the classic quest is presented as the return of the hero, transformed by their experience and with new insight and or skills (Steiner, 2015). In this archetype, the plot elements illustrate the recognition and acceptance of the reality of practice, where organisational tasks predominate and are given value by the COP within which the journey must continue. The transformation of the hero is their ability to manage those tasks within their original aspirations of 'the call' to provide women centred care. The transformation required is recognised in the literature identified in Chapter Two (Bradfield et al., 2019; Fenwick et al., 2012; Hobbs, 2012); what this archetype offers is a metaphor which uses story to give voice to midwives and may serve to inform future journeys.

6.5 Recommendations

In this Chapter, I have discussed the findings of the inquiry and portrayed the stories of the participants, the temporal stages and the plot elements which illustrate the journey to becoming a midwife. The perspectives on employability introduced at the start of the thesis have been further explored in light of the findings and further literature and I have used the analysis of the participants' stories as a journey with archetypal elements of a quest to inform the discussion. From this discussion, the following recommendations are proposed.

6.5.1 Recommendations for professional education

1) The graduate skill of personal time management and organisation of self is valuable for NQMs. Education providers and their partners should endeavour to ensure that NMC proficiencies relating to this are prioritised and strategies are in place, including case load management to develop these in students.
2) Theoretical perspectives on decision making and opportunities to reflect on these, from and in practice, will prepare students for the journey ahead. Rehearsing support strategies and recovery mechanisms in anticipation of a critical event or 'ordeal' will also enable NQM to develop the autonomy expected of them.

3) Developing emotional intelligence and negotiation skills to enable students to navigate their journey through placements and the landscapes of practice, should form a key part of practice-based curricula such as midwifery.
4) Those with responsibility for the professional standards in midwifery education should review the efficacy of designing and implementing complex sets of proficiencies and ensure equal consideration is given to the social structures and processes that form professional identity.

6.5.2 Recommendations for employers

1) The value of being 'with woman' is at the heart of midwifery practice and providing an environment where NQM can align this value with their work will enhance both retention and service provision. Outside of staffing constraints, this means addressing cultural norms which prioritise completion of tasks over quality-of-care provision.
2) Attention should be paid to providing support to midwives following adverse incidents ensuring they are kept informed of the outcomes of any investigation.
3) Recognising the value of formal and informal peer support should feature in staff updates and professional development opportunities. This may involve consideration of cultures that foster, 'the welcome,' and positive social relationships, recognising their benefit to midwives, the organisation and childbearing women and families.
4) Preceptorship processes should include supportive discussions about perceived professional identity and future plans for employment. This should take place alongside opportunities to reflect on, and feedback to the employer, how professional and organisational identities diverge or complement each other.

6.5.3 Recommendations for future research

1) Investigation which draws on the experiences of NQM whose experiences are not framed by being a white female is needed and will add to the applicability of the understanding of employability for these groups.
2) Evaluation of the utility and efficacy of the proficiency approach to ensuring professional standards in midwifery practice.
3) Exploration of the value of the story archetype and quest plot elements enabling further development and applicability for those who educate and employ midwives.
4) Further exploration of the career and employment decisions of NQM.

6.6 Limitations of the Inquiry

Narrative inquiry, as a methodology, is reflective of other qualitative experience centred approaches which are open to the criticism that the a priori expectations of the investigator guide the data analysis (Casey et al., 2016). The discussion of reflexivity in Chapter Three goes some way to addressing this limitation, as does the recognition that the experiences of the researcher are a legitimate component of the ontology and epistemology of narrative inquiry (Clandinin & Connelly, 2000; Riessman, 2008). Nonetheless, the findings of this inquiry are necessarily shaped by my experience and those of the participants and it is equally important to recognise my influence as a researcher in how the stories were constructed. I did build in opportunities for the participants to read and comment on the stories, but it would be remiss to argue that this represented equal control of content or that the stories were co-constructed which is an often-cited aspiration of narrative inquiry (Elliott, 2011; Holloway & Galvin, 2017; Riessman, 2008).

