An analysis of the meaning of confidence in midwives undertaking intrapartum care

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Abstract

Midwives are often the lead providers of maternity care for women. To provide the variety of care required by women, they need to be confident in their role and practice. To date, only limited evidence exists in relation to confidence as experienced by midwives. This thesis aims to explore the phenomena of confidence through the lived experience of midwives. In particular, this will encompass confidence in the context of the intrapartum care setting.

The theoretical basis for the study was hermeneutic phenomenology, guided by the work of Heidegger and Gadamer. Midwives were recruited from three clinical settings to obtain a diversity of views and experiences. Rich data from diaries and in-depth interviews, from twelve participants, provided insight into the phenomena of confidence and the factors midwives encountered that affected their confidence.

The phenomena of confidence consisted of a dynamic balance, between the cognitive and affective elements of knowledge, experience and emotion. This balance was fragile and easily lost, leading to a loss of confidence. Confidence was viewed as vital to midwifery practice by the participants of the study; however, maintaining their confidence was often likened to a battle. A number of cultural and contextual factors were identified as affecting confidence within the working environment, including trust, collegial relationships and organisational influences. Midwives also described various coping strategies they utilised to maintain their confidence in the workplace environment.

This study provides unique insight into the phenomena of confidence for midwives working in intrapartum care, resulting in a number of recommendations. These highlight the importance of leadership, education and support for midwives in the clinical environment in enabling them to develop and maintain confidence in practice.
Declaration

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Publications and Conferences

Publications

Conferences
International
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An analysis of the meaning of confidence in midwives undertaking intrapartum care.

National
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Midwifery Research Conference – October 2007 Liverpool.

What makes a confident midwife?
Glossary

ARM – Artificial rupture of membranes. Technique of rupturing membranes to induce or augment labour.

Band 8 – Grade of midwife, usually managerial.

CTG – Cardiotocograph. Printed trace of electronic fetal heart rate recording.

Diamorphine – Opioid drug used for analgesia in labour.

Effaced/effacement - A process by which the cervix becomes thinner during labour.

FH – Fetal heart.

Fully dilated – The cervix is completely dilated.

Intermittent monitoring – Method of monitoring fetal heart rate.

IOL/Induction of labour/Induced – Induction of labour by medical or surgical means.

IUD – Intrauterine death – Death of fetus in utero.

Multigravida – Pregnant with second or subsequent child.

Pool birth/pool delivery – Birth of baby in pool.

Primigravida – Pregnant with first child.

Second stage of labour – From full dilatation of the cervix to the birth of the baby.

Shift leader – Senior midwife in charge of shift.

Shoulder dystocia – Failure of the anterior shoulder to pass under the symphysis pubis.

Show – Plug of bloodstained mucous often evident at start or during labour.

Syntometrine – Drug used for active management of the third stage of labour.

USS – Ultrasound scan.

VE – Vaginal examination. Digital examination of cervix to assess dilation of cervix and progress of labour.
Acknowledgements

This study would not have been possible without the midwives who participated, generously giving their time and sharing their experiences. I am grateful to them for their participation and their candid accounts of their experiences.

An enormous thank you to my supervisors Tina Lavender and Linda McGowan for their invaluable support and guidance throughout this process. In particular our, always entertaining, supervision meetings helped to provide me with inspiration.

Finally, thanks, as always, to Andy for his constant support and love.
Chapter 1

Introduction
Chapter 1: Introduction to Thesis

1.1. Introduction

This thesis presents a phenomenological study exploring the meaning of confidence to midwives undertaking intrapartum care. The purpose of this thesis is to understand the phenomena of confidence through the lived experience of midwives. In particular, the focus will be on confidence in the intrapartum setting, in which midwives care for women in labour. The views of midwives from three separate intrapartum settings with associated varying philosophies of care will be explored.

My interests in confidence arose out of my experience as a midwife providing intrapartum care in a hospital environment. I was interested in the way in which midwives worked and why some midwives practised in different ways. In particular, I was aware that some midwives embraced challenges and were keen to learn and develop whilst others were content with maintaining the status quo. I became aware of apparently competent midwives stating that they did not have confidence in particular skills or methods of working and the negative connotations associated with this. This not only had the effect of restricting their practice but could also have an effect on the care that they provided to women. I was interested to understand why some midwives felt they lacked confidence and why, for others, it was less of an issue. I was also aware of the environmental culture where over-confidence was considered detrimental to practice. Although the term confidence was widely used, this was only at a superficial level, with no apparent in-depth discussion or understanding of how it
might affect individuals. It was as a result of my interest and the apparent lack of evidence surrounding confidence that I conceived this study.

1.2. Background

As main providers of maternity care midwives can be said to be influential in the birth experiences and outcomes for women. Throughout the 1970’s and 80’s childbirth became a medicalised phenomenon with obstetricians taking a lead role in the care of all women. This was particularly evident in intrapartum care, where much of the decision-making was vested in obstetricians. Birth became more technological with an associated rise in interventions. The role of the midwife as the practitioner of normal midwifery constricted and much of their previous autonomy was lost (Mander 2002).

Over the past decade government policy documents, such as, the National Service Framework for Children, Young People and Maternity Services (DOH 2004) and Maternity Matters (DOH 2007) have led to changes in the way maternity care is provided by midwives. Women are being provided with more choice in their care, including place of birth. They are also being encouraged to make decisions about their care in partnership with health professionals. As a result, there has been an overall shift towards low-risk care, with midwives taking the role of the lead professional. In order to provide this service, midwives need to be confident in their practice. However, many midwives have trained and practised in a medicalised environment (Stevens 2011) and change may affect their confidence in their skills. This study aims to consider the views
of midwives in relation to confidence whilst working in different intrapartum settings and under different philosophies of care.

1.2.1. The current midwifery environment

Midwives provide care for women throughout pregnancy, birth and in the postnatal period (ICM 2011). Midwives are sole providers of care for the majority of women in labour. In other cases they work within a multidisciplinary team, yet remain the professional who provides the greatest support for women in labour. The increasing birth rate and shortages of midwives (RCM 2011) have placed more pressure on midwives working in this environment. Government led changes in care provision (DOH 2004, 2007), with the focus on low-risk care and more choice for women, have also resulted in midwives adaptation of their practice. Midwives currently provide care in a variety of settings, including Consultant-Led Units (CLU), Midwife-Led Units (MLU) and home. The majority of midwives work for the National Health Service (NHS) within hospital Trusts, with a small minority practising independently or as a private group (e.g. One to One Ltd). This leaves midwives in contemporary practice providing care in a variety of settings and under differing philosophies.

1.2.2. The context of intrapartum care in the UK

Intrapartum care is the care of women during labour and birth. In the UK, the majority of intrapartum care is provided in hospital settings such as Consultant-Led Units; often better known as the labour ward or delivery suite. Other settings for intrapartum care include Midwife-Led Units; these can be either on the same site as a CLU (stand-alongside units) or on a completely separate site
(stand-alone units). Other settings in which intrapartum care takes place include birth centres (BC); these being separate from the hospital setting, again with midwife-led care. The home environment is also an option for women having midwife-led care.

These settings are often distinguished by their philosophies of care. Within the hospital setting, a medical model of care dominates (Kirkham 1999; Deery 2005). This provides for a working environment which is very hierarchical in structure; with obstetricians being at the top of the hierarchy, midwives in the middle and women at the bottom (Hunt and Symons 1995; Pollard 2003; Keating and Fleming 2009). These settings tend to provide a very technocratic model of care (Porter et al 2007; O’Connell and Downe 2009; Sinclair 2009), often for women with complex needs, but also for those without. The majority of women give birth in such units (HES 2011), where there is often a high throughput with subsequent pressure on midwives. This often leaves midwives caring for more than one woman despite the government recommendations of one to one care for women in established labour (NICE 2007).

Midwives conducting care under a midwife-led model are often distinguished from traditional labour ward midwives due to their differing philosophy of care. Two main philosophies have been described; that of “with woman” or “with institution” (Hunter 2011: 173). However, these are not exclusive to each area and many midwives attempt to practice the “with woman” philosophy in consultant-led care settings. This can lead to tension between the culture of the setting and the philosophy of the midwife. Midwives practising this philosophy
have been described by other midwives as “brave” (Lavender and Chapple 2004: 328) or “mad” (Russell 2007: 130). Other members of the multidisciplinary team, such as medical staff, have also displayed negative attitudes, including a lack of trust and respect, for midwives providing care in this context (Walton et al 2005). Much of the dissonance between midwives relates to the contrasting philosophy between a medical model of care and a midwifery or social model.

It is acknowledged that midwives providing intrapartum care often do so in difficult and often stressful circumstances (Sandall 1995, 1997; Deery and Kirkham 2007). This is especially the case for midwives who work in intrapartum care settings in a hospital environment. This can lead to stress and burnout resulting in poor physical and psychological health and midwives leaving the profession (Shallow 2001; Ball et al 2002).

1.3. Confidence

Confidence is a widely used term in society, generally associated with positive outcomes. It is viewed as a positive attribute for an individual to hold, either as self-confidence or as a person whom others have confidence in. These factors often appear to be related. Self-confidence, in particular, is equated with success and often attributed to those who act as role models or leaders (Goleman 1998).

The term confidence is often vague in meaning and can be understood as either an overall state or one specific to individual situations. It generally appears to be accepted as relating to a global state of being. However, there appear to be
difficulties in defining confidence with many of the studies examining confidence offering little discussion of what it actually is. Self-confidence is defined in the Oxford English Dictionary (OED 2007) as “a feeling of trust in one’s abilities, qualities and judgement”. A similar concept in psychology is that of self-efficacy, which is defined as “the belief in one’s capabilities to organise and execute the courses of action required to manage prospective situations” (Bandura 1995: 2). These terms have very similar attributes, often being used interchangeably (Schwarzer 1992; Davies and Hodnett 2002; Gillespie et al 2007; Lauder et al 2008). However, whilst confidence is often viewed in generalist terms, self-efficacy is often understood to be situation specific. The description of self-efficacy as performance in a given situation, leads to this conclusion. Indeed, self-efficacy has been described as “specific to a particular task” (Goddard et al 2004: 4). However, others (Schwarzer and Jerusalem 1995; Scherbaum et al 2006) have considered self-efficacy in a more generalist manner in relation to the individual’s overall belief in themselves to perform in a variety of situations. Hence, it can be argued that general self-efficacy can be a general belief, not just situation specific. This further adds to confusion around the terms. The difficulty in distinguishing the terms confidence and self-efficacy have led me to consider them congruent in reviewing the literature for this study.

I chose to consider the term confidence in relation to midwives as this is a term in general use. Midwives were likely to readily understand the term and it was one I had frequently heard used in practice situations. However, I am mindful of self-efficacy and will examine and discuss current theory and the
appropriateness of the interchangeability of terms confidence and self-efficacy in relation to the findings later in the thesis.

1.3.1. The development of confidence

The sources and development of confidence as such are unclear. However, Bandura’s (1997) self-efficacy theory provides some insight into how individuals develop self-efficacy. Given the apparent acceptance of self-efficacy as a similar concept to confidence, this section will consider self-efficacy theory in relation to the development of confidence.

Bandura (1997) suggests that there are four sources of self-efficacy. The first and most influential method of these is that of enactive mastery experience. This is development of confidence through experience. By successfully performing a task an individual increases their sense of self-efficacy. However, failure in a task can undermine self-efficacy. Successful mastery of a skill by repeated performance is required for the individual to feel confident in it. Consistent failure may undermine confidence and lead the individual to cease attempts at that particular task.

Secondly, individuals develop confidence through vicarious experience, that is, observing others of similar capabilities to themselves achieve success or experience failure. Where a person has uncertainty or little direct knowledge of their capabilities they tend to rely more heavily on vicarious experience and observation of others.
Thirdly, a person’s confidence can be enhanced by another expressing faith or confidence in their capabilities. Such verbal persuasion can encourage an individual to use greater effort and to sustain it for longer. Any subsequent success will enhance confidence. Verbal persuasion may also be used to undermine confidence and an individual can be persuaded that they lack capability. This may result in them avoiding a situation or giving up quickly in the face of challenges. The credibility of the persuader and the individual’s confidence in that person is an important factor in their influence. Hence, those in authority or held in high esteem, such as managers or senior midwives, can be particularly influential in this regard. The traditionally hierarchical nature of care provision often places the midwife at a disadvantage. Many midwives will act in an acquiescent manner to the influence of a senior person (Hollins Martin 2007). More recently highlighted issues, such as bullying within the professional environment may also have an impact. Loss of confidence is recognised as a psychological consequence of bullying (Gillen et al 2004; NHS Employers 2006). This may be as a result of bullying from those in senior positions or that of horizontal violence by peers, as described by Kirkham and Stapleton (2000).

Fourthly, affect, mood and stress can affect an individual’s judgement of their perceived self-efficacy. Hence, positive or stressful environments can influence the individual’s belief in their confidence and abilities. Midwives have described how stress and workplace culture can lead to a decline in confidence, ultimately leading to them leaving the profession (Curtis et al 2006a).
Two further factors are important in self-efficacy theory. Self-efficacy is closely related to outcome expectancy and personal control (Schwarzer 1992; Bandura 1997). Outcome expectancy is the anticipated outcome of an action. It is this probable outcome that motivates individuals to attempt the task or action. Schwarzer (1992) suggests that self-efficacy and a sense of personal control are fundamentally linked. Furthermore the degree of perceived personal control impacts on the individual’s outcome expectancies. Confident individuals have been described as possessing an internal locus of control, that is, they have a belief in their own ability to determine events (Stephens 2006). Those with an external locus of control believe that fate and the acts of others have a greater effect on outcomes than they themselves.

1.4. The importance of confidence for midwives

As healthcare professionals it is essential for midwives to practice to the best of their ability. In order to offer women choice, promote normal birth, act as the lead professional and advocate for women midwives need to be confident (DOH 2003). This is particularly important when an organisation is undergoing change, as has midwifery, in line with current government policy (DOH 2004, 2007). Whilst caring for low-risk women has always been the remit of the midwife, changes have frequently led to a disruption in working patterns and the requirement to adapt to new working practices. Midwives have mostly risen to the challenge but may have suffered confidence issues along the way. Some of these issues can relate to professional identity and role, with changes in role undermining midwives’ confidence (Larsson et al 2009). Lavender and Chapple (2004) highlighted midwives’ concerns around providing care for low-risk
women, with some midwives identifying a lack of confidence in providing such care. Midwives have also reported a lack of confidence in labour ward skills when working under a team midwifery system (Meerabeau et al 1999; Ashcroft et al 2003). The anxiety midwives encountered when working in a team role had an effect on them considering birth as a normal process (Shallow 2001).

Midwives who are attempting to work within a social model of care and promote normality often feel pressure placed upon them to conform to unit practice (Stapleton et al 2002). Added to this is the background threat of litigation. This alone has been cited as a contributory stress affecting an individual’s confidence and a contributing factor to midwives leaving the profession (Symon 1998; Ball et al 2002). Ball et al (2002) examined in detail the reasons given by midwives for leaving practice. Of those who cited dissatisfaction with midwifery as the main reason for leaving, a significant proportion referred to lack of confidence as a factor. Of midwives currently practising, it is possible that confidence issues may have an effect on their well-being. Shallow (2001) noted that fear and anxiety about practice led to increased levels of sickness. Staff shortages and a poor skill mix increase the risk of near misses and adverse events (Ashcroft et al 2003), which can impact upon care.

A sense of powerlessness arising from the culture within a unit can contribute to a lack of confidence held by the individual (Kirkham and Stapleton 2000). Where midwives have a lack of control and hence power, they are more likely to resist women who request the unusual for fear of affecting the status quo (Stapleton et al 2002). This in turn detracts from the philosophy of woman
centred holistic care. Those working in high pressure, low control positions are more likely to suffer from stress and consequently a lack of self-worth and confidence (Handy 1999). Women may subsequently be disempowered as midwives do not have enough confidence in themselves or the system in which they work to provide them with real choice.

However, positive experience and team support can provide a sound and secure base for midwives to develop and maintain their confidence. In considering midwives' support needs, Kirkham and Stapleton (2000) found that midwives' confidence improves where they are made to feel valued or praised. Lavender and Chapple (2004) also noted that midwives felt a greater sense of job satisfaction, no matter what the workload, when they perceived they were valued. Midwives who have autonomy and some sense of control over their workload are more likely to experience a higher sense of job satisfaction and confidence (Sandall 1995).

It is not known to what extent confidence affects midwives in the workplace, nor is it clear how the workplace environment and culture can affect confidence. Whilst a number of studies have attempted to measure confidence in newly qualified midwives (Donovan 2008; Jordan and Farley 2008), there has been little attempt to explore confidence in experienced midwives. Yet their confidence may be important for the development of the profession as they are often role models and mentors for junior midwives. In particular, there is a lack of understanding of what confidence actually means to midwives and how this can be affected in practice.
1.5. Outline of the Thesis

The thesis is comprised of nine chapters, brief details of which are outlined below:

**Chapter one** has introduced the research idea and provides some context in relation to confidence, self-efficacy and midwives working environment.

**Chapter two** involves a more detailed review of the literature surrounding the topic area. This will help to contextualise the study and highlight gaps in knowledge around confidence.

**Chapter three** provides detail regarding the theoretical background to the study and the justification for the use of phenomenology. It also addresses some of the ethical issues which were considered. Reflexivity, a thread running through the thesis, is discussed in more detail in this chapter.

**Chapter four** describes the study design and methods used in the study. This chapter includes a description of the settings and discussion of the sample, including recruitment and consent issues. Justification for the method of analysis and a discussion of rigour are also included in this chapter.

**Chapter five** discusses a methodological aspect of the study; this being the use of diaries in a phenomenological context. Evaluation and a discussion of the
diary aspect of the study are presented in this chapter. The demographic details of the participants are also included.

**Chapter six** introduces the phenomena of confidence as experienced by the midwife participants of the study (main aim). A discussion of the various elements and aspects of confidence takes place here.

**Chapter seven** focuses on the themes arising which relate to factors affecting midwives’ confidence in practice. These include factors relating to trust, vulnerability, self-protection, control, belonging and conflict. The findings within the themes are accompanied by an alongside discussion.

**Chapter eight** synthesises and discusses the study findings, re-contextualising them in relation to current knowledge and practice. The unique findings of the study are highlighted, along with the identified strengths and limitations.

**Chapter nine** presents the conclusion to the thesis, along with implications and recommendations for practice and research.
Chapter 2

Review of the Literature
Chapter 2: Review of the Literature

2.1. Introduction

This chapter will present an overview of existing literature which is relevant to the aims of the study. This includes identification and review of existing literature in relation to midwives’ confidence. As the initial scoping search revealed limited literature relating to this specific area, the review will also include discussion of literature surrounding confidence and self-efficacy related to other healthcare professionals where relevant. The review will provide rationale and situate the study within the context of midwifery.

2.2. Approach

Given the paucity of data relating to the focus of the search, that is midwives and confidence in intrapartum care, I chose to undertake a narrative review in order to capture wider data with which to form a narrative thread (Baumeister and Leary 1997). Whilst systematic reviews are considered the ‘gold standard’, the focus of such a review can be limiting (Collins and Fauser 2005). Narrative reviews are wider in scope, allowing for greater flexibility and the inclusion of wider literature (Hammersley 2001; Collins and Fauser 2005). This flexibility suited the approach required for this review. Given the limited availability of studies in this area the aim of the review is to incorporate appropriate evidence surrounding the phenomenon of confidence. Both qualitative and quantitative literature was considered in order to provide a comprehensive review of current literature. Whilst the review itself is not a systematic review, a systematic approach to retrieval of the literature was undertaken. Furthermore, the
retrieved literature was approached in a structured way to ensure consistency and transparency as far as possible (Green et al 2006).

The review was carried out using a variety of databases including Medline, CINHAL, EMBASE, ProQuest, Ovid, ASSIA, zetoc, scopus and PsychINFO. A hand search and internet search of all relevant journals was also undertaken. The reference lists of all relevant papers were hand searched and links to related papers and citations were followed where available. The initial search took place in 2007, with a further search in December 2011 in an attempt to identify any subsequent new literature.


The search strategy was undertaken in three phases, from a very focussed search to a wider search:

- Midwives and confidence, self-confidence or self-efficacy and intrapartum care.
- Midwives and confidence, self-confidence or self-efficacy.
- Health professionals, nurses, doctors and confidence, self-confidence or self-efficacy.
The papers identified included search terms in the title or abstract. It was intended that this would highlight any papers where the main aims or findings were either confidence or self-efficacy. Due to the small number of papers identified using this method, the search terms were extended to whole papers where the terms included “confidence”, “self-confidence” or “self-efficacy” and “midwives”. However, this provided an unmanageable number of papers. A difficulty in using confidence as a search term is that it highlights a large number of papers where the term is used in relation to confidence intervals. Hence, whole paper searches were not carried out in relation to the terms “health professionals”, “nurses” and “doctors”. All papers identified were reviewed for relevance.

Inclusion criteria:

- Papers with aims or hypothesis related to confidence, self-confidence or self-efficacy.

And

- Papers relating to midwives or other healthcare professionals, including; nurses, doctors, General Practitioners.
- Papers relating to any healthcare setting.
- Papers written in English.
- Primary or secondary research papers.

Exclusion criteria:

- Papers not written in English.
- Opinion pieces.
2.3. Challenges in reviewing the literature

My main focus was that of confidence, however, during the search process it became evident that the term self-efficacy was used extensively. Self-efficacy as a concept is widely studied in relation to psychology (Scherbaum et al 2006). There was little evidence of a perceived difference between the terms in many of the papers, particularly as a number of papers used the terms confidence and self-efficacy interchangeably (Jeffreys and Smol laka 1998; Davies and Hodnett 2002; Gillespie et al 2007; Lauder et al 2008; Lauder et al 2011; Banks et al 2011). It proved difficult to separate theories relating to confidence from self-efficacy and self-efficacy theory appeared to dominate this area. I considered that it was important to include relevant papers relating to self-efficacy in this review to ensure a comprehensive overview of the relevant literature.

The lack of evidence relating to confidence and midwives led me to consider relevant literature associated with other health professional groups. In the majority of cases, this was nurses and to some extent medical doctors. There are clearly issues arising in doing this as midwives have a distinctly different role to either group. However, health professional literature, particularly nursing, is likely to share some commonalities and have relevance to the role of the midwife.
2.4. The literature

Reviewing the literature in relation to midwives and other healthcare professionals revealed a number of themes. Seven studies related to intrapartum care and confidence. Other areas considered in this review include the definitions used in relation to confidence and the development of confidence through education and training. Confidence will also be discussed in relation to experience and competence. Studies considering over and under-confidence will also be discussed. Finally, the link between confidence and well-being will be examined.
<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Sample and Setting</th>
<th>Design</th>
<th>Findings/Results</th>
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<tbody>
<tr>
<td>Alexander et al. (2002)</td>
<td>To evaluate the midwife ventouse practitioners course and the midwife ventouse practitioners perception of its effect on their practice.</td>
<td>18 midwives who had completed the midwifery ventouse practitioners course at Bournemouth university. Response rate 100%</td>
<td>Focus group (n=8) – not reported on. Questionnaire (n=18) Open and closed questions Confidence measured by VAS – 10cm line Questionnaire results reported</td>
<td>6 midwives reported increased confidence in general. 7 midwives reported increased confidence in ability to define fetal position and station either on abdominal palpation or on VE. 4 increased confidence in ability to “handle” prolonged labour and to delay intervention. 2 noted increased confidence in using syntocinon. Questionnaire: VAS (10 point scale) used to indicate confidence when undertaking first ventouse birth after certificate. Mean score = 7 SD: 1.7 Range : 4.3 – 9.9</td>
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<tr>
<td>Davies and Hodnett (2002)</td>
<td>Development of a self-efficacy questionnaire. Obtain nurses views of labour support and self-efficacy.</td>
<td>Nurses providing labour ward care at five hospitals in Canada. Response rate 88% (152/173).</td>
<td>11 point questionnaire was used to determine nurses’ self-efficacy in labour support. Three further questions relating to perceived competence Not directly related to self-efficacy questions.</td>
<td>All nurses had high self-efficacy scores in relation to their ability to provide labour care. Nurses working in postnatal care areas had less confidence in labour support than those working in the labour ward setting.</td>
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<tr>
<td>Findings/Results</td>
<td>Students felt confident in caring for women in labour. Students feel confident in certain skills irrespective of the length of their course. Students undertaking the 3 year course tended to have the lowest overall levels of confidence. Does not state whether any statistically significant findings. 85% of midwives were confident to monitor low risk women using intermittent fetal auscultation. 72% felt confident in interpreting CTG traces. Community midwives were less confident than midwives working in a regional unit in interpreting CTG's. Midwives without continuing education qualifications were less confident in CTG interpretation. Midwives working part-time were less likely to be confident using intermittent monitoring.</td>
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<td>Design</td>
<td>Questionnaire using tool designed to measure confidence. Used VAS. Closed questions only used. Considered specific areas in relation to antenatal care, intrapartum care and postnatal care. Also questions relating to teaching students and confidence in relation to caring for a woman on their own responsibility throughout her pregnancy, birth and postnatal period. Questionnaire. 5 point ordinal scale. Authors describe attitude scale as &quot;moderately reliable&quot; and &quot;probably sufficient.&quot;</td>
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<td>Sample and Setting</td>
<td>45 graduates at 2 universities. (61 approached) Midwives working in a regional maternity unit, a district maternity unit and a related community district. Response 117 out of 242 approached. (46% response rate)</td>
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<td>Aim</td>
<td>To explore confidence levels of students following 3 and 4 year degree courses (direct entry) and 18 month degree course (RN's) To survey midwives attitudes and practices related to fetal monitoring. Included consideration of midwives confidence in various methods of fetal monitoring and interpretation of CTG’s.</td>
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Findings/Results

There was a statistically significant relationship between high self-efficacy scores and therapeutic presence, but not between self-efficacy and non-intervention. Therapeutic presence ($r = 0.451; P < .001$) and mastery experience ($r = 0.423; P < .001$) were noted to be the most significant predictors of self-efficacy. Verbal persuasion had little influence. Vicarious experience was not considered related to self-efficacy.

Non-intervention. Outcome expectancy and vicarious experience were positively (but not significantly) associated with self-efficacy. Mastery experience and verbal persuasion were not related to self-efficacy. Self-perceived confidence was high. (83% scored confidence between 7-10 on the scale).

There was a statistically significant correlation between time spent delivering intrapartum care and confidence levels but the authors suggest the correlation is weak and therefore not clinically important. Even midwives who spent little time providing intrapartum care rated their perceived confidence as high. There may therefore be disparity between midwives competence and confidence. The level of academic qualification had no significant effect on the confidence score.

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<td>Jordan and Farley (2008).</td>
<td>Influence of preceptors (mentors) on student midwife self-efficacy. Two specific areas were considered; therapeutic presence and non-intervention.</td>
<td>125 recent graduates. (215 approached. Response rate 58%) USA</td>
<td>Two tools were developed by the authors and used in the study. – 'Midwife Student Self-Efficacy scale' and a practice questionnaire.</td>
<td>There was a statistically significant relationship between high self-efficacy scores and therapeutic presence, but not between self-efficacy and non-intervention. Therapeutic presence. Outcome expectancy ($r = 0.451; P &lt; .001$) and mastery experience ($r = 0.423; P &lt; .001$) were noted to be the most significant predictors of self-efficacy. Verbal persuasion had little influence. Vicarious experience was not considered related to self-efficacy. Non-intervention. Outcome expectancy and vicarious experience were positively (but not significantly) associated with self-efficacy. Mastery experience and verbal persuasion were not related to self-efficacy. Self-perceived confidence was high. (83% scored confidence between 7-10 on the scale).</td>
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<td>Stewart and Guildea (2002).</td>
<td>To identify the relationship between time worked on labour ward and self-confidence in CTG interpretation.</td>
<td>Participation - 741 Hospital and community based midwives - Wales UK. Response rate &lt;50% of those approached.</td>
<td>Questionnaire Scale of measurement 0-10 (No confidence – Extremely confident)</td>
<td>Self-perceived confidence was high. (83% scored confidence between 7-10 on the scale). There was a statistically significant correlation between time spent delivering intrapartum care and confidence levels but the authors suggest the correlation is weak and therefore not clinically important. Even midwives who spent little time providing intrapartum care rated their perceived confidence as high. There may therefore be disparity between midwives competence and confidence. The level of academic qualification had no significant effect on the confidence score.</td>
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<td>Wilson (2011)</td>
<td>Measure competence (main aim) and confidence in perineal repair.</td>
<td>145 Midwives from 6 NHS Trusts. UK. Low response rates (14% and 16%) in some phases.</td>
<td>Intervention study. Focus groups and questionnaires pre and post intervention. Unclear how confidence was measured.</td>
<td>Correlation between frequency of skill and confidence. Higher self-confidence = higher perceived competence. No difference pre/post intervention in confidence. Experience influenced confidence. Support (particularly from SOM) and positive feedback were important for confidence. Observation and participation in skill itself were important for confidence.</td>
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</table>
2.5. Intrapartum care and confidence

Seven studies related to intrapartum care and confidence (Dover and Gauge 1995; Alexander et al 2002; Davies and Hodnett 2002; Stewart and Guildea 2002; Donovan 2008; Jordan and Farley 2008; Wilson 2011) (see table 1). Of these, only five identified papers had aims related directly to intrapartum care skills and confidence (Davies and Hodnett 2002; Stewart and Guildea 2002; Donovan 2008; Jordan and Farley 2008; Wilson 2011). Two studies related to student midwives (Donovan 2008; Jordan and Farley 2008). Two studies (Dover and Gauge 1995; Alexander et al 2002) did not state confidence as an aim, however both reported on specific questions related to confidence. Participants in all studies were midwives with the exception of Davies and Hodnett’s (2002) Canadian study, in which the participants were nurses who provided labour support. Although the participants were nurses and not midwives, it appears that the majority of intrapartum care and support in the study setting was provided by nurses (Davies and Hodnett 2002). Hence, it was anticipated there would be expected similarities in the role.

2.5.1. Confidence and specific skills in intrapartum care

All of the studies relating to specific skills were quantitative in nature and made some attempt to measure confidence. Three of the studies measured confidence in relation to specific skills such as CTG interpretation (Dover and Gauge 1995; Stewart and Guildea 2002) and perineal suturing (Wilson 2011); whilst Donovan (2008) measured confidence in relation to a range of antenatal, postnatal and intrapartum skills. Davies and Hodnett’s (2002) paper focussed on general self-efficacy or confidence in labour support, whilst Jordan and
Farley (2008) considered the self-efficacy of student midwives in relation to two specific aspects of labour support. Although the identified studies focus on a specific area or skill, these skills relate to the intrapartum setting and therefore the studies were included here.

The studies all used questionnaire surveys to measure self-reported confidence, employing various scales to do this. As all the studies utilised different outcome measures and means of measurement, no meaningful direct comparison is possible. Only Davies and Hodnett (2002) described the development of the tool for measuring self-efficacy. They were also the only authors to provide a definition, using Bandura’s self-efficacy definition. However, they used the terms self-efficacy and confidence interchangeably, so it can be extrapolated that they also attributed this definition to confidence. The other authors all discussed confidence rather than self-efficacy and none provided a definition for this.

All of the included studies, except one (Davies and Hodnett 2002), used a measurement of confidence in a particular skill at a single time point. Davies and Hodnett required the same questionnaire to be completed a week apart in an attempt to ensure consistency. Two studies (Donovan 2008; Davies and Hodnett 2002) collected data regarding confidence in relation to a number of aspects of care and skills as discussed above.

In all the studies the measure of confidence was self-reported. Only two of the studies relating to intrapartum care considered competence in skills as well as
confidence (Davies and Hodnett 2002; Wilson 2011). Whilst some studies outside of intrapartum care area have attempted to externally confirm confidence in some way (Hausman et al 1990; Barnsley et al 2004), neither of these studies did, relying instead on self-report competence. Davies and Hodnett (2002) asked the respondents to rate their skills in three areas; provision of comfort, emotional support and advice. Each of these related to a number of questions in which respondents had been asked to rate their confidence, so no direct comparison could be made. It is unclear the extent to which competence and confidence were related in Wilson’s (2011) study; however, findings indicated experience and frequency of performing the skill enhanced midwives’ confidence. Both Dover and Gauge (1995) and Stewart and Guildea’s (2002) studies relating to CTG interpretation revealed high levels of confidence in midwives in undertaking these skills. Dover and Gauge (1995) did note that midwives working in community areas were significantly less confident than midwives working at the regional unit, as were part-time midwives, indicating the skill is likely to be associated with experience in the intrapartum area. Stewart and Guildea (2002), in their discussion, suggested that there may be inconsistencies between midwives’ self-reported high levels of confidence in CTG interpretation in light of a report (CESDI 1997) which suggested issues relating to competence in the area of CTG interpretation exist. However, there is little evidence that competence and confidence correlate (Morgan and Cleave-Hogg 2002; Barnsley et al 2004), except possibly in relation to newly qualified individuals (Lauder et al 2008; Roxburgh et al 2010). The use of self-report confidence measures is not necessarily a criticism as confidence can be considered subjective to the individual experiencing it and
therefore difficult to ascertain by others. Comparisons with competence are more likely to provide a fixed point against which to measure confidence, but may also be subjective.

Two studies relating to intrapartum skills (Dover and Gauge 1995; Alexander et al 2002) did not state confidence as an aim. However, in both studies specific questions relating to confidence were asked. Dover and Gauge (1995) used questionnaires in a descriptive correlational study to determine midwives attitudes towards fetal monitoring. The questions related to confidence were connected to specific skills, these being the use of intermittent monitoring or interpretation of cardiotocograph traces. Alexander et al (2002) completed a mixed methods study of eighteen midwives who had recently completed an educational course; the midwifery ventouse practitioners course. The authors followed up a focus group of eight midwives with a questionnaire survey to all midwives who had undertaken the course. A visual analogue scale allowed for the midwives to provide a measure of self-reported confidence at a single time point when undertaking their first ventouse birth following the course. Both studies reported high levels of confidence in the skills measured.

All of the studies related to intrapartum skills revealed high levels of confidence in midwives in relation to the skills being measured. This may indicate that midwives are genuinely confident in these areas and their skills. However, the majority of the studies had methodological limitations which may impact on the interpretation of the results. Many of the studies used non-validated tools with which to measure confidence. Additionally, the studies were very focussed on
particular skills. As a result, none of the studies attempted to explore factors which may have impacted on or facilitated confidence in the study settings.

2.5.2. Confidence in intrapartum care

Three papers considered confidence in intrapartum care in a general sense (Davies and Hodnett 2002; Donovan 2008; Jordan and Farley 2008). In one further study (Alexander et al 2002), participants commented on more general aspects of confidence following an educational course.

Davies and Hodnett's (2002) study focussed on confidence in labour support, hypothesising that nurses who provided support in labour regularly would be more confident than those who did not. Findings indicated high levels of reported confidence in nurses regularly providing labour care, compared to lower levels in nurses providing postnatal care. The study also explored organisational factors which facilitated and prevented support, although the authors did not relate these to confidence.

One quantitative study considered more general aspects of labour care and self-efficacy in student midwives. Jordan and Farley (2008) devised the “Midwife Student Self-Efficacy scale” (2008: 415) to measure two aspects of self-efficacy and outcome expectancy in practice. The first of these was related to non-intervention, which was characterised by three behaviours which would be classified as interventions in labour, amniotomy, continuous fetal heart rate monitoring and oxytocin use without indication. The second was classified as therapeutic presence, and was characterised by emotional and practical
assistance and information provision in labour. This is similar to the labour support of Davies and Hodnett’s (2002) study. The study hypothesised that the behaviour of mentors (preceptors) would impact on the self-efficacy of students in relation to these two aspects of care. Self-efficacy scores were high for both aspects of care, although they were higher for therapeutic behaviour than for non-intervention. The authors in this study related the findings to aspects of Bandura’s theory, including outcome expectancy and some of the sources of self-efficacy. They determined that self-efficacy was most strongly predicated by outcome expectancy for both behaviours. Outcome expectancy is the anticipation that a particular behaviour will produce a desired outcome. However, it is likely that an individual will only attempt a behaviour where the outcome is in some way desirable. Hence, this outcome is unsurprising. Other findings included the fact that actual performance of the behaviour, such as the supportive therapeutic behaviours, impacted on self-efficacy; and may explain the higher score accorded to this behaviour. For non-intervention in labour, the authors determined that it was vicarious experience through observation of their mentor’s behaviour that impacted on the student’s own self-efficacy.

Whilst Donovan (2008) considered some very specific aspects of confidence, her study covered a range of skills and attempted to gain an overall sense of confidence. However, the study was limited by a focussed closed questionnaire approach. Therefore, only specific responses were obtained. Alexander et al (2002) similarly focussed on specific areas, but the use of open questions captured data indicating that ventouse practitioner midwives felt generally
increased confidence in general abilities and intrapartum decision-making following an educational training course.

2.6. Defining confidence

In reviewing the literature it became evident that few studies made any attempt to define the term confidence. This compares with studies exploring self-efficacy, which commonly defined self-efficacy based on Bandura’s original work. As discussed earlier, some cross-over of definition was evident with studies purporting to consider confidence using self-efficacy as a definition. Only two studies (Stewart et al 2000; Clark and Holmes 2007) used pre-defined descriptions of confidence. Stewart et al (2000) acknowledged the lack of analysis of the term, using their own definition of confidence as ‘a judgement which influenced whether an individual was willing or not to undertake an activity’ (Stewart et al 2000: 903). Clark and Holmes (2007) used a description focussed on nurses, describing confidence as ‘a sense of security which is soundly based on the nurses’ [sic] awareness of her own capability, values and rights’ (Lathlean and Corner 1991 cited in Clark and Holmes 2007: 1214).

One qualitative study, involving Canadian student nurses, aimed to define confidence (Crooks et al 2005). More specifically the authors focussed on what they termed “professional confidence”, which they subsequently defined as “an internal feeling of self assurance and comfort” (Crooks et al 2005: 361).

For others, the assumption appeared to be that confidence, as a term in everyday usage, would be easily understood by participants. However, a lack of
any definition in many of these, largely quantitative, studies suggests the possibility that participants and researchers may have differing understanding of the term. It is evident, therefore, that whilst self-efficacy definitions are based soundly on Bandura’s work, definitions of confidence are varied, with little theoretical basis.

2.7. Development of confidence

2.7.1. Education

The development of confidence or self-efficacy related to education was a strong emergent theme in the literature review. There is a plethora of literature relating to student self-efficacy, however, for the purposes of this review only relevant papers relating to midwives and nurses have been included. A limited number of papers explored midwives’ confidence in relation to pre-registration education or their preparation for practice as newly qualified midwives (Donovan 2008; Jordan and Farley 2008; Licquirish and Seibold 2008). A further paper discussed student nurses’ and midwives’ confidence jointly (Lauder et al 2008), whilst other papers discussed student nurses’ confidence alone (Crooks et al 2005; Clark and Holmes 2007; Roxburgh et al 2010). Given that midwives’ and nurses’ confidence has been explored in similar ways, this review will focus on papers relating specifically to both student midwives’ and nurses’ confidence. Whilst midwives and nurses roles differ, however, it is anticipated that students from both professions are likely to face similar issues relating to confidence. In particular, it can be expected that students of both professions would face anxiety and a lack of confidence in relation to skills development and competence in the clinical setting. This similarity in confidence was

The majority of the studies used a quantitative element to measure self-reported confidence or self-efficacy. Lauder et al (2008) and Donovan (2008) both considered different cohorts of students in their studies of confidence. Donovan’s study explored confidence on the final day a midwifery degree course for three separate cohorts of students at two institutions. These cohorts had undertaken eighteen month, three year and four year degree courses respectively. It was unclear at which time point in the degree programme that Lauder et al (2008) collected data and whether this was different for the different cohorts. In this study, data was collected from both different institutions and different programmes of training; including adult, child, mental health and learning disability nursing and midwifery. Neither study identified any significant differences in confidence or self-efficacy between the groups. However the measures used were different for each study. Donovan (2008) used a self-devised questionnaire to consider specific skills, whilst Lauder et al (2008) used the general perceived self-efficacy scale (GPSE) (Schwarzer and Jerusalem 1995). The GPSE is much more generalist in scope, giving an overall general self-efficacy score. Although different measures were used, it is apparent that the type and length of degree course had no impact on participants’ perceived self-efficacy, either generalist or specific.

Two studies (Crooks et al 2005; Licquish and Seibold 2008) used qualitative methods to consider confidence. Licquish and Seibold (2008) explored
students’ experiences as part of a larger study considering midwives’ competence for practice. This Australian study provides valuable insight into aspects of practice that may impact on a student’s confidence. The importance of a clinical mentor, who should act as a role model for the student was highlighted. Factors increasing student midwives’ confidence in practice included the being provided with space to develop their competence and decision-making skills whilst being supported. Mentors were important in the development of confidence and reciprocal confidence demonstrated by mentors was important in building individual confidence. However, negativity by mentors and lack of support could adversely affect a student’s confidence. The importance of mentors in development of confidence has also been highlighted in UK studies (Hughes and Fraser 2010; Skirton et al 2011).

Crooks et al (2005) considered which factors assisted or inhibited the development of confidence in student nurses. The authors identified a linear development of confidence from knowing, to doing, to reflection. Only one method of enhancing support was identified; this being peer support. One barrier was also identified; that being an inability to publicly express concerns. The study was described as focus groups in which semi-structured interview questions were used. No example of the questions used is provided and therefore it is difficult to determine whether these were limiting in exploring the student experiences. Furthermore, it is unclear how many students participated or whether there were any differences between the focus groups. Much of the study focussed on the nursing student development of confidence which is likely to be different to the qualified midwife’s experience of confidence as their
clinical role and experiences are expected to be very different. However, I considered it relevant to this review as it was one of the few qualitative studies aiming to explore confidence in a healthcare professional group.

2.7.2. Post registration training
Post registration education or specific training has been found to increase confidence. Watkins and Dodgson’s (2010) review of educational interventions found education significantly improved health professionals’ confidence in relation to breastfeeding practice. Furthermore Benjamin et al (2009) found those who had undertaken specific genetic training in any format had more confidence in integrating genetic information into practice than those who had not. Other studies (Alexander et al 2002; Ringsted et al 2004) found confidence to have increased in areas not specific to the training intervention. Alexander et al (2002) reported increased confidence in ventouse practitioners in relation to general intrapartum decision-making as well as specific skills; whilst Ringsted et al (2004) found increases in confidence in relation to professional role.

No significant increase in confidence was found in Wilson’s (2011) intervention study relating to perineal suturing. Whilst competency in the skill improved following an educational intervention, no differences in confidence were evident. However, the author claims that perceived confidence was correlated to competency and the ability to perform the skill unaided. This study was limited by low response rates and hence the results should be interpreted with caution.
Increasing knowledge has also been linked to confidence acquisition. One identified paper (Samwill 2002) aimed to assess the knowledge and confidence of midwives in counselling women about screening tests for Down’s syndrome. This study indicated that only 39% of midwives felt confident in counselling women. However, there was a positive correlation between better knowledge and increased confidence.

Other studies have highlighted the effect of training on increasing confidence but not necessarily knowledge. Payne et al’s study (2002) measured confidence before and after a training intervention to equip nurses to provide mental health advice for NHS direct. Confidence was found to have increased post-training, although the increase in knowledge was non-significant. Interestingly, confidence also increased in those who did not undertake the specialist training, though not to the same extent. This may have been due to experience gained in the role over the same time period, although training may accelerate the acquisition of confidence. This study also suggested that cascaded training also increased confidence.

The time for which confidence is increased after an educational intervention is an area of interest. Salmon et al (2006) considered midwives’ confidence in relation to routine enquiry for domestic violence. This prospective longitudinal study considered midwives’ confidence before, following and six months after completion of an educational programme. The study reported statistically significant increases in confidence following completion of the programme. Although six months after completion of the programme confidence levels had
fallen, they still remained higher than before commencement of the programme. However, Hopstock (2008) found nurses confidence in resuscitation skills did not decline until two years following training. A structured training programme designed to increase the confidence of junior doctors was found to have no effect on confidence measured before or two years after the programme introduction (Ringsted et al 2004). The study reports that the programme ran for one year. Hence, it can be assumed that individuals completing the confidence assessment at two years may not have received any training for a year. This reflects the findings of Salmon et al (2006) and Hopstock (2008) who found that confidence declines over a period of time following training.

This contrasts with students’ confidence, which develops rapidly following qualification (Clark and Holmes 2007; Skirton et al 2011). Clark and Holmes (2007) indicated that it took newly qualified nurses up to six months post qualification to feel confident in practice. Whilst others (Marel et al 2000) have suggested that the first postgraduate year is the most influential in terms of both experience and confidence acquisition in junior doctors. No studies indicate at which point this development of confidence stops, if at all. There does, however, appear to be a discrepancy within the literature in relation to confidence and experience. As discussed, some studies indicate confidence declines in the time following an educational intervention. Other studies indicate confidence increases in proportion with experience (Yang and Thompson 2010). However, no identified study followed a specific cohort longitudinally for more than two years.
2.8. Experience and confidence

It may be expected that individuals who are experienced in particular skills and tasks may be more confident than those who are not. Studies exploring the link between experience and confidence appeared to confirm this view. For Stewart et al (2000) experience was key factor in increasing confidence.

The amount of time spent working in an area was relevant to confidence. Davies and Hodnett (2002) found overall confidence to provide support in labour was high among participants across the five study hospitals; even though the amount of time spent in supporting women, rather than completing paperwork and other tasks, was less than 30%. However, nurses who provided postnatal, rather than labour, care were significantly less confident about providing support in labour. In a study relating to confidence in CTG skills, Stewart and Guildea (2002) also found that confidence was related to experience, time spent in the area and staffing grade, although academic qualifications were not. This contrasts with Dover and Gauge’s (1995) similar study in which they determined that those without post-registration academic qualifications were less confident in CTG interpretation. They also found midwives working part-time were less confident in intermittent fetal monitoring, although this may be due to less cumulative experience compared to those working full-time. They did however find similarities in the correlation of confidence with overall experience and time spent working in an area.

Frequent exposure and relevant education in the subject area were both associated with enhanced confidence in Metcalfe et al’s (2008) study. They
found that higher graded midwives expressed greater confidence than those on lower grades, although it is not clear if they also had greater experience. However, both education and area of work were also important in determining confidence in midwives’ confidence in genetic activities. Benjamin et al’s (2009) similar study also found differences in confidence dependent on length of time in practice. Interestingly, both those with more than twenty years in practice and those with less expressed confidence in issues relating to genetic counselling, these being in different skills dependent on the length of time post-qualification. This may be due to changes in education and culture as well as experience. However, education was also important in determining confidence in midwives’ confidence in genetic activities, echoing Metcalfe et al’s (2008) study.

Frequency of exposure to the skill of carrying out perineal repair correlated (strongly) with the individual’s perceived self-confidence (Wilson 2011). This was also demonstrated in Morgan and Cleave-Hogg’s (2002) study where clinical exposure was the most significant predictor of confidence in medical students. The experience of completing skills and gaining in confidence reflects Bandura’s (1997) enactive mastery experience in self-efficacy theory.

The finding of confidence increasing with experience may also explain the findings of Donovan’s (2008) study. Donovan compared confidence in students of different cohorts, whose length of training period varied. Included in this study were nurses undertaking the eighteen month degree course and direct entry midwives undertaking three and four year degree courses. The least confident students were found to be those on the three year degree course. This may be
explained by the fact that the eighteen month students had previous experience as nurses and the four year students also had more experience in the healthcare setting. Hence, this equates confidence with experience.

Yang and Thompson (2010) found acquisition of confidence to be linear, in relation to experience. However, in attempting to measure confidence and competence, Stewart et al (2000) comment that ‘measuring confidence is problematic as it does not appear to be a linear construct’ (2000: 906). They suggest that confidence may fluctuate in relation to skills competence, therefore is difficult to capture. However, the majority of studies point to an increase in confidence in relation to experience.

2.9. Confidence and competence

Whilst competence is a prerequisite of the midwife’s role and is measured by examination, confidence is necessary for the individual to develop skills within the workplace environment. It is also confidence in ability that ensures the individual will continue to use these skills. However, whilst competence can be objectively measured; confidence is subjective and not necessarily visible to others. It is important that confidence is not misplaced in terms of competence. Hence, a number of studies (Hausman et al 1990; Stewart et al 2000; Morgan and Cleave–Hogg 2002; Barnsley et al 2004; Friedman et al 2005; Lauder et al 2008; Roxburgh et al 2010; Yang and Thompson 2010; Wilson 2011) have compared confidence with competence in specific tasks or decision-making skills, with the aim of identifying correlation between the two.
A number of studies relating health professionals’ competence to confidence were identified. Only one of the studies included midwives (Wilson 2011), however, others included medical doctors (Hausman et al 1990; Stewart et al 2000; Morgan and Cleave–Hogg 2002; Barnsley et al 2004; Friedman et al 2005) and nurses (Lauder et al 2008; Roxburgh et al 2010; Yang and Thompson 2010). Whilst some studies have attempted to measure self-reported confidence and competence, others (Hausman et al 1990; Barnsley et al 2004) attempted to measure competence objectively, whilst obtaining participant self-report confidence measures. One study (Hausman et al 1990) provided observers, in this case supervisors, to score individuals for confidence. They noted that observers were able to detect under, but not over, confidence in participants. This clearly has implications for clinical practice as it has been highlighted that over-confident individuals may be more likely to misdiagnose or otherwise make a mistake by virtue of their failure to look at alternatives (Friedman et al 2005). This being because they are so confident in their initial opinion. A similar approach using independent assessments of competence along with self-assessments of confidence was used by Barnsley et al (2004) who found no relationship between junior doctors’ competency and their self-assessed confidence. Interestingly, in this study, self-reported confidence was higher for all assessed skills than was actual competence. Morgan and Cleave–Hogg (2002) determined that educational attainment and practical assessment of skill competency did not correlate to medical student confidence.

The relationship between competence and confidence was examined by Stewart et al (2000), concluding that the junior doctors in their study did not
base their confidence on their known competence in a task. Rather, in determining their ability to complete a task participants would often make a judgement relating to the risks associated with the task. The authors did, however, suggest that confidence did influence the study participants in their determining whether to undertake a task, when present.

Wilson (2011) measured self-reported confidence and competence in midwives before and after an educational intervention. Whilst there was no significant difference in confidence before and after the intervention, the greater the individual's self-confidence, the greater their perceived ability and competence. However, there was no objective measure of competence used post-intervention to determine the accuracy of these individual judgements.

Some studies (Friedman et al 2005; Yang and Thompson 2010) demonstrated a correlation between clinical experience and self-reported confidence, with those who had been qualified for longer experiencing greater levels of confidence, although not competence. This was similar for both nurses (Yang and Thompson 2010) and medical doctors (Friedman et al 2005). However, there appears to be some correlation between confidence and competence in less experienced individuals. Lauder et al (2008) suggest a weak correlation between confidence and competence in student nurses, whilst Roxburgh et al (2010) reports a moderate correlation in newly qualified nurses. This difference may be explained by the fact that newly qualified individuals and students are less confident in their role when compared to experienced individuals.
The link between confidence and competence is of interest in light of Bandura’s self-efficacy theory. In being self-efficacious an individual makes assumptions about both the outcome of an action and their competence to complete the action. Scherbaum et al (2006) suggest that self-efficacy is belief in competence itself. Therefore, it can be extrapolated from the studies discussed that individuals’ believe themselves to be more competent that they actually are. Hence, they subjectively display more confidence than ability.

Whilst the link between competence and confidence may be tenuous, this may not be as surprising as it first appears. Confidence is required for individuals to attempt tasks and hence gain competence. Therefore, it should be expected that individuals will be confident before they become fully competent in certain tasks. In this way confidence can be seen as a very important aspect of developing competence and practice.

2.10. Over and under-confidence

Both over and under-confidence can have practice implications. Under-confidence is suggested to be paralysing, affecting an individual’s ability to work unsupervised. However, over-confidence may lead to inappropriate practice decisions as individual’s fail to take into account their own lack of competence. In Hausman et al’s (1990) study with physicians, a multiple choice examination was used followed by a self-assessment measure of confidence in their answers, along with supervisors’ assessments of confidence. Interestingly, they determined that over-confidence was associated with a lower score in the multiple choice examination. However, they offered little explanation for this,
instead concentrating on the under-confident participants. An association was noted between participants who assessed themselves as under-confident in their examination answers and were also identified by supervisors as lacking in confidence. However, there was no such link with over-confident students. The study did indicate that participants with abnormally high or low confidence indices were likely to leave the programme within the first year.

Other studies have also reported high levels of confidence in study participants. Baumann et al (1991) reported on two studies, with physicians and nurses respectively, finding that all participants were highly confident in their answers to clinical scenario problems. This was the case even where there was uncertainty between individuals, leading the authors to conclude that many were over-confident. Over-confidence appears to occur regardless of the experience of the individual. Friedman et al (2005) measured over-confidence in diagnosis ranging from 25% in students, to 41% for post-graduate medical residents. However, this dropped to 36% for more experienced medical faculty. Apparent over-confidence is a worrying trend, with practice implications. However, Kröner and Biermann (2007) suggest over-confidence in self-report studies may occur due to phrasing of the questions asked, rather than over-confidence per se. It is therefore important to consider the value of attempting to measure over-confidence in this way.

2.11. Confidence and well-being

It is accepted that midwives working in the NHS and particularly on delivery suite are subject to a stressful and demanding environment (Macklin and
Sinclair 1998). Managing stress can be multifactorial, requiring the use of various coping mechanisms. In particular, self-efficacy is considered to buffer the effects of stress in the workplace. A study of stress and coping in nursing students indicated that self-efficacy is a strong moderating factor in stress and hence important in maintaining psychological well-being (Gibbons et al 2011). Whilst Isikhan et al (2004: 240) suggest that a “self-confident approach” helps nurses and physicians to cope with stress in the workplace. Conversely low self-efficacy, coupled with high workplace demands, contributed to emotional distress in nurses providing palliative care (Fillion et al 2007).

Resilience in the workplace is regarded as essential to withstand the effects of stress. It is also considered a factor in individual well-being and job satisfaction. Gillespie et al’s (2007) study found a strong correlation between resilience and self-efficacy. Although their study participants were operating room nurses, similarities can be drawn between the stressful and demanding environment of the operating room and that of the delivery suite, which involves theatre and emergency working. In a study utilising an intervention to increase the workplace resilience of nurses and midwives, McDonald et al (2011) found a reported increase in both resilience and confidence following the intervention. However, it is possible confidence may have increased as a result of the intervention alone, rather than as a result of increased resilience.

The well-being of midwives in the workplace is little researched, despite dissatisfaction with the working environment being a reason for midwives leaving the profession (Ball et al 2002). A direct relationship between self-
efficacy and well-being in healthcare professionals was found by Nielsen et al (2009). Their study also considered the effects of team efficacy, finding that team efficacy, rather than self-efficacy positively enhances job satisfaction. Additionally, self-confidence is important to midwives in developing a strong professional identity (Larsson et al 2009).

Other studies have suggested that confidence is a crucial factor in empowerment (Scott et al 2003; Corbally et al 2007; Bradbury Jones et al 2010). Corbally et al (2007) found confidence vital for nurses’ and midwives’ empowerment, linking it to a form of personal power in the workplace. Scott et al (2003) suggest self-confidence is one of the most important factors in empowerment, a lack of confidence inhibiting empowerment. Additionally, they determined that midwives and nurses understand the importance of confidence (and self-esteem) to empowerment. A factor of empowerment is the ability to be assertive in the workplace, which has also been linked to self-confidence (Gerry 1989).

It is clear, therefore, that confidence is important for individual psychological well-being, including the management of stress and the utilisation of coping mechanisms which may lead to improved job satisfaction.

2.12. Conclusion

A number of studies have considered confidence in relation to healthcare professionals. However, few have focussed on midwives and none have considered the phenomenon of confidence or the factors which may affect it in
relation to experienced individuals. It is clear that the terms confidence and self-efficacy are often used interchangeably and studies purporting to explore confidence have used self-efficacy tools. Other studies use widely differing definitions of confidence or none at all.

In general, studies considering confidence in various skills indicate that confidence is high in these areas, especially where the individual is familiar with the skill. The majority of identified studies have focussed on the measurement of confidence in some way. However, measurement is often at a single time point and does not provide insight into factors that may affect confidence.

Factors such as education and experience appear to be important to developing confidence in an area. Newly qualified individuals appear to demonstrate similar levels of confidence regardless of their training route. However, there is evidence that confidence can decline over a period of time following an educational or training course. Confidence does appear to increase with time post qualification. However, there is also evidence to suggest that over-confidence is more likely to occur in those qualified for longer. Confidence and competence in a skill do not always show a close correlation, which may have implications for practice. There also appear to be personal benefits associated with confidence. In particular, confidence has been linked with empowerment, enhanced job satisfaction, increased self-esteem and coping abilities in health professionals.
This literature review has highlighted the dearth of studies considering midwives’ confidence in relation to intrapartum care. Where such studies exist, they are limited to measuring confidence in particular skills rather than gaining an overall view of confidence. No qualitative papers aiming to explore confidence per se in midwives or nurses were identified, therefore highlighting a gap in knowledge. The study presented in this thesis aims to add to knowledge by exploring both what confidence means to midwives and the factors which may affect confidence in clinical practice.
Chapter 3

Theoretical Perspective
Chapter 3: Theoretical Perspective

3.1. Introduction

This chapter will discuss the conceptual theoretical framework underpinning the research design. This will include some of the important concepts of the theoretical framework and relevant issues and debates surrounding this. Overall a qualitative paradigm was chosen as appropriate to the exploratory nature of the study and its focus on human experience. A hermeneutic phenomenological approach has been adopted as an appropriate methodology for this study for two main reasons. Firstly, to examine the phenomena of confidence itself and secondly, to consider midwives’ lived experiences of confidence. This will be discussed in greater detail throughout the chapter.

3.2. Theoretical framework

The exploratory nature of the proposed study requires a qualitative approach. In order to undertake qualitative research the researcher must be aware of their influences and how this affects their paradigmic stance. According to Kuhn (1970) a paradigm is a particular range of beliefs and values that contribute to the way of seeing the world for a particular discipline. Lincoln and Guba (2000) emphasise the individual human element within this and the effect in which the individual views the world has upon their paradigmic stance. Differing views exist as to what a paradigm consists of. Lincoln and Guba (2000) suggest that a paradigm consists of four elements; ethics, epistemology, ontology and methodology, whilst others (Dykes 2004) include only epistemology, ontology and methodology. Crotty (2003) recognises that there is often a lack of consistency in relation to terminology within qualitative research which can lead
to confusion. Therefore, for the purpose of this thesis I intend to clarify my stance within the accepted terminologies.

Epistemology is concerned with providing a philosophical grounding, and deals with the study of the nature of knowledge (Cluett and Bluff 2006). It can be considered as understanding “what it means to know” (Crotty 2003: 10). Whilst different epistemologies exist, two dominant ones emerge; objectivism and constructionism. Objectivism is the search for a truth or meaning that already exists. As such, it is suited to positivist stances and quantitative methodologies. Constructionism, in contrast, considers meaning is constructed as a result of our living or being in the world. It is suited to qualitative methodologies. It is constructionism that is most relevant to this study.

Within the constructionist epistemology, meaning is not waiting to be discovered, instead it emerges through human consciousness and its engagement with the world. In constructing meaning humans are interpreting what they experience in order to understand. Lincoln and Guba (2000) refer to a constructionist-interpretivist epistemology to highlight this. Crotty (2003) points out that we do not create meaning, rather that we construct it from that which already exists, that is, the world. Constructionism, in particular social constructionism, accepts the importance of culture and meaningful reality as constructed by humans within that culture. However, the question of culture can raise its own issues and problems and can in some instances prevent us considering meaning further. This can include the simple acceptance of understandings as “truth” (reification). Additionally, layers of interpretation of
cultural meaning can remove us from engagement with the world, passively accepting inherited cultural meaning (sedimentation) (Crotty 2003). Whilst both of these are essential for understanding in human culture, it is important for us as researchers to explore the meaning of phenomena more deeply. Hence methodologies such as hermeneutic phenomenology takes us “back to things themselves” (Seifert 1987: 7) whilst acknowledging that we too (as researchers) are subject to inherited cultural meanings and acceptance of “truth”.

In addition, ontology sits alongside epistemology in informing the theoretical perspective (Crotty 2003: 10). Ontology is concerned with the study of being and adds the “what is” to the “what it means to know” for each theoretical perspective. As such it is difficult to examine ontology and epistemology separately as they are inexorably linked. Some methodologies consider ontology in greater detail and the phenomenology of Heidegger will be discussed later in relation to this.

Epistemology and ontology form the theoretical perspective which is the philosophical stance underlying the methodology. Whilst some distinguish the theoretical perspective into a separate category (Crotty 2003) others do not (Denzin and Lincoln 2000). For this study the theoretical perspective adopted is interpretivism, which informs both phenomenology and hermeneutics. Interpretivism is an attempt to understand human reality (Crotty 2003) and as such is suited to this exploratory study. The hermeneutic phenomenological methodologies of Heidegger and Gadamer in particular are consistent with the interpretivist tradition.
3.3. Methodology

3.3.1. Phenomenology

Phenomenology has been chosen as the most appropriate underlying philosophy associated with the exploratory nature of the study. Whilst phenomenology has been developed by various philosophers, it is the hermeneutic philosophy of Heidegger that will form the theoretical underpinning for this study. This philosophy is suitable as, put simply, it considers the phenomena from the point of view of the person experiencing it.

3.3.2. The development of phenomenology

Husserl is commonly held as the founder of the phenomenological movement (Koch 1995), from which a number of other approaches or methods have developed. Husserl was searching for the essential structure of experience, a pure description of experience. His “lifeworld” is a key concept and consists of objects of which we are conscious and by being conscious of them, they mean something to us (Husserl 1931). This is known as the concept of Intentionality. Intentionality refers to the internal experience of being conscious of an object and directing one’s thought towards it. The “object” itself does not have to physically exist for this to take place. The lifeworld is understood as what individuals’ experience pre-reflectively without resorting to interpretation (Dowling 2007). In doing this Husserl assumes Cartesian duality, a mind-body split.
Husserl’s transcendental phenomenology is descriptive. This descriptive phenomenology would return to “things themselves” and to the essence that constitutes consciousness and perception of the human world (Seifert 1987: 4). Husserl believed descriptive phenomenology would bring us to the essence of that which was being sought (Husserl 1931).

Questions about the source or success of the experience are irrelevant to Husserl, it is only the experience itself that concerns him. Hence, he performs the transcendental phenomenological reduction. Also known as “bracketing”, this must be performed by the researcher in order to gain essential understanding. Husserl describes bracketing as “refraining from judgement” (Husserl 1931: 109). In doing this, the researcher suspends all previous assumptions and understandings. The process of bracketing defends the validity or objectivity of the interpretation against the self-interest of the researcher (Koch 1995). Once the standpoint of the reduction has been attained, the investigator can then set about answering the kind of questions that Husserl considers phenomenology ideal to answer (Cerbone 2006).

3.3.3. The development of hermeneutic phenomenology

Heidegger, a student of Husserl, developed phenomenology in a slightly different way. Whilst he agrees with the importance of description of the experience, he is more concerned with understanding. Whereas Husserl takes a transcendental approach Heidegger adopts an existential ontological approach. Heidegger’s interest is in “Being”, noting that it is both “the most universal and emptiest of concepts” (Heidegger 1962: 2). To consider the
"Being" of something is to ask for the nature or meaning of that phenomenon (van Manen 1990). Leonard notes the Heideggarian phenomenological view of the person arises from the ontological question “what does it mean to be a person?” (Leonard 1989: 42). Heidegger is concerned with Dasein (“Being there”), in particular, what does it mean to be in the world (“Being-in-the-world”). For Heidegger Being is an ontological priority. Being is always the Being of an entity and Dasein is that entity (Heidegger 1962). Being is a fundamental characteristic of Dasein. Dasein’s understanding of being relates to Being-in-the-world, to which it belongs essentially (Heidegger 1962: 33).

Heideggarian phenomenology is therefore concerned with the experiences and interpretations of Being-in-the-world (Walters 1995). Heidegger rejects the Cartesian view of the person and the subject-object separation it engenders. In particular, he sees the person as being embodied (Leonard 1989). Embodiment can be described as the union of the mind and body as a whole, with all things being experienced by this one “self” (Sadala and Adorno 2002). Consciousness, through which we experience phenomena, is always embedded in the body (Langdridge 2007) and it is through the body that we live and relate to the world.

The Husserlian stance of separating the researcher by bracketing, reflecting a positivist perspective, is an attempt to maintain complete objectivity. Whilst the success or appropriateness of this phenomenological reduction is debated (Koch 1995), the hermeneutic phenomenology of Heidegger values the contribution of the researcher’s experiences to interpretation. One of the
strengths of hermeneutic interpretation being the recognition of situated meaning (Walters 1995).

Heidegger therefore rejects bracketing, believing that such pre-conceptions are essential to understanding and interpretation of meaning. The world the person inhabits comes from culture, history and language and is inclusive. Hence, he concerns himself with ontology, particularly pre-ontological understanding which is implicit and manifests itself in how we act. Humans are temporal beings embedded in historical and cultural concepts and traditions shared with others in the community. This is also true for the researcher, who cannot set this aside. All understanding and interpretation is grounded in ‘fore-having, fore-sight and fore-conception’ (Heidegger 1962: 192).

Heidegger recognises the “everydayness” of Dasein, that is the averageness of the situation in the world. The everyday Being is within the world and accepts the norms of that world. In everydayness Being exhibits essential structures shared with others, the “they” (das man). In order to interpret Being, Dasein draws on the pre-ontological state (Heidegger 1962). To understand the Being-in-the-world the everydayness and averageness of Dasein becomes visible (Heidegger 1962).

Heidegger acknowledges that time is inexorably part of understanding. Dasein is essentially a futural being; that is, he is always looking forward. Heidegger orders time as, future (Ahead-of-itself), past (Already-in-the-world) and present (Being-alongside) (Cerbone 2006). Future is called by Heidegger
“understanding” or “projection”. Dasein is in the future in that it is always ahead-of-itself. What Dasein does is determined by what it is, that is, how it behaves for the future relates to how it sees itself now. The past, already-in-the-world, “befindlichkeit” relates to us finding ourselves already in a situation (in the world) and with a particular orientation to that situation. Our orientation is constituted of mood, disposition, inclination, beliefs and experience. “Befindlichkeit” is the historical nature of Dasein. The present is described as being-alongside (entities encountered within the world). Heidegger calls this “falling” and this relates to absorption in current activity. Dasein is always falling in that it is always caught up in some kind of ongoing activity. Hence, Dasein is temporally situated in the world. This temporality allows future, past and present to be experienced in unity. Therefore, what is experienced by the person is also coherent with what was experienced in the past and what is expected to be experienced in the future (Mackey 2005). A particular Dasein’s uniqueness relates to its facticity in that its mode of being exists at a particular time (Schmidt 2006).

Heidegger brings an interpretive approach to phenomenology. He sees us as self-interpreting beings (Heidegger 1962). We are constituted through our acts of interpretation and are unable to understand without reference to our historical and cultural background. Hence, we cannot have a world and cannot have life at a cultural level except through the acts of interpretation (Koch 1995). This interpretivist stance also relates to the hermeneutic position that Heidegger develops. Hermeneutics essentially is to interpret and Heidegger believes we
cannot describe without interpreting. Hence, he brings together ontology and phenomenology with hermeneutics to develop his own philosophy.

Gadamer (1989), in Truth and Method, developed the concept of hermeneutics further by drawing on the hermeneutic phenomenology of Heidegger. In particular, Gadamer wanted to discover how understanding was possible (Fleming et al 2003). His philosophical hermeneutics require an awareness of both tradition and prejudice for understanding to occur (Gadamer 1989). Tradition relates to the historical awareness that we all possess, whilst prejudice is a similar concept to Heidegger’s fore-structures of understanding. Historical awareness is particularly important to knowledge and understanding as we are all part of history and it cannot be avoided (Fleming et al 2003). It is only through pre-understandings that interpretation and, hence, understanding is possible. Once prejudices are acknowledged, understanding can then take place through language and tradition (Walsh 1996).

Gadamer (1989) brought the concept of horizons to hermeneutic phenomenology. Each individual has a unique horizon which is constituted of their historical and cultural understanding. Gadamer describes this horizon as “a range of vision that includes everything that can be seen from a particular vantage point” (Gadamer 1989: 301). The horizon relates to a particular individual at a particular point in time and, whilst encompassing a range of meanings, it is not infinite (Hekman 1984; Phillips 2007). The horizon at any one time is both historically and contextually bound (Gadamer 1989). It will change as the individual’s experience, understandings and situation changes. For
Gadamer (1989) the horizon is essential to interpretive understanding. In reaching understanding, the researcher’s horizon is fused with the horizon of the participant. The researcher cannot know another’s horizon as if they were that individual, as that would involve them abandoning their own horizon (Phillips 2007). Neither can the researcher impose their horizon on that of the participant (Gadamer 1989; Hekman 1984). Instead, another’s horizon challenges us and extends our range of vision enabling understanding to be reached. For Gadamer “understanding is always the fusion of these horizons supposedly existing by themselves” (1989: 305).

3.3.4. The hermeneutic circle

Heidegger uses the hermeneutic circle as a description of the way interpretive understanding is achieved. This “circle of understanding” is an essential concept for Heidegger (1962: 195). Within hermeneutic Heideggerian phenomenology it is impossible to understand the whole without understanding the parts. Prior to entering the circle, it is essential to make explicit the fore-structures of understanding and tradition that we bring with us (Heidegger 1962; Gadamer 1989). It is important for interpretation that our fore-structures of understanding are challenged in considering the phenomena itself. It is essential for the researcher to remain focussed on the phenomena under investigation and not become distracted (Gadamer 1989). Interpretation itself is seen as a circular process whereby the parts are considered in terms of the whole of the understanding of something and then considered in new ways (Mackey 2005). Various stances have been taken with regards to the circle itself (Crotty 1996). Geanellos (2000) describes it simply as the process of
interpreting parts of the text in relation to the whole and the whole in relation to the parts. Others see the circle as a sharing of culture and language between participant and researcher (Leonard 1989). Gadamer (1989) suggests that whilst the circle has been understood as a formal relation between the whole and the parts, he does not think it is formal in nature. He also considers that it is not simply methodological, but that it incorporates elements of ontological understanding. This is due to the necessity to confront both tradition and prejudice in reaching understanding.

3.4. Issues surrounding the use of hermeneutic phenomenology.

Although phenomenology is primarily a philosophy, a number of methodological interpretations and approaches have developed and become acceptable to the researcher. A number of problems and criticisms of the use of phenomenology as a methodology have arisen over recent years. There is an acknowledged ongoing debate regarding the suitability and the way in which these methods are used (Walters 1995; Crotty 1996; Paley 1997, 1998). Often these relate to either the researchers failure to grasp the underlying theoretical perspective, or criticisms of its interpretation or application.

3.4.1. Criticisms relating to nurse researchers.

Researchers in health, and particularly nurses, have been drawn to using phenomenology as an approach. It is popular in that it allows researchers to examine lived experience; that is, to see phenomena from the point of view of the person experiencing it. This has been of import to those studying patients’ feelings or the emotional effects of illness or treatment. However,
phenomenology is not without its critics and much of that criticism has been levelled at its use in nursing research.

3.4.1.1. Failure to understand the philosophy.

Crotty (1996) and Paley (1997, 1998), amongst others, criticise nurses for their failure to understand the underlying philosophy. This failure in understanding can lead to a mix of methods being applied and a failure to follow the same philosophical principles throughout. They have also criticised nurses for a failure to relate both analysis and findings to the underlying principles. Horrocks (2000) meanwhile, suggests that the problems arise as a result of nurses not returning to the writings of Heidegger, but instead relying on others interpretations of them. This may be in part due to the complexity of the original texts which, even in translation, are demanding to read.

It is argued that nurses do not fully acknowledge the philosophy of phenomenology itself and tend to use it as a stand-alone methodology. Nurses are also admonished for failing to describe or confirm the school they are following, i.e. descriptive or interpretive phenomenology (Paley 1997, 1998). Walters (1995) suggests that there is a misconception among some researchers that there is a single phenomenological method. Other criticisms include problems with nurses using the terms hermeneutic and phenomenology interchangeably (Paley 1997, 1998).

One of the difficulties for nurses using phenomenology is the very fact that phenomenology is primarily a philosophy. Therefore, no clear step by step
method exists to follow. As health professionals more used to tangible and defined guidelines and protocols, this requires a shift in thinking. It can be difficult for researchers to make the link between the theoretical concepts and the practical method of undertaking research. As a result, where detailed methods for “doing” phenomenology have emerged they have been readily adopted by researchers. This adoption of such methods may occur without the understanding of the theoretical basis, hence a disparity can occur.

3.4.1.2. Failure to seek the phenomena itself.

It is important to ensure that phenomenologically guided research concentrates on the phenomena being explored first and foremost. For Heidegger, the interpreter must keep their focus on the phenomena in order to be orientated to and guided by the things themselves. He sees this as the “first, last and constant task” (Gadamer 1989: 269). The individual’s experience of the phenomena in their lifeworld leads us to reaching understanding of it. A person is a Being-in-the-world and as such has an inseparable connection to it (Intentionality). Research into a phenomena then leaves us subject to the individual’s own viewpoint. A potential problem is the failure to explore more deeply to reach the phenomena itself. Researchers have been criticised for following the belief that Heideggarian phenomenology is exploring the individual’s lifeworld in a subjective way (Crotty 1996, 1997; Paley 1997; Horrocks 2000). Nurses, in particular, have been criticised for their apparent reliance on a wholly subjective standpoint. Crotty (1996) argues phenomenology is not as simple as looking at things from the perspective of another. He suggests that although many cite philosophers and other
researchers whose main emphasis is on the phenomena itself, they then go on to focus exclusively on the subjective in their analysis. Whereas Heidegger rejects bracketing in favour of the need to acknowledge and understand one’s fore-structures of understanding, he does not intend the outcome to be a wholly subjective one. What is often missed is the fact that the phenomena is the essence of what is being explored.

In adopting this approach, researchers risk failing to capture the essence of the phenomena itself. In particular, researchers fail to grasp that Heidegger is searching for the Being (hidden) in everydayness, not simply describing the everyday lifeworld of the individual. That is, his search for Being is ontological, not ontic. Heidegger’s task is also existential, considering the experience of existence, although debate exists as to the extent of Heidegger’s existentialism (Crotty 1996). Although Heidegger considered his philosophy to be existential, not existentialist, it is easy on reading Being and Time (Heidegger 1962) to draw conclusions about his position relating to existentialism. Indeed, many have considered Heidegger to be existentialist (Crotty 1996). It is a description and interpretation of the phenomena that we are primarily searching for. The experience of the individual is an essential factor and provides valuable insight into their experience of the phenomena, but is not the singular focus of the research.

3.4.1.3. Issues relating to bracketing (the phenomenological reduction)

Although the stance for this research follows the Heideggarian perspective it is important to note that some issues can arise with researchers using bracketing
inappropriately. Whilst bracketing is rejected by Heidegger, the problem appears to be that some researchers claim to be following phenomenology per se, but go on to mix the approaches of Husserl and Heidegger. This can result in an incoherent approach.

However, bracketing is only relevant for those following the Husserlian school of the discipline. Crotty (1996) believes that some nurses do not do this effectively and as a result are not discovering the true essence of the phenomenon under investigation. In itself, bracketing is open to different interpretations (LeVasseur 2003). For some it can be a way of giving rise to clarity and comprehension of vision (Cluett and Bluff 2006). Others see it as a way of introducing reliability to findings (Beck 1994). However, some would dispute this. van Manen (1990), believes that in trying to “forget” what we “know” we are at the mercy of presupposition creeping back into our reflections. Koch (1995) notes that Husserlians claim to describe the phenomenon as it is, but she suggests that one cannot separate description from one’s own interpretation. The suitability of this method for this type of research must therefore be questioned and researchers must be clear which school they are following.

3.4.1.4. Issues surrounding analysis
Arguments also surround analysis and there have been criticisms of nurses using inappropriate frameworks. Different methods of analysis have been described by van Kamm (1966), Colaizzi (1978), Giorgi (1985), Smith et al (1999) and Todres (2005). All of these methods are similar in that they use various prescribed steps in their approach. Nurses, in particular, have been
criticised for their approach to analysis using these methods. Some approaches, such as Giorgi (1985) and van Kamm (1966) have been associated with Husserlian phenomenology but have evidently been used by nurses claiming to be following Heideggarian philosophy. Colaizzi (1978) describes his framework as being derived from Heidegger, but Koch (1995) disputes this, believing that such structured approaches are an anathema to Heidegger’s interpretive approach. It is therefore important to analyse the data using an approach suited to hermeneutic phenomenology. The approach used in this thesis is guided by van Manen (1990) and will be discussed in greater detail in chapter 4.

3.5. Ethical considerations

It is vital in any research study to observe ethical principles in order to protect the participants from harm (Manning 2004; Polit and Beck 2006). There are four main principles; beneficence, nonmaleficence, autonomy and justice (Manning 2004). Beneficence and nonmaleficence are concerned with promoting benefits and minimising harm to participants. Autonomy respects the individual’s ability to self-determination, that is the individual consents to participation in the research. Justice refers to equity of treatment and non-discrimination.

As a researcher I wished to ensure the study participants did not suffer harm or discomfort in taking part in the study. Given the potentially sensitive nature of confidence and the context of the study, it was possible that study participants may disclose data that caused them distress. Therefore, I ensured that each hospital Trust had a counselling service available and that any study
participants would be able to access it, should this be necessary. To ensure autonomy and justice for participants a rigorous recruitment and consent process was followed. This is described in detail in chapter 4 (4.7).

To further protect the participants it was important to ensure anonymity and confidentiality. In order to maintain confidentiality, the study participants were initially allocated a study number which was used as an identifier on their data. The original list of names and contact details, together with the study number was kept in a locked filing cabinet at study setting A, along with all generated data. As the primary researcher for this study I was the only person with access to the raw data and participants contact details. All tapes and diaries were transcribed as soon as possible following data collection. For the purposes of the thesis participants are identified by a pseudonym allocated to ensure anonymity. Additionally, the data presented has been examined for any other potential identifiers to ensure the participants’ anonymity is not compromised.

3.5.1. Reflexivity
Reflexivity has been defined as “the process of continually reflecting on our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings” (Finlay 2003: 108). It is suggested as a method of increasing the validity and trustworthiness of qualitative research (Finlay 2002; Mays and Pope 2006). The use of reflexivity accepts and acknowledges the researcher as a central influence in the qualitative research process. Clearly within constructionist-interpretivist epistemology the researcher is interpreting and constructing meaning from the
data. Finlay (2003) suggests five variants for “doing” reflexivity. These include reflexivity as introspection, intersubjective reflection, mutual collaboration, social critique and ironic deconstruction. Ahern (1999) proposes ten steps to reduce “researcher bias”. Whilst the steps have some relevance with respect to acknowledging one’s own stance, Ahern links reflexivity with the process of bracketing and uses the somewhat confusing term of “reflexive bracketing”.

There are however, some issues to be considered with the use of reflexivity. Being reflexive is not necessarily an easy task and researchers risk falling into the trap of excessive self-analysis at the expense of the research (Finlay 2002). A balance therefore needs to be achieved. A further drawback with reflexivity is the limited self-awareness that we posses (Cutcliffe 2003). Even with techniques to illuminate prejudices, there may be a large proportion of beliefs outside consciousness which cannot be acknowledged. Cutcliffe (2003) also discusses the potential importance of “tacit” knowledge in the research process. That is historical knowledge, similar to the “tradition” of Gadamer, which Cutcliffe considers cannot be fully expressed due to our unconscious acceptance of it. However, hermeneutic phenomenology accepts that the influences of culture are necessary and will to some degree prevail. It is difficult to envisage how this problem can be overcome, but acknowledging that it exists is reflexive in itself.

As a methodology Heideggarian hermeneutic phenomenology is inherently reflexive as fore-structures of understanding have to be acknowledged from the outset. They have to again be re-evaluated and acknowledged before entering
the hermeneutic circle, which continues throughout the interpretive process in order to reach understanding. It is, therefore, a concept central to this philosophy.

In this study the fore-structures of understanding and prejudice that I bring with me as a researcher and a midwife have been acknowledged and identified as far as possible from the outset. In determining my own philosophic and epistemological stance, I was aware that I would be unable to effectively “bracket” or perform the phenomenological reduction required by Husserl. Indeed, hermeneutic phenomenology was chosen not only to suit the research question, but also to acknowledge my own position and prejudices. This position of reflexivity continues throughout the study; from design, data collection, analysis and dissemination.

My prejudices began to emerge immediately following the initial concept of the study. I began to think, in depth, about the phenomena of confidence within the cultural and contextual awareness I had. I became aware very quickly that I was challenging long held and accepted beliefs. This challenge continued with examination of the literature around the phenomena. As the study developed I continued to confront my prejudices as data collection occurred. Listening to the views of participants at interview, discussions with colleagues and analysis of data, developed this further. A reflexive research journal was kept throughout, enabling me to examine my own views and opinions as they changed throughout the study. The physical recording of these views allowed me to acknowledge and challenge them. It is however, important to note that some
understandings, both for myself and the participants, may be so entrenched culturally and historically that they are difficult to illuminate.

3.5.1.1. Cultural and contextual position

As a researcher deeply entrenched in the culture in which I was working it was initially both difficult and enlightening to acknowledge my own prejudices. This is also something which continued throughout the study. It is important that this is an evolving uncovering of one’s own position as other issues come to light throughout the research process. During the study my role changed and I moved away from the clinical role to a researcher role, both physically and metaphorically. This also will have had an effect on my own stance as the study developed. As with Gadamer’s perception of horizons, my personal horizon would change during the study, with these changes captured in my research journal.

I was aware that I could be viewed as an insider, both professionally and as a clinical midwife employed at one of the study settings for the research. This was in some ways advantageous as I was aware of the much of the cultural background in that study setting. This insider knowledge and the fact that I was a clinical midwife and therefore shared a commonality with potential participants was beneficial (Burns et al 2010). I feel this gave me credibility with participants. It also provided me with much background understanding of the organisational culture in which these midwives worked. However, there were difficulties associated with this too. I was aware that my own beliefs and prejudices were most likely to surface in this environment by virtue of my own entrenchment in it.
I therefore had to make an effort to conduct the data collection and analysis with the eyes of an outsider as far as possible. The problems of over-identification with both participants and their role are well documented in the literature (Burns et al 2010). Additionally, there is a heightened risk of making judgements or assumptions based on prior knowledge of the culture of the study area (Breen 2007). My close identification with one study setting became even more apparent when collecting data from the other study settings, as it brought into perspective the detailed knowledge I had about that setting. In contrast I felt the need to probe where necessary to gain more contextual information from these other settings. However, again, my professional position as a clinical midwife and a researcher I believe provided me with credibility in these settings also.

As a midwife working in intrapartum care I was well aware of some of the cultural issues of working in this specific environment. I had anticipated difficulties in recruitment due to the sensitive nature of the phenomena under investigation. I had also anticipated the possibility that only midwives who felt very confident in their practice would respond to me. Hence, I had an awareness from the outset of potential limitations to this study. However, in light of the lack of evidence in this area I believed that a study such as this could provide original and valuable insight.

3.5.1.2. Possible prejudices surrounding the phenomena

As both a researcher and a midwife, I had my own fore-structures of understanding and prejudices around confidence. I expected that confidence would not be a constant, but that it would vary with the task in hand. However, I
did expect that an individual would possess a general overall persona of confidence. I was orientated towards tasks and skills affecting and being affected by confidence in the workplace. Additionally, I felt that a midwife’s position the hierarchy may affect confidence in some way, although I was not clear how. I wanted also to explore the concept of projection of confidence; that is, the professional persona of appearing confident whilst not actually feeling confident. With regards to the phenomena of confidence itself I struggled to describe it myself. Despite being aware of various definitions I was unsure how appropriate these were to midwives, as they appeared to me quite removed from the context I was examining.

Throughout this thesis I will attempt to acknowledge and illuminate my own prejudices, both in an attempt to reach understanding and to provide clarity and transparency to the study.

3.6. Rationale for methodology

The study is an exploration into the phenomena of confidence as experienced by midwives working in intrapartum care. Being exploratory in nature, it was decided that a qualitative methodology would be the most suitable approach. Hermeneutic phenomenology guided by Heidegger and Gadamer has been chosen as the most appropriate philosophical stance and will form the theoretical basis for this research. Heidegger’s ontological focus about what it means to be in the world is particularly suitable for this study, as both the phenomena and the way individuals respond to it is central to the research question. Phenomenology is appropriate as it allows for in-depth exploration of
the phenomena of confidence. It also encompasses the lifeworld views of the study participants; that is, midwives working in intrapartum care.

As a concept, confidence is in many ways intangible and is constructed through interpretation. Hence, an interpretive stance was required which necessitated a hermeneutic approach. The phenomena to be explored I believe is related to the individual’s situatedness, including their temporality. The participants in this study are subject to cultural and historical influences. In addition, as a researcher, I bring my own situatedness to the research, both culturally and contextually. To bracket would therefore be an extremely difficult task. Whilst being reflexive and aware of my prejudices I do not feel that bracketing could be realistic or achievable. Hermeneutic phenomenology allows for the impact of these influences to be taken into account and recognises their importance within the interpretive process.

3.7. Conclusion

This study will explore the phenomena of confidence, specifically in relation to midwives undertaking intrapartum care. The study will be guided by hermeneutic phenomenology as discussed above. In order to maintain clarity and avoid some of the problems associated with nursing research, due consideration will be given to the philosophy behind the methodology in order to produce a coherent approach. It is intended that this will be evident throughout the thesis through further discussion and the highlighting of relevant concepts, as appropriate.
Chapter 4

Study Methods and Design
Chapter 4: Study Methods and Design

4.1. Introduction

This chapter will discuss the overall study methods and design. The aims and objectives of the study will be presented at the outset. A consideration of design issues related to the study will be undertaken, followed by a discussion of the overall design and methods used within the study. The approach undertaken in relation to data analysis will be examined. Finally, a discussion of rigour in relation to the study will conclude this chapter.

4.2. Aims and objectives

Main aim

To understand the phenomena of confidence from the perspective of midwives undertaking intrapartum care.

Secondary aims

- To understand midwives’ experience of confidence in the intrapartum setting.
- To understand the factors that contribute to the enhancement or reduction of confidence in midwives working in different intrapartum settings.
- To evaluate the use of qualitative diaries as an appropriate method of data collection with health professionals.

Objectives

To utilise information in relation to confidence and intrapartum care in order to
• Provide input into managing organisational change.
• Highlight positive role models.
• Inform training.

4.3. Design
The study is a longitudinal prospective study utilising qualitative method of data collection. The study design allows for data collection from three settings in order to obtain the views of midwives working in these different settings.

4.4. Design considerations
4.4.1 Sample size
In phenomenology the sample is chosen to provide detailed data of the phenomena under exploration (Sandelowski 1995). This is undertaken using purposive sampling. Whilst many qualitative researchers aim for data saturation, others argue that this is not the goal of phenomenological studies (Hale et al 2008; Hays and Singh 2012). The aim of data collection in a phenomenologically focussed study is to obtain detailed and in-depth data from a small number of participants to inform, not to generalise (Lincoln and Guba 1985; Sandelowski 1995; Hays and Singh 2012). This is then subject to intensive and comprehensive analysis (Dykes 2004).

Various sample sizes have been suggested for phenomenological studies, with some authors suggesting six participants is adequate (Morse 1994; Smith and Osborn 2007). One of the difficulties of collecting data is a phenomenological study is in ensuring the amount of data is manageable, but is sufficient to
produce credible findings (Sandelowski 1995). In keeping with the theoretical underpinning of phenomenology, I anticipated that a small sample size would give rise to rich data, enabling in-depth analysis. The phased design of the study (see section 4.5) allowed for data collection from one setting (study setting A) first. Significant amounts of detailed data were collected from the midwives at study setting A. Hence, similar numbers were recruited from study settings B and C. This decision was based on the expectancy that the amount of data generated would be similar to study setting A, and in anticipation of the likely response rate, again informed by study setting A.

4.4.2. Use of multiple study settings

Working practices and workplace culture can vary widely between Trusts, therefore it was considered advantageous to obtain data from other settings. Polkinghorne (1989) suggests variation sampling whereby the participants share experience, but differ demographically in order to uncover aspects of experience common to the population. This would enable a wider range of data to be collected to inform knowledge. As I was familiar with the working practices and culture of study setting A, I considered that a greater insight into the phenomena of confidence could be gained from considering midwives’ experiences in different settings. Although as a qualitative study the findings will not be generalisable, this prospective design coupled with the exploratory nature of the study will add to the growing body of knowledge in this area. A description of the individual settings is provided later in this chapter (section 4.6).
4.4.3. To define the concept of confidence prior to data collection?

In developing the research question, the issue of definition of the concept of confidence arose. Some researchers favour undertaking a concept analysis in order to define the concept under exploration. Indeed, it has become a popular method described in nursing literature over the last decade (Beckwith et al 2008). A concept analysis is an attempt to create an absolute definition of a concept. Once defined, theory can be developed based upon this definition (Morse et al 1996).

However, whilst such an analysis may provide a strict definition, the undertaking of concept analysis has been criticised (Paley 1996; Beckwith et al 2008). Parahoo (1997) acknowledges that in defining attributes of a concept too strictly we may miss the very essence of the phenomena. The philosophy of phenomenology requires the phenomena to be explored through the lifeworld experiences of the participants. Hence, strictly defining the phenomena prior to undertaking this type of research is in conflict with its fundamental nature. Van Manen (1990) suggests that one of the basic steps for hermeneutic phenomenological research is to investigate lived experience rather than conceptualise it. Therefore, for this study, it would be inappropriate to undertake a formal concept analysis of confidence. I was, however, aware of the various dictionary definitions of confidence, along with definitions of self-efficacy utilised in psychology. This enabled me to be conscious of the general components of confidence, without being restrained by a strict conceptual definition.
4.5. Overview of design stages

In order to obtain longitudinal prospective data and manage the three study settings in a timely manner, the study was designed in the following stages:

**Stage 1:** Study setting A – Diary

**Stage 2:** Study setting A – Interview

**Stage 3:** Study setting B & C – Diary

**Stage 4:** Study setting B & C – Interview

**Stage 5:** Triangulation of data from all sources

See figure 1 below.
Figure 1: Diagrammatic overview of study

Stage 1
Study setting A
Diaries

Stage 2
Study setting A
Interviews

Stage 3
Study setting B
Diaries

Stage 3
Study setting C
Diaries

Stage 4
Study setting B
Interviews

Stage 4
Study setting C
Interviews

Stage 5
Triangulation
4.6. Sample and setting

4.6.1. Sample

A purposive sample of midwives working in intrapartum care across three settings was recruited. In phenomenological research it is the quality of the data that is important (Todres 2005), hence recruitment of a smaller sample which provides in-depth data is required. Purposive sampling, in which midwives providing intrapartum care were approached, was therefore appropriate for this study. Such sampling of those whose experience is likely to allow exploration of the phenomena in question is the strength of purposive sampling (Patton 2002). The inclusion criterion for the study was limited to midwives who were providing intrapartum care as part of their role at the time of recruitment. This allowed for the capture of team and caseload midwives whose workload varied, but included intrapartum care. Exclusion criteria were limited to midwives who were not providing intrapartum care at the time of recruitment.

4.6.2. Setting

Midwifery practice can vary depending on the philosophy of the unit in which the midwife works (Keating and Fleming 2009). The type of practice and the political workplace environment may affect midwives’ experiences of providing intrapartum care. For this reason it was important to consider more than one setting for the study. In order to gain as wide a perspective as possible, three separate diverse settings across the North West of England were included in the study.
Study setting A is a large regional unit providing both consultant-led care on the main delivery suite and midwifery-led care on an integrated midwifery-led unit (MLU). The unit provides care for over 8,000 women per year from the surrounding urban area. There is a diversity of social class within the area and a small ethnic population (10%). A total of six midwives, three from the CLU and three from the MLU were recruited.

Study setting B is a caseload-holding team of midwives attached to a medium sized midwifery unit within a general hospital. These midwives provide intrapartum care in both the home and hospital setting. The caseload team provide care for 40 women per whole time equivalent per year. The area includes a high ethnic population of over 30%. The team also work with disadvantaged groups. Three midwives were recruited from this setting.

Study setting C is a stand-alone birth centre, providing midwife-led care, with midwives working mainly in teams, with some core staff. The unit provides care for approximately 300 women per year from the local population. The surrounding area is mainly suburban and includes some rural areas. Women booking at the unit are required to live within a six mile radius of the unit. Three midwives were recruited from this setting.

4.7. Recruitment

Midwives were approached initially by letter and information sheet sent to their workplace address inviting them to take part (see appendices 1 and 2). They were invited to respond to my request to participate in the study either by
telephone, email or face to face contact. This approach provided the midwife with sufficient time to consider whether they wished to take part in the study. The participants were all health professionals with an excellent understanding of the English language. However, it was important not to make assumptions and to ensure that the midwife was providing fully informed consent. A meeting was arranged individually with each midwife who contacted me and wished to participate. A detailed explanation of the study was provided by myself and each individual had the opportunity to ask questions. The explanation of the study included assurances of anonymity, confidentiality and the right to withdraw from the study at any time. Written consent was obtained from midwives willing to participate (see appendix 3).

4.8. Ethical approval

Prior to commencement of the study, ethical approval was gained from the Local Research Ethics Committee (LREC) (Ref: 06/Q1501/162) (see appendix 4). Permissions were sought and gained from Heads of Midwifery and the local Research and Development Committees at each hospital Trust.

4.9. Diary – Stages 1 and 3

Stages 1 and 3 of the study utilised diaries as a method of data collection. The diaries enabled initial thoughts on confidence to be captured prior to the later in-depth interview. The purpose of the diary was twofold; to collect data, and to focus participant's mind on the issue of confidence prior to a subsequent interview. As a data collection tool, diaries have been found to be effective, sensitive and trustworthy method of data collection (Richardson 1994; Ross et
The diary data can also be used to generate questions to be explored at interview (Burgess 1981). The diary followed by interview method is viewed as a useful method of data collection when seeking deeper understanding (Zimmerman and Wieder 1977; Way 2011). Given that the phenomena being explored could lead to personal and sensitive data being collected, it was important to use a method that respected the privacy of the participant. Diaries have been found to be useful in collecting hidden data, that is intimate thoughts and feelings of the participants (Waddington 2005). It was also important to use a method of data collection that would enable an individual's thoughts and feelings to be captured as they occurred. Diaries enable data to be captured both in context and as soon as possible after the experience (Bolger et al 2003). It was anticipated that such diaries were suitable as a method of capturing the phenomena of confidence on a day to day basis. Hence, diaries were chosen as the most appropriate method for capturing an in-depth personal perspective, prospectively and longitudinally. Diaries also suited the hermeneutical phenomenological approach in that they allowed the participant to tell their own story in the context of “Being in the world”. This approach allowed for a narrative, uninterrupted by the researcher's questions and enabled data produced to be time situated.

Bolger et al suggest that “diary research is most effective when the design and research question are complementary in form” (Bolger et al 2003: 588). Hence, the diary questions and instructions to participants were broad, in keeping with the exploratory nature of the study. A list of five broad questions, such as “In what clinical situations did I feel confident?” was provided within the diary as a
guide and participants were asked to record anything else they felt was relevant to them within the concept of confidence (see appendix 5). The questions were deliberately wide in order to allow the participant a high degree of freedom in what they recorded. However, for practical purposes, it was necessary to give some guidance to avoid the risk of failure to complete or large amounts of irrelevant data (Symon 2004). The diaries were designed to be completed in response to any event that participants felt affected their confidence. Event based diaries are more suitable for exploring the specific phenomena on which the study is focused (Bolger et al 2003).

Midwives were asked to keep the diaries, either written or electronic, for a period of ten working days, when they were providing intrapartum care. The time period chosen was to obtain information over a variety of shift patterns, but not to be so long that midwives would lose motivation to complete them. There was no obligation to make an entry for every shift as the aim was to capture events around confidence that were significant to the midwife involved. Hence, all entries were self selected by the participants. One of the difficulties with the use of diaries is the dedication and motivation required from the participants to complete them (Bolger et al 2003; Kaun 2010). In order to facilitate diary completion it was important to incorporate some flexibility given the busy and often unpredictable environment in which the participants worked. Therefore, the timing of completion of the diary and the quantity of data recorded was left to the choice of the midwife.
The diary, and an explanation of its use, was provided to the midwife at the time of consent. Participants were provided with a choice of completing either a paper or electronic diary. If required the electronic diary could be completed either by Dictaphone or by using a word processing package. The Dictaphone had an advantage that the participant would be able to complete this in the field, whilst the use of a word processing package would require time spent at a computer terminal and therefore was less likely to be contemporaneous. Electronic diaries do have some advantages compared to paper diaries, particularly in terms of compliance when entries are required within a fixed time period (Stone et al 2002, 2003; Palermo et al 2004; Kajander et al 2007). However, disadvantages include equipment difficulties (Palermo et al 2004), cost (Bolger et al 2003) and potentially increased time in completion (Kajander et al 2007). Two of the main potential disadvantages with paper diaries are that of failure to complete or obtaining irrelevant data (Verbrugge 1980; Richardson 1994; Bolger et al 2003; Symon 2004). As the diaries were focused on events as a trigger for completion, rather than specific time points it was anticipated that compliance would be greater. This assumption was made on the basis that there would be less pressure on participants to comply with deadlines. A further issue with the use of diaries is that completion may take place after the event has occurred. Given the nature of the study and the workplace environment of the participants, it was realistic to expect that this may occur in any case.