A further potential limitation of narrative inquiry is the core nature of the methodology in facilitating the telling of stories; a term more often associated with fiction than academic endeavour. There may be criticism that as the stories were retrospective, some of the detail from previous years may be missed. However, Elliot, (2005 p145) contends that researchers should be aware that narratives

'never communicate raw experience' and are always constructed within a social context to give a particular meaning. Seeking raw experience or 'truth' is not, as discussed in Chapter Three a rationale for engaging with narrative inquiry. Rather the reader should consider that the stories in the data collected were constructed for the purpose of the interview, in response to the interview question and with me as the audience in mind as they were told. It is possible and to be expected that stories told in a different context may have, or be analysed as having, a different plot.

As I described in Chapter Three, the findings discussed represent the experiences of five newly qualified midwives, all of whom were white and female and had studied at the same university in the Northeast of England. The participants had all completed a three-year undergraduate programme and had no previous experience of working in the NHS as a nurse or otherwise. A sample that included those with nursing or other health care experience may have presented an alternate journey and plot elements. Thus, in future research it would be interesting to explore the relevance of the quest narrative to these groups.

Reflecting on the stories as a journey, this inquiry heard the voices of those who had survived the 'road of trials.' The voices of those who could not move through the stages or were thwarted in some way are missing from the findings; although in the stories of Ava and Sophia, we may hear a whisper of what they may be. As an experienced midwifery educator, I have counselled many students who were thinking of leaving their studies; their voices remain in my story and in the motivation to undertake this doctorate; however, those who leave are difficult to find and may be the most unwilling to relive their experiences.

The voices in the stories were those of white females; a group who dominate the midwifery profession in the north of England. Although the number of male midwives in the UK is very small, their experiences in negotiating the female-dominated landscapes that exist in maternity services would be and have been, a further area of study (Bly et al., 2020; Jones, 2013). In particular, an exploration of gender would add to an understanding of the lack confidence associated with female

workers highlighted in the literature review (Carlin et al., 2018). It is also necessary to recognise the impact of ethnicity on those working in the NHS reflecting the need to address the inherent inequalities in opportunity and experience for those of differing backgrounds (RCM, 2021a). However, it was not the intention of this inquiry to develop a data set that could be generalised to represent a wider population. Narrative Inquiry as a methodology aims to capture the lived experience of the participants and their stories serve to provide depth and detail rather than represent a single truth (Riessman, 2008).

A further limitation often presented for qualitative methods such as narrative inquiry is the small sample size when compared to quantitative studies. As I presented in Chapter Three when discussing the sample for this inquiry, the quest for a large and representative sample is a feature of positivistic approaches to knowledge generation (Vasileiou et al., 2018) whilst qualitative approaches are concerned with richness and depth (Ormston et al., 2013). Nonetheless, it can be argued that a small sample may limit the application of the findings (Flick, 2018). Additionally for narrative inquiry in particular, the large amount of data from even a small sample that needs to be managed and analysed in a way that avoids simple journalistic reporting is a challenge for a lone novice researcher (Pino Gavidia & Adu, 2022). A final limitation for consideration at this stage is that narrative inquiry is dependent on the ability of the participants to construct a narrative response which may be challenged by literacy, language barriers, or other factors such as emotional responses to the topic (Nolan et al., 2018). The participants' in this inquiry were willing and able to construct their stories but the voices of those who felt less confident in their story or their relationship with me [as discussed in Chapter Three, Section 3.3.4 & 3.4.4] have not been heard.

6.7 Summary of Contributions

This narrative inquiry provides a new lens through which to consider the research problem of attrition from the midwifery workforce. My analysis of the data first, as individual stories with temporal stages of a journey and then, via presentation of an archetypal quest, serves to represent

the experience of becoming a midwife as story with a recognisable plot: a characteristic of narrative inquiry (Frank, 1995; Riessman, 2008). The individual stories provide deep and authentic accounts of each journey, proving the context and voice which narrative inquiry can foreground (Caine et al., 2013). In addition, the analysis of the stories as a journey which reflects the archetype of a quest with the presence of an ordeal or traumatic event, key to the development of identity as a midwife, presents a new view on the experiences of NQM and is a valuable addition to the literature on transition.

My discussion of the findings as they relate to the three employability perspectives previously described [possession, position, and process] illustrates that the model proposed by Holmes (2013) has some merit in shifting attention away from the skills and attributes agenda. However, the interrelationship between possession, position and process is evident in the stories and the findings contribute to the employability debate by developing an understanding of what employability means for professions where the three perspectives cannot easily be separated. Graduate skills such time management and organisation are highlighted as influencing the journey, as are relationships with women and other midwives. Thus, the employability lens has provided new and comprehensive understanding of what it means to 'become a midwife'. Of equal importance is the contribution to the employability literature by describing the complexity of professional identity when the skills expected of that profession are prescriptively regulated (Clark & Zukas, 2013; Holmes, 2013, 2015; Jackson, 2016). The findings demonstrate professional and organisational identity is built from the learning which takes place within the social structures of practice.

6.8 Conclusion

To conclude the discussion, I return to the context of the thesis presented in Chapter One. As a DBA, my thesis has enabled me to use an innovative and interdisciplinary lens to address the practice problem of the education and employment of NQM. The discussion has addressed the differing perspectives on employability and in doing so has also explored the complexity of identity

development on the journey to becoming a midwife. I have presented the journey as a story archetype and identified recommendations for those who educate and employ midwives alongside areas for future research. The thesis has, therefore, addressed the research questions and produced a contribution to my practice and the practice of others.

Chapter Seven: Final Thoughts

This thesis has been a personal journey for me at a time when I am considering what it means to me to be employed as a midwife, albeit an academic one. The epigraph presented a view on that; the regeneration of midwifery through education but also, and importantly, through the relationships that midwives have with each other and the women they care for. My aim of contributing to the understanding of becoming a midwife through an employability lens has been addressed and presented via the discussion and proposed story archetype illustrated in the previous chapter. The findings illustrated the relational aspects of the work of midwives as they develop an identity as both a midwife and an employee, and I hope that the recommendations will be able to contribute to discussions about how best to prepare and retain midwives in the future NHS workforce.

Utilising narrative inquiry within the thesis has enabled me to revisit story as a source of practice knowledge and reflect on to what extent the stories my daughter heard me telling, led her down the same path to become a midwife. The existing relationship that I had with the participants would also have been informed by some of the same stories as I shared my knowledge and experience, modelling an identity that they recognised. I discuss in the Chapter Three the impact of this relationship on the inquiry and pause to reflect, in conclusion, how many of my own stories did I hear being told? Indeed, are they mine, or do the stories belong to the practice of midwifery. Wenger (1998) and Bourdieu (1986) would both argue the latter and place the education and employment of midwives firmly in the social structures and communities which construct their identities. Through undertaking this thesis, I have had the opportunity to remind myself of the power of language and story in shaping those structures whilst constructing a new story about me and the midwives who took part, which can contribute to understanding of becoming a midwife.

Finally, reflecting again on what it means to be a midwife, I conclude with reference to the work of Davis-Floyd et al., (2001,p108) who describe how midwives have had to rethink and reinvent

themselves and their practice in relation to changing contexts. The paper argues that framing contemporary midwifery as resistant to medical or institutional control:

> *'does not capture the flexibility of contemporary midwives or the subtleties of the adjustments they make as they adapt their practice… to the complexities of the modern world,'*
>
> (Davis-Floyd et al., 2001, p. 109).

Adaptations and subtleties that this inquiry has shown through the stories of the participants, who I will thank once again, as midwifery moves on into the next generation.

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Appendices

Appendix 1: Study information for participants

Recruitment email

Hello {#First Name#},
As a graduate of the Northumbria University BSc (Hons) Midwifery programme we would like to share the below message on behalf of Suzanne Crozier, Head of Subject & Lead Midwife for Education in the Department of Nursing, Midwifery & Health:

> *I hope you are well and that possibly you recognise me, and you will read on. I am undertaking a research study exploring the experiences of midwifery graduates once employed as a midwife. I have created* ***an information sheet*** *which provides further information of the nature of this study and would be grateful if you would read through and give some thought as to whether or not you would like to participate. If you are interested, or would like further information, please contact me directly via* ***email****. I will send a reminder email in a month but please do ignore that if you have decided not to take part.*
> *Thank you for taking the time to read the email and the information. I hope that you and your family and friends are well in the current circumstances.*

Best wishes,
Northumbria University Alumni Association
Sent on behalf of Suzanne Crozier, Head of Subject & Lead Midwife for Education

Stay connected to your Alumni Association **here**.