The paper diaries the participants were provided with were small enough to fit into a pocket, so they could be easily carried and accessed. This was a deliberate decision in order to increase the likelihood of diary completion in
close relation to the event itself (Bolger et al 2003). A potential difficulty of the diary method is that of retrospective completion. This was considered an acceptable risk in the circumstances as the diaries were more likely to be completed nearer to the event than an interview. Hence, there would be less data lost due to recall failure (Verbrugge 1980).

In addition to the collection of data, I was interested in the way the diaries would be completed by participants. Diaries have become an established method popular with health and social care researchers (Jones 2000). In particular, the use of the health diary considering development and experience of illness is utilised frequently by researchers. The use of diaries for data collection has also been considered and critiqued by others (Verbrugge 1980; Ross et al 1994; Gibson 1995; Bolger et al 2003; Välimäki et al 2007). There has been little exploration of the use of diaries with health professionals; with the majority of studies being quantitative in nature (Bakker et al 1996; McCourt 1998). However, Steen and Bharj (2003) utilised reflective diaries in a programme exploring midwives experiences and attitudes when caring for women facing abuse; concluding that such reflective writing could be beneficial in both the promotion of learning and in service evaluation.

In consideration of the method, I became aware of the lack of evidence regarding the use of qualitative diaries with health professionals. There was, however, evidence regarding the suitability of diaries with other populations. It was, therefore, considered a secondary aim of this study to evaluate the use of
qualitative diaries by health professionals in a phenomenological study. This included considering acceptability, adherence and quality of the data recorded.

4.10. Interview – Stages 2 and 4

Stages 2 and 4 of the study utilised semi structured in-depth interviews. This method was considered to be appropriate both to the hermeneutic phenomenological approach and to the exploratory nature of the study. The qualitative research interview is defined by Kvale (1983: 174) as “an interview, whose purpose is to gather descriptions of the lifeworld of the interviewee with respect to the interpretation of the meaning of the described phenomena”.

The aim of the interview in a phenomenologically guided study is to focus on the phenomena to be explored. It is particularly useful for exploratory research to capture the views and experiences of individuals as it is a flexible and adaptive tool when utilized in a semi-structured or focussed way. In addition, where the subject matter under discussion is potentially sensitive, as it was here, the face to face interview provides a private and confidential setting for participants. For this study, the interview provided a forum to discuss diary entries and allowed for further probing and clarification by myself.

Van Manen (1990) sees the role of the researcher in the hermeneutic interview as keeping the interviewee orientated to the substance of the phenomena being explored. The interview allows for the researcher to explore events as experienced by the participant. It also allows for an exploration of how the participant understands and perceives the world and to gain meaning from this.
Hence, this method of data collection is particularly appropriate to phenomenology.

A reflexive stance was adopted by myself prior to undertaking the interviews. The interview has been described as a conversation, more than simply collecting data (Kvale and Brinkmann 2009). This conversation allows the researcher to become immersed in the subject of the data being generated (Gadamer 1989; Fleming et al 2003). However, Oppenheim (1992) believes that the interview is not an ordinary conversation, and requires a skilled individual to carry it out. Whilst treating the interview as a conversation from the outset may engender a more natural flow to proceedings, there are a number of difficulties to overcome. This includes the potential risk of the interviewer influencing the direction of the conversation or giving an indication of their own views which may in turn stifle those of the participant. Instead, Polit and Beck (2006) suggest that the interviewer should be a neutral agent in the interview process. Britten (2006) confirms this stance, indicating that the interviewer should avoid imposing their own structures and assumptions and remain open to the possibility that ideas may emerge that are very different from that which the researcher expects. Hence, I attempted to maintain an encouraging and enabling atmosphere, whilst remaining neutral within the interview. The participants were all articulate professionals and were aware of my position as researcher and therefore did not overtly try to elicit my views. They were also comfortable to talk at length with little prompting from myself.
The interviews were used to explore diary entries further, and to further explore the phenomena of confidence and the participant’s lifeworld experience. In addition, they were valuable in attempting to understand the context of the working environment, as perceived by the participant. The interviews were largely participant led in order to allow previously unconsidered areas to be explored. Although a conversation between the participant and researcher, it is important that the researcher is able to maintain some focus on the area under exploration (Kvale 1983; Kvale and Brinkmann 2009). With this in mind, a broad interview schedule was developed covering wide subject areas around the phenomena of confidence (see appendix 6). As the study was exploratory, the schedule was initially developed based on areas previously highlighted in the available literature. In addition, any areas I considered may be of importance were added. It is important to note that the schedule did not consist of a list of questions and I was keen not to impose any pre-conceptions of my own on the participants. However, I did consider a guide could be helpful in focussing the interview if required.

The interviews were conducted at a mutually convenient time, either in a private location at one of the study settings or in the individual’s own home. The interviews were audio-taped with consent in order to capture all relevant information for analysis.
4.11. Data analysis - Stage 5

4.11.1. Data analysis 1: All sources

As a philosophy, hermeneutic phenomenology offers little in guidance relating to analysis. However, a number of approaches have been developed. As discussed in chapter 3 (section 3.4.1.4), a number of these are suited to the Husserlian approach. For this study it was essential to consider methods of analysis specifically suited to hermeneutic Heideggarian philosophy.

Hermeneutic phenomenology aims to transform lived experience into a textual expression of its essence (van Manen 1990). In order to examine phenomena, phenomenology explores how the phenomena present themselves to the individual. The individual experiences the world, and hence the phenomena, through consciousness. It is through this conscious state that the individual is able to “Be” within the world. Language is the medium in which humans can express their experiences in consciousness and it is through language that understanding takes place. Language is a central concept in hermeneutics and Gadamer in particular believes thought and language are inexorably bound together. Therefore, we think in terms of language and as such are unable to understand or expose the phenomena without using language. Translation is the process of making sense of the language used and interpreting this to reach understanding. (Ricoeur 1998; Kearney 2007) For Ricoeur translation can be either literal, from one language to another, or ontological, translating one to oneself and to others. In using language, through speech and text we are translating and therefore interpreting. Hence, the act of reading and
understanding the text is interpretive in itself. It was therefore essential that analysis was sympathetic to this stance.

A hermeneutic phenomenological approach to data analysis guided by van Manen (1990) was carried out. It is important to note that van Manen provides a guide to interpretation, not a step by step method. This is in keeping with the nature of phenomenology. As discussed in the previous chapter, a number of prescriptive methods ascribed to phenomenological analysis have been open to criticism and as such were considered inappropriate for this study.

Phenomenological, hermeneutic reflection is central to van Manen’s (1990) approach to analysis. He believes that to gain insight into the essence of a phenomenon involves “a process of reflectively appropriating, clarifying and making explicit the structure of meaning of the lived experience” (van Manen 1990: 77). In order to gain this insight and subsequently the meaning of the phenomena, van Manen suggests the use of themes as structures of meaning. He details three ways of doing this. Firstly, a “wholistic [sic] approach”, considering the text as a whole. Secondly, a “selective approach”, highlighting statements that appear to be significant or revealing in the text. Thirdly, a “detailed approach”, considering every sentence or sentence cluster in detail (van Manen 1990: 92). Analysis was approached in a systematic way in order to ensure consistency. In order to analyse the texts, a combination of the three approaches was utilized.
Transcription of data was undertaken by myself using standard transcription techniques. This allowed for me to revisit the interviews in real time in terms of tone, emphasis and context. One of the main advantages in transcribing data is that it allows the researcher to become closer to the data (Carter 2004). It is also an early stage of analysis (Pope et al 2006; Kvale and Brinkmann 2009) in that key themes begin to emerge from the text.

Data was managed by hand and word processing software for organisation. The use of a specialist computer programme to aid analysis was considered inappropriate due to the approach and the nature of the data. Data analysis is a complex, iterative and creative process (Carter 2004). I was concerned that using such a programme would interfere with this process and overall essence of the emerging themes could be fragmented and lost.

Following transcription, all texts were read in their entirety a number of times. This is part of the “wholistic” approach advocated by van Manen (1990). It was particularly important in this study and added to the overall “feel” of the data. It was also a technique that was returned to on a number of occasions throughout analysis. This is very relevant to hermeneutic phenomenology where the essence of the phenomena is being pursued. In terms of the transcripts from this study much of the essence of the data was only observable from reading the whole of the document. Participants frequently returned to an incident they had discussed earlier and sometimes the thread of an idea was clear when reading the whole text, but would be lost when concentrating on single sentences or clusters of sentences.
Significant or revealing statements were drawn out of the text in line with van Manen’s (1990) selective approach, and these contributed to the thematic analysis. Certain sentences or clusters of sentences clearly stood out within the text. It became obvious that differing participants would sometimes use the same phrase or metaphor to describe a situation, idea or feeling. Other phrases in the text revealed themselves to be particularly pertinent or sometimes provided the distillation of an idea into one sentence or phrase.

Significant sentences were read in isolation and together with the whole text in order to discover meaning. Reading each line in detail helped to determine the meaning of what was being said. The emphasis and language used was often a focus in this very detailed approach. Some issues that had been missed in the overall reading of the transcript could be highlighted here and added to the overall understanding.

Whilst van Manen (1990) does not specifically discuss the hermeneutic circle, he does describe the circular process of moving between the parts and the whole. The circle itself is a key concept to both Heidegger’s and Gadamer’s philosophies regarding interpretation. Hence, the hermeneutic circle was employed in considering the whole and the parts of the data. In doing this, it was necessary to move from the whole text to parts of the text and back again in order to gain understanding in a cyclical, dynamic process. In addition, I considered other interpretations of the circle, such as moving between culture and context, and between the cultures of the participant and the researcher
These interpretations were also utilised as I felt it was appropriate to analysis in this study. In effect, there was more than one circle occurring simultaneously during analysis of data. Using the guide suggested by van Manen (1990) and the hermeneutic circle was particularly suited to exploring the phenomenon of confidence. Phenomena are multi-dimensional (van Manen 1990). Hence, it was crucial for the data to be viewed in its entirety as well as in detail for the full meaning to become clear. Prior to commencing the analysis I had attempted to take a reflexive stance and continued with this throughout data analysis. Heidegger determines that fore-knowledge in the form of fore-having, fore-sight and fore-conceptions is key to the hermeneutic circle and can only be resolved through entering the circle. Hence, the utilisation of the circle enabled such fore-structures of knowledge to be made explicit and acknowledged.

Van Manen (1990) sees the act of writing as central to reflection in the analysis process. Writing and re-writing is a circular process in itself, in that ideas around understanding and interpretation begin to be formed. They are then returned to, reflected upon and then gain more depth with subsequent re-formulation. This re-writing is referred to by van Manen as a complex process of “re-thinking, reflecting and re-cognizing” (1990: 131). Writing can create a distance from which we can reflect on the subjectiveness of daily existence, i.e. decontextualise, but which can also return us more closely to the phenomena under investigation. Writing and re-writing aided reflection on the text itself and on the questions posed within it. In this way decontextualisation and recontextualisation of
thoughts around the phenomena of confidence occurred. Throughout analysis, writing was used to maintain and gain a depth of understanding.

A reflexive research journal, kept from the outset, helped to me return to and evolve thought processes throughout analysis. Developing themes were noted and emergent questions posed with which to interrogate the data further. This aided the dynamic cyclical process in which the depth of the data and the phenomena was explored. As themes emerged, writing and re-writing helped to develop them from brief notes into a text of interpretive understanding.

Texts were considered individually and also jointly with data from the same setting and finally with data from all settings. Diaries were initially analysed separately then in conjunction with interview data; firstly for each individual setting, then for all settings as described above. Commonalities and differences were considered and explored. Discussions between myself and supervisors enabled a consensus to be reached.

4.11.2. Data analysis 2: Diaries as a method in phenomenological research.
Overall thematic analysis was guided by van Manen (1990) for both diary and interview data. However, in order to evaluate the use of qualitative diaries as a research tool with health professionals a different type of analysis was required. Primarily, this was in response to the secondary aim of the study to analyse the diaries as a tool for collecting data in phenomenologically guided research. Reviewing the text as captured by the diaries indicated that the structure and
construction of the text would give meaning to the narrative itself. Therefore, a method of analysis which would incorporate consideration of the construction of the text itself was required. This was important as the overall construction of each individual text contributed to the tone of the narrative. Therefore, for the analysis of the diaries as a method Langdridge’s (2007) critical narrative analysis approach was utilised. This method is broadly based on the work of Ricoeur whilst maintaining a hermeneutic approach. This analysis allows “focus on the structure and form of the story as it appears in the text, rather than to impose any predetermined framework of meaning” (Langdridge 2007: 132).

A six stage process is undertaken within this style of analysis. Stage one of the process requires the researcher to critique “the illusions of the subject” (Langdridge 2007: 134). At this point the researcher examines their prejudices and adopts a reflexive stance. As discussed earlier, I was aware of my preconceptions as a midwife relating to the research subject itself. In addition I had to consider my preconceptions regarding the use of diaries as a research method. When designing the study I knew that I required a method of data collection that could capture participants’ thoughts as contemporaneously as possible; for this, diaries appeared the ideal medium. However, I did have some reservations around the extent to which they would be completed. The reasons for my concerns were twofold. My first concern centred around whether the participants would have the time and the motivation to complete them. My second concern related to the subject matter of the study itself. I was aware that writing about confidence could be very personal to the participant and this might
affect the depth of the narrative. However, these were my own preconceptions which I acknowledged in accordance with the hermeneutic approach.

The second stage involves the identification of narratives within the text. This also involves consideration and identification of the tone of the narrative and the rhetoric used in the text. This was vital in respect of the diary data where rhetoric and various grammatical devices were used by participants to impart tone into the text. In particular, this stage was key to uncovering much of the emotion and changes in emotion within the text.

The third stage requires the researcher to consider the identity of the participant. For Langdridge (2007) the narrative itself gives bearing and construction to the individual. The tone and rhetoric of the narrative described in stage two also adds to the individual the narrative brings into being.

The fourth stage of the process requires the development of themes. This requires a review of the whole and parts of the text, which is completed in a systematic manner. Langdridge (2007) details a wide approach to this, rejecting the concept of coding the data. At this stage of the process I incorporated van Manen’s approach as this is sympathetic to the wide technique detailed by Langdridge. It is also in keeping with the analysis of the text as a whole.

The fifth stage of the process is what Langdridge terms “destabilising the narrative” (2007: 139). Essentially this is a critique of the text in light of the identified pre-conceptions of the researcher. The hermeneutic circle is
completed at this stage, with the researcher repeating the steps as required in line with the philosophy of the circle. The final stage is termed a “critical synthesis” (2007: 140) of the findings. This requires clear findings relating to the narrative, themes and the reflexivity of the researcher.

Although critical narrative analysis is more prescriptive, the focus on the textual tone and narrative suited analysis of the diaries as a research method. It also allowed for the identification of themes emerging from the text in a manner very similar to that described by van Manen (1990). Hence, thematic analysis occurred in the same way for both the interview texts and the diaries.

4.11.3. Participant validation

Many of the strategies used for analysis in phenomenology, and qualitative research in general, include the requirement for participant validation. Lincoln and Guba (1985) suggest that it is a strong check on the credibility of the research findings. Others, such as Fleming et al (2003), consider that returning to the research participants at all stages of the research process can ensure confirmability. Whilst Mays and Pope (2006) also consider participant validation to be important, they also acknowledge that limitations exist. They accept that the researcher’s perspective and subsequent interpretation for a wider audience will differ from that of the participant by virtue of their role in the research process. As a result participant validation can be part of a process of reducing errors, rather than a check on validity. Sandelowski (1993) goes so far as to suggest that participant validation may actually undermine the research findings in terms of trustworthiness.
In Gadamer’s (1989) hermeneutic phenomenology, the concept of the fusion of horizons requires the prejudices of the researcher for interpretation to take place and meaning to emerge. Although this interpretation should represent that of the participant it is inevitable that it will not be identical. Gadamer (1989) suggests that if we are to understand at all, we will understand differently. This must be acknowledged as part of the interpretive process. In addition, in returning to the participant it is likely that a period of time has elapsed and the participant’s horizon and viewpoint may have changed. The original statement or idea expressed by the participant will be time situated and may consequently present difficulties to the participant in returning to it. This may be simply because the individual has forgotten their original conversations. Alternatively, some participants may not wish to return to the data but feel obliged to do so to please the researcher (Sandelowski 1993). Similarly Ashworth (1993) considers that participants may be unwilling to contradict the researcher. The process of participant validation itself is potentially difficult and Sandelowski (1993) suggests that the idea of returning to research participants for corroboration of findings is too simple.

There is also the question of what is data collection and what is analysis in the research process. By continually returning to participants to discuss findings as advocated by Fleming et al (2003) it is possible that the original meaning or interpretation will become very much changed. Barbour (2001) suggests that researchers may discount their own interpretations, instead relying on those of the participant without question. Furthermore, the participant may provide
additional data or revise their views when confronted with an interpretation of their original data. This may have more to do with self-presentation of the participant, rather than an actual misinterpretation of the views themselves by the researcher. Ashworth (1993) argues that participant views incorporate self-presentation to the researcher and therefore cannot be used as a check on validity.

Whilst I engaged in returning to the participants of study setting A, at least in part, I made the decision not to do this for study settings B and C. The reasoning for this is as follows; firstly, having read around the subject of participant validation and in light of the arguments set out above, I no longer felt this to be relevant to interpretive research. Secondly, the participants at study setting A had indicated that they were in agreement with my interpretations as presented to them. When presented at both national and international conferences, the findings appeared to resonate with the audience, some of whom had been participants in the study. Additionally, the design of the study itself allowed for discussion and clarification of diary entries with participants during the subsequent interviews.

4.11.4. Triangulation

The study was designed to include triangulation of data for two main reasons; firstly, to increase credibility (Robson 2002; Donovan 2006); and secondly, to ensure completeness of data (Denzin 1989; Redfern and Norman 1994; Mays and Pope 2006). Provided the combination of methods used is appropriate to the study, triangulation can increase the validity of that study (Donovan 2006).
Denzin (1989) describes various methods of triangulation, which include triangulation of data, triangulation of investigator, theoretical triangulation and methodological triangulation. Whilst triangulation is frequently used to describe studies combining both quantitative and qualitative data, Denzin (1989) includes “within method” triangulation. This involves combining similar methods of data collection approaches. Here, diaries and interviews were used as both were suited to the overall methodology. The views of midwives from different settings were also elicited in order to gain a more complete picture of the phenomena under investigation.

Analysis required triangulation of data from all sources. Initially, data from all sources were analysed separately. Diaries were analysed individually and with other diaries from the same setting. They were also analysed with interviews from the individual and eventually with all data from that setting. Interviews were analysed in a similar way. Ultimately all data from diaries and interviews at the three study settings were analysed together. Discussions between the researcher and supervisor enabled a consensus to be reached, fulfilling the role of investigator triangulation which involves examination of the data by two or more researchers. Knafl and Breitmeyer (1989) suggest that triangulation has two distinct applications; one where the focus is on the convergence of a triangulated approach; the other describes a multi strategy approach to achieve completeness. Both elements were used within this study.
4.11.5. Consideration of rigour in phenomenological research

In any study it is important that the research is of such quality as to produce trustworthy and believable findings. In order to ensure quality, the researcher may adopt what is often termed a rigorous approach. One of the difficulties with the concept of rigour is that is can become the ultimate aim to the detriment of the study itself (Sandelowski 1993; Barbour 2001). Rather than being an aim in itself, rigour should occur within the context of the research design, process and analysis (Koch 1994; Barbour 2001). Traditionally, qualitative research has often been judged in a similar manner to quantitative research despite its obvious differences. This can lead to discrepancies in judging the quality of the research. Language incompatibilities between quantitative and qualitative research have led to a divide and a failure to recognise the inherent differences between the two methods (Whittemore et al 2001; Morse et al 2010). In addition, standardised checklists have been used as a method of critiquing qualitative research in an objective manner. However, the usefulness of checklists for qualitative research per se has been debated (Mays and Pope 2006). Barbour (2001) suggests that whilst helpful in improving methods, reliance on checklists can in itself be counterproductive in promoting rigour.

It is essential to embed rigour throughout the research process where possible and this is what I have attempted to do in conducting this research. It is important to choose a methodology that suits the study aim (Morse 1991); hence I have chosen phenomenology for an exploratory study to focus on the meaning of confidence for midwives. Maintaining an ethical stance throughout the study processes is important (Davies and Dodd 2002; Hannes et al 2010).
This relates not only to obtaining relevant ethical approvals, but also to maintaining a high standard of ethics towards participants, data and analysis processes. I have endeavoured to maintain ethical integrity in all aspects of the study. This includes maintaining confidentiality of the participants at all times and conducting the research in line with research governance standards and ethical guidance. In presenting data I have used anonymised quotes and made every attempt to ensure the participant cannot be identified. A reflexive stance is also important in terms of research credibility (Koch 1994; Finlay 2002; Mays and Pope 2006; Hannes et al 2010). As a hermeneutic phenomenological study, acknowledgement of my own pre-conceptions as a researcher was vital to the underlying philosophy. This also is in congruence with the need to integrate the underlying philosophy into the study method and findings (de Witt and Ploeg 2006). Reflexivity has been discussed in greater detail in chapter 3 (3.5.1) and will be a key thread running throughout the thesis.

Other factors which are considered good practice in enhancing rigour include maintaining a clear audit trail (Walsh and Baker 2004). This involves providing clear details of the data collection and analysis undertaken. Additionally, the rationale for decisions made should be open and transparent. Given the iterative nature of qualitative analysis it can be difficult to provide detailed descriptions of the thought processes involved. However, I have attempted to provide a clear description of the way in which I approached analysis. It is important to note that although the steps taken in terms of analysis may be replicable, the findings are unlikely to be. The reason for this is twofold; firstly the data collection is both time and contextually situated and, secondly, different
researchers will undoubtedly bring their own, different, pre-conceptions and theoretical stances to the data (Sandelowski 1993). This is particularly relevant in an interpretive phenomenological study such as this.

In analysing the data it is suggested that negative cases should be revealed and discussed (Mays and Pope 2006). Data from this study was diverse; however, no negative cases as such were apparent. There were differences between data from different settings which will be highlighted within the findings. The diversity of views emerging from the data will also be examined within the findings where relevant. Due to the breadth and depth of the data emerging from this study only the main themes will be discussed in this thesis. Other methodological features which may be considered to confer rigour in a study include participant validation and triangulation both of which are discussed in greater detail in this chapter (4.11.3 and 4.11.4). Additionally, discussion of data with supervisors during the analysis process allowed consensus to be reached adding to the confirmability of the findings.

Throughout this thesis I will attempt to provide clear descriptions and rationale for decisions in the research process. In presentation of the findings data representative of the participants will be submitted to evidence my conclusions and discussions.
4.12. Conclusion

This chapter has provided an overview of the study methodology and clarified the study aims. The design has been discussed and justified, including the approach to data collection. The three settings for data collection as a means of gaining a breadth of data have been introduced. This chapter has also examined the rationale behind the choice of methods and the overall design of the study.
Chapter 5

Findings 1

The Participants and their Diaries
Chapter 5: The Participants and their Diaries

5.1. Introduction
This chapter will describe the demographics of the sample and the different settings in which the participants were employed. The methods used for collection of the data will be described in greater detail. A discussion focusing on the use of diaries as a method in a phenomenological study will provide the main body of the chapter.

5.2. The participants
Twelve midwives were recruited from three settings in the North West of England. Setting A comprised of two sample groups; a consultant-led unit (Sample Group 1) and an integrated midwifery-led unit (Sample Group 2). Three midwives were recruited in each sample group. All midwives were core staff with the exception of one midwife who worked on both the MLU and in the community. Setting B comprised of a caseloding team of midwives from which three midwives were recruited (Sample Group 3). Setting C was a birth centre (stand-alone midwifery led unit) in which midwives worked within teams. Three midwives were recruited from this site (Sample Group 4). See table 2 for an overview of setting and sample details.
Table 2: Overview of setting and sample

<table>
<thead>
<tr>
<th>Setting</th>
<th>Phase of study</th>
<th>Sample group</th>
<th>No of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting A</td>
<td>Phase 1 &amp; 2</td>
<td>Regional unit consisting of:</td>
<td>3 participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultant Led Unit (CLU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sample group 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Midwife Led Unit (MLU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sample group 2</td>
<td></td>
</tr>
<tr>
<td>Setting B</td>
<td>Phase 3 &amp; 4</td>
<td>Caseloading team</td>
<td>3 participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sample group 3</td>
<td></td>
</tr>
<tr>
<td>Setting C</td>
<td>Phase 3 &amp; 4</td>
<td>Birth Centre</td>
<td>3 participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sample group 4</td>
<td></td>
</tr>
</tbody>
</table>

Setting A – Phases 1 and 2

Data collection from two sample groups (CLU and MLU) was completed in this setting first. Within this setting, two separate sample groups were recruited; sample group 1 from the CLU and sample group 2 from the MLU. Although there were two different units operating on this site, the CLU and the MLU, there were many similarities between them. Four of the staff interviewed had at some point worked on both units and discussed this in their interviews. There was also evidence of culture infiltration from the CLU to the MLU, with many shared policies existing. This site provided valuable insight into midwives’ confidence.
when working in a large tertiary hospital Trust. However, there were also some obvious differences between the two units on that site.

**Setting B – Phases 3 and 4**

Data collection at this site occurred concurrently with setting C. The midwives at this site worked as a small caseloading team, providing care for both low-risk and high-risk women. Intrapartum care was provided in the home environment and also within the hospital CLU. All midwives within this team had specifically applied and chosen to work there, with most previously working within the hospital or team environment.

**Setting C – Phases 3 and 4**

Setting C was a birth centre attached to a general hospital. However, no obstetric facilities were available on site. If necessary, transfers were undertaken to the CLU, which was situated at another hospital six miles away. Midwives working in this unit had specifically chosen to work there and, at the time of the study, did not rotate between units. The majority of staff at the birth centre worked in teams providing antenatal and postnatal care in the community as well as facilitating home births. A few midwives worked as core staff within the birth centre.

Across the settings the participants ranged in experience from 4 to 27 years post qualification as a midwife. Seven of the participants were employed on a full-time basis and five employed part-time. See table 3 for details of the participants and their pseudonyms which will be used throughout.
Table 3: Participant details

<table>
<thead>
<tr>
<th>Name</th>
<th>Study Setting</th>
<th>Sample Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona</td>
<td>A</td>
<td>1 - Consultant led unit</td>
</tr>
<tr>
<td>Anna</td>
<td>A</td>
<td>1 - Consultant led unit</td>
</tr>
<tr>
<td>Amy</td>
<td>A</td>
<td>1 - Consultant led unit</td>
</tr>
<tr>
<td>Hannah</td>
<td>A</td>
<td>2 - Midwife led unit</td>
</tr>
<tr>
<td>Mary</td>
<td>A</td>
<td>2 - Midwife led unit</td>
</tr>
<tr>
<td>Siobhan</td>
<td>A</td>
<td>2 - Midwife led unit</td>
</tr>
<tr>
<td>Sara</td>
<td>B</td>
<td>3 - Caseload team</td>
</tr>
<tr>
<td>Alice</td>
<td>B</td>
<td>3 - Caseload team</td>
</tr>
<tr>
<td>Laura</td>
<td>B</td>
<td>3 - Caseload team</td>
</tr>
<tr>
<td>Helen</td>
<td>C</td>
<td>4 - Birth Centre</td>
</tr>
<tr>
<td>Katy</td>
<td>C</td>
<td>4 - Birth Centre</td>
</tr>
<tr>
<td>Jemma</td>
<td>C</td>
<td>4 - Birth Centre</td>
</tr>
</tbody>
</table>

5.3. Data collection

5.3.1. The participant diaries

All of the participants completed paper diaries. The participants were provided with a short list of questions, designed to act as prompts to be considered when completing the diary (see figure 2, below).
Figure 2: Diary questions

<table>
<thead>
<tr>
<th>In which clinical situations did I feel confident?</th>
</tr>
</thead>
<tbody>
<tr>
<td>In which clinical situations did I feel less confident?</td>
</tr>
<tr>
<td>In which interactions with others did I feel confident?</td>
</tr>
<tr>
<td>In which interactions with others did I feel less confident?</td>
</tr>
<tr>
<td>Looking back on your day, which factors overall do you feel affected your confidence?</td>
</tr>
</tbody>
</table>

Analysis of the diaries was completed independently, with other diaries from the same setting and with diaries from all settings. Additionally diaries were analysed in relation to the corresponding interview and with all interview and diary data, in relation to the phenomena of confidence. A secondary outcome of the study was to examine the use of diaries as a data collection method in a phenomenological study with health professionals. A separate analysis was completed in relation to this outcome and is detailed below (5.4). The diaries were analysed separately in terms of method, using Langdridge’s (2007) critical narrative approach (see 4.11.2.). In addition, data collected at interview regarding the diary method provided greater understanding and context to the use of diaries by midwives in a phenomenological study. An example of a diary transcript is provided at appendix 7.

5.3.2. The interviews

Locations for interviews varied dependent on the participant’s preference. Six interviews took place in the participants own homes. The remaining six interviews were carried out in the participant’s workplace, in a separate private
The interviews lasted between 1 hour 10 minutes and 2 hours 15 minutes.

The interviews were wide in scope and very much participant led. Initially, participants were asked how they felt about keeping a diary. This was usually followed by an open question asking the participants to describe and explain the scenarios in their diary. Occasionally participants had started discussing confidence before the tape was switched on. In this case I allowed the participant to continue their thought processes without interruption and returned to the question about the diary at a later, appropriate stage, in the interview. The semi-structured approach allowed the participant the freedom to guide the interview in a manner which suited them and ensured the flow of conversation. The open questions asked such as “talk me through your diary entries?” resulted in participants talking at length, often without any prompting, about their experience and their perceptions of it. Only if participants did not cover the areas in the interview schedule were they asked directly about these areas. Interestingly, it appeared that those areas which the participants had not spontaneously raised were of little significance to them. This was evidenced by the fact that when prompted about these areas, they had little to say about them. This indicated that the semi-structured method succeeded in eliciting what was important to the midwives when talking about the phenomena of confidence. Probing was used, as appropriate, to gain greater understanding of each participant's thoughts and comments in relation to their lifeworld experience. Reflection within the interview was also used in order to clarify understanding, using open questions such as “so am I right in thinking that?".
One area I had intended to consider related to confidence outside the workplace environment and how participants felt it affected their confidence within the context of work. This question was asked of all participants at study setting A. However, it elicited little in the way of response. There appeared to be a clear divide between work and home for the participants and whilst they were happy to discuss workplace confidence they had little to add about their home life. This may be because they did not consider a link themselves. Alternatively, it may be because they found this too personal to discuss within this study. As a result of this, this area was not pursued in the following phases of the study, with participants from study settings B and C.

Throughout the interviews midwives talked at length about their experiences and the effects these had on confidence, drawing upon events to illustrate this. Whilst all midwives talked about events that had happened to them during the diary phase of the study, many also reflected on situations which had occurred prior to the study or since completing the diary. An example interview transcript is provided at appendix 8.

Throughout the study midwives were assured of anonymity and participants appeared very candid about their experiences. Two midwives disclosed information that they requested I did not use in this thesis or any publication. This information was very personal to them, but it was something that they wished to share with me at the time. This disclosure of data the individual wishes to keep private can occur within qualitative research (Goodwin et al.
The type of information the participants disclosed was similar, but related to different incidents. For both the individuals the incident had taken place some time before the study commenced; for one it was several years before. Neither of the incidents related to intrapartum care per se, but the participants clearly felt they were important to their confidence. The information they provided was not something I had requested, but something they themselves volunteered. There was nothing in either incident to raise concerns or to compromise me as a researcher.

The participants who did disclose information they wished to remain confidential were both working at study setting A. I knew both of the participants as colleagues as they worked within the same hospital Trust as myself. When I reflected on this, I did consider whether they would have been more comfortable disclosing this data to an individual they did not know. Alternatively, I questioned whether they disclosed this private information to me because they trusted me personally and as a researcher. None of the participants from other study settings disclosed data to me that they wished to remain private. Neither did any other participants disclose similar incidents. I considered at length why this disclosure had occurred when it was clearly very personal to each of the participants. At this site I was an “insider” in many ways as I was still working as a clinical midwife when the interviews took place. I also knew the unit and its culture very well. Corbin Dwyer and Buckle (2009) suggest an advantage of being an insider is that participants may more readily disclose personal data. The interviews themselves may also have provided a platform for the participants to divulge incidents they would not otherwise discuss. This may
have benefits for them in re-examining their reactions to these incidents. Their concerns around the sensitivity of the data I believe related to the risk to their anonymity if these incidents were publicly disclosed. I obviously respect their confidentiality and have not included this particular sensitive data in data analysis.

This prompted me to reflect on whether being unable to use this data has influenced my findings. As a researcher following the Heideggarian tradition, I was unable to bracket such information. As I was aware of it, it clearly would influence my world-view. It had obviously affected the individual participants and their own views significantly, for them to feel the need to disclose this information to me. Neither of the incidents had taken place during the time period of the study and, hence, were not recorded in their diaries. As the incidents had taken place before the study I was aware that some incidents can affect confidence for a considerable period of time. Understanding this made me consider whether data from other participants demonstrated a similar link. I also considered whether the inability to include this confidential data may have influenced the study findings in any way. In removing the incidents from the transcripts, there were no obvious differences in terms of emerging themes between them and other transcripts. I believe that the findings presented in this thesis do reflect the overall views of all the participants.

5.3.3. The use of field notes and reflexive journal

Prior to, and following, the interviews the participants often discussed matters relating to confidence which were not captured on audio tape. This also
occurred during telephone conversations arranging meetings and at initial contact. On these occasions I completed short field notes. In these I recorded date, time, setting and participant, along with any further details I considered may be important in contextually situating the interview. This also allowed me flexibility in recording my own additional observations. They were also a useful reference point when analysing the interviews where the participant began discussing the subject prior to the tape being turned on or after the tape was switched off.

Throughout the study I used a reflexive journal to contextualise and develop my own thought processes with regards to the study and the phenomena. It became evident throughout the journal that I was becoming much more aware of the issue of confidence within the working environment. I recorded some of the issues I had become conscious of within the working environment. This added to my overall understanding and helped to immerse me, contextually, within the data when undertaking analysis.

This is a phenomenological study with diary and interview data as the principal data collection methods, therefore, neither field notes nor my reflexive journal will be used for verbatim quotes. Both the field notes and my journal were used during analysis to assist my own reflection and interpretation of the data. As such they acted as a prompt to help me contextualise and situate the data as an aid to understanding in analysis.
5.4. An analysis of the use of diaries to capture lived experience.

On choosing to use diaries as a method of data collection I became aware of the dearth of literature surrounding their use both in phenomenological studies and with midwives. As a result, it was a secondary aim of the study to consider their use for data collection. In addition to the discussion in this thesis, a paper entitled “Using diaries to explore midwives’ experiences in intrapartum care: an evaluation of the method in a phenomenological study” has been published (Bedwell et al 2012) (See appendix 9).

5.4.1. Writing the diary

Diaries were completed and returned by all of the study participants. All diaries were completed in a handwritten format, despite participants having been offered the option of completing a diary electronically. It may have been that it was easier and quicker for participants to complete a paper diary (Kajander et al 2007). The ease of a pen and paper diary may allow the individual to make spontaneous entries. Alternatively it may be that recording personal thoughts and feelings is more intimate within a paper diary. The personal nature of the phenomena under exploration may lend itself to this. The physical and personal act of writing itself may allow the individual to record their private emotions more readily; the action of writing keeping them connected with their feelings and thoughts (Dobson 2002). Interestingly, reading the paper diaries gave me, as a researcher, a much greater feeling of connection with both the data and the writer of the diary than reading the transcripts did. A much more intimate and personal feel was evident in these paper diaries.
For analysis, the diaries had been transcribed exactly as written as far as possible, including all grammar, punctuation and marks to indicate emphasis. Despite this, something of the essence of the diaries seemed to be lost in the process. Therefore the original handwritten diaries were used during analysis as these gave a greater personal feel to the data. For the purposes of presentation within this thesis transcriptions of the diaries are used.

The number of entries recorded in the diaries varied, as did the amount and type of detail included. Two participants returned diaries with only two entries; however the entries were very detailed. In contrast two participants returned diaries with ten entries; one very detailed the other less so. The remainder of diaries contained between three and eight entries. Although some diaries contained more detail than others, it did not follow that those with the least entries gave the least detail. In fact, those with fewer entries often wrote in greater detail about a single incident than those with a greater number of entries. One of the difficulties with the use of diaries for data collection has been termed “diary fatigue”, in which detail is lost from the entries as they progress (Bolger et al 2003; Kaun 2010). The diaries in this study appeared to be consistent throughout in terms of detail. However, the fact that some had fewer entries than others may indicate a degree of diary fatigue, especially those that were very detailed, but consisted of fewer entries.

The grammatical style of the diaries varied considerably, as did their presentation. However all diaries were reflective in nature to some extent and participants all utilised similar devices to communicate their experiences.
Participants appeared to employ a three stage strategy in doing this. They would usually initiate an entry by describing an incident which they believed affected their confidence. Participants would then often describe their feelings and emotions surrounding the incident. Finally the participant would reflect on the incident and their emotions. For some a further stage would include considering or devising a strategy which they could use to manage similar future situations.

The differences in styles used by participants in completing the diaries are apparent; some consisting of detailed paragraphs, others written in bullet points. In addition, many participants used abbreviations and jargon. The participants all knew that I was a practising midwife and obviously felt comfortable using jargon throughout their diaries. The following excerpt is from a description of events made in a diary.

“2.30am – called to CDS to take over from a caseload colleague who had been with a woman for a long time – IOL at 36 wks for poor CTG/IUGR. Been contracting 1:2-3, strong for many hours – top dose of synt – been 3cm for 3 VE’s. Caput + moulding +.” (Laura – Diary entry)

As a professional insider and practising midwife the meaning of the above quote was clear, providing much contextual background in few words. However, to a non-midwife researcher much of what was written would make little sense. The use of shared professional language and jargon indicated some sort of perceived inclusiveness and understanding between the participant and myself.
as a researcher. Having an interview phase to the study also allowed for any queries over meanings of the entries to be explored further and clarified.

5.4.1.1. Focussing on the phenomena

All of the participants appeared focussed on the concept of confidence in their diaries. Many described events that had affected their confidence, which they later referred to in much greater detail at the interview. One participant in particular provided little detail of incidents, but focussed very strongly on the aspects that affected her confidence. She had clearly reflected on the case and her entries demonstrate a crystallisation of her views.

“G1. Pre lab SROM – prostin spont contractions. [Gravida 1. Pre-labour spontaneous rupture of membranes – Prostin (drug to induce labour) spontaneous contractions]

Increased confidence

- Knowing the woman and being able to speak to her appropriately in order to communicate effectively
- Belief that J [woman’s initial] was responding instinctively (and relief that she could!)
- Trusted colleague with shared philosophies -> I was able to discuss not having syntometrine as I hadn’t discussed it yet with J -> yet another physiological 3rd stage!
- Helpful responsive doctor.

Reduced confidence

- Unhelpful, unreliable shift leader.
- Student questioning why I wasn’t doing a VE prior to “allowing” a primip [primigravida] to push.
- Being tired, feeling stressed about visits the following day.”

(Sara - Diary entry)
This entry prompted a long discussion during the interview about the incident and the factors that affected her confidence. Hence, the diary was a suitable aide memoire in terms of acting as a prompt to recall a particular incident that the participant chose to discuss. This quote also demonstrates the success of using the diary method in focussing the mind of a participant on the phenomena being explored prior to interview. Other participants also acknowledged that the use of the diary prompted them to consider events in greater detail.

“It did make me think more and it's almost like telling a story. You know it makes you think about the sequence of events and what the influences are brought into play.” (Katy - Interview)

One participant acknowledged that she did not always note the incidents in her diary, but that it did prompt her to consider them in terms of confidence.

“When I first said I was gonna do it I did write a couple of things down, so perhaps I wouldn't have thought about it as much if I hadn't written those couple of things down. So it probably was useful. But then I got to a stage where I stopped and just started thinking about them on my own and didn't get round to writing them down.” (Fiona - Interview)

One of the criticisms of the use of diaries is the time required to complete them. There was concern that the requirement to complete a diary would be onerous, leading to a failure in completion.

“I actually enjoyed it, but it's not something I would do every shift.” (Siobhan - Interview)
A further criticism of diaries is that they may be completed retrospectively. Given the time and workload constraints on midwives, it was anticipated that diaries may not be completed contemporaneously, but rather at the end of a shift. Although focusing on incidents and how midwives felt at the time of these incidents, it was not vital that they be completed immediately as, for example, a symptom diary would be. It was accepted that some data may be lost in these situations. Furthermore, as all participants used the diaries for reflection this short delay in recording incidents may be advantageous. This allowed participants time to write about events in an unhurried way which may actually provide greater insight into the phenomena under investigation. Despite some entries being made after the event, the data remained time situated in that participants were often recording thoughts as they occurred. Significantly some participants made separate entries to record their thoughts as they occurred. This is reflective of the unsolicited personal diary, where prompts are individual thoughts and feelings, rather than specific events. One midwife made the following entry.

“Thoughts over weekend.
I think I feel more confident in abilities with the women than out of the room/off phone with colleagues – discussing what I’ve done/decided.
Maybe should just shut up and believe in self. Is helpful writing diary!”
(Siobhan - Diary entry)

In this way participants began to adapt their diaries to become more retrospective and reflective. Another midwife made an entry reflecting on several of her previously worked shifts at once; in particular discussing the
similarities between them in terms of poor staffing, high workload and lack of support.

“I have worked several shifts recently where I have seen my registration floating before my eyes. The shifts have been busy and short staffed resulting in too high a workload. This stresses me as I feel I cannot do a proper job and give proper care to the women involved.” (Anna - Diary entry)

This participant continues writing about her options for dealing with the situation and her general frustrations with the Trust management. This act of reflection may have the added benefit for the participant of putting her thoughts into perspective, so she can subsequently consider them more objectively.

5.4.2. Choosing what to include

Participants had been provided with five fairly broad guide questions in their diary (see appendix 5). The questions had been deliberately designed in a wide format to facilitate the recording of incidents and events that participants considered important. This was in accordance with the phenomenological nature of the study in exploring midwives’ experiences. The interview phase of the study explored participants reasons for including particular events. Why particular events were included was key in providing insight into the phenomena, participants’ experiences and context.

The use of questions as prompts at the front of the diary was found to be helpful by many of the participants. However, individuals were often prompted by experiences to complete the diary. If they felt they had nothing to write about
then they did not make an entry. This self-regulation of entries actually prevented the generation of irrelevant data, which had been a concern at the outset due to the open format of the diary.

“Times when nothing particularly happened on that day, there was nothing particularly good or bad to mention or so I didn’t bother. There was nothing that happened on today’s shift that’s made me think any more confidence wise so I kind of left them shifts out… I went off the front of the diary. That was a good thing the little list of questions on the front page, if there was anything I wasn’t really sure of I used to refer back to that really....... But other times if it was a particularly bad day or whatever I’d just remember what I’d done and I’d just go and write it up. If it was a particularly bad shift or whatever I didn’t need prompting kind of thing I’d just write about what happened.” (Hannah - Interview)

The concept of “good” (positive) and “bad” (negative) experiences was raised by some of the participants. The “bad” experiences, as discussed by Hannah above, were spontaneously added as diary entries, whereas the positive experiences were more likely to require prompting. Despite this, the diaries appeared balanced between “good” and “bad” experiences. However, midwives’ perceptions were often that they had written predominantly about negative experiences and they were often surprised to discover this balance. One midwife described the reasons for her diary entries at interview.

“I: What was it that prompted you to enter those specific incidents in the diary?

P: I think mostly they were, particularly about confidence, either things that made me feel fantastic about myself, er, very few of those. But
mostly they were about feeling insecure and not very confident. And, er, I wish I’d said that I wish I’d done that, you know. Yeah it was more about feeling sort of a bit insecure about things and berating myself about them.” (Mary - Interview)

Some of the diaries contained more intimate and personal data than others. This did surprise me as I was expecting there may be a degree of detachment given that these were solicited diaries. Some of the participants acknowledged that they had felt embarrassed or self-conscious writing the diary, but this had not prevented them from recording fairly personal data.

5.4.3. Self-presentation within the diary

Some participants were clearly concerned about how they portrayed themselves and others within the diary. One midwife described at interview how she felt about her entries.

“Once I got into it I just seemed to be, to give a load of abuse about people. ((Laughs)) I didn’t name any names, but there inference was there. Occasionally you know erm I found it alright, but when I read them back I found it was sometimes a bit petty what I’d written…” (Mary - Interview)

Another was concerned about how to write the diary without being overly critical of others.

“I suppose it made me think about things more than I would have done normally, about what I can write about you know how to word it an stuff
Their concerns may have arisen over the loss of control of their diary when it was handed over. Writing has a degree of permanence about it and once out of the control of the writer can leave them feeling vulnerable. Van Manen terms this loss of control “textual autonomy”, whereby the text becomes vulnerable to examination by others (van Manen 2002: 248). The diary, once written, becomes part of the presentation of that participant. This self-presentation and the impression it creates can be important to the individual (Goffman 1959). In particular, participants may be concerned about portraying themselves as they wish to be perceived by others. For some, therefore, being critical of others may be a concern for their self-image.

Other participants, however, did not comment on this concern but were in fact openly very critical of others. One in particular used very disparaging language in relation to certain individuals within her diary.

“Bloody xxxx [name] is shift leader and goes out of the way to make you feel shit about your abilities.” (Siobhan - Diary entry)

For some participants the diary could be a useful and ‘safe’ environment to voice their opinions. This could allow them a release from their professional persona in a way that would not be otherwise available to them. It also demonstrated trust in me as a researcher to maintain their anonymity.
5.4.4. Writing emotionally

The emotions experienced by midwives when writing their diary were clear in both the language and style of writing used. Particularly strong emotions were evidenced by the use of grammatical devices such as underlining words or using capitals and punctuation to highlight particular words or phrases. This emotion was captured particularly well in the paper diaries where the occasional scoring of a word into the paper was evident. The techniques used to highlight emotion were particularly effective clearly intimating their feelings at the time to the reader.

Some of the diaries were written in an almost conversational way. One midwife records her own feelings in brackets while recounting an incident.

“Midwife on handing over made comment about her ‘going up the road for an epidural’
(I hate that)” (Helen – Diary entry)

For one midwife the anger she felt at the way she had been treated by a colleague continued from the event itself, through her diary entry and was still evident at interview.

“Reading this back I sound bitter + twisted which is not the case really. I felt that a colleague had been unprofessional to criticise care without taking a full handover or reading the notes. (I am still angry when I write about this now)” (Mary - Diary entry)
“It was what I felt at the time and it was a bit cathartic ... I read it back this morning and, the way I’d written it, I went back to how I felt at the time and I got the same anger or same frustration from reading it.” (Mary - Interview)

Diaries highlighted changes in both confidence and emotions of the participants during a shift. Furthermore, they clearly illustrated that confidence can vary between tasks being undertaken concurrently.

“We had just gone live with the new centralised monitoring system (which I had not had any training for), so I felt a lack of confidence with relation to this, + wished we had been in a room that didn’t have it. I encouraged B to try a change of position (kneeling up on bed) – which she found to be a great relief and the early decelerations immediately stopped. Such a simple action + I felt frustrated that the very experienced mw [midwife] who had previously been looking after her had not tried a change of position in the first instance. B soon had urges to push + progressed quickly to a normal birth – all well. With regard to confidence in this case – I felt confident with regard to my practice + care that I gave, but a lack of confidence with regard to new equipment.” (Laura – Diary entry)

Another participant noted the differences in confidence and why they occurred.

“I felt clinically confident – supportive staff - no eyebrows raised about stopping (good) reassuring CTG [cardiotocograph] for bath/pool. Less confident in caring for A as I had never met her before – her midwife was on A/L [annual leave].” (Alice – Diary entry)
Midwives recorded other views in some cases. Often they wrote about how they felt about other staff or the unit in general. One participant described an incident she had recorded and then her own reflection on it.

“I arrived on a early shift.
Night staff were arranging a transfer to C.U. [consultant unit] (Because the woman was so distraught and demanding an epidural (But only 2cm [dilated]))
I knew this woman, I knew she was a bit highly strung.
I felt confident to say don't transfer her yet I think I can calm her down she knows me. And she did and went on to deliver normally at the MLU later on that day.
Reflection: I am just so happy that I challenged that decision by another midwife to transfer, the woman just needed to see confidence in the midwife, I think some of the midwives can't cope with women who can't cope with pain, which is an issue and denying the woman the possibility of a “better birth experience”. She should feel supported not abandoned, this is an issue and a career development opportunity for some midwives.” (Jemma- Diary entry)

In this way many of the entries indicated that the participants considered their overall working environment and the effects of this on themselves and their confidence. They were very aware that they were not working in isolation and many of their comments and thoughts demonstrated this. This also added to an understanding of the context and culture of the workplace.