Update your mailing preferences for the Northumbria University Alumni Association **here**. If you do not wish to receive any further emails from Northumbria University Alumni Association please **click here**. Our Privacy Policy can be found **here**.

Or alternatively you can write to us at:

Advancement Office
Northumbria University
Pandon Building
Newcastle upon Tyne
NE2 1XE

Participant Information Sheet

Title of Project: Employability in Midwifery: The role of identity development.

Introduction

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve. Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you would like to take part.

What is the Purpose of the Study?

I am conducting this study as part of my Doctorate in Business Administration at Northumbria University and I am interested in exploring the development of identity as a midwife in the first few years of employment. My interest has arisen from many years of providing midwifery education and the interaction between what the profession of midwifery aspires to be and what the NHS as an employer requires. You may know that the Nursing and Midwifery Council (NMC) have published new standards to prepare midwives for practice in the UK. These standards aim to 'equip midwives of the future with the knowledge, skills, values and behaviours to meet women's changing and often complex, individual needs and choices' (NMC, 2020). There is an argument, however that to be successful in that aim the profession needs to consider that becoming a midwife is more than possessing a set of skills, values, and behaviours. Midwives must establish an identity as both a professional and an employee upon graduation and entering the workforce. This understanding of how graduates become midwives is less well explored in the midwifery literature than the skills and abilities they possess. This study has been deigned to address that gap in the literature and to explore the meaning that identity holds for midwives within the context of employability.

Why have I been invited?

You have been invited to take part because you graduated from the BSc (Hons) Midwifery Studies programme at Northumbria University between 2017 and 2019. This means you will have had some experience working as a midwife and should have completed a period of preceptorship. It is not important that you are still employed as a midwife or if you have changed employer or where you work. It is important that you have had some experience working as a midwife in an employing organisation such as the NHS or other provider. The experiences of midwives who are no longer employed as midwives would also be valuable to the study – this could include those who are working in other occupations now or who are self-employed

Do I have to take part?

No. It is up to you whether you would like to take part in the study. I have sent you this information sheet to help you make that decision. If you do decide to take part, remember that you can stop

being involved in the study whenever you choose, without telling me why. You are completely free to decide whether to take part, or to take part and then leave the study before completion.

What will happen if I take part?

The study is using a method called Narrative Inquiry which is invites participants to share stories of their experiences of a particular topic, for this study that is how you became a midwife. The story may start wherever you feel it should as a student, or perhaps when you were at school or college or earlier. If you are happy to take part I will arrange an interview date and time that is convenient and safe for you – this will need to be online using tools such as Teams or Skype. Narrative interviews typically last between 1 and 1.5 hours. We may decide that a further interview would help complete the story, but this may not be necessary. The interview will be recorded on a separate recording device (not Teams or Skype) so it can be stored securely. I hope to interview between 6 and 10 midwives and to complete the interviews by the end of January. After that I will analyse the stories and then arrange a further short conversation to share the analysis with you and confirm its accuracy. All the data I collect (the stories in the interview) will be anonymized. I will make a note of your age, the date you graduated, the length of employment as a midwife and the number and types of employing organisations you have worked for. I will not make a note of which organisations these are or where they are located as this is not relevant to the study. If you are interested in taking part, I will contact you to arrange a short phone call where I can explain more about the study and answer any questions that you may have and arrange an interview date.

What are the possible disadvantages of taking part?

The study will require some of your time for the interview and there may need to be more than one, but I will endeavor to arrange these at convenient times. Talking about your story may include recounting some difficult experiences that you have had whilst becoming a midwife. I will undertake all the interviews myself and my background in midwifery education means that I am sensitive to what these may be. However, if you think this may cause you some distress you should think carefully about taking part. If you do become distressed during the interview, we will pause and take time to recover and consider if you want to continue. The ethical approval of the project included a risk assessment which deemed this study as medium risk, and you can be assured that the university is confident that steps are in place to minimize any risks. This includes your option to withdraw at any time and the contact details of both my supervisors and the Chair of the Faculty Research Committee.

Will my taking part in this study be kept confidential and anonymous?

Yes. Your name will not be written on any of the data I collect; the written information you provide will have an ID number, not your name. Your name will not be written on the recorded interviews, or on the typed-up versions of your discussions from the interview, and your name will not appear in any reports or documents resulting from this study. The consent form you have signed will be stored separately from your other data. The data collected from you in this study will be

confidential. The only exception to this confidentiality is if the I feel that you or others may be harmed if information is not shared.

All paper data, including the typed-up transcripts from your interview and your consent forms will be kept in locked storage. All electronic data: including the recordings from your interview, will be stored on the University one drive, which is password protected. All data will be stored in accordance with University guidelines and the Data Protection Act (2018). Personally, identifiable data such as your contact details will only be stored until the study is complete in September 2021.

What categories of personal data will be collected and processed in this study?

Name and email address for contact purposes

Age, date of graduation, length of employment and number of employers as a midwife for analysis purposes.

What is the legal basis for processing personal data?

GDPR requires researchers to be transparent about the legal basis for undertaking research which will collect and process personal data. For this project as part of a University approved study Article 6(1) (e) applies .... "processing is necessary for the performance of a task carried out in the public interest". The study will not collect special categories of data such racial or ethnic origin, political opinions, religious beliefs, or sexual orientation

Who are the recipients or categories of recipients of personal data, if any?

The data collected will not be shared beyond the myself and my supervising team; Dr Jackie Adamson and Dr Valerie Egdell.

What will happen to the results of the study and could personal data collected be used in future research?

The findings of the study will be made available in my DBA thesis which will be published. I also anticipate that a summary will be reported in a journal or presented at a research conference, however the data will be anonymized and you or the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. I will provide you with a summary of the findings from the study as part of the Narrative Inquiry process.

Who is Organizing and Funding the Study?

The study is organised solely by Northumbria University and there are no external funding bodies involved

Who has reviewed this study?

The research project, submission reference 20856 has been approved in Northumbria University's Ethics Online system. It has been reviewed to safeguard your interests and I have granted approval to conduct the study

What are my rights as a participant in this study?

You have a right of access to a copy of the information comprised in your personal data (to do so individuals should submit a Subject Access Request);

You have a right in certain circumstances to have inaccurate personal data rectified; and a right to object to decisions being taken by automated means.

If you are dissatisfied with the University's processing of personal data, they have the right to complain to the Information Commissioner's Office. For more information see the ICO website

Contact for further information:

Researcher : suzanne.crozier@northumbria.ac.uk

Supervisors: jackie.adamson@northumbria.ac.uk Valerie.edgell@northumbria.ac.uk

Name and contact details of the Records and Information Officer at Northumbria University: Duncan James dp.officer@northumbria.ac.uk

You can find out more about how we use your information at: www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/

or by contacting a member of the research team

Appendix 2: Consent form

CONSENT FORM WHERE NO PERSONAL DATA IS COLLECTED

Project Title: Employability in Midwifery : The role of Identity development _____

Principal Investigator: Suzanne Crozier

please tick or initial where applicable

I have carefully read and understood the Participant Information Sheet.	☐
I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.	☐
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.	☐
I agree to take part in this study and participate in up to two narrative interviews.	☐
I also consent to the retention of this data under the condition that any subsequent use also be restricted to research projects that have gained ethical approval from Northumbria University.	
I agree to the University of Northumbria at Newcastle recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 2018 which incorporates General Data Protection Regulations (GDPR).You can find out more about how we use your information here - Privacy Notices	☐

Name/signature of participant..... Date.....

Appendix 3: Debrief information

PARTICIPANT DEBRIEF

Name of Researcher: Suzanne Crozier suzanne.crozier@northumbria.ac.uk

Name of Supervisor. Dr Jackie Adamson jackie.adamson@northumbria.ac.uk

Project Title: Employability in Midwifery: The role of identity development.

What was the purpose of the project?

The project aimed to use Narrative Inquiry or storytelling to understand more about employability in midwifery and how this may be illustrated through the development of identity as a midwife and an employee. The project is part of my Doctorate in Business Administration thesis and I am grateful for your contributions to my work. I hope that the findings will fill a gap in the current published literature about midwives which tends to focus on the development of skills and attributes such as resilience.