The comments made in the diaries appeared very genuine and the midwives writing them demonstrated a compassion and empathy with the women they
were caring for. One discussed the problems in transferring women in the second stage of labour.

“She was not too distressed, so I felt confident and tried to make it as efficient and bearable as possible – it is HORRIBLE transferring in the 2nd stage.” (Katy – Diary entry)

Another midwife described how she cared for a woman in upsetting circumstances following an intrauterine death. The midwife clearly found this traumatic.

“Awful day because:
Primip [primigravida] came in with IUD [intrauterine death] (sudden) in labour. Had to watch whilst it was confirmed on USS [ultrasound scan] by senior reg [Registrar] – Awful.
Went to delivery suite with her as they couldn’t provide staff. V. v. Upsetting.” (Siobhan - Diary entry)

The fact that the diaries were able to capture the emotions of the participants was probably due to their open, fairly unstructured nature. This allowed participants the freedom to write as much and in whatever style they wished. Writing about emotional events can be beneficial to the individual, allowing them to gain some control over them (Pennebaker and Seagal 1999). At the outset I had wondered how candid participants would be in terms of their entries. Also I had considered whether they would only record positive events. However, it was the negative events that participants chose to write about in greater detail. This disclosure of their feelings about negative or traumatic events is something an individual will do if permitted (Pennebaker 1997). This can allow the
individual to put their feelings into context and view them more objectively (van Manen 1990). Pennebaker et al (2003) suggest that writing about emotional trauma is essential in coping with that trauma. The type of words used to describe emotions can be important in relation to health, particularly if these words are positive (Pennebaker et al 2003). As a result the individual is likely to improve their well-being in terms of psychological and physical health (Pennebaker 1997). This may be important given the low morale and high rates of sick leave within the NHS (Healthcare Commission 2007).

5.4.5. Using the diary as a reflective journal

All the participants used reflection in the diary to some extent, with some recording data in the manner of a reflective journal. Others provided less detail and reflected briefly on their thoughts and feelings. Some participants were very aware of the reflection aspects of their diary.

“It’s probably quite waffly really ((Laughs)). It’s like a reflection really but trying to steer more to like confidence issues really.” (Laura - Interview)

Some participants reflected formally, using headings; whilst others incorporated reflection into their descriptions of events and their feelings around these events. However, they all appeared to manage reflection in a similar manner following on from a description of events and emotions. This reflection appeared to be used to understand and make sense of the events which had led to the diary entry. In this way the diaries provided more detail and self-interpretation by the participants than I had expected. It has been suggested that of the use of reflection by midwives is beneficial for practice (Hansom and Butler 2003).
Johns sees reflection as ‘fundamental to professional practice’ (Johns 2009: xi). Reflection in itself is strongly associated with learning (Phillips and Morrow 2008; Johns 2009), both formally and informally. The increasing use of reflection in both undergraduate and postgraduate midwifery education has enabled many midwives to become skilled in using tools of reflection. Various theories and models of reflective practice have been described (Boud et al 1985; Gibbs 1988) and the methods of reflection undertaken by the participants appear to broadly replicate these.

However, for some of the participants, reflection may not be the straightforward exercise it appears. One midwife commented about how she felt about her reflections in her diary.

“Reflection can affect my confidence positively or negatively. Sometimes I end up thinking what if I had/hadn’t and wondering if we would have had a different outcome.” (Sara - Diary entry)

Other midwives discussed at interview their perceived difficulties with reflection and the fact that it can be a negative as well as a positive experience. It appeared that the use of diaries did highlight areas of reflection to the participants. However, it may be that reflection is intuitive to midwives. Termed reflection-in-action by Schön (1991), this reflection takes place concurrently with the event being reflected on. Alternatively, it may be something participants may not otherwise consider at the time and which is reflected on later, when prompted by making the diary entry. This type of reflection is termed reflection-on-action (Schön 1991). All participants did reflect in their diaries, but it is
unclear how much of this reflection would have taken place over positive events without the use of the diary as a prompt. In contrast, it appeared midwives would focus and reflect on negative events without the need for the prompt of diary completion.

The fact that participants spontaneously used the diary as a reflective journal indicated that reflection was part of their everyday practice. This suggests that participants may have moved from “doing reflection” to “reflection as a way of being” (Johns 2009: 9). This may account for the fact that reflection was used by all participants when examining events relating to confidence. Some moved on from simple reflection and developed plans or discussed potential coping mechanisms for the next time a similar event happened. Doing this may help the individual contextualise and move forward from a difficult event.

5.4.6. Advantages and limitations of the diary method in this study
Diaries have been found to an effective method of data collection longitudinally, in relation to both decision-making and recording participant feelings and emotions (Moffat et al 2007). This study has demonstrated that diaries can also be used to detect changes of confidence within a much shorter space of time, such as within a single shift. It has also demonstrated that differences in confidence can occur concurrently when carrying out different tasks. Hence, diaries can be useful in capturing various aspects of the phenomena under exploration.
The use of diaries as a method has also proven to be feasible within this population, resulting in the capture of rich data. However, it is important that the study is well planned in relation to the use of diaries in order for them to be an effective method of data collection (Bolger et al 2003; Kaun 2010). Consideration must be given to the timescale for data collection, as even over a relatively short period of time such as in this study there was evidence of diary fatigue. It is envisaged that much longer would have become onerous for participants.

A limitation of the study included the fact that not all participants provided intrapartum care on a daily basis. Therefore, it took longer than expected for participants to complete diary entries. This may also have had an effect on the number of entries received overall. The data itself was generally detailed, but this is an area that would need to be taken into consideration in future studies.

In a phenomenological study such as this it is important to provide some guide to enable the participants to understand what is required of them, but not be too prescriptive otherwise illuminating data may be missed. This population of midwives was clearly well motivated and able to understand the focus of the study. In addition, there were no difficulties in language or communication as may occur in other populations. For this population diaries are an appropriate, effective and feasible method of data collection. However, for a phenomenological study such as this it is important to have a further means of exploring the data, such as interviews. The reason for this is that although the data alone from the diaries is illuminating, the method itself does not allow for
further discussion as would an interview. These diaries were designed to be event based and as such they were successful in allowing the participant to identify and record their experiences around the phenomena. In this respect the diaries did prove very helpful in providing data around the factors that affected midwives’ confidence. The situation of data within context and time was a particularly important and successful aspect of the diaries. From this, they provided identified areas to be discussed at interview, some of which would otherwise be missed.

The flexibility around participants’ use of the diary was particularly useful in capturing participants’ own reflections on their recorded events. This added an extra aspect of self-interpretation within the diary that was not at the outset wholly expected. It provided much deeper insight and understanding of participants’ views of the phenomena under investigation. It is important to note that the participants in this study did appear well focussed on the phenomena to be explored and this may not be the case with other phenomena or subject matter. When used as a reflective journal the diary may have an added advantage as a personal outlet for the emotions of the writer. This may provide an informal means for individuals to record and consider their emotions and reactions to situations in a more objective manner.

Overall, diaries, used in conjunction with interviews as in this phenomenological study, were successful in capturing the lived experience of the participants in relation to the phenomena of confidence.
5.5. Conclusion

This chapter has introduced the participants and discussed the methods of data collection employed in the study. It has also discussed some of the challenges in data collection. The main body of the chapter considered in detail the use and suitability of diaries as a data collection method within a phenomenologically guided study. This included midwives’ experience of using the diaries as well as the data collected within them. The strengths of the diary method indicated they were feasible within this study population and within phenomenologically guided research. They were also suitable for capturing emotions, along with personal and relatively contemporaneous data. A particular strength was that the diaries allowed for capture of exploratory data with little researcher influence. Limitations included the time required for data collection and the potential necessity for follow up to clarify and explore diary entries further. The conclusions gained from the diary phase of the study indicates that appropriately designed diaries are a useful method of collecting data surrounding lived experience of the study participants.
Chapter 6

Findings 2

Midwives’ Perceptions of Confidence
Chapter 6: Midwives’ Perceptions of Confidence

6.1. Introduction

This chapter will explore the participants’ perceptions of the phenomena of confidence. Both the descriptions of confidence provided by the participants, along with deeper analysis of the data will be discussed, providing insight into the phenomena itself. The chapter will consider the elements identified by the participants which contribute to the phenomena of confidence.

6.2. “It’s just there” – Midwives’ perceptions of confidence

All participants were asked to explain what confidence meant for them. This was to establish their views in terms of what they believed confidence to be, rather than a dictionary definition. It was clear from the interviews that participants found confidence a difficult concept to articulate. Confidence was clearly important to them, but it was evident that it was an almost sub-conscious state.

“It’s about being able to practice, not without thinking, but naturally maybe intuitively.” (Mary)

For many, confidence was only considered by individuals when they felt it was threatened or lacking.

“You don’t really think about confidence do you. It’s just there. When it isn’t that’s when you think about it.” (Jemma)
When asked directly about confidence midwives described it in positive terms. The overall impression was that confidence itself was something positive to possess. In addition, participants’ believed that confidence was vital to their ability to practice.

“I don’t think, if I didn’t feel confident I don’t think I could practice and if anything happened. You hear people say they’ve had an awful incident and I can really understand you can be destroyed, I mean confidence is very precious. It doesn’t take much to burst that bubble. ..” (Katy)

The fact that midwives’ perceived confidence as “just there” suggests the phenomena is embedded in their everyday lifeworld. The implication of confidence as intuitive suggests a process which occurs without conscious thought processes. However, intuition is a process that utilises knowledge and experience, allowing the individual to reach a decision in a short space of time (Gladwell 2006; Sadler-Smith 2008). This allows for decisions about confidence to be reached quickly allowing the midwife to continue with the necessary task. It is argued that intuition enables individuals to progress and function efficiently (Sadler-Smith 2008). Hence, midwives did not dwell on areas where they felt confident as judgements were made quickly and with little conscious thought, allowing them to concentrate on the task in hand. The unseen and intuitive nature of confidence presented some challenges in determining the phenomena.
6.3. The struggle to describe confidence

All participants were asked “what does confidence mean to you?” In describing confidence, all participants used a combination of ideas to determine what they believed confidence to be. This included describing how they believed individuals developed confidence, self belief, the characteristics of confidence and emotions associated with confidence. Despite difficulties in describing confidence, participants all believed they knew what confidence was in the same way that they knew when they were confident. When asked directly about the meaning of confidence midwives used the terms, “happy”, “comfortable”, “knowing”, “knowledge”, “experience”, “competence”, “in control”, “faith”, “sure”, “relaxed”, and “intuitive”. All participants provided three or more terms to describe confidence, with the majority describing four or more. Interestingly, despite the fact that each individual’s situation in the world affects their own particular standpoint, there were many similarities between the participants’ views of confidence.

All participants described emotions and feelings as well as more tangible elements such as knowledge and experience to describe confidence.

“Confidence is a feeling isn’t it, for me it’s like a feeling erm… I think it’s just knowing ... what you’re doing.” (Amy) [Bold type=emphasis]

The majority of participants also used what they considered to be characteristics of confidence, such as assertiveness, as descriptors.
“Erm… oh gosh……I think it’s something to do with being assertive, something about being. It sort of links to being a advocate as well. I don’t know, I’m really struggling actually……I can’t think of anything else actually…..I suppose it means something about being comfortable with what I’m doing and the way I’m doing things......... And I suppose something to do with knowledge erm the theoretical background and feeling comfortable with that as well.” (Sara)

Being comfortable in a situation was a description many participants used to determine when they were confident.

“Erm confidence, when I’m feeling relaxed like comfortable with what I’m doing, that type of thing……” (Fiona)

On reading the transcripts the word comfort seemed to be used interchangeably with confidence by a number of participants; with half using the word to describe confidence at some point. Clearly midwives felt comfortable when they were confident, which gives the impression of a calm secure feeling. When working confidently, participants referred to working within their “comfort zone” or “safe zone”. This gave the impression that confidence provides a safe space around the midwife. One midwife referred to her comfort zone as a wall, somehow conferring protection.

“You almost build a little wall around whatever’s going on, you build a little fence around it don’t you and within that. Erm I’m not saying that you’re in control but you are definitely.........erm.... You can anticipate what’s going to happen. Nothing’s going to happen generally that’s going to be totally alien to you, you’re within your comfort zone.” (Katy)
6.4. Uncovering confidence

Participants discussed at length how they felt when they were confident, even though they had difficulty in describing confidence itself. Further analysis of the whole of the transcripts revealed a much greater depth and added to the overall developing phenomena of confidence. In particular, by entering the hermeneutic circle and moving between the whole and the parts of the transcripts I was able to develop a deeper understanding of the meaning of confidence itself. Furthermore, as a whole the individual transcripts provided context, situating the data. The thread of some narratives ran through the transcripts and participants would often refer to previous comments or incidents adding to the overall understanding. Often this was enmeshed within the text and needed deeper analysis to uncover it. From the data as a whole it appears that confidence is derived from three main concepts. These are; a deep seated knowledge including experience and skills; self-trust or belief; emotion. All of these can vary dependent on time and contextual situation giving a dynamic element to confidence.

Knowledge was agreed by all participants to be crucial to confidence. None believed confidence could be present if the individual did not possess the knowledge with which to complete the task. Often knowledge and experience were discussed together almost as one and the same, with knowledge coming from experience and vice versa. Both knowledge and experience were something the individual had to have gained themselves. Participants spoke little about knowledge acquired vicariously; that is, through observation of
others. This indicates that for knowledge to be a sufficient base for confidence it must be something which the participant has experienced for themselves. Knowledge appeared to be composed of several things including knowledge of task, experience, self-knowledge and knowledge of other variables surrounding the task. These variables may be other individuals, environment or equipment. Knowledge of these factors could be as, or more, important than the knowledge of the task itself. These factors will be discussed in depth in chapter 7. More implicit within this category was self-knowledge. However, although knowledge and experience was raised by all participants it was clearly not the only factor required for confidence.

“It’s not just experience, it’s more than that isn’t it….. Something else..”
(Fiona)

This "something else" was the intangible part of confidence that midwives found difficult to describe. One of the difficulties in articulation of confidence seemed to be linked to the fact that little attention was paid to it until it was lacking. When confidence was lacking then often strong emotions were associated with it. Emotion, therefore, emerged as a component crucial to confidence. Participants all used words associated with emotions when attempting to define confidence. It was also apparent throughout the study that emotions were often at the fore where any discussion of confidence was concerned. As such, emotions can be powerful and, therefore, are likely to have a bearing on an individual’s belief in their abilities to complete a task (Goldie 2007). The implication of emotions in confidence will be discussed in greater detail at 6.4.1.
Reasoning was another component of confidence. Although this occurred subconsciously, it was clear that this managed the balance of emotions and knowledge (affective and cognitive aspects). This in turn led to the belief or decision about the individual’s ability to complete the task. Although not overtly described as such by participants it was evident from the transcripts that reasoning regarding confidence in making a judgement or completing a task occurred.

“It’s belief isn’t it?....I think a lot of confidence is knowing you can do it, believing in yourself..... But it’s hard sometimes when you’re having a bad day or things are going wrong, it sort of takes its toll and you really have to tell yourself ‘look xxx[fname] you can do this’.” (Anna)

6.4.1. The emotional nature of confidence

It was evident from the data that confidence itself elicited strong emotional responses from participants. Midwives frequently used emotions to describe confidence itself. In addition, they used very emotional descriptions about how they felt when their confidence was affected. Goldie (2007) suggests that to be emotional about something means you care strongly about it. Therefore, it can be extrapolated that midwives must care strongly about their confidence. The strength of feeling around confidence was evident in both diary and interview data. Diary data in particular revealed the strength of the emotions, both in the grammar used and style in which they were written. Given that the diaries were completed within a relatively contemporaneously, they demonstrated strength of emotion that may have been later modified or lost by the time of interview.
However, many midwives at interview also talked of their experiences of confidence with evidently strong emotions, indicating that in some cases these lasted long beyond initial reflection. Extremes of emotion were commonly expressed by participants, such as anger at a loss of confidence and elation at a successful outcome. One midwife described her anger at herself for losing confidence.

“I was so angry with her ... And with myself ... Because I had allowed her to make me doubt myself.” (Anna)

Another midwife is positive, both because the woman is glad to see her and the fact that she has a good outcome previously.

“This woman walked in the door and I actually knew her straight away because I delivered her first baby........ And she saw me and she just said ‘I’m so glad it’s you’ and that made me feel really good. But it obviously made her feel really good as well erm...We had a sort of trusting relationship because, obviously, I was there for her first baby.... And I knew that she could do it and... And that was a wonderful waterbirth.” (Jemma)

A common thread in relation to a lack of confidence was that of anxiety. This appeared to be the dominant emotion when confidence was lacking and for some could be acute.

“Confidence is also about ........ That feeling of insecurity ‘oh god what is it again’...” (Mary)
Confidence itself has been described as an emotion (Barbalet 1993; Varlander 2008). Considerable debate exists regarding the definition of an emotion (Parkinson et al 2005; Izard 2009), however, some agreed defining characteristics exist. Generally, this is that an emotion consists of a physiological and psychological response (James 1884; Denzin 1984; Philippot and Feldman 2004). Participants often described emotions associated with confidence that would correspond to the definitions of emotion; such as, happiness or anxiety. Confidence for them always appeared to be associated with another emotion, rather than being an emotional concept itself.

Participants described confidence as a faith, trust or belief state. This accords with some of the formal definitions of confidence and self-efficacy, both of which have been described as a belief (Collins English Dictionary 2011; Bandura 1982, 1997). Whether or not a belief is an emotion has also been open to debate. Whilst some cognitive theorists (Marks 1982; Oakley 1992) suggest that a belief can be an emotion, this is not accepted by other philosophers (Wollheim 1999; Goldie 2000). Emotions have been described as a guide and motivator for action (Goleman 1996; Barbalet 1993; Izard 2009). Similarly self-efficacy has been described as a motivator for action (Bandura 1982; 1997). One might consider that if confidence is a belief in the success of future action, then this would be a reasoned judgement rather than an emotional response to a situation. Confidence would remain a motivator for action as it removes some of the uncertainty of the future (Barbalet 1993). Indeed, participants all spoke of emotions associated with confidence rather than confidence being an emotion itself. Confidence does share some similar characteristics to emotions in that it
is a subjective individual experience, often difficult to describe (Parkinson et al 2005; Izard 2009). Izard suggests that in addition to basic (affective) emotions, individuals are subject to what he terms as “emotional schema”. This he suggests is “an emotion interacting with perceptual and cognitive processes to influence mind and behaviour” (Izard 2009: 8). This appears to be in accordance with confidence itself which includes reasoned judgement and knowledge with emotional elements.

Even if confidence can be described as an emotion, it was not perceived as such by participants who continually associated it with stronger emotions. This may be that confidence was a “low intensity” emotion, generally sub-conscious or because the strongest (“high intensity”) emotions were present when confidence was lacking. Participants described various emotions arising from situations in which they believed confidence was an issue. These were all “high intensity” emotions and included anger, embarrassment, anxiety, fear, happiness, elation. It is these emotions that may play a part in participants’ reasoning of their future abilities and, hence, confidence. Confidence does appear to be time situated and contextual and emotions at the time of making a judgement regarding confidence or anticipated emotions from completing a task may all provide input into an individual’s confidence judgement. Hence, emotions can be an important component to confidence.
6.4.2. The changing nature of confidence

The perception among participants was that they felt generally confident in their practice.

“I am confident in my practice. I know that. Certain times I’m not, but on the whole I am... I don’t know what I’m doing all the time, but the majority of the time, yeah.” (Hannah) (Bold = participant emphasis)

However, all discussed at length situations in which they were not so confident. It was evident from the data that confidence was contextually situated, and as a result was a constantly changing phenomena. Participants themselves all discussed the concept of a global constant confidence and the changing nature of confidence. Whilst some felt that individuals possessed an overall confidence, all believed that confidence was a constantly changing phenomena dependent on circumstances.

“I think most people have a general level of their own confidence in themselves and then obviously things that they feel more comfortable with.” (Amy)

It was clear from the data that confidence was not a constant and varied considerably dependent on the situation and context. In particular, confidence at any one point is time situated and susceptible to other contextual influences. Time alone could also affect participant’s confidence. One described how night duty or a long shift could affect her confidence in her ability to make decisions.
“On nights, I just can’t make decisions then and I will ask for other opinions, or just stick to the guidelines even though I know really that might not be right for the woman..... I don’t feel confident then .. When I’m tired...” (Anna)

Here the participant relies on other influences to make decisions, which may in turn affect her confidence for the future depending on the success or failure of her actions. Whilst initially it appears to be one issue affecting confidence (tiredness), other variables are introduced to help overcome this, which may then affect confidence in a different way. This reliance on others, or on guidelines, may lead the midwife to hold the belief that she has to rely on these in order to maintain confidence in the future.

Confidence could change very quickly for participants and could vary many times in a single shift. The fluctuations in confidence were demonstrated clearly in the diary data (see 5.4). At interview one midwife described how she felt about the changing nature of confidence.

“It’s almost like a rollercoaster sometimes you know you have this really good experience and then you can have one that you just think....” (Katy)

I had considered that midwives may possess a global confidence which affected all their actions. At the outset to the study I anticipated there may be a spectrum of confidence experienced by midwives. Rather than a global spectrum of confidence in which participants vary, it became apparent that each participant experienced their own spectrum of confidence. The rollercoaster image described above gives the impression that changes in confidence can occur
consecutively. However, others described experiencing different perceptions of confidence in tasks carried out simultaneously. One participant describes an overall confidence in labour, but a lack of confidence in an aspect of that labour.

“I felt confident about the whole thing but ? was my VE [vaginal examination] right because the contractions 1:10. Then I thought of course it’s right. Because text books tell us your contractions need to be this or this otherwise you’re not in labour, you sometimes get a niggling doubt.” (Jemma – Diary entry)

All participants recognised that there was a fragility to confidence and that changes in confidence could occur very quickly; principally where it was under threat. In particular, confidence was viewed as a state that was constantly in flux. Many participants described scenarios in which confidence could change rapidly, giving rise to both anxiety and relief. One described how her diagnosis of a fetal position was questioned by a registrar, only to be confirmed as correct by a senior registrar. During this time her confidence changes dramatically.

“But that sort of 5 minutes you’re thinking god I’ve done it wrong and your confidence is on the floor and then you think oh no I was right after all.” (Amy)

Some participants referred to the creation of a comfort zone, an individual space or “bubble” which they inhabited when they were confident. For them this zone had elements of familiarity which enabled them to practice with confidence. However, this zone or bubble was easily breached leading to a shattering of confidence. Different participants used the same analogy of
“bursting the bubble” to describe this. One midwife describes how she felt when an incident affected her confidence in practice.

“I almost wanted to cry and walk out and ((Laughs))... It’s amazing how little it takes really to burst your bubble.” (Katy)

The fragility of confidence was heightened for some in that it took very little to reduce their confidence. So whilst it may take time to build confidence it could be removed in an instant. In addition, the incident that affects confidence does not have to be significant, rather it is often the “one small thing” (Mary) that could crush confidence.

“It [confidence] can be affected by so many things., You can be confident one minute but then one thing changes that and you question did I do that right? Or you doubt yourself.” (Amy)

All the participants discussed losing confidence in detail, with the majority of the diary data and interviews devoted to this. This occurred despite the fact that all the participants believed they felt generally confident and did discuss situations where their confidence had been enhanced. However, this is unsurprising given the apparent sub-conscious nature of confidence. It was only when confidence was threatened that participants turned their attention to it. It did become apparent that losing confidence was a significant factor to midwives’ self-esteem. In addition, it was also much more difficult to rebuild confidence after it had been lost. Participants’ used various strategies to maintain and rebuild confidence which will be explored in more detail in the following themes.
6.4.3. Developing and determining confidence

Participants frequently described how they believed confidence developed and used this to describe and explain confidence. All acknowledged that confidence was something they developed through experience. However, gaining and maintaining confidence was an ongoing process which continued regardless of the number of years the participant had been qualified. Fiona felt it had taken her a number of years to be confident enough to consider a different way of working.

“I’ve started to look at other things such as independent midwifery which is obviously under erm going through a lot of problems at the minute, but that I do see as a different way of working that I would feel a lot more comfortable with. But I’ve only done that after all of these years experience. I haven’t looked at that before, I think it’s taken all these years to get confidence in practice to know that I can do that now.” (Fiona)

All of the participants believed that confidence increased with experience, with all believing clinical experience to be crucial to confidence development. This development of confidence in line with experience reflects findings of previous studies with medical staff (Hausman et al 1990; Friedman et al 2005) and nurses (Crooks et al 2005; Yang and Thompson 2010). In addition, participants in this study maintained that this was an ongoing process and although they became more confident, they did not become complacent. The participants in this study continued to express doubts about their confidence regardless of the experience they had.
“I don’t think it makes any difference how long you’ve been qualified if you’re out of your normal comfort zone.” (Katy)

It was important for participants to be able to confirm their confidence. Participants described three main strategies they utilised to determine their confidence; reflecting on outcomes, peer feedback and self-comparison. The first of these was reflection on outcomes and participants would seek confirmation that their actions and decisions had been correct. They would use outcomes as evidence of this.

“I did look back at this patient afterwards. I was thinking about it and in a way that’s increased my confidence cos that’s made me think oh that was the right thing, you were thinking the right thing.” (Fiona)

In this way confidence became self-fulfilling; by being confident and experiencing a good outcome, midwives became more confident about their practice. Another midwife describes how after previous good outcomes she feels confident to make the same decisions again. In this case it is to allow labour to progress without interference. Again she feels rewarded by a good outcome.

“Felt confident in decisions to allow multip [multigravida] to do her own thing, which resulted in a ‘good’ birth for the woman.” (Siobhan - Diary entry)
This reflects Bandura’s enactive mastery theory whereby a good outcome of an action reinforces positive self-efficacy (Bandura 1997). The individual is therefore more likely to be confident to follow that course of action again.

The second strategy used by midwives to confirm their confidence was that of obtaining direct opinions from colleagues. In this context this was usually in the form of impromptu feedback and was not something that was specifically elicited from others. The higher the perceived status of the individual providing feedback the greater the positive impact on the individual’s confidence. Being made a shift leader by a more senior member of staff enhanced one midwife’s confidence.

“So xxxx [shift leader] actually makes you feel confident cos I know she has confidence in me.” (Siobhan)

Other members of the multidisciplinary team could also enhance a midwife’s confidence.

“To be honest the doctors who know you know if they can trust you....I’ve had consultants tell new doctors ‘oh yes xxxx [name] listen to her, you can trust her’, which is good for my confidence that someone senior will listen to you...” (Alice)

Interestingly, comments from students, women and relatives, although having some positive impact, appeared less influential in terms of midwives’ confidence. This may be because they were outside or lower in the hierarchy than the midwife herself.
This peer feedback is included in what Bandura (1997) terms verbal persuasion in the development of self-efficacy. Midwives in this context used it as a confirmation of their observable confidence. For them spontaneous comments and actions of others which inferred confidence was a valuable way of estimating their confidence. This enabled them to maintain their confidence and also helped them to build confidence. A positive spiral of confidence could occur, with comments enhancing a midwife’s confidence, encouraging her to continue in her action, gain more positive comments and continue.

The third strategy utilised by participants to confirm their confidence was self-comparison with others. Social comparison theory was introduced by Festinger et al (1954) who hypothesised that individuals could use others who were similar to themselves to develop accurate evaluations of their own performance. Festinger’s theory has been developed further to consider which particular attributes are essential in order for another to be considered similar (Suls et al 2002). Participants in this study appeared to choose midwives who were similar in status, perceived experience and philosophy. This comparison was not always a conscious decision, rather it was subconscious, but was evident throughout and at many levels. Suls et al (2002) suggest that self-comparison can be intentional or unintentional but can still effect the individual’s subjective feelings of well-being.

In addition to comparison with similar individuals, comparisons may also be made in an upward or downward direction. Upward comparisons are made with
others who are considered to be performing better and downward comparisons with those who are performing less well (Buunk et al 2010). Both upward and downward comparison have each been argued to be better than the other for the individual concerned and the literature surrounding this area is complex (Wood et al 1985; Wood 1989; Taylor et al 1990; Buunk et al 2001; Buunk et al 2010). Buunk et al (2010) suggest that social comparisons at work may have both positive and negative consequences for nurses.

A positive work environment with upward social comparison can contribute to well-being, whilst a negative environment with downward comparison can lead to negative consequences such as burnout. There was some evidence in this study that midwives did use both upward and downward comparison. Upward comparison may assist an individual’s development and confidence in the workplace. Participants discussed others who they believed were role models and by whom they were inspired, with some clearly using upward self comparison to positively frame themselves.

Downward comparison appeared to be used especially when the individual was under stress due to issues such as staffing. In this situation participants spoke of a prevailing sense of an inability to cope which affected the whole mood of the shift. Although this appeared transient, over a prolonged period it is likely to affect the whole morale of the workplace. If individuals continued to make downward comparisons, it is likely that their well-being would suffer, possibly in a similar manner to that described by Buunk (2010). An interesting aspect of downward comparison focussed on the individuals themselves. In this,
participants appeared to use their past selves as comparators. Using self-comparison with a less confident version of themselves appeared to help them maintain confidence. That is, they believed they were more confident now, often due to increased knowledge and experience, and this enhanced their confidence further.

6.4.4. Characteristics of confidence

In attempting to understand the phenomena of confidence, it became apparent that participants often understood confidence by reference to individuals they believed to be confident. Participants did have some difficulty in determining how they knew an individual was confident. However, when asked about individuals they believed to be confident they were able to offer descriptions of characteristics that such individual’s possessed.

The participants all suggested that those who stood out to them as confident individuals were calm and considered in their actions and often quiet in their demeanour.

“Quiet and considered... A good listener. Someone who would take what you say seriously, but take on board and look at the whole problem or the circumstance..............There’s probably someone I’ve worked with, or seen in this unit, or delivered with, you know, so erm. I’ve been confident in their skills.” (Katy)

“I think they just do things, they don’t make a big fuss about it and talk about what they do, they just do it. I think if somebody’s making a big song and dance about it and somebody, I would say is like blowing their
own trumpet, saying how this, you know what I mean, that to me isn’t a confident person. A confident person can just go into a room and talk to the patient, the woman and … You know they can just do it, it’s not a big effort it’s not a big showy thing. They can just do it. They’ve got the knowledge, the experience of just knowing what to do especially if it’s a very difficult situation. I think somebody who is quiet and can do the job to me that’s a confident person.” (Fiona)

The perception of a midwifery role model as being a calm confident individual is similar to that raised by Keating and Fleming (2009) in their study considering the facilitation of birth in an obstetric unit. Participants in this study were generally suspicious of those midwives who were particularly loud or made themselves stand out in some way. Many felt that this was in some way covering up for a lack of confidence. However, it was important that midwives were assertive and not intimidated by others.

“Not scared to do anything, not scared at all to take a challenge on, don’t back down to anything, just carry it on……. As I say, not to be intimidated by anybody, just, I think that’s the big thing about confidence, to stand up for what you say………..” (Hannah)

The majority of participants identified both assertiveness and the ability to be an advocate for the women they were caring for as characteristics of confidence. Additionally, being able to demonstrate some of the positive elements of confidence such as the possession of knowledge and experience were important. In terms of emotions, midwives who were confident were often described as relaxed and intuitive about their practice. Importantly, they were also viewed as midwives who could instil confidence in the women themselves.
“[I] think a confident midwife knows her own practice and confidence and manages to give some of that confidence to the women...She can somehow put it across, not false, but in a genuine way, she can give them something.........” (Jemma)

One of the objectives of the study was to be able to highlight positive role models for midwives. To be able to do this, it was important to understand the characteristics that a confident individual possesses. The descriptions of confidence, coupled with participants discussions of their own role models (see chapter 7.2) helped determine the overall impression of a confident midwife.

6.5. Maintaining a balance

It was clear that participants’ believed confidence was important to them and they strived to maintain it. Confidence itself is a balance of elements on different levels. Firstly there is a critical balance within confidence itself and the factors affecting the reasoned judgement the individual makes regarding their confidence. Secondly, there is the balance between over and under-confidence. Thirdly, there is consideration of the balance between gaining and losing confidence.

6.5.1. Balancing elements of confidence

In order to determine their confidence, midwives need to make a reasoned judgement regarding their ability to carry out a task successfully. To meet this aim midwives had to balance their understanding of their knowledge, experience and skills with that of their emotions. Although knowledge could be
argued to be objective, for these participants it was very much subjective as it related to their own belief in their knowledge at the time of making the judgement. As already demonstrated, emotion plays a central role within confidence and the emotional context of making a decision about confidence could vary considerably. This could be the case even where the task about which the decision was being made was the same. Hence a judgement may be made about confidence related to a skill or decision, but the outcome of this judgement may vary dependent on other circumstances. Therefore, if the circumstances were constant one would expect the same judgement to be reached. However, in clinical practice the temporal and contextual circumstances in which such decisions are made are constantly changing. For participants this meant that their confidence judgements could vary considerably.

Previous experience and outcome success or failure clearly contributed to the process whereby the individual made a confidence judgement. The main factor affecting judgements about confidence appeared to be the emotions experienced by the midwife. These emotions equated to the temporal situatedness of the individual. That is the future, past and present were all brought into perspective in making a judgement. The individual would consider the future outcome of an action and their likely emotion at this outcome. They would also take into account the lived emotion of past experiences and outcomes. This, coupled with their emotion at the time of making a decision was a key factor influencing their judgement. This is congruent with Heidegger’s (1962) sense of the individual as futural being; whereby the individual looks to
the future, but is orientated in the world by past experiences. The moment of existence (i.e. the present) brings future, past and present into focus.

The circumstances or environment in which the decision making occurred was influential as was the likely future circumstances. For example, an individual may have completed a task previously with a good outcome and hence positive emotions. However, this could be mitigated by the individual’s current emotional state or the expectation that a future action may have to be completed in an unfavourable environment. So although an individual had previously successfully completed a task they may lack confidence to carry out the same task in a different environment. Similarly an individual may have had limited previous experience, but some knowledge of a task, positive emotions at the time of making a decision and anticipated positive emotions at completing the task in a supportive environment. The balance between knowledge and emotion in determining confidence is vital, but can be affected by external factors. These external factors will be explored further in the following chapter.

6.5.2. Balancing under and over-confidence

Whilst overall confidence was viewed as a very positive characteristic, the portrayal of confidence was a critical balance between appearing under or over-confident. Being over-confident in particular was seen as a negative characteristic and midwives were especially keen not to portray themselves in this way.

“I hope I don’t make anybody feel intimidated by the confidence I have got, because that’s not my intention whatsoever. I’d probably hate to be
challenged about it. If someone said to me you appear overconfident I’d be quite hurt by that, I would, cos I’m not like that at all.” (Hannah)

A midwife working at the birth centre was aware of a bank midwife’s reaction to her at handover. Whilst the bank midwife was experienced and had worked at the unit previously, she displayed some nervousness in handing over care. The participant was concerned that it was her own portrayal of confidence that was affecting this midwife.

“I felt she was very nervous handing over to me and you wonder how you are to colleagues for her to seem nervous handing over to me.... Almost apologising to me..... Anyway this has made me think I’m not going to give those vibes off ever ever again. I didn’t think I did, but I obviously did to that midwife.” (Helen)

Participants often used others as a comparator to maintain the balance between under and over-confidence. Participants were particularly critical of midwives who they perceived to be over-confident. Many of the perceived over-confident midwives were thought to be “waiting for a fall” or “needing to be taken down a peg or two” (Siobhan). In particular, the issue of over-confidence appeared to be most acute where the individual concerned was relatively newly qualified. It has been suggested that newly qualified midwives display greater confidence than those who have been qualified for longer (Meerabeau et al 1999). Lucas (2011) suggests that this may be due to the fact that newly qualified midwives have little experience of poor outcomes. It was unclear as to why such criticism was levelled at perceived over-confident midwives. It may have occurred as it highlighted to the individual their own self doubt. However, there was clearly a
belief that this demonstration of over-confidence was in some way flawed. It may have been that the participants agreed with Lucas (2011) that newly qualified midwives are simply unaware of the risks associated with the role. Kissinger (1998) suggests that over-confidence can be dangerous in a clinical setting and risks having a resultant adverse effect on patient outcomes. It is possible, therefore, that participants wanted to distance themselves from what they believed could lead to poor practice. Interestingly, other studies of medical staff and nurses suggest that over-confidence occurs in more experienced staff (Freidman et al 2005; Yang and Thompson 2010). The participants in this study did not comment on over-confidence in experienced staff, rather the assumption was they had gained confidence through experience.

Another reason for the particular criticism of apparently over-confident individuals may be based on gender expectations. It is often more acceptable within society for women to undervalue their abilities (Blanch et al 2008). Studies involving medical students indicate that women are far more likely to express a lack of confidence than their male counterparts (Vivekananda-Schmidt et al 2007; Blanch et al 2008; Nomura et al 2010). As midwifery is a female dominated profession, it is likely that participants accept this as the norm; midwives expressing confidence are somehow different to the majority of the staff and are therefore treated with suspicion.

Under-confidence was also viewed in a negative manner, but participants appeared more tolerant of this in others, especially in junior staff. Many
appeared surprised to discover experienced staff could lack confidence. In these cases midwives were less tolerant.

“I knew that one of the midwives wasn’t really confident anyway, but she’s very experienced she’s about 35 years experience and you just think blimey you know, why does she like believe that? .. It’s as though she seems to think that she doesn’t know what to do or can’t cope with certain things, I don’t know why she’s lacking in confidence. It’s just that it doesn’t matter how many years qualified you are you might not have moved on mightn’t you. Odd isn’t it. So that was her and she was like asking delivery suite at the consultant unit what to do, I was quite amazed at that really.” (Jemma)

There is a critical balance evident between what is perceived as over and under-confidence. Individuals clearly attempted to maintain this balance themselves and were highly critical of those who did not. Part of the reason for the difference in criticism of over and under-confident midwives may be due to the social comparisons the participants employed. It is suggested (Buunk et al 2001; Buunk et al 2010) that individuals can use either upward or downward self-comparison to enhance their feelings of well-being. This involves the individual in self-comparison with an individual who is dissimilar to themselves. As discussed above various theories exist as to the benefits of upward or downward comparison (Suls et al 2002), but it has been argued (Wood et al 1985; Taylor et al 1990; Buunk et al 2001) that downward comparison can boost self-enhancement and self-esteem. If this is the case, then participants may gain enhanced confidence by downward comparison with those who they perceived to be under-confident. Conversely, upward comparison with over-
confident midwives may leave them feeling inadequate and this may account for the criticism levelled at these individuals.

6.5.3. The balance between gaining and losing confidence

As has already been discussed at 6.4.2., confidence is not only dynamic and constantly changing, it is fragile and can be easily lost. Often for midwives it was just “one small thing” that led to a loss of confidence. This may be a comment by a colleague, or a poor outcome or an unexpected or unfamiliar event. In contrast, it took a great deal for confidence to be gained or rebuilt. Midwives were often walking a tightrope attempting to maintain this balance. They were aware of the effects on their self-esteem that a loss of confidence could have. They were also aware of the difficult emotional work they would have in rebuilding their confidence. To avoid this, midwives would attempt to protect their confidence as far as possible, using various coping strategies. Additionally, they would employ a number of various methods and approaches to regain their confidence. The methods which midwives used to protect and rebuild their confidence will be discussed within the themes of the following chapter.
6.6. The Phenomena of Confidence

The Balance

For midwives working in intrapartum care confidence is a dynamic balance. It is a reasoned belief about one's future abilities, based on knowledge and experience and emotions and is contextually and time situated. When present it is intuitive and sub-conscious and acts as a motivator. However, confidence is fragile and easily lost, leading to self-doubt and an inability to act. Confidence is most likely to occur when the individual has control over their environment and decisions.

6.7. Conclusion

This chapter has examined midwives' perceptions and understanding of confidence. It has uncovered the difficulties midwives had in describing confidence and its sub-conscious, intuitive nature. The key elements of confidence have been highlighted. Specifically, the links between the affective and cognitive elements of confidence have been discussed; these being the interplay of emotions and knowledge which lead to the individual's self-belief and confidence to complete a task. The critical importance of emotions in maintaining confidence has been also exposed. For midwives in this study mastery experience was the most significant factor in gaining confidence. Under and over-confidence were deemed negative attributes and participants attempted to avoid this by monitoring their own confidence. Midwives determined their own confidence by peer feedback and self-comparison with others.
The balance of confidence as described is crucial for understanding the contextual effects of the workplace on confidence and the midwives attempts to maintain their confidence. The following chapter will discuss this in greater detail.
Chapter 7

Findings 3

The Battle for Confidence
## Chapter 7: The Battle for Confidence

### Figure 3: Overview of themes

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7.1. Introduction: The battle for confidence

Throughout the study it became apparent that participants encountered a constant struggle to maintain their confidence. Midwives appeared to have an inherent confidence, but this could be affected dependent on a number of circumstances occurring within the workplace environment. Internal and external factors could affect this confidence and these included the influence of colleagues, environment, experiences, outcomes and organisational factors. Often maintaining confidence in the workplace was seen as a battle or struggle for survival and some used the language of conflict to describe situations. On losing confidence one midwife says.

“You do tend to have a run of what you call bad luck, don’t you? And it’s difficult to pick yourself up every day and come in, you know, fight your battles every day. Because it is a bit of a battle every day, sometimes, you know…” (Mary)

This chapter will focus on the lived experience of participants in relation to the phenomena of confidence, specifically focussing on the struggle midwives encountered in maintaining their confidence. The strategies used by midwives to gain and maintain confidence will also be explored and discussed. The chapter will conclude with a discussion of the differences between study settings, highlighting any relevant themes.
7.2. Trusting in self and others

Overall participants all expressed confidence in their clinical practice and skills. However, they all acknowledged that a number of factors could affect their confidence either negatively or positively. One of these factors could be trust, either in their own judgement or in another individual. Whilst they generally expressed trust in their judgements self-doubt could still occur even when the individual did feel confident. Crucially, all believed that it was colleagues who had the biggest influence on their perceptions of self-confidence.

“I’d say most of this confidence issue is about other members of staff ...And comments from colleagues, sarcastic comments from colleagues, about your plan of care and your actions and the way you look after other labouring women.” (Helen)

“The thing I feel confident about is my clinical practice. When I’m in a room with a woman delivering, or just looking after her, I feel confident. And then I realised every time I talk to my colleagues I don’t feel as confident and I doubt myself constantly.” (Siobhan)

It was important to participants to be viewed as confident in the clinical setting. In particular, midwives wanted to be trusted by their colleagues. This had a positive effect on their confidence.

“It’s nice to know that people have that kind of faith in you really and that you are confident in what you’re doing, and that they are not worried to work with you.” (Hannah)
Working with trusted colleagues helped to enhance a midwife’s confidence. Smith suggests “that trust becomes relevant when social interaction is based on uncertain knowledge about the likely action of another and one depends on their response for a beneficial outcome” (Smith 2005: 300). The degree of trust in others varied and one caseload midwife made the following diary entry about one particular birth.

- “I feel especially confident when the 2nd midwife at a birth is one of the caseload team, because we work together so well and trust each other. This was the case at this labour. We “dove-tail”.
- When the FH [fetal heart] dropped we acted as a team, appropriately and instinctively. Discussing with the parents afterwards they felt “safe” at all times – boosting my feelings of professional confidence.” (Sara - Diary entry)

When this entry was explored further at interview the participant explained that she and her colleague worked with complete trust in one another and knew instinctively what each other would do. She felt this gave her enhanced confidence. Additionally, the outcome of events and the obvious trust the parents placed in her provides her with a further boost to her confidence. This, she feels, will provide her with the confidence to act in the same way in the future. This reciprocal trust could be self-fulfilling in terms of developing confidence. This cyclical reinforcing of confidence helped midwives to gain more confidence in themselves and their abilities.

Another midwife described how perceived reciprocal confidence enabled her to develop confidence in pool birth.
“I found out that the person who came in had never done a pool delivery before and she was shift leader, so obviously she was confident in me and I was confident in her thinking she’d done loads.......It struck me how colleagues can affect your confidence both positively and negatively. So she must have had confidence in me to allow a pool delivery on her shift when she hadn’t got the experience herself…” (Mary)

Handy (1993) suggests that for trust to work it must be reciprocal. This is harder to do if the individual does not have experience of the task or the other person. Hence this shift leader must have had trust and confidence in the participant.

Whilst all expressions of confidence in them enhanced an individual’s confidence positively, it was particularly influential if the expression came from a midwife that the individual respected. Other members of the multidisciplinary team could also enhance a midwife’s confidence.

“I think we are very much trusted to plan care for our women. I have a good relationship with some of the consultants who support our way of working... They trust you, you know that. And that helps when you’re pushing boundaries.” (Alice)

Midwives often had clear views of who they perceived to be “good” midwives, in terms of attitude, skill and expertise. These midwives shared similar positive characteristics, including confidence, and were viewed as role models by some participants. A link between confidence and expertise has previously been identified by Simpson and Downe (2011), with expert midwives being perceived
as confident. Byrom and Downe (2010) found confidence to be an essential characteristic of a “good” midwife and a “good” leader. Students have also identified confidence as being a positive characteristic of a role model (Davis 1993). One participant described the characteristics of her personal role models.

“Our attitude to the women, they’re just so pro-normality and they have such a passion for what kind of experience they want the women to have. They want the women to have a good experience no matter what they want and they’re just so pro that, and they do it and they’re full of confidence that they can do that.” (Siobhan)

The relationship between confidence and success has been highlighted by Goleman (1998). In addition he suggests that those with high levels of self confidence can influence those around them (1998: 69). Participants clearly related confidence with successful expert midwives and they would often actively seek out these individuals and use them as role models on which to build their own persona. This reflects findings by Keating and Fleming (2009) that midwives are influenced by individuals who they view as inspirational.

Despite their inherent confidence in themselves, midwives would sometimes trust another’s judgement ahead of their own. There was an assumption that others were both more knowledgeable and confident.

“I do tend to feel that my colleagues always know the right thing to do at the right time.” (Mary)
“You always think, well they must know better than me.” (Amy)

This judgement may be a result of the perceived confidence of the other person rather than their actual ability. Alternatively, it may be the individual’s own self doubt or lack of confidence that leads them to believe others are more knowledgeable.

“A lot of midwives are confident when they talk to you about themselves, they’re very definite about their views, about labour, about women. They’re certain about things, whereas I’m not always certain about things.” (Mary)

However, this trust in others could be misplaced. One participant discussed at length how she trusted another’s judgement even though she doubted it at the time. In the event the participant accepted this judgement until a second midwife questioned her.

“I know I’m more experienced than that midwife, I know I’m more years qualified and I’ve doubted some of her decisions in the past, but because she was in the room with me I was bowing down to what she was saying.....” (Siobhan) (Bold = participant emphasis)

This midwife questions herself at length as to why she acquiesced when she admits she would never normally ask this individual for advice. She reasons with herself objectively about her own knowledge, experience and doubts, yet continues to be guided by this individual. Goleman (1996) suggests that individuals will trust others who are considered to be experts, which is not the
case here. Neither is the individual concerned hierarchically superior to the participant. The participant does, however, describe this person as appearing very calm and confident. It is possible that the fact that this person emanates confidence encourages trust in her even if this is misplaced.

The context of the decision-making process and the potentially stressful situation may also have contributed to a lack of confidence and reliance on others for support. Situations of increased stress can cause group members, of both high and low status, to become more willing to accept the input from others in decision-making (Driskell and Salas 1991). Given that situations in midwifery can be stressful and unpredictable this may be a frequently occurring issue within decision-making in the profession. This, combined with the traditionally hierarchical structure, may contribute to the difficulties in maintaining confidence that midwives may face in the workplace.

Some participants found that working with midwives they did not trust, or had little confidence in, could affect their own confidence, particularly where they were unsure of the best course of action.

“Other colleagues, when they’re twitchy, it kind of gets to me. When they start twitching I think is there something to twitch about, maybe I’m missing something? Maybe I’m just too long in the tooth? Maybe I need to go back to some sort of training if they’re getting twitchy about that and I would never have got twitchy about that.” (Helen)

Midwives who felt that women they were caring for had trust in them could also be a confidence enhancing factor. A caselodging midwife who frequently dealt
with potentially high-risk situations believed that mutual trust and confidence was important for both parties.

“So you do feel confident knowing that you’ve got that good relationship, you know, and if things. Then they will go in [to hospital]. It’s mutual trust really, they’re trusting you that you’re going to be an advocate for them and do right by them. And to tell them if there really is something that they need to be worried about, and that you’re trusting that they respond to that judgement as well.” (Laura)

As a result of this mutual trust she felt she could ‘push the boundaries’ in providing care, offering women greater choice safe in the knowledge that they would respect her judgement should a problem arise.