How will I find out about the results?

The interviews with midwives should be completed by the end of January 2021. After that time the stories from the midwives who participated will be analysed and then I will contact everyone again to gain confirmation that my interpretations are reflective of your story and that you continue to consent to their inclusion.

If I change my mind and wish to withdraw the information I have provided, how do I do this?

If you wish to withdraw your data then email me or my supervisor (named above) within 1 month of taking part and given them the code number that was allocated to you (this can be found on the top of this sheet debrief sheet).

Additional Information

The data collected in this study may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team identified in the information sheet. Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed 12 months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's personal information, nor any data provided by them, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

The process of Narrative Inquiry means that you will be involved in discussions about the findings and analysis of the stories which have been collected. If you wish to receive further feedback at any time about the findings of this research study then please contact the researcher at suzanne.crozier@northumbria.ac.uk

This study and its protocol have received full ethical approval from Faculty of Business and Law Research Ethics Committee. If you require confirmation of this, or if you have any concerns or worries concerning this research, or if you wish to register a complaint, please contact the Chair of this Committee stating the title of the research project and the name of the researcher:

Appendix 4: Follow up email

July 1st 2021

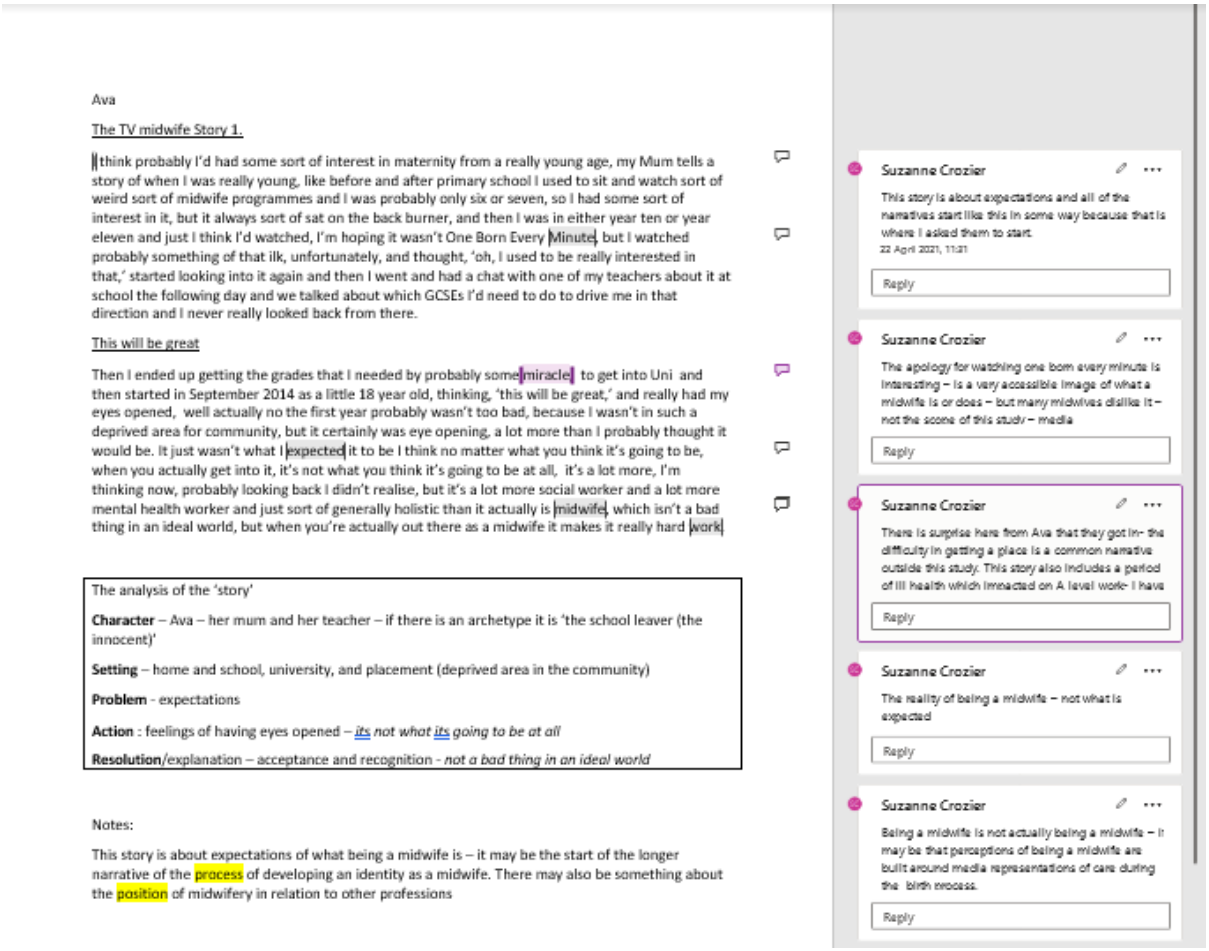
Dear xxx

I am running a little behind with my research, but I have attached my initial analysis which is a summary of your interview and the key parts of your experiences. You will see I have given you a pseudonym (I can change this if you would like me to) and also a couple of other defining details just to maintain anonymity. The document is password protected which I will send in another email. It would be great if you had time to read it and add any comments or further reflections and send it back in the next two weeks. Equally if you don't have time that is ok I can continue with it as it is.

I hope everything is still ok at work and you have some good plans for the summer and many thanks again.

Appendix 5: Data analysis examples

a) Interpreting individual transcripts. Breaking down transcripts into segments, identifying 'stories,' analysis of the plot and reflexive notes.



Ava

The TV midwife Story 1.