7.3. “The chink in the armour” - Vulnerability

Participants were very conscious of their vulnerability in relation to confidence. Whilst a confident persona provides protection, any hint of vulnerability leaves the individual at risk from an attack on their confidence. Hence, appearing vulnerable to others was a concern for midwives and important in maintaining their confidence. For the participants, self doubt and surveillance by others exposed their lack of confidence and made them vulnerable to attack. Most frequently this attack on their confidence came from other midwives and colleagues. Midwives were particularly reluctant to expose themselves to situations in which they would become vulnerable. One midwife from the birth centre notes that she is reluctant to ask for advice of the CLU as this will expose her vulnerability and may lead to consequences for her own confidence.
“You can’t ask them for advice, because if they see a chink in the armour they’ll have you.” (Helen)

Situations that left midwives feeling vulnerable were, a lack of familiarity with the task or environment, being required to justify their actions, feeling under surveillance by others and helplessness.

7.3.1. Unfamiliar territory

Familiarity with the task, environment, other colleagues or even normal birth itself was important to participants in maintaining their confidence. A lack of familiarity in one or more area could have an adverse effect on their confidence.

For all participants, working in an environment that is unfamiliar to them placed them at a perceived disadvantage. A lack of knowledge or experience of the area leaves midwives feeling less confident in that environment. One participant discussed the difficulties for more experienced midwives moving to new environments as there are higher expectations of them.

“To get moved after so long and be put in a new area it must be awful and their confidence must just go right down, you know, you’re working with different people and everything’s expected of them because they’ve been qualified a while. ........You mention it to someone about moving and the fear on their face, just the pure fear of having to move.” (Hannah)
One participant described how it can be the change in environment itself that can affect confidence. This can be something simple, such as not knowing where things are or even the entrance to an area.

“Where is everything? Where’s all the paperwork? Where is all the equipment? Where do I make her a drink? So lots of little things like that. And they’re all things that if I was to go and work in a unit with which I’m not familiar I would feel that would affect my confidence, even though I’ve been qualified for quite a long time.” (Katy)

Being unfamiliar with colleagues can also affect an individual’s confidence. One participant describes how this it affects her confidence in the way she portrays herself.

“I don’t know them particularly well and that affects my confidence in the way I erm portray myself, the way I hand over my case or discuss or even approach them.” (Amy)

Unfamiliarity with the woman they were caring for could affect the confidence of midwives in the caseload team, who were used to providing continuity of care.

“I didn’t feel confident during the birth and I think it was because of the stage at which I’d become involved and I knew, I felt, that I’d come into the labour too late to build up a rapport with her on that particular morning.” (Laura)

This was much less of an issue for the other sample groups who generally did not know the women they were caring for. However, one birth centre midwife
described how caring for a woman she had previously looked after enhanced her confidence.

“We’re lucky really here because we sometimes get to see women with each pregnancy. And that’s great because they know you and you know them, and it’s like a relief for both of us.” (Jemma)

Participants’ confidence in labour itself could be affected by a lack of familiarity with normality.

“I think cos I don’t see many normal births where I work that I’ve probably got less confidence in normal birth than some midwives…Cos I see so many other, see so many people being induced and see so many being [caesarean] sections and we see so many problems with it being a tertiary unit and all that kind of thing that. But I still…If I worked somewhere else I would have more confidence in normal birth.” (Fiona)

More than one participant described how caring for a woman whose labour progressed differently to the way in which they expected could affect their confidence.

“I was watching the woman, watching and listening to her and I thought oh it looks like this looks like things might be happening here, jolly good. So we waited and had a cup of tea and a chat and she said ‘ohh it’s getting hard work’ and I said ‘what do you want to do?’ and she said ‘I want to find out how I’m doing’ and I said ‘right ok ..I can examine you’. And I examined her and she was a fingertip [dilated].. not effaced, long. And that’s something that really does knock my
confidence, because you’re seeing one thing happening.. But it’s not happening at all.” (Sara)

Some found gaining confidence in normality could be a struggle. One midwife describes the difficulty in regaining confidence in normality after the familiarity of high-risk care when working on the CLU.

“I would have made everybody medicalised, I had to sort of sit on my hands and think have confidence in yourself, have faith that women can give birth normally and don’t need their blood pressure doing 97 times and don’t need you know this that and the other, they can just give birth and then their bodies will recover generally. It took a, I’ve been on the MLU now for two and a half years and I’d say it took me a year to stop being medicalised, to stop trying to create problems to be honest.” (Siobhan)

It was clear from a number of the participants who were either involved in providing high-risk care or who had previous experience of this that this was an issue. They acknowledged that this could have implications in providing care for low-risk women. They were aware that women could be low-risk, but there was a sense that they were always looking out for problems. Conversely, none of the midwives who were working in low-risk areas believed they would lack confidence in identifying complications of labour. However, they may lack confidence in caring for woman who required high dependency care. Specifically, the midwives working in low-risk areas were aware of their lack of experience in particular tasks relating to high-risk care, such as venepuncture, or knowledge of the protocols.
7.3.2. Justifying their actions

Being required to justify their actions to others was important to a midwife’s confidence. Midwives often felt exposed when questioned by others and the requirement to justify their actions often gave rise to self doubt and a lack of confidence. Usually the questioner was another midwife, either a shift leader or peer, but also could be medical staff, students and to a lesser extent women and their relatives. Sometimes this self doubt could be momentary in response to the questioner. One midwife doubts herself after a student queries her about not carrying out a vaginal examination to confirm full dilatation prior to a woman beginning to push.

“She [the student] just said to me ‘why aren’t you doing a VE? [vaginal examination], You’re letting her push’..... I could just tell that this woman was doing it. That made me just think ‘Ohh perhaps I should be doing it’ and then I thought ‘don’t be silly, you know what you’re doing’.” (Sara) (Bold = participant emphasis)

On other occasions this loss of confidence may last for some time, with midwives continuing to doubt themselves some time after the event.

Many midwives described similar techniques used to prevent any acknowledgement of vulnerability. Questioning by others could be perceived as a threat to their confidence and midwives would often try to pre-empt situations when this may occur. This could present itself in either altering of the care they carried out or how they handled the potential questioner.
“I am careful about how I tell certain shift leaders things... You have to time it right. Or use the right wording...” (Anna)

By trying to pre-empt the questioner the midwife tries to gain control of the situation, to prevent herself appearing vulnerable. However, in some cases she is demonstrating obedience or submission to the questioner (Hollins Martin 2006, 2007). Often this will be without the others knowledge as the midwife is acting in the way the questioner would expect. In this way midwives prevented themselves from standing out and being vulnerable. However, this could cause problems for the individual in compromising their own philosophy of care. This could lead to feelings of helplessness or anger towards the individual who has caused them to behave in this way.

Midwives also sometimes felt the obligation to justify their actions or inaction without actually being directly questioned about it. A birth centre midwife describes how she feels she has to justify her actions in keeping a woman in early labour in the birth centre when there is an “unwritten rule” that they are sent home.

“Birthing unit has a very strong culture of sending woman home if not established in labour.
You have to justify her being there.
That gives me something to feel uncertain. If the Band 8’s turn up you have a full explanation to give. Which in turn may influence your management of care.” (Helen - Diary entry)
There were differences between midwives regarding the extent they believed those they were caring for could affect their confidence. Whilst the majority did not consider it as a factor, others found that relatives could undermine their confidence. One midwife in particular felt that being questioned by relatives could affect her confidence.

“I think it makes you a bit paranoid doesn’t it at times, like they’re trying to catch you out, or you feel you have to justify everything you’re saying. I think that’s, that can be a lack of confidence backing everything up because, because, because like you’re trying to prove to them that you do know what you’re talking about.” (Amy)

It was interesting to note that questioning by women was not seen by participants as a factor affecting their confidence. However, they could suffer from self doubt if a woman they were caring for laboured differently to their expectations.

Even when they felt confident, midwives were aware of the potential for exposure. One midwife describes how she ensures she always has the facts to hand so she doesn’t get “caught out” (Hannah) with anything. Having guidelines and all the details she needs helps her to be assertive rather than vulnerable.

“I felt quite intimidated trying to transfer a patient I suppose, cos I felt that I would get challenged by the person I was speaking to, ‘Why do you want to do this, why do you want to do that?’ But I suppose over time and working on the MLU for so long it doesn’t bother me now, I just do it. So I suppose I’ve got more confidence in that respect, because now I think I’ve got all my facts in front of me here, the
reason I’m calling isn’t because I don’t want to look after this woman it’s because I’ve got a reason for moving her.” (Hannah)

This fear of being caught out or “tricked” (Amy) could lead to a change in the way an individual would present information in the future. Rather than portray herself as certain about something and later find that this was wrong, one midwife chose to present herself as less sure of something.

“It makes you learn doesn’t it? That if that happens again it doesn’t really matter or …. You just make sure you say ‘I think it might be’.” (Amy)

7.3.3. Being under surveillance

Midwives’ confidence appeared to be enhanced or maintained when they felt trusted and were working in a perceived secure environment. However, this changed when they felt they were under surveillance. This could lead to a change in their confidence and their subsequent behaviour. Confidence could be affected by simply being watched carrying out an activity.

“I had a student midwife and a medical student and two birth partners and the woman all watching one thing I was doing. And I was quite nervous actually and I didn’t realise I would be, but I was cos I had all these eyes on me….. I thought if I do something wrong, I think it was an ARM [artificial rupture of membranes] or something, I can’t remember. But I just remember everyone looking at what I was doing and I felt like saying just talk amongst yourselves I’m just going to get on with this (laughs). I suppose, I knew what I was doing, I just thought if I do this wrong I’m gonna look so stupid, erm and I’ve gotta try and look as though I know what I’m doing. I’ve got a student midwife here who’s looking onto me as being a 4 year qualified midwife she must
know what she’s doing, you know that type of thing…But generally I feel confident in most things, but just little things like that.” (Hannah)

However, participants often felt they were under surveillance from the organisation itself. Other midwives, particularly shift leaders and managers, were often viewed as agents of the organisation. Where midwives believed themselves to be under surveillance they could begin to doubt or question their actions. This idea of surveillance was heightened for those working in the hospital environment. A diary entry from a caseload midwife sums up how she feels in a home environment.

“Being in a comfortable environment, with no-one looking over my shoulder.” (Sara – Diary entry)

Midwives working in the birth centre could also feel under surveillance from the CLU, despite the fact they were on a separate site.

“They must have to come across, travel that 7 miles [to] look at what we’re doing…. ‘What’s she doing here?’ I don’t know why they come across the culture of the management has changed definitely and when they come across from xxxx [CLU name] it’s like they’re coming across from xxxx [CLU name] and they’re just seeing what we’re doing…. Anyway, that’s.. I don’t know if that knocks my confidence. I’m sure it does.” (Helen)

The idea of being observed by the organisation was quite strong for some participants. One midwife discussed the introduction of new technology and how this could be used for surveillance of midwives practice.
“Somebody from our team said to me they were on duty and there were two members of core staff sitting looking at this [computerised CTG]. And it was of a room where there was a junior midwife caring for this woman and they said, ‘we’re just going to wait and watch this and see how long it is before she does something about it.’ …. That is just so horrendous isn’t it? Talking in terms of confidence, what would that do for the confidence of that midwife? The midwife in my team overheard this, so how many other people overheard it? And they’re thinking ‘oh when I’m in my room there’s somebody looking at what I’m doing and waiting to catch me out’.” (Laura)

Interestingly, despite midwives’ perception of being under surveillance, many did not believe they practised defensively. However, the majority did mention litigation, complaints or incident reviews as factors which had affected their confidence. Where these had occurred they appeared to have longer term effects on the individual concerned. One participant described how a complaint affected her confidence both within work and at home for some time.

“I did take it quite personally and it did quite affect me actually, because…My mum even commented that it affected me cos I went on and on and on about it, and even a week, 2 weeks later I was still talking about it. And my mum said ‘that really got to you didn’t it?’ And I said ‘it did, it really knocked me completely’.” (Hannah)

The fact that this individual had allowed this confidence issue to invade her home environment deserves attention. This suggests that this incident is significant for the participant concerned. The carry over effect from work to home life and vice-versa was something that participants did not discuss. Even
when prompted at interview individual’s suggested that there was a distinct divide between their feelings at work and at home.

7.3.4. Feeling helpless

Feeling helpless was something that affected a midwife’s confidence negatively. One area common to all midwives, except those in the caseload team, was the perception of being helpless in the face of management. All midwives saw management as a separate entity over which they had no control, but which had control over them. One midwife in speaking about management plans for rotation between the birth centre and the CLU stated.

“If that’s what they want to do, that’s what’s going to happen.” (Helen)

Some cultures encouraged reliance on others to make decisions. On the CLU there was a hierarchy of control in evidence, with the shift leaders viewed as part of the management. One midwife believed that her confidence was affected by the way in which the unit was managed. She felt it was very restrictive, providing limited options for autonomy.

“It isn’t really encouraged to discuss things generally I don’t think…. We don’t really discuss, you go to the shift leader, ask her what to do and you take her advice on it. If you choose not to take her advice on it then that’s where trouble starts.” (Fiona)

Midwives working in the caseload team were also aware of the control influences on the CLU.
“I know that if the shift leader had known I was doing that ‘I think you should have done’.....” (Sara)

Another area outwith many midwives control was that of staffing levels and this was a subject that elicited many comments. All felt that a lack of staff affected their own confidence. For hospital staff there was an immediacy and sometimes panic about how they would cope on a shift. An overall feeling of negativity prevailed when this occurred.

“Everybody automatically goes into this negative attitude anyway, ‘oh god this is, we need more midwives, we need this, we need that, we’re never gonna be able to’.... And everyone gets really stressed out about it.” (Hannah)

Another midwife felt that even when staffing was adequate midwives would be moved to other areas, so the problem recurred. This clearly led to frustration in attempting to provide adequate care in these situations.

“They [managers] say the staffing level is fine and quite patently it is not. It’s not fine and we’re very very short staffed and when we do have a full quota of staff on the MLU they get sent to elsewhere, so we never have a full quota of staff and if you’re dealing with something oh it’s just horrendous trying to coordinate. And you think the management need to come in and see what good work we do under pressure. And we still do it well with a smile on our face and we still give those women a good experience, if we can, of course it doesn’t happen all the time, but if we can.” (Siobhan) (Bold = participant emphasis)
For caseload staff the issues that arose were often in relation to planning workload and covering on call rotas.

“*We’re short staffed at the moment because we’ve got someone on maternity leave and one on holiday, we’re having a hairy few weeks really..... At the moment we’re struggling and we have one on-call quite often and that I find that quite stressful, and that can affect my confidence if I’m thinking oh I’m on call and I’ve got visits to do and what’s going to happen with this woman and she’s in labour and I’m here.*” (Laura)

The caseload team were also very aware of staffing issues within the hospital environment and that this could impact on them as a team should they need help. The issue of stress and lack of confidence as a result of poor staffing levels was raised by all participants. This echoes the findings of Kalisch et al (2010) which considered job satisfaction and well-being in nurses. A significant correlation between adequate staffing levels and job satisfaction was found to exist. Furthermore, midwives who feel time pressured and who are unable to influence workplace decisions are more likely to report feeling under stress (Mackin and Sinclair 1998). The participants in this study did perceive that stress could affect their confidence. This was often compounded by a feeling of helplessness in relation to management input. An individual with an external locus of control is likely to consider that they have little influence or control over events that affect them (Rotter 1975; Peterson and Stunkard 1992). This appeared to be the case for participants in relation to both staffing and
management decisions. This resulted in participants accepting the situation, but feeling undervalued.

### 7.4. Appearance as protection – Putting on the armour

Midwives’ perception of how they appeared to others was very important to them. This included their appearance to other staff and to the women themselves. They used a positive persona in order to protect themselves and hide any lack of confidence. One midwife spoke of how she intentionally tried to portray herself as confident to other midwives.

> “I’m probably not as confident a practitioner, I just hide it very well and they think I’m confident, but in my head. So if they’re looking I know what I give off to people, I give off confident practice but in my head there’s many things that knock my confidence.” (Helen)

Being viewed as calm and professional was something that midwives held in high regard and was often thought of as a characteristic of a confident midwife. Midwives commented on appearing calm and confident even when this was not the case and many midwives cited emergency situations as an example of when this may happen. For most participants this was an automatic presentation of their professional self, although they were often aware of it at the time. Midwives believed this professional confident presentation was of particular importance to the woman they were caring for in order for her to feel safe in difficult situations. It also acted as a method of self-protection, allowing them appear confident in order to maintain others confidence in them.
“I think if those women know I’m not confident in a situation, I’ve lost everything in this labour.” (Helen)

Whilst individuals presented a persona, it was possible that teams of midwives did this also. A midwife in the caseload team noted that as a group they were known as “quite stroppy and assertive” (Alice). She felt that as a result many staff saw them as a confident group and doctors in particular tended to leave them alone in terms of working practices. Individuals within the group also benefitted from this group persona and were viewed as confident practitioners. The confident team persona may also have the advantage of acting as a collective protection of its members.

There was some disparity of views as to whether presenting a confident exterior to women was a good thing. Whilst most participants felt that midwives should be honest about a lack of confidence, this could vary dependent on the situation. In particular, midwives differentiated between what they saw as emergency and everyday situations. In terms of emergency situations, most saw it as a positive method of protecting the woman.

“I think that’s part of our professionalism, I think that’s how have to act, if you weren’t acting like that what’s the point. And also you have to take a deep breath and be calm and confident and act like that because you’re giving that woman, you’ve got to reassure her.” (Siobhan)
In other situations, such as not knowing how to operate equipment or needing a second opinion, some midwives felt it was preferable to be honest with the woman about their lack of confidence.

“You can tell and I’m sure that the women can tell, if you don’t know what you’re doing. They can tell that you’re fiddling around with something, that you don’t know what you’re doing. That’s part of being confident that you can say I’m not comfortable with this or I need more information about that or whatever. It’s like honesty as well, being open and honest.” (Fiona)  

Another participant understood that some midwives may prefer to hide a lack of confidence.

“I suppose if somebody wasn’t confident you’d rather they just said that to you ‘look I’m not really too confident about this, I might seem to be but I’m not’ That’s up to them whether they tell you that isn’t it you know what I mean, not everybody wants to disclose if they’re not confident do they.” (Hannah)

It may be that midwives, although believing they should be honest with the woman, are also aware that displaying a lack of confidence may reduce the woman’s confidence in them. Being a professional and an expert brings with it an expectation of confidence and women require this from their caregivers. Kröner and Biermann (2007) suggest that individuals’ believing an expert to be lacking in confidence may also assume they are lacking in competence or skill. They suggest that this is because individuals’ intuitively “know” why others display a lack of confidence; this being because they do not have the necessary
competence to carry out the task (Kröner and Biermann 2007). A study conducted by Ogden et al (2002) in the context of general practitioners consultations with patients noted that doctors verbalising a lack of confidence was particularly damaging to the patient’s confidence in the doctor. They suggest that by showing honest uncertainty doctors underestimate the effect on the patient. By appearing less confident the woman may reach the decision that the midwife is also less competent. This will have implications for the woman’s own confidence and ability to trust the midwife, which may in turn increase her anxiety and affect her ability to labour (Leap et al 2010).

This attempt by participants to portray confidence is similar to the use of impression management described by Goffman (1959). In doing this the individual acts out a role which they want the audience to accept as reality. By portraying a confident exterior the midwife anticipates she will be accepted as such and the audience will react to her in the way they would react to a confident person. Much of what midwives do here is surface acting, that is, putting on the face whilst underneath continuing to feel their own emotions of anxiety or fear (Hochschild 2003).

Whilst midwives clearly undertake impression management with women they are caring for, it is apparent that it also extends to colleagues. One of the reasons for impression management may be that of the professional persona midwives are expected to portray. It is relatively straightforward to understand why this may be the case with women, but it is less clear why they maintain this persona with colleagues. Part of the reason for this may be due to the
vulnerability an individual feels when exposed as being under-confident in front of colleagues. The reasons for this vulnerability appear to be determined by the culture of the environment in which they are working, particularly in relation to the power bases that exist. Delivery suites are often difficult and stressful environments within which to work. Midwives want to portray themselves as the commensurate professional, which to them includes being a confident practitioner. The implication seems to be that a lack of confidence places an individual in a poor light, as maybe somehow lacking in that professional status. A colleague who is under-confident may be seen as a threat to the smooth running of the area and as a risk to work with. Therefore, the individual's deliberate portrayal of confidence may be to prevent colleagues losing confidence in her as a professional.

As discussed (chapter 6) some of the participants expressed concerns about working with others who are believed to be under-confident. This may be because they believe it puts them in a vulnerable position themselves. As such a midwife who does not display confidence may find their status within the area in which they are working diminishes and may potentially leave them vulnerable to criticism and bullying.

7.4.1. Determining confidence in others

Whilst midwives knew they were often portraying a professional persona of confidence, they were also aware that others were doing so. The extent to which they recognised this in others varied with judgements made about individuals based on their previous knowledge of them. Midwives appeared to
make judgements on another’s confidence from what they knew of them. If they knew them well or had worked with them for a period of time then they were often sure in their judgement of them. If they did not know them then there was a presumption that the other person was confident.

Midwives recognised that others utilised the same techniques as themselves to portray confidence, with varying degrees of success.

“I think some midwives are better at hiding it [lack of confidence] than others. I mean we had a midwife and we always said she’s like a swan on the top of the water, but her feet were paddling like mad underneath.” (Jemma)

Interestingly, in this situation a participant and her colleagues were aware of the fact that this midwife was deliberately portraying a professional persona. However, some participants questioned themselves about how they actually knew a midwife was confident. One midwife debated at length with herself as to how she knew others were confident.

“You know that they’re confident but how do you know that? I suppose you know their own personality if they’re sort of loud so to speak, I suppose if they’ve been in the job a while you would assume that they’re confident and if they work a lot of the time in certain place then.. How do you know that? I don’t know.... Because you can’t really say they’re not timid cos some of the girls upstairs are timid aren’t they in their personality but you know they’re an ok, a confident midwife when you get in that room and doing a deliveries and on the ward and that, they know what they’re doing and you know they know what they’re doing but cos they’re not sort of open about it. It’s probably
often the people who come across as confident aren’t, people who, they’re afraid to ask cos they don’t want to look silly but really they don’t know. I don’t know how I know about confidence, I know how I feel confident. But probably the people I would say to you are confident are not as confident as I think they are. So yeah I’d say the way they portray themselves, are they loud? do they volunteer for work?……….. But that’s probably completely wrong. I’m probably thinking of the other way do you know what I mean, the people I probably think are timid and unconfident are probably the most confident.” (Amy)

Many of the participants shared this confusion in determining how they perceived confidence in another. For many it was an intuitive process based on their experience and knowledge of another. Intuition was defined by Jung (1971) as “perception via the unconscious”. However, Sadler–Smith (2008) contends that intuition is not completely abstract, but rather takes into account all experience and knowledge gained by the individual. Benner and Tanner (1987) suggest that nurses develop intuition in relation to nursing care as they progress from novice to expert. It is possible that midwives use the same stages to become experts in using intuition to determine confidence in another. The work environment and their status within it appeared to be very important to participants. Given the importance of the workplace, it is reasonable to assume a midwife’s sense of intuition will be developed sufficiently to determine whom she can rely on.

An interesting dichotomy appeared to exist for midwives. They wanted to appear confident to others and actively strive to attain this, yet are unable to articulate what it is that makes them believe a person is confident. In addition,
the participants were sometimes aware when others were actively projecting confidence. Again there was often no specific factor that made participants aware of this. However, it does raise the question of intuition; were participants somehow aware that the confidence of another was a projection, rather than genuine, without thought, confidence? As a result, many participants were concerned about the effectiveness of their active portrayal of confidence in some situations.

“I keep expecting someone to see through me.” (Anna)

This comment was echoed by others who demonstrated a real concern that they would be “found out”. This reflects imposter theory in which high achieving women believe they have deceived others into believing they are something they are not (Clance and O’Toole 1987; Kumar and Jagacinski 2006). This can result in anxiety and affect an individual’s well-being (Kumar and Jagacinski 2006). Midwives were clearly aware of the emotion work they put into their professional persona and understood they were using it to conceal their true selves. In a similar way to how they measured their confidence, participants measured the success of their own presentations by the reactions and comments of others. In addition, they used self comparison with others to confirm their success.

7.4.2. Positive impressions

Whilst midwives wanted to portray themselves as confident professionals, they were very anxious about what they described as looking or feeling stupid. They
would go to lengths to avoid this and some indicated they would alter their behaviour in certain circumstances where they felt this was a possibility. One midwife in particular was apprehensive about expressing her views in front of certain people for fear of appearing foolish.

“I would just listen and have my own view but not express that view, I think that’s just confidence maybe in my own knowledge. They’re going to know more than I do and I don’t want to look stupid, not that you can know everything, but I don’t want to challenge somebody if they’re going to make me look silly.” (Amy)

Participants were also concerned about how events outside their control could reflect upon them. One midwife described how she transferred a woman with prolonged rupture of membranes to the CLU for antibiotics according to protocol. However, by the time she arrived the woman had established in labour and no antibiotics were given. Whilst she believes she acted in an appropriate manner at the time she still remains concerned that this makes her “look absolutely stupid” (Helen) to both the woman and the CLU staff. Similarly another describes how she “feels stupid” when she does not know the induction protocol even though she works in a unit that does not undertake inductions. She goes on to discuss her feelings about this.

“Ohhh you can take it quite personally can’t you? You can perceive a criticism of your practice which probably isn’t meant, but because we want to be all things to all people we don’t always remember that actually if you haven’t been told that, or if you’ve been on holiday, or whatever and there’s a perfectly good reason for you not knowing then that’s fine. Yeah we shouldn’t beat ourselves up about it.” (Katy)
The feeling that as midwives they should be “all things to all people” appeared to have resonance with all the participants. They strived to attain this high standard and how they presented themselves was part of this belief. Asking for help would be avoided by some midwives for what they perceived as minor things, such as finding equipment, using technology and cannulation. Somehow not requiring assistance helped to promote the persona of confidence and there seemed to be an almost professional pride in being self sufficient. Interestingly, midwives suggested that those they thought of as confident midwives would ask for help if they were unsure. However, when it comes to their own portrayal of confidence midwives seem reluctant to do this. This appears to be in conflict with participants’ views about honesty in declaring a lack of confidence to women and others. It may be that midwives are concerned that they will appear under confident if they show any weakness and this may subsequently affect their status with other midwives.

Being viewed as reliable and knowledgeable and providing assistance to other midwives who lacked confidence in certain tasks helped others to develop. The most newly qualified participant felt her confidence had grown as a result of gaining new skills. Her experience of being asked to perform these skills by midwives whom she saw as much more experienced enhanced her confidence further. She particularly enjoyed being viewed as a junior but confident midwife.

“I suppose a lot of people I’ve looked after and my colleagues as well have said ‘you don’t half seem to know what you’re doing’ and ‘you don’t half appear confident’. So I suppose I must give that impression.”
Overall I must do cos some people have commented, so even if sometimes I haven't thought I have a lot of the student midwives I've worked with have always thought I've been qualified longer than what I have been because of that. Which is good, you know I do quite like that.” (Hannah)

7.5. Holding the ground - Maintaining control

A strategy employed by all midwives to enhance and sustain their confidence was that of gaining or maintaining control. This included control of their workload, environment and situation. A degree of control and autonomy in the workplace has been linked to enhanced motivation, role performance, job satisfaction and confidence (Spector 1986; Hundley et al 1995; Ashforth and Saks 2000; Pollard 2003), along with reduced burn-out (Sandall 1997). Alloy et al (1993) suggest that control can be considered a basic psychological need. In addition, a positive correlation has been identified between self-efficacy and control (Ashforth and Saks 2000). This was echoed by participants for whom control was linked strongly with confidence.

“If it feels like I’m in control of the situation, I don’t mean I’m controlling the situation... If I feel that I’m in control then I can relax and practice the way I want to practice, but when things start to run away a little bit that’s when your confidence wavers a little.” (Mary)

“Slow steady shift. Felt confident and in control.” (Siobhan - Diary entry)

For participants, control, as well as confidence, was not constant and could sometimes vary unexpectedly. A caseload midwife found dealing with a difficult
and unpredictable situation outside of her control. Whilst she initially felt in control, the developing situation leaves her feeling not as “confident and relaxed as I would normally have done” (Laura). It is clear that confidence and control can be time situated dependent on surrounding events.

Advance planning of care gave control to some midwives, especially when the case was outside of the norm. This was particularly evident with the caseload midwives who often had a challenging and high-risk caseload. Agreeing a plan of care in advance, with both the woman and relevant obstetricians, gave them some control and enhanced their confidence.

“So quite often with the woman, the obstetrician and ourselves we’ll get a birth plan together so when you get to delivery suite you say ‘it’s ok it’s all been agreed, it’s all been agreed, this is the plan and this is what we’re going to do’ ((Laughs)). So then they back off a little bit then........ At first when we did things like that it was ‘oh those caseload midwives, taking risks and they’re going to come a cropper.’” (Laura)

Ashforth and Saks (2000) suggest that an individual’s self-efficacy is an important component in their perception of the control they have in the workplace. Individuals with apparently high self-efficacy are likely to persevere in their attempts to gain control in environments even where there is little opportunity to do so (Wood and Bandura 1989; Wise 2007). This certainly appeared to be the case for the midwives working in areas such as the CLU which allowed little apparent autonomy, with participants using a number of different strategies to gain or maintain control. A failure to gain some sort of personal control in the workplace has been linked to feelings of anxiety,
helplessness and stress (Thompson 1981; Denzin 1984; Macklin and Sinclair 1999; Ashforth and Saks 2000). Once helpless, an individual retreats and disengages from the role or organisation. In addition, they are more likely to suffer from burn-out (Larsson et al 2009) and reduced self-efficacy (Bandura 1982; Harlos and Pinder 2006).

Research within the midwifery context has highlighted that control is an important element in the empowerment of midwives (Scott et al 2003; Matthews et al 2006). Macklin and Sinclair (1999) found that midwives experienced a sense of helplessness and an inability to influence decisions when they were unable to exercise autonomy on the labour ward. Midwives in this study did experience feelings of helplessness, most notably in relation to management. Interestingly, all the participants appeared to continue to adapt and manipulate situations to retain a degree of control, even when they could still feel helpless in other situations. This seems to indicate there was a resilience to midwives and their ability to persevere where others may accept defeat. It also indicates that the participants did have an internal locus of control, indicating they believed they had some power to change events. It has been suggested that individuals with an internal locus of control will attempt to control their environment where possible (Spector 1982). Often participants would continue to manipulate situations to gain some control or autonomy even where the net gain was small. This suggests that even a small amount of gained autonomy was beneficial to the individual’s confidence, justifying the effort incurred.
Self-efficacy is important in terms of belief in the individuals own control of their behaviour (Ajzen 2002). However, it is their locus of control that determines how they perceive they can change events. Individuals with an internal locus of control believe that their behaviour can alter or control events around them, whilst those with an external locus of control believe events are outside of their control (Rotter 1975; Peterson and Stunkard 1992). Scholz et al (2002) suggest that there is a correlation between an internal locus of control and self-efficacy. Interestingly, although participants described feeling helpless in the face of some organisational factors, such as management imposed changes and staffing levels, on a personal level they did appear to believe they could gain some degree of control. This demonstrated that there was a degree of contextual influence on participants’ self-belief.

Being autonomous, or having perceived autonomy was a positive factor for midwives in their working environment. Midwives in all study settings appeared to feel that autonomy could affect their confidence. Those who worked in an environment where they had greater perceived autonomy expressed that they felt fortunate to work there. One midwife working on the MLU described feeling “lucky” (Mary) as the environment gave her the freedom to practice how she wished. She was acutely aware that this would not be the case if she worked on the CLU. Another midwife from the caseload team used a diary entry to express her thoughts about her practice.

“Caseloading is fab. On CDS [central delivery suite] I often feel “self contained” because we come and go as we are needed, more autonomous.” (Sara - Diary entry)
Midwives working on the CLU perceived they had less autonomy than colleagues working in other areas. Other participants were also aware of this potential disparity in autonomy, which depended on the organisational ideology of the area. Despite much change in the organisation of maternity services over the last two decades the CLU has probably remained the most static in terms of organisation. As such it relies upon a hierarchical framework. Traditionally obstetricians have been viewed as top of this hierarchical framework, followed by midwives with women at the bottom (Hunt and Symons 1995; Pollard 2003; Keating and Fleming 2009). Participants in this study identified a distinction between senior and junior midwives, echoing similar findings of Keating and Fleming (2009). In particular it appeared to be the senior midwives who were the greatest barrier to autonomy on the CLU. Midwives were aware of the role and status of the obstetrician, but in terms of the freedom to practice autonomously it was the senior midwives who exerted the greatest control. Some of the participants acknowledged that the senior midwives and shift leaders maintained this control due to lack of confidence themselves.

“Some of them [shift leaders] are worried about what’s happening in the rooms, so they go in and look at the notes or CTG [cardiotocograph] or whatever and try to direct care, even when they haven’t been asked to......It gives the impression that they don’t have any faith in you, but they do it to everyone it’s more that they can’t trust.. It’s their lack of confidence that shows.” (Anna)

Others believed that concerns for their own role and position in the hierarchy prompted this behaviour from shift leaders.
“I think a lot of the shift leaders are scared for their own position, they have to be seen to be in charge.” (Alice)

Having worked as a midwife within the CLU at study setting A I was aware that shift leaders were often held to account for the actions of junior staff within the Trust. As a result, they had developed a much more controlling stance, which involved specific questioning and direction of care. Participants working at other study settings were also aware of similar issues within their own CLU’s. Midwives at the birth centre resented the unannounced visits by the managers and senior midwives from the CLU, who would scrutinise the board and request updates of progress or reasons for admission. One of the birth centre midwives was concerned about a change in uniform that would lead to senior midwives (band 7) wearing a different uniform. She believed this would lead to a return to a hierarchical system and a change in dynamic for the unit, resulting in a loss of confidence for some midwives.

“The band 7’s have been asked to wear the sisters’ uniform. And I just think.. I know that’s a silly petty thing, but I feel that could knock people’s confidence because they feel intimidated by that authority figure and er, I just think it’s not good for the women as well for the women to see oh that’s a sister they must be better to look after me than she’s just a midwife, oh.. I’ve heard that it drives me mad ‘she’s just a midwife, I had the sister looking after me’, well halleluiah so it didn’t bother me so much. It does bug me, but erm, that’s a backwards step.” (Helen)
Midwives in the caseload team were generally untroubled by senior midwifery control. However, they usually had an agreed plan of care in place for their women and had the support of the consultant midwife and certain consultant obstetricians. This appeared to give them greater legitimacy in the eyes of the CLU shift leader. They also worked as a recognised team which may have given them a degree of protection from challenge. However, as a new team participants explained they had been frequently challenged about their care by senior staff in the CLU. These challenges had diminished as the team developed as a group independent of the CLU.

7.5.1. Strategies used to gain control

Participants used three main strategies for gaining or maintaining control in the workplace. These included controlling the space, controlling interactions and controlling decision-making.

7.5.1.1. Controlling the space

Participants in all study settings valued autonomy and one of the ways of obtaining this was working within their own space free from the interference of others. Midwives on the CLU appeared to be at greater risk from interference by others, mainly due to the size and hierarchical structure of the unit. Midwives on this unit would use the method of creating their own space in order to practice how they wished. This could be either a physical or metaphorical space. One participant suggests that experienced midwives manipulated the system to suit themselves.
“They know the whole system so well. They know how to work it to their best advantage and you’re best just to go to your room and see to your woman and not come out, or only come out to tell, you know, basically what we have been told we have to.” (Fiona)

The tactic of physical isolation in the room was also used by others. By being less visible the midwife removed herself from potential questioning as the shift leader would have to enter the room to do so. Part of the ethos of this self-isolation was the individual’s attempt to regain what they frequently termed as their comfort zone. It was when they were within this theoretical zone that they felt they most confident.

Caseload midwives also used physical and professional space to their advantage. As they were seen to work separately to the CLU, they would often be left to their own devices. This allowed them more freedom to practice according to their own philosophies of care.

Midwives in both the birth centre and the midwifery led unit were physically separate from the CLU and there was much less of a hierarchy in evidence. Midwives in these areas perceived that they had more autonomy. As such they tended to practice in a more individualised way. In addition, the physical space between areas assisted midwives in working in isolation, particularly as they were part of a much smaller working group. Midwives at the birth centre would sometimes work alone in the unit, depending on workload. However, midwives working in both settings were aware of potential interference from other staff and from the CLU. This was a greater problem for the midwives in the MLU as
the CLU was based on the same site and to some extent the CLU culture pervaded. Shift leaders from the CLU regularly questioned midwives on the MLU, maintaining control from a distance.

As well as creating a physical space midwives would create a metaphorical space by limiting the amount and type of information they presented to others. Information was a powerful tool in the midwife’s repertoire. This minimal information strategy served to discourage questioning from others. Usually this was a covert activity such as avoiding others or deliberately staying in their room and out of sight or “forgetting” to update the board. Occasionally it would be more overt, such as providing minimal information in response to questions.

“When I’ve worked in other places we’ve never had to come out of a room and tell any other midwife that our patient was about to deliver the baby, you didn’t have to do that. You could come out and say that lady’s delivered her baby at such and such a time and I’m going to send her here. Here, in this hospital, you’ve got to tell the shift leader when she’s fully [dilated], you’ve got to write the time she’s fully dilated on the board in minutes. And then after 2 hours you expect a senior midwife to walk into your room, whether she’s been invited or not, to find out what’s happened….And that’s just… That’s wrong, that’s not, that like undermines everybody’s confidence doesn’t it, cos why do you need somebody else to be keeping an eye on you.” (Fiona)

“What really annoys me is shift leaders wanting to know every little thing about the woman, that really gets my back up. I’ve been qualified as long as some of them and I am as competent as them and I resent their interference, I’m the one responsible for the woman I’m looking
Information was seen as a powerful tool and many midwives maintained control by limiting the amount of information they provided to others. Self isolation or avoidance of others was often the key to controlling information flow. To some extent there was a guarding of the area around the woman and any information about her. The act of failing to update the board reflects the findings of Berridge et al (2010), where midwives failed to update information which may lead to interference from medical staff. Midwives appeared to be managing shift leaders and senior midwives in a similar way to how they traditionally used to manage medical staff. That is, keeping them out of the room and away from the notes whilst care and labour was progressing normally.

The practice of working in isolation to maintain a degree of control and autonomy is a concerning one. Whilst the midwives in this study indicated they communicated shared information where required, there are potential implications if information restriction is employed inappropriately. Junior staff perceive senior midwives as role models (Hollins Martin 2007). If these role models are only able to gain autonomy by practising covertly, it follows that more inexperienced staff may imitate them without sufficient experience or skill. Many incident reports and government inquiries repeatedly cite communication issues when failures in care occur (Healthcare Commission 2006, 2008; Lewis 2007; CMACE 2011). Failure to escalate concerns is the most frequent reason for referral of midwives to the NMC (Read 2010). Government documents (Lewis 2007; Kings Fund 2008; CMACE 2011) frequently call for improved
interdisciplinary communication, indicating that the situation is failing to improve. It is crucial therefore, that midwives are able to maintain a balance between working autonomously and working in self-induced isolation.

7.5.1.2. Controlling interactions

When participants were unable to isolate themselves in the workplace environment they would try to control which individuals they interacted with. Midwives were well aware of those who they felt had an adverse effect on their confidence and would go to lengths to avoid them. All participants explained that they did this, avoiding certain individuals who could reduce their confidence.

“You like the way some people work as opposed to others, the way they deal with situations, as in speak to you, speak to the woman you’re looking after, you know manage situations. You think oh I’d rather not go to them cos I don’t like the way she spoke to the last woman, or I don’t think she does the best thing, or she jumps in too quickly, or something like that. I do pick and choose, not a great deal, but… yeah I think everyone’s done that.” (Amy)

It was important for midwives to have confidence in the person they were approaching for advice. A midwife working on the CLU explained that if she did not have confidence in particular shift leader she would seek help from another more experienced midwife. Then they together would both relay any relevant information to the shift leader, using an excuse such as “she was just there” (Amy). This was therefore presented as a fait accompli. Similarly, midwives would also choose which medical staff they approached where possible. Often
this was based on the individual’s known stance or personality in order for the midwife to achieve her desired outcome. This appeared to be common to participants at all units. A caseload midwife, for example, suggested that the team members would only approach certain consultants who were sympathetic to their philosophy. Participants would also circumvent certain individuals and layers of the hierarchy where they felt this was necessary. In all environments apart from the CLU it was expected that the midwife would refer directly to the relevant member of medical staff. However, the hierarchical system on the CLU expected midwives to discuss issues with the shift leader first. Participants in the study found this difficult.

“If I have a problem I will speak to the Reg [Registrar] direct not go through the shift leader, why would I?... To be honest they all know me and trust me so they leave me to it, but you see them giving some of the girls a really hard time about this, they’re usually newly qualified and are having the confidence knocked out of them.” (Anna)

In addition, many midwives liked to choose who amongst their peers they would call on for help. Participants were generally much more comfortable with individuals they knew and shared similar attitudes to practice with. A caseload midwife described how she would try to control who would assist her at a birth.

“I like to find out who’s on who’s working so I know who’s likely to come in through the door, I might even approach them and say, you know, when the buzzer goes will you come in?” (Sara)
It is clear that participants were skilled in using emotional intelligence in the workplace. Emotional intelligence consists of five components, relating to an individual’s own emotions and the emotions of others (Goleman 1996; Fineman 2006). The first three components relate to an individual’s own emotions and include, knowing emotions, managing these and using these emotions as motivation. The final two components include recognising the emotions of others and managing the emotions of others. From the data it is evident that the participants were very much aware of their own emotions and their management of them. They were also aware of the emotions of others and were able to use this knowledge to their own advantage.

The deliberate manipulation of situations to gain or maintain control was evidence of participants’ use of emotional intelligence. In particular, the participants appeared to be very aware of the attributes and emotions of other individuals. They would then use this knowledge to actively manage situations to their best advantage. Often this would have an impact on how they chose to interact with particular individuals. If possible, midwives chose to approach those who shared similar philosophies or who would at least be would be sympathetic towards them. However, in other situations this choice would not be available they would be required to interact with potentially difficult colleagues. Sometimes this required an overt display of obedience or acquiescence, whilst covertly maintaining their preferred method of working. Whilst isolation was used as a coping mechanism, it was also used to give the impression of being busy or unavailable, thereby removing the individual from some of the potentially difficult relational situations. In either case directly
challenging the status quo does not appear to be an option for the individual midwife, rather maintaining a low profile and appearing to conform allows them to maintain a degree of control. In this way they are able to control the controller without placing themselves in a more vulnerable position. Emotional intelligence provided the participants with the knowledge of the best way to behave or manage an individual in order to be able to manage and control their own situation in the workplace.

7.5.1.3. Controlling decisions
Control for participants included the freedom to make decisions about their work and the care they provided. Autonomy and participation in decision-making have been linked to perceived control in the workplace (Evans and Fischer 1992). This perception of control can be linked to a number of positive outcomes including and improved sense of well being (Spector 1986; Begat et al 2005). Participants in this study indicated that being able to work in an autonomous manner enabled them to maintain their confidence in decision-making. Two main issues were identified by participants as being influential in control over their decision-making ability, both of which could be described as organisational control (Porter et al 2007). The first aspect of this was the guidelines under which midwives were expected to work. Some participants felt very strongly that guidelines prevented them from working autonomously. The second aspect was that of the senior staff enforcing the guidelines and consequently imposing the hierarchical system where it existed. Participants often felt that senior staff were inflexible in their interpretation of guidelines and often used them definitively in directing care.
Guidelines were frequently cited by participants as a barrier to autonomy. Despite being a guide, many felt that the organisations in which they worked expected conformity to them. Midwives sometimes felt that they had little independent decision-making scope and that the guidelines restricted their ability to use professional judgement. One of the consequences of this was to remove a midwife’s confidence in decision-making in the absence of such guidelines.

In addition, midwives found that they were called to account for care they provided outside of a guideline. This was despite the fact that the individual may have provided care which resulted in a good outcome. This had the effect of reducing an individual’s confidence in their decision-making ability and may lead them to question themselves in future situations. One midwife described how a review following a shoulder dystocia had led her to question her actions. At the time of the incident she undertook a manoeuvre she thought most likely to lead to delivery of the baby. This led to a successful outcome with the baby delivered safely. However, the manoeuvres she undertook were not in the order prescribed by the guideline. This incident was reviewed as per hospital protocol for that situation and subsequently led to an open internet discussion within the Trust. As a midwife currently working at that Trust I was aware of the debate, although I was unaware of the individual involved. The debate centred on a very pedantic stance regarding interpretation of the shoulder dystocia guideline and involved midwives and consultants. It demonstrated the precedence assigned to guidelines and the strict interpretation afforded to them. The midwife involved
was ultimately vindicated and praised for her actions in the circumstances. She described how she felt.

“I was thinking right xxxx [name] that’s brilliant, nothing to reflect on this time everything’s great and I patted myself on the back. And then the review happened and the comment was ‘what’s the midwife doing starting with the posterior arm? why didn’t she?’..... So then I immediately thought ‘why didn’t I? why didn’t I?’ Well, come on because the hand was sticking out because she was on all fours and that was a sort of high then a low, so that was a kind of confidence issue really........So if it happened again I think I probably would think ‘oh god what shall I do?’........ Now I’m not so confident that I did the right thing when at the time it felt instinctively right.” (Mary) (Bold = participant emphasis)

This incident demonstrates how an individual’s confidence can be reduced through the organisation, despite a good outcome and ultimate praise for her actions. The long term consequences for the individual could include self-doubt and an inability to work effectively on her own initiative.

Participants in the caseload team were much more able to be flexible around interpretation of guidelines. They had the advantage of organisational support in the form of some of the obstetric consultants and the consultant midwife at the unit.

“Just cos the policy [says] women who’ve had a [caesarean] section shouldn’t go in the pool, doesn’t mean that you know, just because the policy says women who have had a previous section shouldn’t have a home birth .. You can’t make woman come to hospital, you know and
if a woman thinks she’s not going to be looked after in a hospital then yes she should stay at home, and if she wants to get her own pool then she should do it…. Yes, they’re there, but they’re guidelines that’s what I think. They’re there to guide you and make suggestions, but…. You can only explain those to women and if they don’t want to go with it they don’t… That’s it.” (Sara)

Midwives at all study settings discussed decision-making with the involvement of the women they were caring for. This could sometimes present the midwife with difficulties in explaining decisions to the shift leader; although some felt it added legitimacy and weight to their decisions. It also made it more difficult for the shift leader to overrule any decisions already made.

Interestingly, although the majority of participants were unhappy with the strict interpretation of guidelines per se and the potential effects on their confidence, they would use them to their own advantage. The participants were aware that guidelines were a powerful tool and would use them to control situations. This often occurred when faced with difficulties such as transferring or admitting women to units. The midwife armed with the guideline could make her point irrefutable to the shift leader.

Taking control of decision-making and gaining autonomy from the organisation required assertiveness on the part of the midwife. Interestingly, participants in all study settings described using a similar technique to take control of decision-making. In order to do this, rather than asking for advice, they would tell others what they were planning to do. This technique was used to prevent interference from others in the form of questioning, which may lead to vulnerability and self
doubt. It was evident that this technique evolved as midwives developed in confidence.

“I am becoming more confident and instead of going and asking for advice I’m telling them.” (Sara)

Others, possibly more experienced or confident midwives would autonomously make decisions about care without either asking for advice or seeking approval from others for their proposed plan of care.

Participants themselves had observed different approaches by others and the subsequent outcomes. There appeared to be a continuum beginning with more newly qualified staff who ask for advice, then those who would tell others what they were going to do, through to more experienced and confident midwives who would just practice as they wished.

“I think a lot of the more experienced midwives no longer ask for advice and they just do what they want to do in the first place and just tell the shift leader, whereas the junior midwives are still struggling with lots of things, so ... they go for help.” (Fiona)

Asking for advice often placed the midwife in a position where she felt she must follow the proffered advice. The act of telling another, such as a senior member of staff may offer some protection, but could also lead to conflict where there was a difference of opinion. The ‘safest’ option for midwives who felt confident in the situation was to make the decision without reference to another. This could lead to later conflict, but by then the decision had been made.
All participants discussed decision-making with the involvement of the women they were caring for. This could sometimes present the midwife with difficulties in explaining decisions to the shift leader, although some felt it added legitimacy to their decisions.