I think probably I'd had some sort of interest in maternity from a really young age, my Mum tells a story of when I was really young, like before and after primary school I used to sit and watch sort of weird sort of midwife programmes and I was probably only six or seven, so I had some sort of interest in it, but it always sort of sat on the back burner, and then I was in either year ten or year eleven and just I think I'd watched, I'm hoping it wasn't One Born Every Minute, but I watched probably something of that ilk, unfortunately, and thought, 'oh, I used to be really interested in that,' started looking into it again and then I went and had a chat with one of my teachers about it at school the following day and we talked about which GCSEs I'd need to do to drive me in that direction and I never really looked back from there.

This will be great

Then I ended up getting the grades that I needed by probably some miracle, to get into Uni and then started in September 2014 as a little 18 year old, thinking, 'this will be great,' and really had my eyes opened, well actually no the first year probably wasn't too bad, because I wasn't in such a deprived area for community, but it certainly was eye opening, a lot more than I probably thought it would be. It just wasn't what I expected it to be I think no matter what you think it's going to be, when you actually get into it, it's not what you think it's going to be at all, it's a lot more, I'm thinking now, probably looking back I didn't realise, but it's a lot more social worker and a lot more mental health worker and just sort of generally holistic than it actually is midwife, which isn't a bad thing in an ideal world, but when you're actually out there as a midwife it makes it really hard work

The analysis of the 'story'

Character – Ava – her mum and her teacher – if there is an archetype it is 'the school leaver (the innocent)'

Setting – home and school, university, and placement (deprived area in the community)

Problem - expectations

Action : feelings of having eyes opened – *its not what its going to be at all*

Resolution/explanation – acceptance and recognition - *not a bad thing in an ideal world*

Notes:

This story is about expectations of what being a midwife is – it may be the start of the longer narrative of the process of developing an identity as a midwife. There may also be something about the position of midwifery in relation to other professions

Suzanne Crozier

This story is about expectations and all of the narratives start like this in some way because that is where I asked them to start.

22 April 2021, 11:21

Reply

Suzanne Crozier

The apology for watching one born every minute is interesting – is a very accessible image of what a midwife is or does – but many midwives dislike it – not the scene of this study – media

Reply

Suzanne Crozier

There is surprise here from Ava that they got in- the difficulty in getting a place is a common narrative outside this study. This story also includes a period of ill health which impacted on A level work- I have

Reply

Suzanne Crozier

The reality of being a midwife – not what is expected

Reply

Suzanne Crozier

Being a midwife is not actually being a midwife – it may be that perceptions of being a midwife are built around media representations of care during the birth process.