“You have to involve the woman in her care it’s her decision, so if they [CLU shift leaders] don’t like it, there’s nothing they can do.” (Alice)

Porter et al (2007) suggest there are three main models of control. These include control resting with the professional (classical), control resting with the organisation (bureaucratic) and control shared between the client and the professional (new professional). Participants in this study often described situations of control resting within the organisation. For them the organisation was the management (which included senior midwives) and guidelines for practice which were strictly enforced by the management. However, despite the perceived lack of control faced by the participants, many did attempt to act in the best interests of the women by including her in the decision-making process, indicating that they believed in shared control. This, to some extent, echoes the findings of Porter et al (2007).

In order to practice the new professional ideal of shared control and decision-making participants often had to negotiate the organisational control resting with the management. This often required them to work covertly within the current organisational system. Four methods of decision-making which occurred between nurses and doctors were identified by Porter (1991). Marshall (2005)
applied this in the context of midwives and doctors. For the purposes of this study the greatest barrier to midwifery autonomy appeared to be other midwives, who maintained the organisational status quo.

Participants described midwives using strategies similar to those they would previously have used with doctors to make decisions. These decision-making strategies were described by Marshall (2005) as unproblematic subordination, informal covert decision-making, informal overt decision-making and formal overt decision-making. Unproblematic subordination was described by participants as occurring where shift leaders offered advice without the midwife in question actively seeking it. It could also occur where less confident midwives would ask the shift leader for advice. They would then follow that advice without challenge. Informal covert decision-making would occur where the individual informed the shift leader what their plan of care was and asked their opinion. Whatever the opinion of the shift leader the midwife would follow it. Informal overt decision-making occurs with the input of the individual and would resemble the behaviour of the midwife telling the shift leader what she intends to do and then doing it. Formal overt decision-making occurred when the midwife determined her own plan of care and made decisions without reference to the shift leader. She may then inform the shift leader what she had done. This method of working was most evident in those working in a more autonomous environment. For the participants in this study an extra layer to decision-making can be added, which I will term formal covert decision-making. In this instance the midwife would make and act on her own decisions, regardless of the shift leaders input, but would keep these actions hidden from
the shift leader as it could lead to conflict. The midwife in such situations was often attempting to avoid such conflict or the possible ‘order’ to act differently. This appeared to be a significant method of practice for midwives working in the CLU environment and to an extent some working in the MLU environment, particularly those which have been pervaded by CLU culture.

7.6. Being on the same side

Belonging to a group was important to midwives and an integral part of their working life. It was apparent that belonging could affect the confidence of the individual. Baumeister and Leary (1995) suggest that the need to belong is a powerful and basic interpersonal need. In belonging the individual gains a group sharing similar goals and interests and in return the individual is valued (Brewer 1991). Choosing to belong to a group can provide an individual with social identification by providing the means to define him or her self (Tajfel 1978; Tajfel and Turner 1986; Skevington 1981). In addition, belonging to and being accepted by desired groups may help the individual to develop enhanced self-esteem (Tajfel 1978).

The individual may belong to groups they have chosen or those which have been imposed by another body, such as the hospital Trust (Brewer 1991). Individuals have their own social identity from which they choose which groups to identify with; this could vary depending on the situation, circumstances and individual beliefs. In terms of group membership, participants belonged to both imposed and selected groups. For participants in study setting A the working group they belonged to depended wholly on allocation by the midwifery
management. Midwives in study settings B and C had chosen specifically to work in a caseload team or at a birth centre. The biggest conflict between group allocation and social identity occurred within the midwives from study setting A, where midwives could be allocated to the CLU or MLU. Here participants working on one area may identify more strongly with another area. Often this social identification occurred as a result of the individual’s ideology and philosophy of care which they felt corresponded with one group more than another. Midwives working in areas where they did not always feel comfortable would associate themselves with other environments. An individual may choose to distance themselves from a group or a role which does not accord with their self-perception (Ashforth and Mael 1989). A midwife working on the CLU still identified with the area she had worked on previously.

“I worked on the MLU for a number of years and although I’m used to delivery suite I still see myself as an MLU midwife” (Anna)

Participants from study settings B (caseload) and C (birth centre) strongly identified with the group in which they worked. For group B, the caseload midwives, this meant sharing a philosophy of care. The birth centre midwives shared the ideals of the birth centre philosophy, but acknowledged that individuals within the birth centre group of midwives did not always share similar philosophies per se.

Various groups existed of which the midwife may see herself as integral part. Throughout interviews midwives could be observed to be identifying closely with certain groups. This identification could be on many levels such as ward,
hospital, Trust or professional groups. Sub-groups within these larger groups were evident, such as certain ideological groups. This was of particular importance to midwives where the overall working team was larger, such as CLU, MLU or birth centre midwives. Sub-groups within these larger groups tended to consist of individuals with whom the midwife identified. Often these were midwives of similar status, experience or methods of working.

Whilst various definitions of groups exist (Turner 1991; McKenna and Green 2002) it was interesting to note that a number of participants identified with the shared ideology of certain groups with which they did not regularly meet. This fits with Turner’s (1982) definition which suggests that it is enough for an individual to perceive of belonging to a group which shares a common identity or ideology for that group to exist. Some participants chose to identify with other midwives who were not necessarily a tangible group but shared similar characteristics and philosophies. This group may not be within the same area or even Trust, but would be a wider group to which the midwives saw themselves as belonging. Two midwives from different settings associated themselves with independent midwives in terms of their philosophies.

The participants who believed they shared the ideals of independent midwives and others who worked in a more autonomous manner, saw themselves as part of this group, though not in a formal sense. Although aligning themselves with these groups, the individuals concerned were not members in the sense of contact with other group members. It was rather by aligning with these groups the individuals were able to confirm or normalise their views when surrounded
in the workplace by others with very different views or ways of working. For these participants the subjective membership of such a group was part of their social identity. It was also apparent that they gained confidence from the knowledge that others successfully worked in similar philosophies of care.

7.6.1. Inclusion

Inclusion in a group was very important to participants. Aside from being formally part of a group, they wanted to feel that others specifically included them. This was the case even if the individual did not necessarily choose to identify with the group they were currently working in.

“It’s nice to be part of a team, to be included…. People don’t exclude you in anything.” (Hannah)

Interestingly the need for inclusion in a group was important even though participants had described using self-isolation within the group as a method of control. This suggests that the need to belong and maintain status within a group is valuable to them. For midwives on the CLU this often required them to appear to conform to the group norm and ideals, yet covertly they sometimes worked around guidelines and accepted practice. The midwives who used self-isolation were doing this in a controlled way. They were aware that standing out as ‘alternative’ would mark them out for greater scrutiny and also bring them into conflict with senior staff. This conflict could undermine their confidence. It therefore benefitted them to work ‘unseen’ within the group. This could be what Packer (2008) terms “passive nonconformity” whereby an individual does not strongly identify with the group or the groups norms. However, they do not
overtly oppose or dissent within the group. This allows them to be part of the group whilst not formally promoting the group as a whole.

Midwives often made assumptions about others and their similarities to themselves. This was often demonstrated by the language midwives used, often referring to “us” or “we” in the context of different midwifery groups.

“We all do that, don’t we?” (Jemma)

All the participants at some stage referred to the interviewer and interviewee as “we”, indicating inclusion in a sub-group as part of the research. All midwives seemed to assume that I was similar to them in some way. Whilst some of the midwives in study setting A knew me and could make assumptions, none of the midwives at the other study settings did. It was interesting that they all appeared to accept that I would have similar views and understanding as them. A possible explanation for this was that I shared some commonality of experience with them in terms of my status as a midwife. Hence, I gained credibility and acceptance from belonging to the same professional group.

It was important to midwives’ confidence to be part of a group sharing the same philosophy. It was apparent that groups containing individuals of similar philosophies assisted each other in building or maintaining confidence. Whilst this was evident within all areas, close knit groups benefitted the most.
“Working as a team, working with a group of midwives....Who all have the same sort of philosophy and knowing, not just that, but knowing that we support each other whatever.... has a big impact.” (Sara)

“Camaraderie always good on MLU which leads to increased confidence in abilities.” (Siobhan - Diary entry)

The caseload team stood out within this study as a very strong cohesive and self-contained unit that had fostered fairly good working relationships with other groups and professionals. However, it was apparent that this had taken a number of years to develop with the support of senior midwives and consultants. The participants from this setting worked together very closely as a team. The support they gained from this they believed allowed them to develop their practice and work in a more autonomous manner. One participant commented that she would not have been as confident if she had continued in the role of team midwife. This environment in particular appeared to foster the development of confidence. This has also been reported elsewhere in relation to caseload teams (McCourt and Stevens 2009).

Inclusion in a group was often a positive aspect alone in maintaining confidence. In addition, the active support of a group could play a key part in building confidence. Midwives would often turn to others within their chosen group to rebuild their confidence after a negative event.

“When you have a little crisis of confidence, you will talk to your friends and colleagues and they will say, ‘you’re a good midwife, you’re a fantastic midwife’. So we do try to support each other by saying things...
like that. ‘You’re a really good midwife’ when you’re, we’ve all been there, ‘I don’t want to do this job any more, that’s it I’ve had enough’, “no, no you’re a fantastic midwife, you’ve got such a lot to give, you’re really good at your job’, and all those things.” (Katy)

There were some potentially negative effects on confidence in being part of a group. Fitting in with the culture of the group in which the midwife worked could leave the midwife balancing her own ideology with the need to be supported in the unit. Midwives were sometimes resistant to changing their way of working between groups but they often did so to maintain the status quo. Whilst they were aware of factions and dissenters within certain groups, they recognised the need for groups to be able to function effectively. One midwife commented on the need to train new staff, in particular junior doctors, in the philosophy of the unit in order for the team to function effectively.

“I mean you do, don’t you? you have to get them into the mindset that the unit’s in.” (Sara)

For some midwives belonging to a group was simply a matter of location and some areas seemed to operate a strict inclusion or exclusion criteria based on this. The CLU at study setting A had a sense of exclusivity about it.

“If someone moves from the MLU to delivery suite they are then welcomed into the little delivery suite club ((Laughs)) They’ll have forgotten that they were the one that was on the MLU needing the support of the midwives on the delivery suite and that’s just, that really undermines people’s confidence.” (Fiona)
Midwives moving off the CLU they are quickly dismissed from the ‘delivery suite club’, despite the fact they may have worked closely with members of that team for years. Other midwives also commented on this, some apparently offended by the speed at which they are rejected.

7.6.2. Exclusion and isolation

Whilst none of the participants wished to be excluded per se, they were happy to be excluded from certain groups as long as they remained included in the one with which they chose to identify. A caseload midwife could see some advantages to being excluded from the CLU. She recalls having worked with many of the midwives in the CLU previously, but now that she works in the caseload team she is, to some extent, an outsider.

“Even though people know you well, you’re a bit of an outsider because of what you do.” (Laura)

She feels this can in some ways be an advantage, as it makes her more approachable to students and other staff as she is not in the “clique”. (Laura)

Isolation within groups could occur, but for these participants was not a major issue. Some midwives did describe situations in which they had to “go it alone”, which left them feeling isolated and unsupported.

“I have been challenged on the MLU, we’ve had a chat. We’ve had one of those discussions in the office and I’ve been told that if I feel that way about the protocols and guidelines I should be independent and not work in a hospital.” (Mary)
However, this midwife appears to cope with rejection by taking comfort in the fact she identifies with a larger (intangible) idealistic group. She describes herself as both an “outsider” and a “maverick”. Similarly a midwife working at the birthing unit held similar views seeing herself, to a lesser extent, outside of the group in which she physically worked. Neither midwife appeared to lose confidence, however, both being convinced they were working in a similar style to many other midwives within their perceived ideological group. Ashforth and Mael (1989) suggest it is not unusual for individuals to experience conflict between the various groups with which they identify. When a conflict does occur between their perceived group identification an individual copes by attaching greater importance to the group they identify most strongly with. So, for example, the midwife here may identify more closely with her chosen idealistic group, rather than her organisational one; hence mitigating the issues of rejection from the lower ranked group.

A group itself may face isolation within the Trust environment. The midwives in the caseload team described difficulties they encountered as a new group encroaching on the CLU environment.

“There were times in the beginning, we’re well into our third year now, were times in the past there were sarky comments you know ….. and someone named us the xxxx [name] team ((Laughs)).” (Sara)
7.7. Conflict

It was evident from the data that midwives experienced conflict in most areas of their working life. This was particularly true of confidence with personal, interpersonal and group conflict all contributing to this.

7.7.1. Personal and interpersonal conflict

From the transcripts it became clear that participants perceived themselves pulled in various directions. Not only did they want to be confident in all areas, they also needed to please others. A tripartite struggle exists between the midwife’s self-interest, her position as advocate and carer of women and the interests of the organisation. Midwives were also often placed in a position of mediator between the woman and the organisation. The role of being an advocate for the woman and meeting the needs of the organisation could leave midwives own needs unaccounted for. The organisation is often the strongest in terms of control and the midwife may be obliged to comply with its needs. (Hochschild 2003) The woman, being the weakest in the hierarchical structure, was most likely to lose out.

All participants indicated that they were concerned with providing the best care for the woman. However, both organisational and personal issues could encroach onto this. When it came to confidence issues there appeared to be a strong desire for participants to maintain their own confidence. To some extent this included some degree of self protection. The intention of providing the best care whilst maintaining their confidence could sometimes be at odds within the organisational environment in which they were working. Whilst individuals
consider the course of action with the best outcome for themselves, as midwives they also had to take into account the best outcome for the woman they were caring for. In such situations the outcomes may be in conflict with each other. Participants would frequently put the needs of the woman ahead of their own needs and this could lead to further conflict for the individual concerned. Some participants were clearly prepared to “stick their neck out” (Katy) in order to meet the needs of the woman.

One midwife acceded that in some circumstances she may alter the care she provides a woman in order to protect herself from criticism by a particular shift leader.

“I think sometimes if you don’t have a great relationship with a certain member of staff, particularly a shift leader, it can sort of inhibit. It inhibits me in what I do. I don’t always do thing that I would do with someone else, cos I’m a bit afraid to go and say I’ve done this or I haven’t done this.” (Amy)

Other participants were concerned about the possible comments regarding the care given or the choices they offer to women, often even when the issue was not raised by others. One midwife expected comments from others regarding her decision to allow a woman to labour in the pool following an earlier bleed.

“I felt clinically confident – supportive staff - no eyebrows raised about stopping (good) reassuring CTG [cardiotocograph] for bath/pool.” (Alice - Diary entry)
The mechanism by which a participant deemed their own needs to be more important than the woman they were caring for was unclear. One reason may be to avoid an escalation of conflict. Midwives did allude to a bullying culture which may account for elements of self protection or conformity to the organisation. The ability of senior midwives to influence junior midwives decision-making and practice is already known (Hollins Martin 2004, 2006). In addition, fear of the responses of others to their decisions may prevent the individual from taking on the role of advocate for the woman (Timmins and McCabe 2005). As an employee, the midwife may feel bound by the demands of the organisation over their professional responsibilities to the woman. This may leave the midwife in a position where she has to choose the outcome with the least sanctions for herself.

A further difficulty of this tripartite struggle was the involvement of other individuals. The needs of the woman could bring the midwife into direct conflict with other colleagues. This often occurred where individuals practised different philosophies of care. The midwife would then have to make the, often unconscious, decision whether to acquiesce with the opponent to improve her own position or maintain her position for the woman’s benefit and risk further conflict. If the midwife acquiesces with the colleague then she may initially be acting to protect herself, but this may lead to a decrease in job satisfaction, lowered self esteem, lowered self-confidence and guilt regarding failure to provide the best care for the woman (Chaboyer et al 2001). Alternatively by maintaining her position in what she feels is the woman’s best interests the midwife may leave herself open to further conflict and the potential that the
woman may later change her position. A participant described how she had tried hard to provide a woman with the care she wanted in line with her birthplan, adapting the guidelines to enable this.

“We transferred her, this is the galling bit, within minutes of transferring her she was flat on the bed having diamorphine and telling the midwife how wonderful she was. And this member of staff proceeded to take the previous care apart in front of the husband, myself and her own student so I was really angry about that. I was exhausted trying to work to her birthplan and giving her many options all the way through. I’ve put here [looking at diary] I felt betrayed by the woman and the midwife and I did really and then I began to question the care I’d given.” (Mary) (Bold = participant emphasis)

Another participant described conflict between herself and a midwife in another area.

“Then they start asking questions about the woman and I’m going ‘she’s just labouring’ and all this and they feel that they can interfere....... I know they’re trying to find out if it’s appropriate at this stage of labour. Anyway that drives me mad, knocks my confidence when I ring them and they’re interrogatory.” (Helen)

The balance between the needs of the midwife, the needs of the woman and the needs of the organisation could all lead to conflict and could require a great deal of emotional labour and emotional intelligence by the midwife to maintain the balance of confidence.
7.7.2. Conflict between groups

Being included in a group was important for all midwives to some extent. Between groups there was always some evidence of a “them and us” divide. Often the groups with which midwives identified were part of the area on which the midwife worked. Divisions were evident between areas such as the MLU and CLU at study setting A and C and the caseload team and the CLU at setting B. These divisions could create difficulties for some midwives moving between areas.

“It’s always been a big thing you know them and us and I think that’s always gonna be the case, but I think if you’ve been over and worked over there it does make it a lot easier for when you come back… It does cos you know how the ward’s run, cos you’ve been over there and worked there yourself and when you do phone over and speak to shift leaders or whoever, it does make it easier to talk to them when you’ve seen them and you’ve worked with them yourself.” (Hannah)

From the data it was evident that there was much conflict between certain groups and that this could impact on the confidence of individuals.

“When I say I don’t want it to be them and us it is very much them and us, they just don’t think the same, they’re different.” (Helen)

One participant had described to me an incident between the CLU and the MLU. The shift leader had added a number of names to the delivery suite board which was used to record names and details of women admitted. The midwife
had noticed a number of new women assigned to her and was shocked. She had described that this had affected her confidence as she did not recall being informed about them and was concerned she had not cared for them at all. Later she describes what she sees as the reasoning behind the shift leader’s motives.

“That thing I told you about where on delivery suite the midwife put all those false names on the board, but that was like what we were talking about before, where the midwives wanting to, there were separate little tribes within the hospital where they wanted to protect their own little area. And that the midwife made up all sorts of patients so that she couldn’t accept anyone from the midwife led unit. But really that made me feel awful cos I thought I had another 5 patients. (laughs)” (Fiona)

The terms ‘they’ or ‘them’ were used for other groups, often completely separate groups such as the CLU. These terms would also be used by participants describing other sub groups, within their main group, which they did not consider themselves part of. This was despite the fact they the participants often knew the names of the individuals within that group. The term ‘they’ was often used in a slightly disparaging manner when used to discuss other groups. In some ways this could be seen as a depersonalisation of the other group, promoting cohesiveness in the group the individual belonged to (Tajfel and Turner 1979; Ashforth and Mael 1989). In terms of specific groups all participants were aware of what they termed a “delivery suite clique”. This group generally held the power on the delivery suite and which, interestingly, none of the participants saw themselves as belonging to.
Conflict appeared to focus on the transfer of women or information from one area to another. This was notably from an MLU to a CLU. The midwives at study setting A experienced this as did the midwives at setting C. Caseload midwives did not transfer care to CLU staff, but friction could still arise between the two groups. This appeared to occur when CLU staff had been caring for a woman until the caseload midwives arrived to take over care. One of the main problems seemed to occur due to the perceived status and power of the CLU. All the participants seemed to accept the CLU’s held this position. Midwives who were working or had worked in the CLU environment accepted that they were there to accept transfers when the need for high-risk care occurred. However, this did not prevent criticism of other groups by the CLU.

“It’s a big joke at the minute in the hospital isn’t it? That, you know, the midwives on the MLU can’t know look after the patients well enough and that’s why so many have to be transferred to delivery suite. But that’s not true at all. It’s not that, a lot of patients do get transferred, but it’s because of the criteria that we have for patients to be on the midwife led unit, but I don’t see why the midwives on the delivery suite have such a problem communicating with the midwives on the midwifery led unit cos we’re all supposed to be doing the same thing. But it’s not everybody but there are there are… lots of sort of undercurrents of feeling.” (Fiona)

This criticism was not always contained within the hospital environment. One midwife described how the women she cared for would share details of criticism they had heard with her.
“I hate another thing that happens is other midwives criticise other midwives. The women tell me this, I get so much info off them. The way xxx [the CLU] criticises xxx [the MLU] they’ve even said we don’t know how to take blood pressures at [MLU name]...... sending women in because of raised blood pressure sending them out again ‘oh they don’t know how to take blood pressures at [MLU name]’. Why would you say that about a colleague to a woman?” (Helen)

An MLU midwife describes in her diary how she has to inform the CLU shift leader that she has asked a woman to attend the delivery suite after taking a telephone call from her.

“Then have to run the gauntlet of passing info through to delivery suite.” (Siobhan – Diary entry)

Conflict over transfers could have major consequences for the confidence of the midwife involved. One experienced midwife admitted.

“Sometimes you do dread who’s going to answer the phone, because you don’t always know them and they can be so confrontational and question you about every little thing, and although I must ring and arrange transfer I do double check everything first so they can’t catch me out.” (Katy)

A midwife who directed a woman to be admitted directly to the CLU describes her experience of informing them of the expected admission.
“I was the bleep holder on the MLU and I took the phone call from the woman at home bleeding and she said she’d soaked a towel, a proper bath towel, so ambulance job, come straight to delivery suite. So I spoke to the shift leader who told me in no uncertain terms ‘it was a show’ and made me feel completely stupid..... Really upset on the phone and that was obviously one of my insecure moments and erm. She did she made me feel completely ridiculous on the phone and I took a straw poll of staff in the office and they said oh no we’d have done exactly the same thing and I was still very nearly on the verge of tears and I have to say this person always does get me feeling like that.” (Mary)

Overall, there appeared to be an acceptance of the CLU as a high status area and the individuals working within that area had the same high status conferred on them. There appeared to be an organisational support of this status and the impression given that high-risk areas were more important than low-risk ones. Keating and Fleming (2009) suggest that access to technology and medical aid is valued and accepted as a cultural norm within organisations. Despite acknowledgement of the advantages of low-risk care (Hatem et al 2008), the adopted medical model of care and hierarchical structure still pervades the CLU. As a result, there was a definite power imbalance between the CLU’s and MLU’s. MLU staff believed they were being ‘interrogated’ unnecessarily when attempting to transfer women. Whilst some of the participants acknowledged that this could be justified in terms of the CLU staff being gatekeepers of a busy unit, the manner in which questioning occurred often gave rise to the conflict. Clearly, some of the exchanges described verged on bullying and this was a constant theme in communication between the two areas.
One midwife described a farcical situation with a woman being transferred from one area and back again with each unit citing ‘guidelines’ as the reason for not accepting the woman. The power struggle between the areas is evident at the expense of the woman. This behaviour at the time of a woman’s admission may serve to reduce her confidence in the institution. This in turn may affect her ability to labour.

7.7.3. Managing conflict

Conflict between groups did not appear to be resolved, rather it was accepted as a long standing issue. Midwives were aware of the potential for conflict and were often resigned to the fact that it was likely to take place regardless of their approach. As a result midwives would use various strategies to manage conflict. For some this included making a decision to alter their behaviour. This could take place as a result of conflict with another, but could also occur before such conflict occurred. This pre-empting protected them from conflict, but also compromised the care options they offered to women.

One participant described how a conflict over care had arisen in front of a woman. At the time she felt she had to comply due to the circumstances. Later she wanted to confront the individual but did not feel she could act for fear of later reprisal. She suffered as a result of her inaction.

“I saw her in the corridor later and I wanted to confront her I was so angry... But I didn’t, I knew that I would have to work with her again and she would just give me a dog’s life, so I didn’t but I wish I had. I
This participant went on to describe how she had become angry with herself as a result of her failure to confront this individual. This in turn appeared to have an effect on her self-esteem and confidence in dealing with others. Other participants described colleagues having a similar effect on them, with a similar avoidance of conflict. Waldron (2006) suggests that many individuals will hide their emotions in order to maintain the status quo and the working relationship, particularly where the other person is senior to them. This is important within the team environment in preserving the dynamic of the team. However, for some midwives it was a self-protection mechanism as they knew they would be singled out and possibly victimised for their actions. MacIntosh et al (2010) suggest that women in particular become conciliatory when bullied in the workplace. Although the participants did not in these circumstances consider themselves as being bullied, it is likely that they have affected similar conciliatory responses in order to maintain the status quo.

Where midwives could not avoid situations with the potential for conflict, they would use certain strategies to ensure they achieved the outcome they required. Many equipped themselves with their own arguments before difficult situations such as attempting to pass information on to another area, such as the CLU. For some this included using guidelines as a shield to protect them from the inevitable questioning.
“You can always refer back to the guidelines on the computer and just see if she is suitable. And you can always print that off and have it as a backup in case you need to argue about it, do you know what I mean? Hopefully it doesn’t get to that point but there are times when it’s difficult to move people who shouldn’t really be there, but, that’s what the guidelines are for.” (Hannah)

Others used assertion techniques or, in some cases, were equally confrontational. One birth centre midwife described how she telephoned the CLU to inform them that she has asked a woman to attend their delivery suite.

“So I wanted her to go to the consultant unit to be assessed. Well you’d think I was asking them to pay me 2,000 pounds to see this woman .....I’m very professional on the phone ... And I thought I’m not arguing, this woman’s sat there.. So I put the phone down ... I gave her all the instructions, she had no idea of what had gone on on the other end of that phone...She went out the room and I got back on the phone.” (Helen)

Whilst the midwife has hidden the conflict from the woman she is not prepared to let the matter drop. The midwife continues to be assertive, but is faced with a territorial midwife who is determined that the woman should be seen elsewhere. A confrontation develops with the CLU midwife using her role as CLU co-ordinator to highlight her importance. Whilst this midwife was angry about her treatment, some would face a blow to their confidence in similar situations. The midwife goes on to comment that she expected an incident form to be completed about the incident, indicating she is expecting to be reprimanded for her actions.
7.8. Themes relevant to individual study settings

The data presented so far has been drawn from participants in all sample groups and study settings. The majority of the factors affecting midwives’ confidence appear to be present in all settings. There was, however, one noticeable difference between the settings. This related to the culture of study setting A, with particular reference to bullying, which became evident during analysis.

7.8.1. Bullying

Although many participants alluded to bullying in various guises, it was the participants from study setting A that highlighted this issue. In particular, they related bullying to the CLU and shift leaders in particular. The CLU’s particularly hierarchical structure allowed individual shift leaders a large power base. This appeared to be consolidated by an organisational structure that placed the CLU itself in a high status category.

A number of the participants described feeling fearful or scared in their working environment and intimidation by other staff was evident. This usually took the form of bullying by shift leaders or senior midwives, although some alluded to an organisational culture of bullying. The bullying itself could be overt or, more often, covert and there was a reluctance to name the behaviour as such.

Some participants were fearful of the reactions of others to things they had done. One participant described how junior staff would frequently approach her
for advice in situations rather than the shift leader, whom they were wary of. However, although she would give advice she would be concerned about the reaction of the shift leader when they became aware of this. This was despite the fact that this participant was very experienced in intrapartum care. She described how a shift leader would react, both to her and the other midwife involved.

“Then the more senior midwife has said ‘well who’s told you to do that?’ or the midwife’s then had problems approaching the shift leader later cos they’ve sort of more or less said to them well you went and spoke to xxxx (Midwife’s name) before, why didn’t you come and speak to me? I’ve had 2 or 3 incidents where that’s happened. So that doesn’t help with my confidence or the junior midwife’s confidence, cos I’m then frightened to tell them anything and they’re frightened to come to me in case the shift leader then doesn’t approve.” (Fiona)

She felt that her confidence was reduced as a result of this. This may be because she perceives the implication being that the shift leader does not have confidence in her. It is interesting that the hierarchy of control could affect all members of staff in this way.

Shift leaders on the CLU had the ability to affect the practice of midwives working there.

“I think there’s a lot of bullying goes on and the delivery suite is very hierarchical erm and I think the shift leaders are very ...Erm, what’s the word I’m looking for... They’re very scary for a start, they’re very sure about things aren’t they and they’re not particularly supportive a
lot of them… And they can make you feel very very insecure about practice really. I don’t know whether I’d be this midwife who challenges protocols if I was on the delivery suite.” (Mary)

The CLU had a reputation throughout the Trust that made staff fearful of it.

“It’s definitely the delivery suite thing and people are frightened to come and work in the area. And when they do come they’re frightened of doing anything wrong or frightened of individuals who work in that area.” (Fiona)

This fear could spill over into other areas that had contact with the CLU. One MLU midwife discussed feeling scared to ring the CLU to transfer a woman “for fear of being ridiculed” (Hannah).

An underlying culture of bullying appeared to be evident. It is established that hierarchical workplaces are associated with bullying behaviours (Cleary et al 2010). In addition, bullying within midwifery has been highlighted as an ongoing problem (Ball et al 2002; Gillen et al 2004; Curtis et al 2006b; Hollins Martin and Martin 2010). However, findings from this study highlight the reluctance of midwives to discuss bullying openly. The fears that midwives disclosed when interacting with certain individuals indicated that covert bullying existed. This clearly has an impact on the midwives experiencing it and may account for the greater anxiety midwives at study setting A exhibited in relation to some interactions.
7.9. Conclusion

This chapter has described the main themes arising in relation to midwives’ lived experience of confidence. The themes illustrate the struggle that midwives often encounter in their working lives. Both positive and negative factors were evident in affecting midwives’ confidence. Throughout all the themes, the impact of colleagues was found to be vital to participants’ confidence. It was important for individuals to have trust in their own judgement and in their colleagues. The vulnerability they experience in certain situations is highlighted, along with the coping mechanisms midwives employ in order to protect their confidence and hide their vulnerability. The main factors which affect midwives’ confidence in the working environment and in providing intrapartum care are brought into focus for the first time. These themes illustrate the battle midwives face to gain and maintain confidence in the working environment along with the many strategies employed to facilitate this.
Chapter 8

Discussion
Chapter 8: Discussion

8.1. Introduction

This chapter will synthesise the findings described and discussed in the previous chapters. Initially the discussion will centre on the phenomena of confidence in relation to midwives. Consideration will be given to existing literature surrounding both confidence and self-efficacy; parallels and distinctions will be highlighted. The discussion will then be developed to consider the factors affecting confidence in the context of the workplace environment. This will focus on elements relevant across the themes described in chapter 7. My reflexive position within the context of the research will also be discussed. The chapter will close by considering the unique contributions of this research to the current knowledge base and reflecting on the strengths and limitations of the study.

8.2. The Phenomena of confidence - The Balance

The main aim of the study was to understand the phenomena of confidence from the perspective of midwives providing intrapartum care. The emerging phenomena was that of balance. This balance was evident at many levels, both intrinsic and extrinsic. This balance occurred both within confidence itself; as a balance of cognitive and affective factors that the individual considers in reaching a judgement on confidence. In addition, this balance also occurs in developing and maintaining confidence. The phenomena itself is a balance of competing factors, notably knowledge, experience and emotions which balance in order for the individual to determine their confidence in a task, decision or situation.
A number of extrinsic factors could affect the balance of confidence. These included contextual factors such as familiarity with the environment, situation, task or decision. Cultural factors affecting the setting in which the midwife worked were also particularly important in influencing the balance of confidence experienced by the individual. These factors emerged in response to the secondary aim of the study to determine the factors that affected confidence either positively or negatively and are discussed in greater detail at 8.3.

The balance of confidence was often a sub-conscious one. Despite this sub-conscious state, an awareness of the phenomena of confidence is evident through the way the individual interacts with the world (Heidegger 1962). This is in keeping with the philosophy of phenomenology in which the phenomena is brought into focus through the experience of the individual.

8.2.1. Confidence as dynamic Phenomena

It was evident from the data that confidence is a dynamic phenomena, both constantly fluctuating and event specific. In this, the individual experiences general self-confidence, but this feeling of confidence varies depending on the situation and contextual influences experienced by the individual. This reflects the ‘rollercoaster’ of increases and sudden losses of confidence the participants described. Whilst there is debate regarding general and specific self-efficacy (Scherbaum et al 2006), confidence as described by midwives in this study does not appear to be clearly delineated.
Two main factors contribute to an individual’s perception of their own confidence. These are cognitive in the form of knowledge and experience, and affective in the form of emotions. These are considered by the individual to bring about a reasoned, but subjective, judgement of confidence. Knowledge and development of experience have been found to be essential to enhancing confidence in newly qualified nurses (Crooks et al 2005). Training nurses in specific areas can accelerate development of confidence in that area (Payne et al 2002). Participants in this study clearly believed knowledge and experience to be crucial to confidence development with all describing these in relation to confidence.

Whilst knowledge and experience are cumulative and subject to development over time, emotion can vary considerably. Hence, it is emotion that is largely responsible for the constantly fluctuating nature of confidence. Internal factors such as mood and physical health can affect confidence (Bandura 1997). Findings from this study indicate it appeared to be predominantly external factors which could affect an individual’s emotional state and confidence in a task. These external factors, such as contextual and cultural influences, play a part in an individual’s perception of their confidence. This gives the phenomena of confidence a multifactorial aspect; the essence of confidence being the balance between these factors.

Whilst confidence can fluctuate positively or negatively, many of the findings point to the development of an upward or downward spiral of confidence. In this, a positive outcome provides the individual with positive emotions, which in turn
makes them feel more confident. By feeling confident and envisaging a future positive outcome, the individual is more likely to succeed and gain further confidence. Individuals who are confident are more likely to anticipate positive outcomes, have enhanced initiative and are more likely to continue their efforts in the face of a setback (Schwarzer and Renner 2000; Bandura 1997). Conversely, the reverse can occur with individuals’ experiencing negative emotions and self-doubt as a result of a poor outcome (Bandura 1997). This will contribute to the anticipation of future failure and a reluctance to engage in the behaviour; giving rise to likely negative outcomes and reduced confidence. The presence or absence of confidence can therefore enhance or inhibit motivation (Barbalet 1993). Participants in this study frequently described this spiral both in increasing and reducing their confidence.

Bandura (1997) acknowledges that confidence is more easily lost than gained, and this was also clearly evident in this study. Furthermore, participants in this study indicated that there was a particular fragility to confidence, using terms such as “shattering” or “bursting” the bubble to portray this. There was also an impression that a loss of confidence could occur suddenly and unexpectedly in response to a specific event.

Confidence could vary, dependent on the situation, with the individual being confident in one situation but not another. An important factor however, was the dynamic nature of confidence. Whilst confidence could be affected by one event, there was some indication that this affected an individual’s overall confidence for some time, until they were able to rebuild it. This flow or dynamic
of confidence continued through the individual’s situation in the world, being ever changing.

8.2.2. Confidence or self-efficacy?

From the outset of this study it has been apparent that the terms confidence and self-efficacy are used interchangeably (Schwarzer 1992). During the initial literature reviews, I included literature in relation to both terms. However, it was unclear to me how similar the terms were in relation to midwives’ perceptions of confidence in practice. Certainly Bandura’s (1997) definition of self-efficacy appears more satisfactory than many dictionary definitions of confidence, in that it appears to describe the concept clearly. As this was an exploratory phenomenological study eliciting midwives’ views I decided not to make a definite judgement until after the period of analysis.

The term confidence had been used at the outset and throughout the study, as I believed this was a commonly used term participants could relate to. Although I used the term confidence to describe the study, it was specifically self-confidence I intended to explore. Participants themselves all understood the term confidence to be their own self-confidence. At the outset of the study, prior to my initial literature review, I had been unaware of the term self-efficacy which relates to psychology literature. This suggested to me, as a practising midwife, that it was unlikely that other midwives in practice had knowledge of the term. In the course of the data collection phases of the study it became apparent that my initial conclusions had been correct and that midwives were comfortable and familiar with the term confidence, but not necessarily self-efficacy. I deliberately
did not provide participants with any definitions as my aim was to obtain their views, based on their lifeworld experience, in line with the philosophy of phenomenology. Following analysis it became apparent that many of the key components described by midwives as confidence were analogous to self-efficacy.

The aim of this study was to consider the phenomena of confidence specifically in relation to midwives working in intrapartum care. It did not set out to redefine confidence per se. Despite the linguistic differences in the terms confidence and self-efficacy it was important to consider the participants’ views of confidence in light of Bandura’s (1997) seminal work on self-efficacy. Some participants used the words “belief” or “faith” in oneself and similar descriptions of confidence to those used by Bandura (1997) to describe self-efficacy. Furthermore, many of the participants discussed the development of confidence from similar sources to those described by Bandura (1997); these being, enactive mastery experience, vicarious experience, verbal persuasion and physiological and affective states. However, they did not necessarily attach the same weight to each source. For participants, enactive mastery experience was clearly the main source in gaining confidence. All of the participants acknowledged that gaining experience was a fundamental aspect in developing confidence. Increasing familiarity with the task at hand was important to them, as was achieving good outcomes.

For midwives in this study verbal persuasion by peers was the second single most important factor in gaining and maintaining confidence. Criticism or
negativity could severely affect their confidence. The more highly the individual held the peer, the more likely they were to be affected by their praise or criticism. The effects of peer support are evident throughout the themes identified in chapter 7 and in relation to the overall balance of confidence. As with Bandura’s (1982, 1997) findings, it was significantly easier for confidence to be reduced by peer persuasion than it was for it to be increased. However, this source of self-efficacy was frequently accessed by midwives seeking to rebuild their confidence following a loss of confidence. In this situation midwives would actively seek to gain supportive comments from their peer group, either their working group or a group that they socially identified with. These individuals were often similar in standing and experience to the individual seeking to rebuild their confidence. Importantly, it required significant input in terms of peer support, with many comments from a number of individuals, for there to be a positive impact on confidence. When compared with the single negative comment which could reduce confidence, peer persuasion can be viewed as very influential.

To some extent, participants did utilise vicarious experience in gaining confidence, but less than would be expected from Bandura’s (1997) work. The participants in this study indicated that personal experience and knowledge were vitally important to them in gaining confidence. This may be due to the nature of the role of the midwife in which people, not things, could be adversely affected by misjudgements. Generally individuals overestimate risks, particularly in relation to rare or high-risk scenarios depending on their own experience of them (Hastie and Dawes 2001; Styles et al 2011). Midwives, in particular, have
been found to be more cautious in relation to decision-making than other professions (Styles et al 2011). Midwives in this study appeared less likely to reach judgements about their own ability based on observations of others. Bandura (1997) suggests that social comparison plays a part in vicarious leaning; that is by using self-comparison with another, an individual will make a judgement about their abilities. Midwives in this study did use social comparison. However, this was mainly as a self-appraisal system by which midwives were able to evaluate their confidence and performance in terms of their peer group. Midwives also utilised role models to develop their practice and confidence (Buff and Holloway 2008). These were individuals they had chosen for their particular attributes, including confidence. Vicarious experience was used by participants in developing emotional intelligence (Goleman 1996) through observing the interactions of others. Midwives used information and experience gained through this observation to manage situations to protect their own confidence.

A further source of self-efficacy is derived from physical or affective states (Bandura 1997). This source of self-efficacy has been suggested to be the weakest (Jordan and Farley 2008), but this was patently not the case in this study. Emotion was clearly a fundamental factor and a component of confidence itself as discussed earlier (chapter 6). Physical states, such as tiredness, were described by participants, but appeared to them to be less influential than emotion; although such states could affect an individual’s emotional balance.
Bandura (1997) suggests that all sources and influences on confidence present through the above sources of self-efficacy information. However, midwives frequently described a separate factor that was important to them in influencing their confidence in their working life. This final factor important to midwives, in addition to those described by Bandura, was the effect of the context and culture in which decisions about confidence were being made. Midwives were very aware of the culture and environment in which they worked. Their development and maintenance of confidence took place within this environment and was subject to the pressures of it. This sensitivity to unit culture allowed for midwives’ confidence to be vulnerable to a number of external factors. These included group influence, lack of familiarity with the unit culture, conflict and a perception of little control over situations.

Whilst peer influence in terms of verbal persuasion has been discussed, influence for midwives in this study often arose from non-verbal communication. This was frequently in the form of implied unit practice. This could subsequently affect the individual’s working style and hence confidence. A loss of control or autonomy was often evident in these situations and contributed to a lack of confidence. Similarly, conflict provided an unsettled environment and participants would sometimes adopt a less controversial approach in order to avoid confrontation. Again, this often resulted in a perceived lack of control and confidence. Hence, cultural norms of a unit could have wide ranging consequences for the confidence of an individual. An individual’s locus of control was a strong influence on their confidence or self-efficacy beliefs,
echoing the work of Schwarzer (1992). This sense of control appeared to differ
dependent upon the circumstances the individual found herself in.

Given the evident similarities between the participants’ views of confidence and
Bandura’s self-efficacy theory, literature relating to both will be incorporated into
the discussion.

8.2.3. Benefits of confidence

That confidence, or self-efficacy, is important for work-performance is well
known (Stajkovic and Luthans 1998; Wood and Bandura 1989; Judge et al
2007). Engagement within the workplace is essential for the effective
functioning of the organisation as a whole and for individual well-being
(Schaufeli and Bakker 2004). Self-efficacy is acknowledged to be an important
personal attribute contributing to workplace engagement (Mauno et al 2007;
Xanthopoulou et al 2007, 2009). Furthermore self-efficacy is a motivational
concept in that self-belief in the ability to act and subsequent achievement of
goals encourages the individual to persist in the face of future difficulties
(Bandura 1997; Stajkovic and Luthans 2003; Wise 2007). Midwives in this study
did appear to be motivated and clearly persisted in the face of challenges, as
was evidenced by their continual striving to maintain confidence. A motivated
individual is more likely to engage with colleagues and the organisation.
Xanthopoulou et al (2009) suggest that individuals who are engaged within the
organisation are more likely to seek help or other resources where necessary.
This engagement can, therefore, enhance the learning and development of the
individual, which is required for the development of competence in a given area.
It is important to note that midwives in this study, although motivated, did not apparently engage with the organisation. They did, however, engage with like minded colleagues and did appear to demonstrate confidence in their skills and ability.

Self-efficacy also enables an individual to learn and develop, whereas a lack of confidence increases anxiety which in turn inhibits learning (Denzin 1984; Buchmann 1997). Confidence, in itself, can mediate the effects of anxiety and stress (Saks 1994; Lauder et al 2008). For midwives to be able to develop their clinical practice they need the confidence to engage with the organisation. This will benefit not only the individual, but the organisation as a whole.

In terms of personal benefits, self-efficacy has been linked with self-esteem, an internal locus of control and emotional stability as overall positive self-concept which is associated with enhanced job satisfaction (Judge and Bono 2001). A self-confident approach has also been linked to successful use of coping strategies and enhanced workplace satisfaction (Golbasi et al 2008). Individuals who work within service professions, such as midwives, have been found to be at increased risk of burnout (Schaufeli and Enzmann 1998; Heuven and Bakker 2003). Much of the relationship between these professions and burnout is said to be due to the emotion work individuals in these roles perform. Burnout can be a result of emotional dissonance between the portrayed emotion and the emotion experienced by the individual (Morris and Feldman 1997; Hochschild 2003; Hunter; 2001, 2009, 2010). Self-efficacy is argued to be a buffer to dissonance, with individuals with high self-efficacy better able to manage such
dissonance (Heuven et al 2006). Xanthopoulou et al (2007; 2009) expand on this, suggesting that self-efficacy can enable individuals to cope with many demands of the work environment. It can also increase an individual’s sense of value and optimism, enabling a positive sense of well-being (Xanthopoulou et al 2009). Hence, self-efficacy can be a critical factor in the successful employment of coping strategies. Midwives in this study described a number of coping strategies, both in relation to maintaining their confidence by controlling their environment and interactions and in relation to the coping strategies they used to regain their confidence after a loss.

8.2.4. Focussing on the negative

It was noteworthy throughout this study that although participants were able to provide many instances of when they were confident, they almost always focussed more strongly on situations where they suffered a lack of confidence. Although the study did not attempt to measure confidence, it was evident from their descriptions that the participating midwives did display confidence. Many participants described how they continued to offer women choices which may be outside of the cultural norm for the unit and as a result faced censure. Their ability to persist in the face of adversity, often against cultural norms, further demonstrated this (Bandura 1982, 1997; Schwarzer and Renner 2000). This focus on a lack of confidence, along with their desire not to be seen as over-confident, is of interest.

All of the study participants were female and were similarly negative when discussing confidence. The expression of a lack of confidence is one that
relates to women in society generally (Lenney 1977). Studies of confidence related to gender in medical students have noted differences in female students’ perceptions of confidence (Blanch et al 2008; Nomura et al 2010). Despite being at least as competent as their male counterparts, female students report greater anxiety and self-doubt about their abilities, and are less likely to report their successes or achievements (Hayes et al 2004; Moffat et al 2004; Notman et al 1984). Blanch et al (2008) suggest the reasons for this may include the view that women may value humility over confidence, be more accurate in their assessments of confidence or be more likely to express their anxieties. Women are also thought to compare themselves less favourably to their peers in terms of their abilities and be more sensitive to the context in which the task is undertaken (Lenney 1981). Midwives appeared particularly sensitive to the context and culture in which they worked, which may have affected their confidence in practice.

Participants did appear to be particularly self-critical. Midwives are expected to conform to the expectations women have of them as well as the expectations of other professionals. Some of the participants themselves indicated the belief that they should excel in all aspects of their working lives. These high expectations led to them being particularly self-critical when they believed they had somehow failed. As a result they may dwell on negative experiences as they fail to meet their own standards. However, it may be that their expectations are too high or their assessments of their behaviour and confidence are inaccurate.
A further possible reason for the focus on negative experiences of confidence may be related to the emotions encountered as a result of these experiences. Whilst positive emotions were reported to be present with confidence, it was the negative emotions associated with a lack of confidence that midwives highlighted most strongly. Intense emotions were evident when midwives discussed their feelings in relation to a loss of confidence. Midwives were acutely aware of their emotions, in particular that of anxiety. It has been argued that being emotionally self-aware can reduce anxiety (White 2009). The difficulty for midwives arose in the context in which anxiety occurred. Not only were the participants emotionally self-aware, they were also very sensitive to the emotions and moods of others. This was often most relevant in relation to decision-making. In many cases midwives were anxious, not because of the task or decision itself, but rather they were concerned about the potential response from colleagues. This subsequently impacted on their confidence to complete the task. It may be therefore that the lasting impression of that experience remains at the forefront of the individual’s mind.

Reflection on experience was also important to midwives in this study and again it appeared that the focus was on negative events. The motivation for reflection is often a bad experience (Boyd and Fales 1983). Johns (2009) suggests that it is negative experiences that come to the fore of consciousness; therefore, it is unsurprising that midwives focussed on them. As was evident from the diary data, negative experiences prompted reflection, whilst positive ones were largely accepted without question. Whilst individuals who are accomplished in reflection engage in reflection-in-action (Schön 1991) when undertaking a task,
it was clear that the midwives in this study also engaged in reflection-on-action following a negative experience. This is not to say that the midwives in this study were inexperienced in reflection; rather they demonstrated considerable skill, choosing to return to areas of concern to them. Engaging in self-reflection provides an individual with knowledge on which they can evaluate their ability to deal with potential situations (Stajkovic and Luthans 2003; Johns 2009), hence affecting their confidence. The reflection after the event, as evidenced by the diary data, indicated that individuals returned to negative experiences in order to learn from them.

However, despite the focus on areas in which they suffered from a lack of confidence, participants were continually striving to both protect their confidence and appear confident to others. This would suggest that they do in fact value confidence highly and believe it an important aspect of their role.

8.2.5. Rebuilding confidence

A key and unique finding of this study was the effort it took midwives to rebuild confidence once it was lost or damaged. Sources of confidence/self-efficacy are discussed by Bandura (1997), with facilitation of confidence building discussed by others (Dover and Gauge 1995; Stajkovic and Luthans 1998). However, little attention has been paid to the rebuilding of confidence after a loss. Confidence is initially built through enactive experience, peer support, vicarious learning and affective state (Bandura 1997). However, once lost midwives employed various strategies to regain it. In this context, the main source of efficacy support was that of peer encouragement. Receiving feedback about actions and peer
encouragement has been found to be beneficial to developing confidence in student midwives (Crooks et al 2005; Steele 2009). However, rather than being offered positive encouragement by one individual, it emerged that midwives actively sought out support from a number of their peers. Those they sought support from appeared to be from within the group with whom they socially identified with and who often shared the same philosophy of care. Alternatively, dependent on circumstances, colleagues within their own workgroup and of similar status to themselves were chosen. Clearly, midwives actively chose others they thought were likely be supportive of them in the circumstances.

Knowing they had the confidence of other colleagues helped to enhance a midwife’s confidence. This reciprocal confidence can effectively enhance an individual's own confidence in their practice (Clark and Holmes 2007). Whilst mentors and preceptors have been credited with enabling students and newly qualified midwives to build confidence (Richmond 2006; Licquirish and Seibold 2008; Steele 2009); it is likely that role models and supportive senior midwives do the same. Participants were clearly aware of the benefits of peer support and also described giving this support to others unbidden.

None of the midwives described seeking support from others of differing status, such as shift leaders or less experienced colleagues. Nor did they describe seeking more formal support in this context, such as from a supervisor of midwives or a manager. It is unclear what the reasons were for this. Potentially, midwives felt more comfortable discussing a loss of confidence within their peer group. They may also have had concerns regarding raising
issues of confidence with senior colleagues in case this opened them up to greater vulnerability. Only one midwife discussed having spoken to a manager about an incident. However, she later regretted this as she believed the manager had breached her confidentiality and she feared reprisals from the other midwife involved. It may be the lack of confidence midwives had in the management that prevented them seeking support from them. The emotional nature of a loss of confidence may also lead to a sense of culpability and inadequacy, which can leave the individual feeling isolated and seeking to solve problems independently (Kirkham 1999; Hunter and Deery 2005).

A further strategy midwives used to rebuild their confidence was that of the use of ‘concrete’ evidence. For many this was in the form of established guidelines. This was seen as evidence to confirm that their decision was in accordance with these guidelines. Interestingly, whilst midwives discussed being flexible about guidelines when they were confident in their practice, it was the same guidelines that they relied upon to confirm their practice following a loss of confidence. Guidelines have been seen as an implicit form of management control (Walsh and Newburn 2002; Porter et al 2007), hence, individuals were in a way gaining management support by seeking to prove they had complied with guidelines. This appeared to give them greater credibility and confidence, particularly when faced with opposition. Some guidelines, such as care pathways, have been found to enhance midwives’ confidence (Bick et al 2009; Hunter and Segrott 2010). Furthermore, some participants would seek out evidence in the form of national guidelines, research findings or professional articles for their own peace of mind. It was interesting to note that within the
study settings, local guidelines appeared to have the greatest influence over practice and, hence, were those most often referred to by participants.

A pro-active strategy was used by some midwives who would deliberately seek out similar situations to those which had reduced their confidence in order to meet the challenge. One midwife requested a move to an area to work with individuals who, she felt, reduced her confidence. By doing this she intended to become an accepted part of that group, which she felt increased her confidence to manage these individuals. Others would be cautious of making the same mistake when placed in future situations. Avoidance of certain situations could help prevent a further loss of confidence, but did little to rebuild it.

Time was a significant factor in relation to loss of confidence, with disparity occurring between a loss of and the rebuilding of confidence. Individuals lost confidence quickly, often in response to a single incident or comment. However, it was apparent that the rebuilding of confidence took not only significant input, but a proportionally longer time.

8.3. Factors affecting confidence – The battle
The secondary aims of the study were to understand the factors which contribute to enhancing or reducing confidence in midwives working in different intrapartum settings. These were identified under the themes presented in the previous chapter and will now be discussed in the context of the findings of the study as a whole.
8.3.1. Maintaining confidence within the culture of the organisation

The organisations in which the participants worked were all NHS Trusts, within which exists a culture comprising of shared values, beliefs and attitudes and behavioural norms (Handy 1993; Davies et al 2000). The NHS in particular is comprised of a number of sub-cultures, including management groups, professional groups and divisions or work areas (Mannion et al 2008). In this study it was evident that the study settings experienced some differences in culture, but ultimately all shared certain overarching features, such as management influence on practice. Organisational culture can have a powerful impact and influence the behaviour of individuals working within that culture (Handy 1993). For an empowered organisation, it is vital that the individuals within it are also empowered and possess confidence (Scott et al 2003). It has been suggested that midwives are disempowered in practice by their perceptions of the organisation and the power it wields over them (O’Connell and Downe 2009). The impact of the organisation clearly had an influence on the behaviour of participants and will now be discussed.

It has already been acknowledged that midwives often face a struggle between competing agendas of the needs of the organisation and the needs of the woman (Porter et al 2007; Hunter 2011). However, this study adds a new dimension in that the midwife’s own personal needs are entered into the struggle. The organisation, through senior doctors and midwives, is traditionally powerful, whilst the woman is traditionally passive (Kirkham 1999; Hunter 2006, 2011; Porter et al 2007; Keating and Fleming 2009; O’Connell and Downe...
The midwife is perceived as being pulled in two directions, either providing care which favours the organisation or that which is woman-centred and favours her ideology (O’Connell and Downe 2009). Hunter (2011: 173) describes these ideologies as being either “with institution” whereby the midwife experiences reduced autonomy and an affinity to the organisation or “with woman” where the individual experiences increased autonomy but a more distant relationship with the organisation. Both require emotion work. Midwives in this study were also caught up in this struggle, but factored in their own needs in terms of confidence. It appeared that all the midwives in the study were striving for the best care for women; however their needs sometimes eclipsed those of the women. The struggle is not as simple as it first appears, between the organisation and individual’s ideology. The midwife wants to provide the best care for the woman, but it is not the ideology of the organisation as paymaster that wins out, but the midwife’s own self-preservation. To maintain their confidence midwives needed to strike a balance between their own needs, the needs of the organisation and those of the woman. Midwives in the study evidently struggled with this at times, often making compromises, such as failing to challenge senior midwives or altering their care practices to avoid conflict. Other methods, such as practising in isolation, enabled midwives to attempt to meet the needs of women and themselves in order to maintain the balance required for confidence.

This study highlighted the role of senior midwives as the custodians of the system, echoing the findings of others (Kirkham 1999; Kirkham and Stapleton 2000; Pollard 2003; Hunter 2004, 2005; Timmins and McCabe 2005; Keating
and Fleming 2009). Their role, in many cases, included ensuring the smooth running of the unit. Many midwives perceived them to be acting as agents of the organisation by ensuring practice was within organisational expectations. Senior midwives have been found to be very influential in the decisions and practice of more junior staff (Hollins Martin and Bull 2008, 2010; Hunter 2005). They have also been considered a barrier to assertiveness in the workplace (Timmins and McCabe 2005). This study highlighted the influence peers can have on confidence, but it was most often the senior midwife or shift leader who had the most profound effect on an individual’s confidence. The influence of some senior midwives was clearly wide-ranging within the organisation, often stretching from one area to another. In this way midwives on the CLU could influence the behaviour of midwives working in other areas.

Aspects of the culture in which the midwives worked resulted in them feeling under surveillance, criticised and, in some cases, intimidated. These factors have been identified as features of interactional injustice and linked with negative emotions and a subsequent loss of confidence (Harlos and Pinder 2006). Interactional injustice occurs within the larger domain of organisational injustice and is defined as “mistreatment that occurs in the course of workplace relations between employees and one or two authority figures to whom a reporting relationship exists” (Harlos and Pinder 2006: 258). Midwives in this study perceived a similar type of injustice between senior staff and management and themselves, which resulted in their descriptions of the emotions of anxiety and fear and the consequent loss of confidence they experienced. Perceived mistreatment in the case of the participants in this study
included behaviour verging on bullying from senior staff and the organisation as a whole. Furthermore, there was a clear ‘us and them’ divide whereby the presumption of subservience to management and the organisation occurred. This was described by midwives in all settings, but related to CLU culture particularly. Whilst midwives working in the caseload team and, to some extent, the birth centre believed themselves to be outside of this environment, they all described the influence of the CLU and its culture on practice.

A key element for midwives in feeling confident was when they perceived they had some autonomy or control in their practice. Autonomy is recognised as an essential aspect of midwifery practice (ICM 2011; NMC 2010), and is positively related to confidence in midwives (Hundley et al 1995; Pollard 2003). Pollard (2003) identified that not all midwives desire autonomy, however, all the midwives in this study considered it was necessary for both their role and to maintain their confidence. Whilst it can be said that all midwives have a degree of autonomy (Bluff and Holloway 2008), midwives in this study saw autonomy as being able to make decisions about care which were outside of the guidelines and the cultural norms of the unit. However, this could lead to conflict between the individual and both the organisation and other midwives.

The struggle between the organisation and the individual was evident in relation to the midwife’s perception of their freedom to practice autonomously. An internal locus of control is positively linked to self-efficacy (Schwarzer 1992; Scholz et al 2002). Midwives demonstrated that they did have this internal locus of control in their beliefs that their practice could change outcomes. However,
this was not the case in relation to the organisation as a whole. An obvious difference between midwives working in their own sphere, at a personal level, compared to working within the organisation as a whole was evident. At organisational level participants believed they had no influence over management decisions, therefore disinvested from them. It may be that the effort they placed into gaining fighting for control at a personal level left them no energy to fight at organisational level; even though a change at organisational level may help alleviate the problems they encountered at a personal level. Ashforth and Saks (2000) suggest that individual attempts to gain control may on occasions be counterproductive, as they are often seen as a threat to the organisational authority. This leads to sanctions by the organisation in order to maintain overall control, consequently further reducing autonomy for individuals. Whilst maintaining control at a personal level provided the individual with a means to protect their confidence, it fails to alleviate the culture which is giving rise to the problems they encounter. In this way the culture remains self-perpetuating as there appears to be no challenge to it.

Whilst midwives used control as a method to maintain confidence, they also used other strategies to protect their confidence from the influence of others. Being hidden from view within the organisation by self-isolation was a strategy midwives described, both as a method of self-protection and a way to maintain a degree of control over their practice. One of the ways of doing this was to ensure alignment with the group they were working with. This prevented the individual from standing out and gave them the protection of belonging to a recognised and accepted group of colleagues. Another method was the active
evasion of contact with (some) colleagues and avoidance of information provision to others unless compelled to do so. This reflects the issue of “practising behind closed doors” which was highlighted by Bluff and Holloway (2008: 306) in relation to midwives attempts to provide woman centred care. Others have reported similar methods of practice in an attempt to increase control as well as reduce medical interventions (Crabtree 2004; Russell 2007). The midwives in this study were attempting to provide woman centred care, whilst also protecting themselves from criticism which could adversely affect their confidence.

The practice by midwives of isolating themselves in a physical space in which they felt safe resonates with Fahy et al’s (2006, 2011) theory of birth territory for women. The theory of a physical birth territory is one that allows the woman “to have the power to do as one wants within the birth environment” (Fahy et al 2011: 222). This territory provides a woman with an environment which will enhance her well-being and confidence allowing her to labour (Fahy et al 2011). Midwives in this study were attempting to provide themselves with their own safe environment or “comfort zone” for practice, which shares similarities of being a private space away from the scrutiny of others. Midwives who provided home births indicated they felt more relaxed away from the perceived surveillance of the hospital environment. In providing this space, midwives acted as “guardians” for the women, protecting them from unnecessary intervention (Fahy et al 2011), whilst also attempting to protect themselves and their practice from interference. This ability to practice undisturbed provided
midwives with protection from scrutiny, a sense of autonomy and feeling of enhanced confidence.

To promote choice, support women and facilitate normal birth a midwife needs to be confident (DOH 2003). The midwifery agenda promotes choice for women (DOH 2007; Healthcare Commission 2007). Midwives also have a role in ensuring women are fully informed in making decisions about their care (NMC 2008). Midwives in this study were very aware of this and frequently attempted to share decision-making with women in the manner of the ‘new professional’ described by Porter et al (2007). Varying degrees of success in this were evident, depending on the culture within which the midwife worked. Caseloding midwives appeared to best achieve this method of working to some extent. The autonomy their role provided appeared to enhance their confidence sufficiently to offer greater choice to women (Stevens and McCourt 2002; McCourt 2006). Midwives in the hospital environment often attempted to offer choice, but found themselves thwarted by the organisation and colleagues (Kirkham 1999; Russell 2007; Pollard 2003). An important factor in preserving the midwife’s confidence was to maintain the balance of power between the organisation and the woman. One method of doing this was by the concept of “professional steering” which was used by Levy (2006: 114) to explain how midwives ensured women made choices suitable for themselves and which also favoured the midwife. Midwives used this strategy to protect their credibility and professional territory, whilst avoiding difficult situations and ethical dilemmas (Levy 2006: 121). A difference in this study was that midwives also did this with other midwives, by either withholding or manipulating information as they saw fit. It is
important to note that avoidance behaviours have been linked to a poor sense of well-being when used as a coping mechanism (Gibbons et al 2011). However, it is not clear that this was the case here, rather midwives were using avoidance as a way to maintain control in a situation.

Midwives faced a number of factors in their working environment which could affect their confidence. Some of these fit the term “workplace adversity”, which is “associated with excessive workload, lack of autonomy, bullying” (Jackson et al 2007: 2). Midwives in this study appeared to demonstrate remarkable resilience to this adversity. Resilience, in itself, has been suggested as a means of negating the effects of a stressful working environment (Gillespie et al 2007). Jackson et al (2007) suggest that nurses can utilise strategies to build resilience within the workplace. Self-efficacy has been positively linked to increased workplace resilience (Bandura 1997; Pajares 1997; Gillespie et al 2007). This may be related to the fact that confident individuals are more likely to persist in a course of action, and resilience itself arises through “sustained effort” (Gillespie et al 2007: 435). As discussed, midwives in this study demonstrated the use of a number of strategies which they used to protect their confidence in the workplace. These strategies could have the added benefit of conferring some degree of resilience on the individual. Some strategies already identified as increasing resilience include building collegial relationships, the use of emotional intelligence and reflection on events (Jackson et al 2007) were utilised by midwives in this study. Other strategies they utilised have been associated with increased self-efficacy, such as attempts to maintain a degree of control over their work and environment (Peterson and Stunkard 1992).
Whilst confidence was clearly fragile and easily lost, it is encouraging to note the effort midwives put into protecting and maintaining their confidence.

### 8.3.2. Working practices and differences in culture between the units

All midwives’ perceived similar factors in the organisational culture of the units in which they worked, as discussed above. However, there were some subtle differences between each study setting. The caseload team, MLU and birth centre settings all perceived of themselves as small units within a greater organisation. In particular, the CLU relevant to each setting held the balance of power and was clearly the dominant culture. Although practising differently, the midwives at the individual settings were very much aware of the overall organisational culture which infiltrated their working lives.

Midwives ways of practising varied on a continuum dependent upon the culture of the unit in which they worked. Midwives working in the CLU faced a definite hierarchy (Hollins Martin and Bull 2006; Russell 2007; O’Connell and Downe 2009), whilst midwives working in the caseload team experienced a much more individualised and autonomous approach towards care. Placed between these areas on the continuum were the MLU and the birth centre.

Midwives working in settings with greater autonomy, such as caseload, appeared to maintain an internal locus of control and held the belief that they could influence management decisions. This reflects earlier findings which have found increased autonomy and enhanced job satisfaction in midwives working in caseload settings (Hundley et al 1995; McCourt 2006; Collins et al 2010).
This sample group was the exception, however, with sample groups in all other settings believing they had no control over management decisions. Despite this, some participants from the caseload did describe concerns regarding the opinions of midwives on the CLU and their ability to influence practice. In these cases, they again were practising covertly, behind closed doors, but with the benefit of being an outsider.

Midwives working in the MLU perceived greater autonomy than their CLU colleagues (Thorgen and Crang-Svalenius 2009) and were very much more democratic in their approach; a midwife would often discuss problems in a group before deciding on the best course of action. However, there was some evidence of the hierarchy on the CLU also influencing practice, both through surveillance and the overall perception of the CLU as the dominant area. This reflects the findings of Walton et al (2005) who found problems in maintaining a normal birth environment while in close proximity to a CLU with a dominant medical model of care. Midwives in the birth centre were in a similar situation, but the physical separation of seven miles acted as a buffer to culture overflow from the CLU. However, there was an evident hierarchy within the birth centre, governed by experience rather than grade. Whilst this did not appear as dominant as within the CLU setting, it nonetheless was likely to have an effect on practice.

Despite the very different approaches to care between the settings, there was an overall perception of the organisation as a whole influencing their practice,
through both the overall culture and more specific policy and guidelines which governed their day to day practice.

It is interesting to note that at the outset of the study, initial evidence appeared to point to midwives working outside of the traditional delivery suite environment lacking confidence in their practice (Meerabeau et al 1999; Lavender and Chapple 2004). However, midwives in this study indicated that it was the traditional delivery suite setting in itself that contributed the majority of factors leading to a lack of confidence. This may be because midwives have now become accustomed to providing care in low-risk environments and developed their skills once free of the traditional hierarchical environment. This also echoes Skirton et al’s (2010) recent work which indicated newly qualified midwives felt more confident in low-risk rather than high-risk settings.

8.4. Emotion work
Midwives in this study were conscious of the professional and organisational expectations of behaviour expected of them. As a result they frequently engaged in what is termed emotional labour in relation to their portrayal of confidence (Hochschild 2003). Hochschild’s seminal work explored emotional labour which she related to being “sold for a wage” and emotion work which she determined was used in private and had “use value” (2003: 7). Midwives, whilst portraying a professional persona are expected to provide appropriately focussed midwifery care. Hunter (2005) has explored midwives use of what she terms as emotion work both with women in their care and by student and junior midwives with senior midwives. She found that midwives engage in significant
emotion work, particularly with women, but also to some extent with colleagues. This was clearly reflected in the findings of this study. However, in relation to confidence, midwives described (almost exclusively) emotion work with other midwives. As with Hunter’s (2005) work, the context in which they did this was very much influenced by the culture of the working environment. They described similar strategies to provide the “illusions of compliance” as described by Hunter in relation to junior midwives (Hunter 2005: 260). However, in this study, the utilisation of such strategies was not restricted to junior midwives, but extended to those with many years experience and whom were relatively senior in the hierarchy. Not only were midwives subject to pressure from senior staff, but also faced horizontal pressure similar to the horizontal violence described by Kirkham (1999). Notably, in this study, participants working in hierarchically structured environments appeared to engage in emotion work with colleagues to a greater extent than those working in more autonomous environments. This reflects the findings of McCourt (2006) in relation to midwives’ performances with women.

As with Hunter’s (2005) work, this study reflects the fact that midwives use emotional labour with women and senior midwives. However, it appears from this study that midwives are frequently engaged in emotion work both with peers, other colleagues and management. This indicates that midwives may spend much more of their working time than previously thought managing their emotions. Midwives were aware of the professional and organisational expectations of behaviour placed on them. Organisational expectations often included the requirement of the midwife to adopt a position within the hierarchy
and conform to the group norms of the unit. This allows for the status quo to be maintained within the group or unit (Handy 1993). However, this expectation of behaviour could often be in conflict not only with the individual's personal philosophy, but also with professional expectations such as providing choice. The ensuing personal conflict requires the midwife to engage in emotion work, where the emotions the individual portrays are not those which they feel (Ashforth and Humphrey 1993; Hochschild 2003; Hunter 2001, 2009). However, by failing to act authentically, individuals are likely to suffer from emotional dissonance, which occurs when the feelings expressed are not those that are portrayed (Hochschild 2003; Ashforth and Tomiuk 2006; Hunter 2006). Midwives discussed examples of this conflict in relation to organisational expectations that Trust guidelines are adhered to. Whilst some argued that guidelines were only guidance, participants also often felt that the organisation expected conformity to them. Their professional position required that they offer women choice based on up to date evidence (NMC 2008). Midwives described situations where they conformed to organisational guidelines and suffered emotionally from failing to act in a manner they thought was right. They also described situations where they had not conformed, instead following their own philosophy or what they thought of as their professional responsibility and as a result expected some sort of sanction. This indicates the superiority of the organisation in expecting conformity (Hochschild 2003). By conforming to organisational expectations, midwives can experience dissonance between their feelings and the portrayal of what is expected of them. It is this emotional dissonance that can lead to stress and burnout for some midwives (Hunter 2005).
8.4.1. Presenting confidence

Midwives were very concerned with their outward appearance and how this was interpreted by others. Confidence was seen as a positive characteristic and one which could confer some degree of emotional protection within the workplace environment. In order to appear confident they often made a deliberate and conscious effort to project confidence to both women and other colleagues. This is similar to the presentation management first described by Goffman (1959). Tetlock and Manstead (1985: 60) suggest that presentation or impression management arises as individuals are “highly sensitive to the social significance of their conduct and are motivated to create desired identities within social encounters”. In creating the desired presentation Goffman (1959) suggests that individuals utilise certain acting techniques. Hochschild (2003) identified two specific types of acting that individuals employ; these being deep acting and surface acting. Goffman’s presentation management relies on the individual employing surface acting techniques (Hochschild 2003). In this, the individual projects an image that they wish to portray, whilst not attempting to match their own emotions to the display. It was clear that, in this study, midwives utilised surface acting in order to project a persona of confidence that they did not feel. This differs from emotional labour in that the individual does not attempt to match their emotions to their outward presentation. However, given that there is a disparity in emotion and presentation it is likely that emotional dissonance occurs in a similar manner to that described by Hochschild (2003). It is suggested that the inauthenticity of the performance affects individuals by virtue of the emotional dissonance experienced (Ashforth and Humphrey 1993;
Midwives discussed the presentations of confidence that they employed with women and their relatives. This type of presentation management has been identified as a means for the midwife to cope with the demands of their role (Deery 2009). In this study it appeared that the motivation for this presentation was sometimes paternalistic, used in order to protect the woman by portraying a calm exterior in an emergency situation (Cooper 2001; Walsh 2005; Porter et al 2007; Persson et al 2011). When utilised with other colleagues, impression management was used as a shield to protect individuals from exposure to criticism or attack, which would reduce their confidence. This type of presentation management has been described as defensive, triggered by negative emotional states, in order to prevent a loss of an individual’s established image (Tetlock and Mansfield 1985). Impression management may also be used pro-actively to enhance the presentation of the individual to others (Goffman 1959). It is likely that midwives in this study used this type of self-presentation to integrate within a working team by adopting similarities of behaviour to others within that team; thus enabling them to adopt “in-group” identities. This in turn allows them to gain acceptance and trust within that group (Flynn et al 2001).

It is interesting to note that midwives used presentation management extensively with colleagues. Using Goffman’s analogy of the stage, the audience towards whom the midwife directs her acting would be the woman,
with her colleagues being “back stage”. In this back stage environment the midwife would be able to relax and cease the performance. However, this was patently not the case for the study participants who indicated that much of their presentation management is aimed at their colleagues. Much of this presentation management aimed to project a confident persona to others. An appearance of under-confidence can lead to questioning about an individual’s competence (Ogden et al 2002; Kröner and Biermann 2007). By successfully projecting a confident image an individual is less likely to be subject to questioning or surveillance of their activities and more likely to be allowed a degree of autonomy. This in turn allows the individual greater flexibility in practice and to be accepted as a valued team member. The fact that midwives were very aware that they were managing presentations to others may explain their fear of being “found out”. This may be particularly heightened by the surface acting techniques used which did not require them to attempt to feel the emotions or confidence they were portraying. Hence, they were aware of their inauthentic presentations.

8.4.2. Using emotions to manage confidence

In managing situations with colleagues within the workplace it was evident that midwives were skilled in using emotional intelligence. Salovey and Mayer (1990) introduced the concept of emotional intelligence, which has subsequently been developed by others, notably Goleman (1996, 1998). Emotional intelligence is attributed to five main areas including “knowing ones emotions, managing emotions, motivating oneself, recognising emotion in others and handling relationships” (Goleman 1996: 43). Individuals with
emotional intelligence possess skills in all of these areas (Fineman 2006). It has been suggested that those with emotional intelligence display a greater range of social skills and can be more socially effective (Mayer et al 2000).

Goleman’s (1996, 1998) accepted theory suggests that individuals have the capacity to recognise not only their own emotions, but the emotions of others with a view to managing interactions. Whilst emotional intelligence has been subject to considerable criticism, particularly in terms of its marketability as a commodity (Fineman 2006; Bulmer Smith et al 2009), its basic attributes do resonate with the way midwives manage interpersonal interactions within the workplace. Participants were clearly aware of both their own emotions and those of others, enabling them to utilise emotional intelligence within the workplace (Goleman 1996; Fineman 2006). This was aimed at colleagues and management rather than the women they were caring for. The midwives in this study demonstrated skill in managing colleagues and their relationships with them, with the aim of ensuring the most desirable outcome for themselves. Midwives descriptions of choosing which individuals to seek advice from, avoidance of others, or changing their practice to meet shift leaders expectations are all evidence of this.

A link is suggested between successful use of emotional intelligence and well-being (Ciarrochi et al 2000; Schutte et al 2002); the assumption being that the ability to manage emotions enables the individual to maintain their self-esteem (Schutte et al 2002). Managing emotions allows for positive affect to dominate, giving rise to enhanced self esteem and confidence. Patterson and Begley
(2011) suggest that use of emotional intelligence by midwives can help them to cope with the demands of the role. Midwives in this study used emotional intelligence to influence situations and individuals in order to gain some control or autonomy in their practice and working life. It is unsurprising then that this method of coping can have positive consequences, given the importance midwives place on autonomy (Sandall 1997; Thorgen and Crang-Svalenius 2009).

8.5. Reflexivity

As highlighted from the outset in this thesis I have attempted to maintain a reflexive stance, by bringing my pre-conceptions and fore-structures of understanding into plain view. This is in keeping with the Heideggarian phenomenological approach. It has been important to address these pre-conceptions at every stage of the research process and through the writing of this thesis. During the conception, planning and data collection phases of this study I worked in part as a clinical midwife at one of the study settings. Having worked there a number of years I was immersed in the culture and it was enlightening for me personally as well as professionally to examine my own views. Whilst I actively challenged my pre-conceptions in this setting, I was less aware of my pre-conceptions of other settings, such as the birth centre and caseload team. Some of these were so entrenched that I only became aware of them through the data collection process, when I began to challenge these pre-conceptions. I believe these views were as a result of a lack of familiarity with the study settings and their philosophies of care and gaining insight through the study participants enabled me to examine my stance.
I do strongly believe that my background and experience has enabled me to reach a much deeper understanding of the data and phenomena explored. During analysis I was further able to illuminate my pre-conceptions and explore the data with greater clarity of understanding. My horizons fused with those of the participants, enabling me to reach an interpretive understanding which I believe does justice to their data.

8.6. Unique contribution to knowledge

This study contributes to knowledge through the following:

- This is the first time that midwives’ experiences and views of confidence have been explored in an in-depth phenomenological study to gain understanding of the phenomenon. The diminutive amount of previous literature relating to confidence with this study population has been restricted to measurement of confidence, rather than study of the phenomenon itself.

- This study highlights the, previously unknown, importance midwives place on confidence. The understanding of the fundamental nature of confidence is pivotal in understanding why midwives act or practice in certain ways.

- The study has exposed the fragile nature of confidence and the efforts midwives make to rebuild confidence. The articulation of confidence as a fragile phenomenon is a new finding. This understanding can assist in developing recommendations and practices to enable confidence to be maintained in the working environment.
The study builds on understanding of the reasons why midwives conform to the bureaucratic model “with institution”, rather than ideology “with woman”. These concepts are already well known, however, this study demonstrates the importance of confidence as a contributing factor. In particular, midwives see confidence as vital to their practice and will adapt and sometimes compromise their practice in order to maintain this confidence. For some, this means compromising their ideals in terms of philosophy to protect themselves and their confidence. This may ultimately affect the care and choices offered to women.

The study has provided valuable insight into the factors that affect midwives everyday confidence. Factors that positively affect confidence include; interactions with colleagues, familiarity, feeling in control and inclusion within a group. Negative factors include; interactions with colleagues, feeling helpless or lacking control, a lack of familiarity, feeling under surveillance or other scrutiny and conflict. Understanding these factors may inform management strategies to help maintain midwives’ confidence in the workplace.

The study has also provided insight into the strategies midwives employ to protect and maintain their confidence, including the adaptations they make to their working practices. These strategies and adaptations include; emotion work, including the use of emotional intelligence to influence situations and events; controlling behaviours, particularly around environment and space, information provision to other staff and interactions with other staff; acquiescence when needed to maintain confidence and avoid confrontation.
• Midwives’ well-being is largely ignored within the ambit of the maternity services. This study suggests that often the culture and working environment existing within some settings can contribute to a lack of confidence. Other, more supportive, settings can promote confidence which subsequently can enhance choice and care for women. Although all midwives in this study identified similar factors affecting their confidence, it was evident that those working in small supportive teams believed their confidence to be enhanced in this setting.

• A further unique finding of this study has been confirmation of the feasibility of the use of reflective diaries to collect sensitive data within this study population. Prior to this study, reflective diaries had been little used within phenomenological research with health professionals. The study findings indicated that not only were these successful for data collection, but also that they were appropriate for capturing data in this difficult setting. This finding has resulted in the publication of a methodological paper to disseminate this finding (Bedwell et al 2012). (Appendix 9).

8.7. Strengths of the study

A number of strengths were evident in this study, which are highlighted here.

• The use of Heideggarian phenomenology as the theoretical background for the study allowed me to gain an understanding of confidence in the context of intrapartum care. As anticipated earlier in the study process confidence was largely intangible and constructed through interpretation.
I maintain my belief that the essence of confidence could not have been captured using Husserlian phenomenology. The rich data generated by the use of diaries and in-depth interviews provided insight into both the phenomena and the context of the midwives working environment. Triangulation of data from methods and settings adds to the strength of the study, confirming an unexpected consistency of views.

- The novel use of diaries in the context of a phenomenological study adds to the methodological strength of this study. The diaries allowed for the contemporaneous capture of data which may otherwise have been lost. This finding contributes to knowledge in terms of appropriate methodology within the theoretical perspective of phenomenology.

- The inclusion of three different settings and four study groups provided insight into midwives’ experiences of confidence across a variety of approaches and philosophies of care provision. The midwives in these areas did practice differently; however, they all described similar issues in relation to confidence. The triangulation of data from the three settings indicates a consensus in relation to both the phenomena of confidence and the factors affecting confidence for participants providing intrapartum care.

- A potential strength of the study was that I was a midwife working clinically in the NHS, with knowledge and experience of the culture of intrapartum care settings. The participants often used terminology and discussed practices with which I was familiar. I was able to easily understand this information, without interrupting the flow of the narrative in interview.
8.8. Limitations to the study

Some limitations to the study were identified and will be clarified here.

- Recruitment to the study relied upon individuals volunteering to participate after receiving written information. It is possible that only motivated midwives who perceived themselves to be confident may have volunteered to participate, therefore being unrepresentative. However, all of the participants not only discussed areas in which they lacked confidence, but also tended to focus on these areas.

- All the midwives recruited represented the same midwifery banding (pay grade), with the exception of one team leader. None of the shift leaders from the CLU participated or expressed any interest in the study. There is therefore a lack of representation from this group who were often viewed as influential in promoting or reducing confidence in the participants. Some of the midwives working at the MLU and birth centre did take on the role of shift leader in those settings. They expressed similar views in relation to confidence as midwives who did not take on this role. This may have been because they also worked in a subordinate capacity to shift leaders at least some of the time in practice. The one participant who worked solely as a team leader also shared the views of the other participants in relation to confidence and factors affecting it.

- No male midwives were employed at any of the Trusts taking part in the study. Hence, they have no representation in the data. It may have been interesting to explore their views in terms of gender differences in confidence. However, they are currently a very small proportion of the
working population (0.4%, NMC 2007) and therefore not representative of the profession as a whole.

- The study was carried out at only three study settings within the North West of England. This and the phenomenological nature of the study prevents the findings from being generalisable. It is feasible that the findings uncovered as part of this study relate only to these particular midwives working in these particular units. However, findings of this study have been presented nationally and internationally and have apparently resonated with the audience (see page 14 for a list of presentations). This has been clear from the discussions that have occurred as a result of the presentations, which indicated that other midwives share similar views and experiences.

- As a midwife working in one of the areas in which the research was carried out, I was steeped in the culture of the unit. This may have had an effect on my interpretation of data from this setting. To counter this I have, as far as possible, taken a reflexive stance throughout. I am mindful of Heidegger’s interpretive approach and value this experience as being part of the interpretation process. The inclusion of other study settings also helped to keep me grounded and focussed on the data as a whole, rather than that of the setting I was familiar with. In terms of recruitment, I am unsure as to whether being known to midwives in this setting had any effect either to encourage or to dissuade midwives from disclosing to someone they knew. I did however, gain rich data which demonstrated similar themes to that form the other settings. I would
therefore assume my presence as a researcher and to some extent an insider, did not influence participant’s disclosures in a negative manner

8.9. Conclusion

This discussion has synthesised the overall findings of the study as well as highlighting new areas of knowledge. Confidence has been considered in light of the self-efficacy theory, finding similarities in many of the sources of self-efficacy. The difference in emphasis midwives place on these sources have been made clear. In addition, the contribution of both culture and context of the environment have been highlighted as crucial to midwives’ confidence. The fragility of confidence and the time and effort midwives place on maintaining and rebuilding confidence has been discussed.

The importance of culture and the position of the midwife within this have been examined in relation to confidence, taking into account the various strategies midwives have developed to maintain confidence in various settings. Control, with its strong association with self-efficacy, was a key feature in midwives’ perception of their confidence. Emotion work, in particular the self-presentation of the midwife as a confident professional, has been considered. Emotional intelligence as a method of influence and management in the workplace provides an explanation for some of the decisions and working practices utilised by midwives.

In keeping with the phenomenological basis of this study, I have situated myself by my reflexive stance. Transparency within the research process has also
been ensured by acknowledging the overall strengths and weaknesses of the study itself.

This study is the first to explore midwives’ views and experiences of confidence and examine the phenomena itself. As a result, the importance midwives place on confidence as well as key features, such as its fragility, have been uncovered. Additionally, the study has provided insight into the factors that affect midwives’ confidence in the intrapartum setting and the strategies midwives employ to manage these factors. These unique findings add to the knowledge base in this area.
Chapter 9
Conclusion and Recommendations
Chapter 9: Conclusion and Recommendations

9.1. Conclusion

This study has explored and elicited the lived experiences of midwives providing intrapartum care in relation to confidence. The main aim of the study focussed on the phenomena of confidence itself whilst the secondary aims focussed on midwives’ experience of confidence and factors that impact on confidence in the intrapartum setting. The study findings have demonstrated fulfilment of these aims. The overall study design allowed for the capture of views of midwives working under different philosophies of care and settings. Interestingly, they shared similar views relating to confidence and the factors which affect it in the working environment.

The use of phenomenology as the theoretical underpinning to the study was instrumental in discovering the essence of the phenomena in the individuals’ everyday lifeworld. As a result, the study has provided insight into the phenomena of confidence as a dynamic, fluid concept which is easily lost but more difficult to gain. The fragility of confidence was frequently highlighted by the study participants and it was evident they were aware that confidence could be so easily lost. It was the emotions generated by this loss of confidence that brought it to the mind of the participants. Emotions were strongly associated with confidence and were a crucial determining factor in an individual’s sense of confidence. A further crucial factor was that of knowledge and experience of the individual. This was largely achieved through enactive mastery experience (Bandura 1997). It was evident that a balance between emotions and knowledge was required for confidence to flourish. Furthermore, confidence
was also a balance between internal and external factors, such as the context of the action or decision.

Despite the diversity of settings, cultures and philosophies in which the participants worked, surprisingly similar factors affected their confidence. These factors often shared commonalities in relation to collegial relationships, personal control and emotion work. These stemmed from organisational influences, and were a significant factor affecting their confidence, regardless of the setting. The overall perception was that of midwives struggling to maintain their confidence and their individuality within the system.

The hierarchical, traditional systems of intrapartum care provision appeared to be particularly influential in negatively affecting midwives’ confidence. Whilst these were less evident in areas of low-risk care provision, they remained manifest within hospital and high-risk care settings. Many of these systems appeared to be supported and enforced by senior midwifery staff. The limited literature available at the outset of the study indicated that midwives may lose confidence in moving from these traditional systems to provide low-risk intrapartum care. However, this study indicates that this may not be the case, with study participants indicating that they believed themselves to be confident in low-risk settings. Much of this confidence stems from their perception of themselves as autonomous practitioners in this setting. However, over the course of this study the division between low-risk midwife-led care and high risk consultant-led care has become more apparent in the clinical setting. It may be that midwives have now regained their skills in the low-risk setting. This is
positive for the future of midwifery-led care provision, but remains concerning for midwives who continue to work in a hospital environment.

At the outset of the study I anticipated findings would be related either to confidence in tasks or to global confidence per se. However, the findings indicate that confidence is more important and embedded in midwives lives than I had previously envisaged. The majority of the data indicated that confidence was crucial in decision-making and this was where midwives felt a lack of confidence most acutely. Key findings included the dynamic nature of confidence, its fragility and the effort midwives put into building and maintaining confidence. The cultural and contextual influences on confidence provide insight into some of the factors which shape midwives practice. The findings from this study resonate with previous literature in relation to culture and philosophy of care. I suggest that these findings related to confidence provide further insight and understanding into midwives working practices and the impact of confidence on these.

This study also incorporated an evaluation of use of reflective diaries as a method, finding them to be a feasible and useful method of data collection. They suited the exploratory nature of the study, allowing participants’ thoughts to be collected and to inform the subsequent interview phase of the study. The success of the diaries in capturing the emotions and thoughts of the participants in a timely manner was one of the strengths of the study. It is hoped that this methodology will be considered by others for use in future studies of this nature.
This study is the first to explore the meaning of confidence through the lived experience of midwives working in the intrapartum setting. It has provided an understanding of the phenomena and the influences of the working environment. This understanding has highlighted the factors that can affect confidence, resulting in a number of recommendations for practice. Furthermore, this exploratory study provides a basis for further research, which may be developed either within this study population or the wider multidisciplinary team. It also provides valuable insight into the difficulties midwives face in maintaining confidence and how this can affect their perspective in providing intrapartum care.

9.2. Implications and recommendations for practice

The study findings emphasise the difficulties midwives face in maintaining their confidence when providing intrapartum care for women. Confidence is clearly vital to midwives in the workplace and required for their practice. Whilst confidence is dynamic it is also fragile and hard to rebuild. It is therefore important that midwives are supported to maintain their confidence in the working environment. As a result of this study and the insights gained, a number of recommendations can be made relating to leadership, education and support in practice.

9.2.1. Leadership

It is vital that leaders within the organisation understand the importance of confidence to the individual. It is acknowledged that managers can have a crucial impact on the confidence of their subordinates (Corbally et al 2007). This
understanding is essential in managing individuals, teams and units, particularly in relation to change within organisations when employees are likely to feel disenfranchised. Managers need to be able to understand and manage expectations of midwives in relation to confidence. This is important in terms of changes in working patterns, team management or even rotations within the unit where the individual may face a lack of confidence in unfamiliar environments.

Leadership initiatives which include educational aspects with reference to enhancing confidence/self-efficacy could be important for key staff. This study reflects Bandura’s (1997) position that it is easier to reduce confidence by peer criticism than it is to increase or restore it. It is important therefore that key individuals, such as shift leaders, are able to recognise that placing an individual in a situation which has the potential to enhance their confidence is more beneficial than consistently placing them in situations likely to reduce their confidence.

Appropriate feedback from managers is also an important area to be addressed. Study participants frequently believed the only feedback they received was negative, yet indicated that positive feedback helped them to gain and maintain confidence in practice. This study highlighted midwives perceived need for a degree of positive feedback, which in itself is known to increase self-efficacy (Gibbons et al 2011). Supervisors are often in a position to provide feedback in respect of excellence observed in practice (Paeglis 2012). It would also be a relatively simple positive intervention to implement. Moreover,
showing appreciation of staff by thanking them for working through difficult periods or conditions is likely to enhance their sense of worth and self-confidence.

The handling of incident reviews within the organisation is one in which the management can play a part in showing strong leadership. Study participants felt that critical incident reviews were punitive, although they are designed to be an open non-blame process within the NHS. There was also evidence that others used these reviews to highlight the actions of another in order to publicly castigate them. Strong leadership within the organisation will return these type of reviews to the intended non-blame process and ensure that participants in them are treated equitably.

9.2.2. Education and training

Education and training would help prepare midwives at all levels to understand confidence and the implications of confidence on practice. The current provision of education is focussed on skills provision and competence. Being competent in a skill or task does not necessarily mean the individual will utilise that skill in the clinical situation. It is suggested that providing training and education may help individuals develop self-efficacy in the workplace (Stajkovic and Luthans 1998). It is necessary for educational and training courses to facilitate the development of confidence, if new skills are to be incorporated into practice. Scenario training or vignettes may be an appropriate, non-threatening environment in which to introduce and make transparent the concept of confidence to course participants. This could be introduced into the various sessions within in-service training days which qualified midwives attend on a
mandatory yearly basis. Educating individuals to have an understanding of the impact of their actions and the language they use in interactions with others is important. In particular, raising awareness will enable individuals to gain insight into this important aspect of the effects of various interactions on their, and others, confidence.

It is important to prepare undergraduate midwifery students effectively by acknowledging that they will face challenges to their confidence in practice. Incorporating coping strategies into the educational programme may help to provide students with appropriate means to manage confidence in practice. Both mentors and preceptors for newly qualified midwives need to understand the importance of supporting the neophyte midwife to gain and maintain confidence in the clinical environment. Enthusiastic newly qualified midwives can bring ideas to revitalise practice and drive the profession forward. It is important that these are not lost through a lack of confidence to act on them.

Positive role modelling in the clinical environment can be one method of helping midwives to develop confidence in the clinical setting. Experienced, confident midwives should be encouraged to act as role models for others. Also midwives should be encouraged to seek out role models for their own practice and strive towards gaining confidence in the clinical environment.

9.2.3. Support in practice

Within midwifery, organisational support appears to be paramount in fostering the right environment for midwives to develop and maintain confidence. This
study highlighted the fact that even experienced midwives can suffer a loss in confidence and the triggers for this were similar for all the participants. Support is probably the most important single issue in the maintenance and development of confidence. The best model of support would incorporate collaboration between midwifery supervisors, peers and management. This three headed approach could provide individuals with support necessary for particular situations.

The management of an organisation are influential in the culture it adopts. Trust management groups need to be aware of the necessity for midwives to maintain confidence in order to provide the best care to women. For this an acceptance and understanding of needs of individuals in relation to confidence is imperative. Incorporating change and management of the communication of change to staff is important in enabling and supporting them to maintain confidence in both themselves and the organisation. A supportive culture is likely to encourage individuals to engage within the organisation. It is suggested that individuals who are engaged within the organisation are more likely to be self-efficacious and seek help or other resources where necessary (Xanthopoulou et al 2009). Hence, the culture of the management in terms of support for staff is important for the whole organisation, as well as the individuals within it.

Managers can support individuals to develop confidence through appropriate use of the annual Personal Development Review (PDR). Such reviews can be used to provide appropriate feedback. These can be used as a supportive
forum for individuals to raise concerns and individualised training needs or support can be put in place.

Supervisors of midwives are already an established formal support mechanism within the workforce. Although supervisors act independently of their employers, many supervisors in practice are also managers. Often contact with a supervisor is initiated due to clinical issues or outcomes which are a cause for concern. It is likely that midwives who seek out supervision in these situations will already have suffered emotionally and this will affect their confidence in practice. A supervisor is ideally placed to provide support to the individual, acting as both a role model and source of peer support. This route also provides scope for midwives to be given support to rebuild confidence when it has been lost. It is important that supervisors are aware of the importance of the individual maintaining (appropriate) confidence in the workplace. An understanding of this could be incorporated into the Preparation of Supervisors of Midwives course.

Participants described informal peer support networks which they had developed themselves over time. However, newcomers to an area may not have this network in place and as a result feel isolated and unsupported in what can be a difficult environment, especially if they fail to conform to unit expectations and practice. A more formal, but small scale, peer support network of identified individuals may assist a midwife in this situation. It would be important to differentiate this from either management or formal supervision. Peer supporters would ideally be drawn from a number of areas, thereby having an understanding of the problems midwives face in practice. It is important that
these networks are available to experienced midwives as this study has demonstrated they often face issues relating to confidence, but may be uncomfortable raising this outside of their peer groups for fear of appearing inadequate.

Overall, it is important for midwives to have a network of support at various levels, so that they may access the one that is most suitable for them and their situation.

9.3. Implications and recommendations for further research

This research study was exploratory in nature, focussing on a little researched area. As a result some recommendations for further research can be made.

This study sought to uncover the phenomena of confidence and factors which may affect midwives’ confidence. Whilst tools exist to measure confidence, they are often flawed, are not based on empirical data and are often focussed on specific tasks. The findings from this research could inform future development and evaluation of a tool to be used with midwives in practice to assess confidence. Findings from this study indicate a dynamic nature to confidence and the development and use of any tool to measure confidence would need to take this into account. Whilst tool development is a difficult area, there is potential to incorporate a qualitative element to enhance its usage. This tool could be utilised in a formal setting, such as supervision meetings which have the advantage of being a non-management focussed supportive interaction. It could assist in focussing on individual needs, highlighting areas where
individualised training may assist the development of confidence. It could also be used to uncover the early stages of burnout.

This research has highlighted many factors in the working environment that can affect confidence. These findings could be used to develop a programme of clinical scenario training. This could be included in the current mandatory training and provide a safe environment to explore issues that affect confidence. It would expose and raise consciousness the issue of confidence in the clinical setting, allowing it to be discussed openly. Such training could focus on interactions, communication skills and the use of language within these situations, which can all affect confidence in the clinical setting.

This research has focussed specifically on midwives working in the intrapartum setting. It is likely that the factors that affect midwives may also affect others in the team. Encompassing other professionals in the multi-disciplinary team would add to the holistic view of confidence. An understanding of the confidence issues of various groups may add to improving multidisciplinary working and relationships between the various professions.

This research has uncovered midwives’ perceptions of confidence in themselves and, to some extent, in others. The findings in this study indicate that midwifery practice and the choices offered to women may be affected by an individual’s confidence. However, the impact of individual confidence on women’s perceptions of their care has not been explored. An exploration of
women’s views would provide further understanding into the impact of confidence and how it may affect the care experienced by women.

9.4. Closing Remarks
Throughout this thesis I have focussed on the experiences of midwives in different settings. Whilst subject to many influences on their confidence it was both uplifting and inspiring to witness their capacity to place women’s needs before their own. I hope that this study has highlighted the difficulties midwives face in relation to maintaining confidence. Personally I have gained enormously from the process of completing this thesis. Not only has this study increased my knowledge, but it has enabled me to consider and illuminate my own prejudices and understandings. The study itself has never ceased to be interesting and challenging and I have endeavoured to do justice to the rich data provided by the participants. In conclusion, I believe that this study has contributed vital knowledge and insight into midwives’ experiences of confidence in the provision of intrapartum care, which can be used to inform future practice and research development.
References


Hughes AJ, Fraser DM. (2010) “There are guiding hands and there are controlling hands”: student midwives experience of mentorship in the UK. *Midwifery.* (In press) doi:10.1016/j.midw.2010.03.06.


Metcalf, A., Haydon, J., Bennett, C., Farndon, P. (2008) Midwives’ views of the importance of genetics and their confidence with genetic activities in clinical


Dear Colleague

You are being invited to take part in a research study considering midwives confidence in providing intrapartum care. The study is considering the views of midwives working in different environments across three sites in order to gain a range of views.

We are looking for the views and thoughts of midwives working in the intrapartum area; in particular their views of how working practices and personnel affect midwives confidence. We are not measuring your confidence we are just looking at your views in general of how you feel confidence may be affected, either boosted or reduced by certain factors.

Please take time to read to enclosed information sheet and feel free to contact me with any questions you may have. If you are interested in taking part or would just like to talk about the study please contact me in confidence on xxxxxx or by email on xxxxxx

Thank you for taking time to read this.

Carol Bedwell
Research Midwife
Appendix 2

Participant Information Sheet (Version 3 November 2006)

**Midwives, Intrapartum Care and Confidence.**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. If you would like a full copy of the protocol please contact the researcher (see below) Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

1. **What is the purpose of the study?**

   We are trying to find out more about what midwives believe affects confidence when they are providing intrapartum care.

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

   We are inviting midwives who are currently involved in providing intrapartum care to participate in this study.

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

   No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw from the study at any time and without giving a reason.

4. **What will happen to me if I take part?**

   There are 2 parts to the study. You can take part in one aspect, both aspects or no aspects, it is up to you.

   **Part 1**
   If you decide to take part the researcher will ask you to complete a diary for a period of 10 working days. The purpose of the diary is to make notes about when and what you encounter that you feel can affect confidence. It is up to you what you record.

   **Part 2**
   If you decide to take part you will be asked to spend up to an hour of your time talking to a researcher about your views and opinions of factors affecting confidence in midwives providing intrapartum care. If you are willing to participate the researcher will arrange to meet with you at a time and place which is convenient for yourself. With your permission the interview will be audio taped to ensure all the important information is obtained.
5. **What are the other possible disadvantages and risks of taking part?**

The main disadvantage in taking part in this study is that it may take up some of your time. However, the researcher will be flexible to the demands on your time.

It is possible that the research may bring up sensitive issues. In this case counselling will be available for any participants who require this. If any issue is highlighted that gives the researcher extreme cause for concern regarding patient safety this may be disclosed in accordance with Trust policy. It is stressed that this would be in the extreme and would be discussed with the participant prior to any disclosure. Except in this case confidentiality will be observed at all times.

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

There will not be any direct benefits to you from taking part in this study.