Reply

Story 2 Toughen up

I think the first year wasn't too bad, I had quite a difficult mentor in my really long delivery suite placement at the end of first year, she was a Band seven and just felt like she didn't really have time for me as a really new student on delivery suite, so I struggled a bit through that, but feel that probably made me a much stronger midwife at the end of that than I would have been if I'd had someone who just let me potter around and not really get on with it. She put me in situations, and I didn't really have a choice but to do them and it didn't feel very pleasant at the time, but I think that it probably did toughen me up a little bit and I probably did need that.

Dealing with death

Second year I really, really struggled with second year, it was the non-midwifery placement was painful, I absolutely hated that, I remember thinking, 'I'm going to spend the next two months doing something that I don't want to do at all' . I had to go to intensive care for two weeks and I still tell the story now, that every patient that I touched on intensive care died. It was just it was really awful, one died while I was rolling him, it was horrible, but again it probably, when you get into it and you have to deal with, I mean luckily, touch wood never a maternal death, but plenty of baby deaths, still births and it does teach you how to deal with that sort of side of things a little bit. And then towards the end of second year when we went back into maternity and I was thinking, 'oh definitely chosen the right place to be, thank goodness for that' I think that was like this feeling of relief.

The analysis of the 'story'

Character – Ava –mentor – the patients – Archetype – the difficult mentor ?

Setting –placement (delivery suite and intensive care)

Problem 1 - relationship and time with mentor **Problem 2** non midwifery placement

Action/Feelings :1 *it wasn't very pleasant* – Action 2 – *it was horrible*

Resolution/explanation – acceptance and recognition – *it did toughen me up , does teach you how to deal with death , definitely chosen the right place to be*

Notes

This story is about the process of becoming a strong and tough midwife who can deal with difficult. The narrative is full of powerful adjectives and strong feelings. There is also a story about the relationship with other midwives and the social position the student has – could link into legitimate peripheral participation (Communities of Practice)

Maybe I will split it into two stories when I know how the analysis is going.

Suzanne Crozier

Wider narrative amongst students and in the profession is about the impact of 'mentors' on students' progress and identity development

Reply

Suzanne Crozier

The label of bands and in particular 'band 7' does pop up a lot in the other narratives. It is I think how midwives refer to one another too – who is the band 7 today . how many band 6's are there - for

Reply

Suzanne Crozier

A stronger midwife – a tougher midwife .

Reply

Suzanne Crozier

This links into ideas of what midwifery is and isn't (we have changed the name of the placement to try and overcome that) and is interesting because of Ava's later narrative about working with nurses

Reply

Suzanne Crozier

Story within a story

Reply

Suzanne Crozier

Recognising what is midwifery because of knowing what it isn't

Reply

b) Commonalities and differences among participants, identifying thematic elements.

These are our journey women	Olivia: The manager	Emma: The wise woman	Ava: The innocent	Sophia: The idealist	Mia : The team player
Finding direction	I could do this (intra personal) No one should feel like that	Planting a seed Mother and daughter I don't do science Midwifery is important A female servant Making a difference Now or never It all came together	The TV midwife This will be great	Its magical Not good enough I didn't love my job Inspired by midwives The midwife I didn't have Saints and girl bands The right skills	A Caring Profession Give it a go /Expectations
The student journey	Transferable skills More than a job Being shielded (Participation) Hierarchy A good midwife A bad midwife	The known and the unknown Smoothing the path Being Invisible Staying safe Being yourself Building working relationships Toeing the line	Toughen up Dealing with Death Absolutely fab Friends talking	Two kinds of mentor Loosing motivation The responsibility hit me The midwife I want to be	Up and Down Shared experiences
Choosing the next path- where to work	Getting a job Its on you Asking for help Familiar faces Being seen Treated like a midwife	Wriggle room Retracing steps Being the midwife you want to be	Learn to be a midwife Bound to make mistakes Cushy job/easy path My work mum A different job What if I miss something	Being led Working with risk	Planning the future Make or break
Working as a midwife		Dealing with adversity Recovery Informed choice to be a midwife	A bad run Tipped over the edge Loss and acceptance Being ignored	Situated learning /Learn on the job Just get on with it Humiliation It was like a didn't exist Band 7 on your back	Letting the team down The unknown Came into my own Just a number What have I missed? Bumps in the road