7. **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions [telephone number]. If you remain unhappy and wish to complain formally, please contact xxxxxxx

8. **Will my taking part in the study be kept confidential?**

If you consent to take part in the study your confidentiality will be preserved at all times. Any information obtained will be kept confidential. To protect your identity a study number will also be used on all data. In any reports transcripts or audio recordings you will not be identified by name. Audio tapes will be transcribed and checked as soon as possible. They will be kept until analysis is complete and then deleted. This is in case there is a need to revisit the tapes during the analysis stage.

9. **What will happen to the results of this study?**

You will receive a summary of your transcript and be invited to amend and comment on the interpretation provided by the researcher. The results of this study will be presented and published in professional forums and journals. The researcher intends to use the results as part of a submission for PhD. If you wish we will send you a copy of the results.

10. **Who is Organising and Funding the Research?**

The study is being organised and funded by xxxxxx and xxxxx.

11. **Who has Reviewed the Study?**

The study has been reviewed by the xxxxx Local Research Ethics Committee and xxxxxx.
12. **Contact Details:**

If you require further information about this research please do not hesitate to contact the researcher, Carol Bedwell on xxxxxxx.

The Research Team: xxxxxxxxxxxx (Professor in Midwifery and Women's Health)
Carol Bedwell (Research Midwife)
Appendix 3

CONSENT FORM

Title of Project: Midwives, Intrapartum Care and Confidence

Name of Researcher: Carol Bedwell

1. I confirm that I have read and understand the information sheet dated November 2006 (Version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

4. I agree for anonymised quotes to be used in future presentations and publications.

_________________________  ___________________  ___________________
Name of Participant                       Date                      Signature

_________________________  ___________________  ___________________
Name of Person taking consent (if different from researcher) Date                      Signature

_________________________  ___________________  ___________________
Researcher                                      Date                      Signature

When completed, 1 for participant; 1 for researcher site file.
Appendix 4

06 December 2006

Miss Carol Bedwell
Midwife

Dear Miss Bedwell

Full title of study:  Midwives, Intrapartum Care and Confidence
REC reference number:  06/Q1501/162

Thank you for responding to the Committee’s request for further information on the above research and submitting revised documentation.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<tbody>
<tr>
<td>Application</td>
<td></td>
<td>29 September 2006</td>
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<tr>
<td>Investigator CV</td>
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<tr>
<td>Protocol</td>
<td>1.0</td>
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<tr>
<td>Covering Letter</td>
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<td>29 September 2006</td>
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<tr>
<td>Interview Schedules/Topic Guides</td>
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<td>Advertisement</td>
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<tr>
<td>Letter of invitation to participant</td>
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Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

| 06/Q1501/162 | Please quote this number on all correspondence |

With the Committee’s best wishes for the success of this project

Yours sincerely

Dr
Chair

Email:

Enclosures: Standard approval conditions

Copy to:
Appendix 5

Midwives, Intrapartum Care and Confidence  (Version 2 July 2006)

Diary Schedule

You are being invited to complete a diary to gather your thoughts and ideas of what affects confidence in your working environment. This information is to help us understand how the working environment can affect confidence. The diary is to cover a period of 10 working days, when you are providing intrapartum care to women. Your entries may be detailed or broad in scope. You may write as much or as little as you wish.

Questions to consider throughout the day:

In which clinical situations did I feel confident?

In which clinical situations did I feel less confident?

In which interactions with others did I feel confident?

In which interactions with others did I feel less confident?

Looking back on your day, which factors overall do you feel affected your confidence?
Appendix 6

Midwives, Intrapartum Care and Confidence

Interview Schedule (Version 1 July 2006)

INTRODUCTIONS
The interviewer will thank the participant for attending and will attempt to make them feel as relaxed as possible. The interviews will be held in a place chosen by the participant wherever she feels is most convenient, comfortable and non-threatening.

SETTING OF GROUND RULES

- Explain Study
- Explain tape recording & transcription
- Explain study numbers/confidentiality
- Explain names will not be used or changed if appropriate
- Explain can stop at any time
- Explain can refuse to answer question
- Opportunity to ask questions
- Consent
- Fill in questionnaire
- Check tape

The interview will be semi-structured the following areas will be explored. These questions will guide the interview however the direction of the interview will be respondent led.

How did you feel completing the diary? Explore reasons for inclusion of events.

What do you understand by the term confidence?

What does confidence mean to you?

What are your thoughts on how confidence is affected in the workplace?

Consider areas around:
Technology
Staff - individual and group dynamics
Women/relatives or others
Procedural factors – guidelines etc
Autonomy
Complaints/litigation
Outcomes
Experience/training
General environment/work

How do you feel factors outside of the working environment affect confidence in work?
Appendix 7

Diary Transcript- ‘Mary’
Completed on MLU

Entry 1
I was asked to assist with a ventouse delivery on MLU. Myself + senior colleague had diagnosed OP position but registrar felt that position was OA. The delivery was conducted in the emergency room on the MLU with appropriate equipment available for OA delivery. I was unfamiliar with new equipment and had not been present at an instrumental delivery for at least 12 months. I was conscious of becoming a dr’s assistant and was less of a support for the woman than I should have been. Delivery -> ventouse -> OP position. Difficult delivery.

Confidence issues
Should have trusted my own VE and been more assertive ie delivery to have taken place on D/S. Also should have been familiar with equipment.

Entry 2
I cared for Arabic woman who did not speak English at all. Lucky to have student m/w present who could interpret. Able to conduct care without needing VE since progress was obvious. Physical signs were enough. Very satisfying experience for myself + the student. The woman + husband reported being happy with the case.

Confidence issues
Quiet ward + good staffing therefore able to practice midwifery in my “ideal” way. No pressure to report progress or to run between rooms which can become very tiring.

Entry 3
MLU
Care taken over with a woman who was just -> from E/L to active labour. She was tired after a long night and ketotic – had been vomiting >10 times during the night. The woman had a birth plan which expressed strong ideas about being active and not wanting opioid analgesia. At the end of a “long” shift – ketosis had been addressed via IV fluid + small snacks after anti emetic therapy. She had mobilised around the room with beanbags, birth ball etc. Progress arrested at fully dilated and the woman became upset and aggressive insisting on no analgesia + knowing a definite time for delivery. It was decided that contractions would not be sufficient to expedite delivery and transfer was arranged to D/S for augmentation. Within minutes of the transfer the woman was
flat on the bed, having diamorphine and telling the midwife how wonderful she was. This member of staff proceeded to take the previous care apart in front of the husband, myself + her own student midwife. After an exhausting shift trying to work to the woman’s birth plan and giving her many options all the way through I felt betrayed by the woman and the midwife taking over care. I then began to question the care I had given and wonder if I should have done anything differently. She had expressed strong views to me when I took over care about what she wanted to do and had then become docile and compliant when on D/S – a completely different woman. Reading this back I sound bitter + twisted which is not the case really. I felt that a colleague had been unprofessional to criticise care without taking a full handover or reading the notes. (I am still angry when I write about this now) However I was very pleased to find that the couple had a normal delivery within a few hours, and when I spoke to her the next day she had felt glad to have gone through what she considered to be an empowering 1st stage of labour. I hope this experience doesn’t make my care alter, in as much as I hope to help women to have the kind of birth experience they want. On reflection – It does occur to me now that I may impose my own views too strongly. I do tend to feel that colleagues always know the right thing to do at the right time – my own insecurities surfacing here.

Entry 4
MLU
Took phone call from a woman at home reporting to be actively bleeding ie towel (bath) soaked and clots passed into the toilet. Arrangements made for immediate transfer to D/S. I rang through to the shift-leader to warn her and was told it was probably a “show” and slowed her to make me feel like an idiot. A straw poll of other staff reassured me that I had done the right thing but I was still very nearly on the verge of tears! Absolutely ridiculous, I know, but this particular shift-leader always has the ability to make me feel like this. I find many other staff on the same ward have the ability to make me feel like this too – they have a very condescending attitude. However when I’m on the ward working with them their attitude is different – I am completely baffled why!
Reading back; these comments make me sound childish + I am struck me how insecure I can be sometimes. A few harsh words can reduce me to question every little thing I do.
Entry 5
Cared for a woman with OP position who tried everything to have a normal vaginal
delivery – every position possible, - she tried. She needed a forceps delivery in theatre
once she became tired and pushing did not appear to be effective. She was well over
the “action” line on the partogram when I did an ARM because all the signs prior to this
were that delivery was imminent. Ultimately she had a >4hr 2\textsuperscript{nd} stage. However at the
time I felt the care given was in partnership with the woman since she was trying
everything possible to have a vaginal delivery without assistance. The woman and the
baby were coping very well with labour, even what would be classed by LWH as a
prolonged 2\textsuperscript{nd} stage.
Intervention was called for by myself only when the woman became fatigued. In the
event, the FH was good throughout, no signs of distress + the delivery was a
straightforward forceps delivery. On reflection I did feel under pressure to conform to
the lines on the partogram for “alert” and “action” but since both mother + fetus were
fine felt justified in trying to help her have the delivery she wanted. I am expecting to be
questioned about the length of time on the delivery summary for the 2\textsuperscript{nd} stage and am
hoping to be confident in justifying my actions, but on the other hand feel annoyed that
I will have to justify my practice. The graph we use is not evidence-based. Colleagues
did not all feel they agreed with my practice and I am not sure a junior colleague who
felt the same would be able to “go against the norm” in this situation. In this case
confidence has come from experience, both clinical and academic and a strong
motivation to be a woman’s advocate.

Entry 6
I looked after someone in the pool Multip, 2\textsuperscript{nd} baby, nasty forceps delivery last time so
quite anxious. Rapid progress and she was delivering in the all fours position. This was
my 3\textsuperscript{rd} pool delivery so I called a midwife in to be present at the birth. I assisted at the
delivery, all was well, with the confidence that the 2\textsuperscript{nd} midwife was experienced and
would interject if needs be. Afterwards I found she had no experience of pool birth.
Since I hadn’t helped with all fours in the pool before I would have been a lot more
nervous if I’d have realised.
On reflection I have decided that if I had been concerned in any way I would have
initiated action so it wasn’t really an issue – however it has struck me how colleagues
can affect your confidence both positively and negatively. She also must have had
confidence in me to allow a pool delivery on her shift (she was shift-leader) without
feeling that she had to be an expert herself.
Entry 7
PPH of 1500 mls on MLU after uneventful first stage. The situation was managed well, in my opinion, especially when the registrar insisted she stay on the MLU for suturing – which was not an option. The woman was transferred to D/S where the handover had obviously been given by a disgruntled registrar.
Several comments made by the midwife were disparaging of the case ie 1500ml EBL “so they say” meaning by the MLU staff. Another comment made at the desk in front of other staff with regards to the woman’s learning abilities was quite inappropriate.
I have emailed the midwife to talk about the case but have to report being fearful now of possible repercussions. ie I hate confrontation of any kind but feel strongly that this attitude is endemic now and MLU staff are being constantly undermined. I had a discussion with the MLU ward manager who then approached D/S manager to speak to the midwife (without asking permission first) – Unfortunately I feel this will exacerbate the situation, however, I do feel strongly that this sort of professional bullying cannot be allowed to happen.

Entry 8
I was “taking the baby” at a delivery with the woman in all fours – proceeded to shoulder dystocia with the fetal hand by the head. I took the decision to extract the posterior arm because it was quite obviously outside the vagina and appeared to be the quickest and easiest option. One manoeuvre and the baby was delivered - thankfully without apparent damage. Since then after the ACE review I have become less confident that I did the right thing. It was suggested that McRoberts + suprapubic pressure should have been done 1st (however the notes did not make it clear that the woman was in all fours position - - my fault). It has been suggested that the HELPERR acronym is followed in a particular order and now I am not so confident that I did the right thing – when at the time it felt “instinctively right”.

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Appendix 8

Interview Transcript – ‘Sara’

I Can you explain to me how you felt completing a diary?

R: It was quite interesting actually because it made me stop and reflect on my practice which is always a good thing I think. Erm, I found it quite hard to think about my confidence and what had affected it and then once I’d sort of got into it I found it a bit repetitive what I was writing because it was the same type of thing each time. I think a lot of it is to do with the way I work as a caseload midwife so ..I’m different ((laughs)) as it were.

I: I will probably ask you quite a lot about how you work as we go along

R: Yeah Yeah

R: You say you were picking out similar things, how was it that you identified those particular things to write about?

R: Erm.. I suppose it was thinking back to what had happened erm over that period of time and maybe picking out particular events that had happened during that labour that made me stop and think: what was it that affected it, what did I do then, how did I react and was there something that made me act that way. Some of it, I know some of it was to do with which staff were there as soon as you walked through the door and just knowing who the shift leader is made a big difference…Interesting, because I hadn’t really isolated that as a factor before…

I: As caseloading midwife can you explain a little bit about your role?

R: There’s a small group of us a group of six and we look after the most vulnerable and needy women in the borough so erm a lot of them with mental health problems, domestic violence, drug abuse and women who’ve had a previous traumatic birth and we get referrals. So what we do is we do one to one care though I have my own women that I look after, it’s supposed to be 2 one month and 3 another but it doesn’t work out that way((Laughs)) we have far too many. Erm and so I would go and do all their antenatal care at home, she would meet, I work with two other, although there are
6 of us we work in two 3’s, so that if ever I’m not available she will see someone she’s met during her pregnancy. Erm, so when a woman goes into labour whoever is the on-call midwife would go and see her at home, if that’s what she’s asked for, and then if she is in established labour and wherever she’s planned to have her baby she would let her own midwife know, so we do a lot of very close care.. erm Some women may see us and no-one else at all, maybe only see 2 midwives and have a..I think our rate for last year was something like .. in the region of 80, no... 90% of the woman have had a midwife with them that they’ve met before and I think only 2% had a midwife from outside the team. Sometimes it happens if things aren’t going very quickly, say if someone’s being induced we might not get there in time ((Laughs)) you know some women do go off like rockets don’t they. Erm and then we do all postnatal care at home as well, so during that time you build up a really good relationship with the woman that you’re looking after and also the whole of her family, and I think that makes a big difference to me in the way I work and how I feel about my work as well. Before I was a team midwife so we did some shifts in the hospital and some on community and the postnatal visits, but not with the continuity we have now.

I: So do you do home and hospital intrapartum care?

R: Yes, just depending on where the woman wants to have.. what we’re wanting to do is provide choice of place of birth in labour, but at the moment if we have any women who say well I don’t really know, then we say well we’ll plan a home birth and if you want to go in then we’ll just go in, and that’s just how it is at the moment. Our home birth rate was quite high I think for the first quarter of this year, it was 9% so we’re quite pleased with that.......... 

I: That’s nice to decide in labour what they want.

R: yes, because they just don’t know do they, no idea what it will be like. Oh yes it’s like this so I feel ok to stay at home or no I’d like to go in. that’s nice.

I: Can you just explain to me what initial thoughts you have about what confidence means to you?

R: Erm... oh gosh......I think it’s something to do with being assertive, something about being It sort of links to being a advocate as well, I don’t know I’m really struggling actually......I can’t think of anything else actually.....I suppose it means something
about being comfortable with what I'm doing and the way I'm doing things and that I feel comfortable and working in a partnership with the woman I'm caring for … yeah something about being comfortable about it……………

I: There’s no right or wrong answers I’m just trying to get people’s views on it really.

R: Yeah… and I suppose something to do with knowledge erm the theoretical background and feeling comfortable with that as well as what I've got  ((Laughs))

I: Do you want to talk me through some of the entries in your diary?

R: Yeah, Erm the first one was a home birth. It was a woman having her second baby and I hadn’t actually met this woman before erm because she was on the other side as it were, the other three, erm it just happened to be that I answered the phone because the other midwife had been up all night and was asleep so I got to her first. Erm… About the environment making an impact on the labour and this is something I came back to because it’s about allowing a woman to feel in tune with her body and having the confidence, that, for ME ((emphasis)) having the confidence that she is in tune with her body erm and just letting her body get on with it and for this woman home was definitely the place where that would happen and not hospital because of her previous experiences. Erm I just said, as a midwife knowing that a woman is in touch with her body and responding to what it’s doing allows me to feel that I can trust her, and the trust element has a big impact on my confidence levels I think and it was interesting because even though I hadn’t met this woman before I had actually done a couple of postnatal visits in her previous pregnancy. It was a long time ago, but I think because she was at home that had a big impact on her, I think if we’d have met in the hospital that might have been different, erm she would have been acting differently. And I’ve written a bit about working in a close team, we all work in a very similar way and we all have a very similar philosophy, so that even though I hadn’t looked after her I knew what Trudy who had looked after her, I knew where she was at. Erm and that meant that you can quickly establish your relationship because it’s there. ….Erm ok, this goes back to the first point again about there being something important in trusting the woman to know what’s happening and being able to allow her labour to progress and that women who are fearful or frightened or anxious can be difficult to read and might affect how I feel about the labour and it knocks my confidence sometimes, I’ll come to another case later where things can be difficult. Erm, oh yes, feeling especially confident when the second midwife arrives because she was one of my team erm so
we've done quite a few births together, I wrote we dovetail because what one's not doing the other one is and in this situation we er the woman had been in the bath for a very long time and she was obviously getting towards an expulsive stage and erm the FH went down to 60 and it didn't come back up and we didn't have to say what are we were going to do, we just did it together and the felt good because the great confidence that yes we were doing the same thing and it was the right thing to do.... And it was really good after because xx ((name)) was getting out of the bath and everything and I called an ambulance for backup, we didn’t have to transfer because we just got on with it, but talking to the parents afterwards they felt really safe, they weren’t frightened even though the dad had not been quite sure about home birth as soon as the baby was born he was ((unclear)). And I said to him afterwards I said ‘how did you feel that we’d called the ambulance?’ and he said ‘you were doing that to be safe, you were doing what was right’ and that sort of boosted my confidence for any other future time if we ever had to do that again, that....you know maybe the parents might need that pointing out if they got frightened you know this is for safety.. but afterwards the parents , XX ((name)) went off and I did the notes and went back again, and the parents were so passionate and so excited about what had happened that really gave me a boost, it really boosted my confidence...........Oh yeah I talked about what happened with one of the Registrars in the hospital, you know just chatting, and he was saying oh anyone who goes out to a home birth should be able to use a kiwi cup ((Laughs)) and erm I said that if I wasn’t using something regularly then I wouldn’t really want to use it, something like that. But it was quite helpful because it was quite a useful discussion for me and for him as well, I mean he thinks it's really useful if women have births at home because he doesn't have to do anything...Erm yeah.....sometimes when I reflect on things that can affect my confidence either positively or negatively because sometimes I end up thinking what if I had or hadn’t or should I have done something differently and that working as a caseload midwife increased my confidence. Because I see the whole story I’m not handing over to someone else if I see someone in the community or whatever I’m not saying oh you go to clinic they’ll sort you out , ring clinic, go with her, find out what the next step is sort it out and follow her all the way through ........Oh yeah, the woman’s expectations I think, because we have that relationship they expect me to be assertive when they can’t be and that causes me to be or show more confidence, I might not not necessarily feel it but I can put on a brave face at times.

I: And do you think that’s beneficial to the woman?
R: Yes I think so. It's good for me as well because it gives me a push and one of the later entries there's evidence that I'm more able to face up to things. Do you want me to just…

I: Yes, can we just go back to when you said the FH was down to 60 and you just got on with it. How did you feel about that? Did it concern you or did you just not think about it?

R: It was more thinking about it afterwards it was oh good grief ((Laughs)) it went to 60, but at the time we had things to do we weren't watching a monitor or something like that we had things to do we had to get her out of the bath and get her in a different position and all those kind of things and she had been sounding expulsive and was she ready, yes she was, and once she was out of the bath her waters broke spontaneously and that was obviously what was happening the head was coming down quickly but it was just at 60 for a period longer than either of us were happy. But no I just got on with it really and I suppose thinking, reflecting on that made me feel more confident for the future…. ((laughs)) don't happen again, that would be awful. In the end she just shot out I just caught her……………

I: Just talk your way through the dairy, I might just write down some questions to ask you later.

R: Ok….So the next woman was a gravida 4 para 2 who had quite severe mental health problems. She had huge support from her family, her family were fantastic with her and we’ve looked after her and we’ve looked after lots of her family as well so we really know the family very well. She wasn’t actually on my caseload but I’d met her several times. I was on call and I was called by the labour ward co-ordinator, shift leader, whatever you want to call them, erm and told that this woman had just arrived on delivery suite, she hadn’t bothered ringing us and she didn’t really know what was happening, you know, she thought she might not be doing anything but I knew that she’d been really really quick both the first time and the second time so I was quite.. yeah….But the one thing that did make me feel worse was the person who rang me up because you never quite really know what it’s going to be like when she’s on. It can be very nice and it can be can I help you, oh have a cup of tea, other times it can be like she just won’t help at all and sometimes it feels really difficult, you never know quite what you’re going to walk into. So I was getting prepared to just stay in my room keep my head down and not go out looking for anything erm and that can make me feel
undermined and under pressure at times, yeah (%(Laughs)) So I went into the room to see this woman who’d been put on the bed and on the monitor and I ascertained that there was no reason for her to be on the monitor and I got her off it and got her off the bed because yeah. We prepare our women for being active in labour, we say yeah there’s a bed but you don’t have to get on it and we explain to them the reasons why they don’t have to and I said to her do you want to stay on the bed and she said no no I need to be walking around, that make it quicker. And I was thinking oh no I don’t need even quicker (%(laughs)) So she did get up and she was obviously progressing quickly, she had really strong contractions, she was obviously in tune with her body and just getting on with it quickly and erm it’s a bit scary actually because she was jogging on the spot and she was pushing and I was oh no (%(Laughs)) I’m never going to catch this baby but then she decided she would climb onto the bed on all four and she didn’t jog any more but it was I mean as soon as she climbed up she got one leg up and the head was coming out. In XXXX (%(unit name)) we always have a second midwife, I know not all areas do, when I pushed the buzzer I was ahhh whose going to come through the door, who is it, but it was someone that I felt really comfortable with which was nice and also I’ve just made a note that as I walked up to the room I’d seen which doctors were around and that was oh yes, it’s you, good. When she said I want to push I just believed her and she got on with it, I’d only been there about half an hour and she’d been 2 or 3 centimetres but I was thinking I was conscious during the birth of just catching her and even though the hand was under the chin there was a small labial graze and that was something, that was a reflection I’d had previously on another birth where I’d felt erm ……I felt I was maybe too hands on, I’m generally quite hands off, I’m not sure why I wrote that actually but it obviously meant something at the time…. So now what I’ve written is case loading is fab! (%(Both laugh)) erm but when I go onto delivery suite I feel very self contained because we come and go as we’re needed I feel a lot more autonomous and I’m also very aware I like to find out who’s on who’s working so I know who’s likely to come in through the door, I might even approach them and say you know when the buzzer goes will you come in, a couple, I did that last week which was good erm and I said I don’t know that’s because I feel more familiar with them or because we have a similar way of doing things, a similar philosophy of care. I don’t know that there’s a lot about confidence in that but that’s what I’ve written.

I: You’ve said the shift leader can have an impact on the ward itself, do you feel they have an impact on you in some way?
R: Yeah I feel that there are times when I have to be justifying my actions or justifying my lack of actions erm at times I have a situation later which I’ll come to where I said I was not going to put syntocinon up because this woman’s was contracting 1 in 2/3 and they were very strong and her cervix was not opening and putting up syntocinon was not going to do it and I know, I went to the shift leader, a different one I can’t even remember who it was oh yes I can remember who it was and I said look I’m not going to put it up having already discussed it with the Registrar and it was sort of put to me well if you don’t give it you haven’t given her a fair chance and I had given her a fair chance she’d been 4 for 10 hours, she’s not going to go any further with these huge contractions and trying every position in the book erm…but I felt able to discuss it with her where the one I have difficulty with I would have found that more difficult, but perhaps I am becoming more confident and instead of going and asking for advice I’m telling them.

I: Do you think that’s to do with your autonomy?

R: Yes, yes I feel more secure in what I’m doing

I: Do you find when you go in the shift leaders get involved or do they tend to leave you to get on with it?

R: It, there’s a variety. Some will, some will totally ignore you really and not even include you in things like meal breaks and others do sort of make…..some will be great and they’ll spend time they’ll come to you and make sure you go for your, when you’re ready for your meal break just say and others you never see them from dawn til dusk apart from knocking on your door “Can I have your partogram?”

I: Why do they ask for that?

R: To look at it for handover to see what you’ve been doing…..yeah ((sounds resigned)) make sure you’re being a good girl.

I: And how does that make you feel?

R: It goes over my head now erm I think in the past it would have made me want to go out and justify every single action but now I just think no I don’t want to do that, if they want to look at my partogram they can look at it I write on it everything I need to write
on it, plus all the things I don’t necessarily need to write on like who’s in the room and
who’s doing what, who’s rubbing her back and what she’s saying and you know…. And
you see I don’t know whether some of that is to do with case loading or if some of that
is to do with being a midwife you know I’ve only been qualified 5 years so sometimes I
still think of myself as new, but I’m not really it really is stupid to think of it that way but
erm I don’t know if I’d have been this confident if I’d have been a team midwife. I get a
lot of support within our team, we meet up regularly we go out together and we have an
awayday once a year. We talk to each other a lot, a lot, about cases about things and I
know I mean I was in a team for a year before I came out into the case load and er you
know I wouldn’t have known half the things I do about the midwives as I do about the
ones I work with now, I think that’s because we have to be.. we were employed, we
were taken onto the caseload team because of our philosophies rather than our
experience erm and that really has bonded us very strongly ….

I: So you find you get support from the group?

R: yes, very much, very much.

I: Do you find your philosophy clashes very much with the hospital staff?

R: Erm with some of them yes, and I think that’s inevitable wherever you work….Erm
we have 2 consultants who we work with very closely who are very open to being
challenged, very open and it’s policy in our unit that women who’ve had a previous
section don’t use the pool, right, so we’ll get a woman that has had maybe a previous
traumatic labour and birth that’s ended in a caesarean and that may be what she wants
she might want to use the pool, so we’ll say right we’ll see this consultant and we’ll
make a nice plan and she’ll be more than happy for you to go in the pool and we do.

I: So are you saying you choose your person?

R: We would go to A or B and not to C or D …..I mean if we were to come across
someone who was with one of the other consultants and that’s what they were saying
we would say we’ll come with you to your appointment but it may be that you need to
change consultant and we would assist them in that process. Yeah I mean 2 of the
consultants are very very pro stretching the boundaries erm and you can just say no
I’m in charge and this is how we’ll do it (    ).
I: You said before when you’re on the ward you looked at the board to see which doctors are on, how do you feel about how they affect your confidence?

R: Erm, it can very much affect on who’s around, depending very much on how the woman’s labour’s going. I feel quite anxious at the moment because there’s been changes at the beginning of August and having not met them yet and thinking ohh what’s it going to be like, because erm erm a lot of the SHO’s are trained up….I mean you do don’t you you have to get them into the mindset that the unit’s in erm they’ve got to understand all of that and I think it can be quite difficult if they’ve come from somewhere that’s got very different ways of doing things can be really hard. But I felt with lots of the people recently that I’ve been able to get on with them well and therefore I’ve been able to make radical suggestions in care and things rather than just, and to question what they’ve suggested rather than just going with it. I don’t know if I’ve even answered your question there.

I: That’s alright, I was just wondering really how you felt other people affected your confidence?

R: Yeah I suppose They’re [shift leaders] are more direct, we often don’t have any contact with the doctors, hopefully you don’t have any contact at all… erm… and it’s good when you know some of them will come in and say, you know if you’re around and they’re having hand over and the shift leader will so an so’s here this woman’s so and so and this is what she’s doing and she’s with the caseload team and some of the doctors will go oh that’s ok then they’ll not be wanting me and it’s that sort of attitude that they actually see our confidence as well and I’m not saying that they don’t say that about other midwives I don’t know but they do. I’m sure we have a reputation for being quite stroppy and assertive and pushing for normal which can work against us at times because that’s not what we need and that’s not what the woman wants and we can get questioned why are you suggesting that, well actually that’s what the woman’s wanting, you know and it can cause a bit of a hiccup…..

I: Do you think overall you are viewed differently as case holders?

R: Yeah… we just have to put up with it really ((Laughs)) I think because we are who we are erm it doesn’t cause us a problem. There were times in the beginning, we’re well into our third year now, where times in the past there were sarky comments you know ….. and someone named us the xxxxx team ((Laughs)) And one of the
consultants didn’t really help matters by saying if she had someone come to her clinics who had maybe specific needs she’s say we’ll see if the caseload team will take them because they’ll get the best care there. And it’s like NO ((Emphasis)) you can’t say that, that really does not help. We had to take her on one side and say you can’t say that it just puts everyone’s backs up. So. Yeah …Mmm

I: Do you find as a team you debrief and support each other?

R: Yeah a great deal. We have a weekly meeting where as many of us as can get together and erm but even, even aside from that if we’ve been in with someone in labour we’ll always ring and talk to someone about that. Erm or we’ll ring each other during the process... erm last Sunday I was looking after a woman, it was the one who’d been 4cms for hours and hours and wasn’t going to do anything and her cervix wasn’t, it was rigid it wasn’t dilating erm I felt from early in the afternoon that theatre was probably inevitable and not what we wanted this woman was a 16 year old planned a home birth erm …you know she’s been working blinking hard all day and all night and erm getting towards the evening our group leader had to come in a give me her phone because she’s on holiday this week so I had to get her phone and it was quite a relief to go and sit in her car with her and say look this is what’s happening, this is what I think’s going to happen and I’m not going to put synto up and for her to say well yeah it sounds like from what you’re telling me that that’s the best move really erm you know and just to say I’m feeling really under pressure because I’ve worked with this girl all the way and her family and her family are all there and there’s a lot of pressure and a lot of tension at times and just to unload some of that was really good, really good….. yeah so yeah we often discuss cases and say I wonder if I should have done this or should I have done that or what do you think what would you have done and we might all have different answers but it doesn’t matter you know we’re not judging each other we’re just giving a different opinion…. Mmm it’s good, it is it’s fantastic……I wouldn’t do it I wouldn’t work any other way.. The next one was a primip it was just a home assessment that I went to gain a woman that I didn’t know and …she was at home she’d been contracting for a fair number of hours and her mum had rung she was getting worried and scared oh its alright I’ll come and see her it’s no problem and I went to see her and having not met her before, it was about 3 o’clock in the morning, and so I said we’ll just sit down, well I’ll sit down you do what you like, and we’ll see how things are going and I was watching the woman watching and listening to her and I thought oh it looks like this looks like things might be happening here jolly good so we waited and had a cup of tea and a chat and she said ohh it’s getting hard work and I said what do
you want to do and she said I want to find out how I'm doing and I said right ok ..I can examine you and I examined her and she was a fingertip.. not effaced, long and that's something that really does knock my confidence because you're seeing one thing happening.. but it's not happening at all and then she went on.. she stayed at home a little while longer but she slogged and slogged all day right through to the night and she ended up with an emergency section... But I talked to xxxx ((name)) one of my colleagues who'd look after her for the rest of that day and she said exactly the same as me she said looking at her and listening to her you'd think she was 8 cms really she was really closing in on herself and everything and obviously her body was trying to get that baby out and something wasn't right and it wasn't going to come and I can think of several woman and I think because I'm caseload I can think of several women in the same things happened and .. erm... I've got to learn from it and my confidence does grow but I'm still disappointed things aren't straightforward and I think it was building on that and other experience that made me stronger last week with the 16 year old (    ) .... I think because, one big thing was my involvement in her pregnancy and her family erm she lived with her mum and 3 of her other siblings and she also had an older sister, her partner was around a lot and you used to go for an antenatal and for some women you can do it in half an hour but for her it was an hour and a half all the talking well she actually did all the talking and her mum and everything else, erm .. so I was really involved in this family in lots of talking and planning about the birth and she started on the Saturday evening and I hadn't been working but my colleague xxxx ((name)) had been to see her about half past six and at half past ten and at half past three and she's examined her at ... I can't remember now, either half past six or half past ten, and she was about 1, 1 to 2 centimetres and by half past three she'd had enough and she was using the entonox then and she stayed at home until 8 and then xxxx ((colleague name)) rang me and said 'she's going to come in I think she needs an ARM and see what happens then..' Sooo she came in and she was she had the ARM and she was 2-3 at half past ten in the morning and 4 hours later she was 4 but she was contacting 1 in 2/3 really really strong erm so... I felt really strong when the consultant ( ) he's not ( ) he just thinks he's bets he thinks he knows what right for everyone and the registrar when they wanted the synto starting and I said no it's not appropriate and I discussed it with the other midwives and they felt that we should try it but I stood firm and then when the next registrar came through because it took forever and ever and then we got another shift change by this time we had a rising baseline as well and the variability was reduced as well ... and erm, and as soon as I saw him I though oh thank god it's you, we might get some action here erm and he listened to me he listened to explain what had happened throughout the day he didn't just stand and
look at the partogram he said tell me what’s been happening and he listened and he said do you think we need to go to theatre and I said yes I said I think we should have gone to theatre earlier this afternoon and he said well I’d like to just come and examine her and I said well ok come and see her and see if that’s what see if she’ll agree and she said yes that was fine and he agreed with me 4cms and really rigid I mean a woman’s been contracting for hour you expect it to be paper thin and have stretch in it…….And we went and we were pleased that everyone was really nice in theatre and I was really confident here because I knew the whole place and I really understood what was happening and the midwifery staff were people that I liked and I just got on with it.. and they listened to me as well and that made a big difference …..

I: How did you feel about the registrar wanting to examine her?

R: I think yeah it was ok I mean I’d examined her perhaps 2 hours previously and maybe I suppose I was hoping he’d say oh she’s 8cms! Erm… because the alternative in the afternoon was, see if she’ll have an epidural and put the synto up, but having an epidural might stop the contractions and then we’ll have to put synto up so what…. She didn’t want an epidural, well can you not persuade her?... No. It felt fine actually I think because I’ve worked with him a lot……..So it didn’t feel a problem and I was hoping that perhaps miraculously something would have happened erm…. And he I think it was the way he put it across he wasn’t saying well I don’t think you know I don’t think you can possibly tell .. no that was fine, not a problem with him…………The next ones another home birth I looked after this couple in their first pregnancy but I wasn’t there for the birth because I was having some time off erm, she’d been with her first baby she was 8 cms when she went in. We suggested a home birth when she had a miscarriage last year, yeah she had the miscarriage on the day she laboured the day she had her baby this year, she didn’t tell me that til after….. Last year, when she had the miscarriage, I’d already booked her and it was quite nasty she had a lot of pain and tissue stuck in her cervix it was horrible, I’d actually been out to see her at home and got her referred straight in. So this time I looked after her all of the way through she said she’s always wanted a home birth right from the beginning and her partner wasn’t quite sure, mainly because not because he was worried about safety but he was worried about the mess and he was worried about not having any time on his own… Erm so I just looked after them all the way through Jane (pseudonym) had always planned a home birth and Mike (pseudonym) came round to the idea and erm one of the midwives I worked with is on mat leave at the moment and she’d actually looked after Jane when she’d had her last baby and they knew she was on mat leave and how
did she get on, she knew she was having a home birth and she had the baby at home
she had it in the pool actually she got a pool at home, oh did she, really, now.. so that
set them off and they got a birth pool in a box and she had that which was absolutely
fantastic so erm it was very quick and straightforward and she called me out 7 o’clock
one morning and I went out to see her at about quarter past half past 8. She was in the
pool, contractions were really spaced out and she said oh I think I’d better get out, I
said get out then so she got out and they were still really spaced out and I had a
student coming from Liverpool actually and I said can I go and pick this student up and
I’ll give you a ring and see how things are going. And I thought it’ll be later on today
really, so I went and picked her up and they rang me again about quarter to 11 and
Mike said Jane thinks the heads coming now. Oh ok we’ll be there then and it wasn’t
quite but she was back in the pool and she was obviously progressing really well and I
rang the second midwife who rang a third midwife to bring the entonox tubing that I’d
somehow forgotten to put in my bag and she just got on and had the baby so the
student had a baptism of fire got off the train at ten past ten and we had a baby at ten
to twelve, she’d never seen a home birth or a waterbirth so she thought it was fab.
Anyway, so things that helped were knowing the couple from the previous pregnancy,
being comfortable in the environment and I’ve written here with no-one looking over my
shoulder…. Working with a close colleague and trusting the woman to be in touch with
her own body and what was happening. Her labour was much shorter this time I know
she was 8cms when she went in but we supported her at home quite a bit in her first
one…erm……and a good sized baby 9lb 4. It was lovely, yeah lovely.

I: How do you think being a caseload midwife affects your confidence in normality?

R: yeah very much, not that we don’t get women who are high risk and need drips and
monitoring and everything erm, but yeah it has restored my faith in normality and in the
huge variety of normality and it is something to do with seeing the whole picture. Also
seeing women afterwards, we ask all the women afterwards to do a birth story however
they want to do it er that sort of gives you feedback. It might be that it brings up
questions for them they might need to say what happened there, why did you do that.
But talking to them afterwards we always spend some time maybe a week or two or
three or four weeks afterwards talking about what happened in labour

(End of side 1)
I’m more aware of my actions and what affects my actions might have… Which is good. … So the next one’s a bit more complicated a gravida 9 para 4 induction of labour for raised BP with low platelets erm bit quick though. She had her ARM at 10 o’clock, no contractions, immediately started contracting 1:2 and had her baby 51 minutes later… That was nice and quick. But it was good that my colleague, it’s complicated I had someone in clinic and I couldn’t get there immediately and then I had to take this woman home from clinic and my colleague went up to look after this woman and I went as well as soon as I could, so we were both there at the birth which was good. The doctors who were there, the same doctor I had the discussion about the kiwi cup actually, but it was good because I knew they would do the minimum, minimally interfere erm the woman was just listening to her body and just reacting instinctively. We started to get some deep decelerations and so the doctor came in and looked at them and then the woman started making the noises so he just said I think your baby’s going to be here very soon can I examine you just to make sure that is what’s happening. She was 8cms, she’s been 4 half an hour beforehand. She felt in the pat that she’d lost it when she was pushing and she said I’m frightened and her partner and we said everything’s just going along as it should be you’re ok erm so she was just I mean she wasn’t thinking about what she was doing she was just doing and the experience increased by belief in women’s ability to birth instinctively…And yeah another experience of listening to women in labour rather than relying on a VE to tell you what’s happening. And that’s something I know I’ve probably talked about quite a lot but when a woman can do that and just allows things to happen that’s lovely, it’s when they start being frightened or intellectualising what’s happening then you get confused messages, really confused messages……..Right, last one, there aren’t em I’m afraid.

I: That’s alright

R: This was a young woman first baby who I’ve looked after right from the beginning of her pregnancy had lots of social problems, no contact with her mum, has no sisters, didn’t really know anything about having babies and then unfortunately for her, well I don’t know that it was unfortunately because… well, talk about that after, normally we do a birth talk at about 34 weeks but I hadn’t been able to do it with this woman because every time we’d arranged it I’d ended up being with someone in labour. Erm she had, where are we Tuesday, she rang to say that her waters had broken. I was asleep, anyway one of my colleagues, xxxx ((name)), which means it happened on the Saturday not Tuesday, Ok, or was it Sunday I can’t remember anyway. So erm they
waited a bit and then they gave her some prostin on the night erm and she started in spontaneous contractions oh quite a while later so the things that increased my confidence were, knowing the woman and being able to speak to her appropriately and communicate effectively, she tend to go off into her own little world and I had to bring her back to try and explain what was happening, erm, a belief she was responding instinctively and that comes back to not having had the birth talk because maybe if she’d had the birth talk she might have been moiré scared and not got on quite as quickly because she was she was just totally in tune with her body she wasn’t asking what’s happening what’s happening or anything like that she was just doing it and I was quite relieved that she could because I was quite anxious that because of everything else that had happened in this pregnancy that she might find it difficult in labour. Erm, again I got there and she was on the bed on the monitor so I we kept the monitor on because she was induced and she’d had this prolonged pre-labour rupture of membranes erm but got her off, you don’t look very comfortable, would you like to get up ((Laughs)) erm and she walked around for a bit and said oh I’m really tired I want to lie down, can I lie on the floor so I said yeah, how about I get a mat first though so I got a mat a bean bag and a ball and everything and she lay on the floor then she got up on all fours and was moving around and I had already collared two midwives working will the buzzer goes will you come in please. I had the student with me as well but because she’s not from here she couldn’t do anything. Erm I hadn’t been able to discuss syntometrine at all with this woman for the third stage and that’s what I normally happens in our unit we give syntometrine and it was good that the midwife who did come in I was able to say to her I haven’t discussed syntometrine and she said oh that’s alright we’ll just have physiological then. Obviously we had it and if she needed it then we would do it, but she didn’t she just had a nice physiological third stage, a helpful doctor erm because when I got there the doctor had just been in to see her and look at her monitoring and he said oh well you’ll not be wanting me then, I’ll come back in 4 hours. It was about ten past two I think, I’ll come back in 4 hours and see what’s happened, so ok fine and got her up off the bed and she just got on an had her baby quickly at twenty past six. There was a knock on the door at ten past and I just shouted it’s alright doctor we’re pushing, and he didn’t come in and that was fine. The things that decreased my confidence were an unhelpful, unreliable shift leader. That’s the same one I’ve identified earlier. Because we had a really really frantic week last week, my normal hours are 30 hours a week and I did 44 last week. Erm I was the only one on call on Wednesday and we knew this woman was going to be doing something, I had to do visits during the day because the other midwives who had been on call the night before had been out all night. I had to and they were postnataals that had to be
seen they weren’t just antenatalts that could be put off to another day. So our group leader was on holiday so I spoke to our consultant midwife and said this is the situation and she said what do you want to do and I said I want them to know whatever happens they can’t rely on anyone to come in erm until. And she said how about 9 o’clock, you can get your visits done and go home and have some rest and I said ok. So then I got a phone call from one of xxx ((colleagues name)) women who had ruptured her membranes and I had to ask her to go in to be seen on the ward and her partner wasn’t very happy and I had to explain the situation, even if any of us where able to see her she would still have to go into hospital. So I was rung at 7 o’clock that that woman was 4cms and wanted to go in the pool and was I coming I said no I’m not coming…… I’m not coming and I’m not on til 9 o’clock. Oh ok. Anyway someone else had started looking after this woman and I’d spoken to xxxx ((colleague name)) who was her main midwife and xxx ((colleague name)) said I’m not going in til 9 o’clock and I said that’s fair enough … and I was the understanding that they then realised that if they had one midwife in they couldn’t have anyone else … then I got the phone call at quarter past two saying she needs to go to delivery suite. It had been a frantic frantic week and I was very very tired. And although the midwives working were very helpful the shift leader can be very unhelpful because what I walked in to see my woman the midwife who was with her said oh I didn’t know you were coming I haven’t got anything else to do… I mean in retrospect I’m really really glad I was there, but that was just.. And then someone else said I’m not doing very much, we told her we could have looked after but she said oh no caseload like to come in for their own women… so, anyway, that was unhelpful. Actually the student was a bit unhelpful because I didn’t do a VE on this woman and of course she just pushed and she just said to me ‘why aren’t you doing a VE? you’re letting her push’ and I said ‘well if I can’t see anything in half an hour then I’ll examine her’. I could just tell ((Emphasis)) that this woman was doing it. That made me just think Ohh perhaps I should be doing it and then I thought don’t be silly, you know what you’re doing. Erm and the other thing that lowered my confidence was feeling tired, being stressed and feeling stressed about the visits that would have to happen the next day and who would do them because Jo had only gone to bed at half past 3 … that’s just workload stuff…

I: So would you say mood does affect your confidence?

R: Tiredness and thinking about other things that need to be done. Because we’re case loading we’re always having to think about what’s going to happen the next day and whatever. We’re short staffed at the moment because we’ve got someone on maternity
leave and one on holiday, we're having a hairy few weeks really. Usually in the good old days we have 2 on call every day, all day, all night all through the week, whereas at the moment we're struggling and we have one on call quite often and that I find that quite stressful and that can affect my confidence if I'm thinking oh I'm on call and I've got visits to do and what's going to happen with this woman and she's in labour and I'm here an that can be ..... 

I: Just out of interest you talked about the doctor coming round and coming back again 4 hours later, do they do ward rounds on your labour ward or?

R: No, it was just because he said he'd come back in 4 hours and see .. But he wouldn't just automatically come into the room. If I'd have been out of the room he'd have come and found me otherwise he'd knock and wait and say do you need me.

I: Do your shift leaders ever come into the room unannounced?

R: o I don't think so, no…no…I wouldn't expect them to

I: Now when you were talking before you said policies and rolled your eyes, talk to me about policies

R: Well policies. Because we've got a policy that's what's got to happen and they don't take into account that that's maybe not what the women want to happen and that you can't do anything without her consent.. It really really does drive me mad that....we had an incident when we hadn't been case loading terribly long and .. I've got a thing about the third stage I'm quite open about it and if women want syntometrine that's fine but they need to know they have an option erm and I don't think that I can give a woman an injection without having discussed it.. unless she's bleeding bleeding yes fair enough. But because we do the birth talks and we talk about all the stages and we talk about the third stage and what happens and sometimes we'll have a woman who's had a baby before and she'll say oh I was really sick afterwards I couldn't hold my baby I was throwing up and you say did you have an injection, oh I don't remember oh no I didn't have an injection and you look in her notes and you know damn well she’s had syntometrine. And..... So anyway we were having a few physiological third stages and a supervisor of midwives rang me up and asked for my evidence to be offering this to woman, and I said well my evidence is I can't stick a needle in someone without her permission and it was, she found this really hard and I
was a bit worried about it. Anyway it threw up a huge can of worms at the next supervisor of midwives meeting because they realised no-one knew what the policy was ((Laughs)) But it irks me that anyone in a medical role could think they could do anything to anyone without getting permission, and just cos we’ve got a policy, just cos the policy women who’ve had a section shouldn’t go in the pool, doesn’t mean that you know, just because the policy says women who have had a previous section shouldn’t have a home birth .. you can’t make woman come to hospital, you know and if a woman thinks she’s not going to be looked after in a hospital then yes she should stay at home and if she wants to get her own pool then she should do it ...............Yes they’re there but they’re guidelines that’s what I think. They’re there to guide you and make suggestions, but…. You can only explain those to women and if they don’t want to go with it they don’t … that’s it.

I: Am I getting this right that the way you work give you the confidence to stand up for the women around the guidelines?

R: Yeah, yeah I will do definitely.... Definitely.... Yeah.... If a woman wanted to do something and I felt very unsure about it I’d be quite open with her and share that. Erm.... If someone was wanting a vaginal breech at home ((Laughs)) Well that’s quite up to you to do that, let me tell you about my experience and my lack of experience in this area and I’d look at ways of getting support and conf, you know. The bottom line is that the woman understands and ( ) I suppose the thing is making sure they understand both sides and that you’re not putting a slant on it. .... ((Laughs)) I should tell you I’m an NCT teacher as well... so that’s in my background as well, which is where I suppose a lot of it is where I come from about women consenting to care or making their own decisions with the correct information.

I: Do you feel that the way you work affects your confidence in woman’s abilities to make their own decisions?

R: Erm... I don’t know. Maybe it comes from the relationship because you know those women. It’s like the young primip erm with the very long labour and the section, she’d always said from the beginning that she didn’t want an epidural and many hours in she started saying I think I might want an epidural and her mum was you’re not having one you’ve always said you wouldn’t have one as her mum was going out the room at one point I said we know in pregnancy that was the decision she made but know she’s in labour and she’s never been in labour before and if she wants to change her mind she
can change her mind. Erm we will make sure that it is the decision she wants to make but we have to bear that in mind ... and I think I would have found that difficult otherwise because I think I would have sided with her mum if I hadn’t known the girl I think I would have said oh obviously you’ve decided you didn’t want an epidural so oh no listen to what your mum’s saying, whereas I was able to see it the other way ...... She didn’t have one, she didn’t have one. I’d said to her mum you need to have a discussion with her about it you need to talk about it and they did and they had a long chat and er, not, I wasn’t in the room when they had that discussion, and they did have that discussion and the mum said ok fine if that is what she wants to do then I’ll support her but the girl did actually say well I fell ok now, it was the knowing that she could have it probably made her not need it .... You know if someone says you can’t have something you’re more determined to have it aren’t you .......

I: As we’ve gone through I’ve written things down which we’ve more or less talked about anyway, the only other thing and I know you’ve covered it to an extent is the change from being a team midwife to being a caseload midwife and that affecting your confidence?

R: Yeah ......Yeah. I think it’s a combination of facts, working as a team, working with a group of midwives who are all who all have the same sort of philosophy an knowing not just that but knowing that we support each other whatever ... erm.. has a big impact. And the other thing just knowing the women really does change how I feel about things and how I do things and ......I'm much more confident in my ability to listen to them, to listen to them antenatally and in labour as it were ... To let them get on with it, to listen to their fear and also that women are, fell more able to voice those concerns because they know you.

I: Just out of interest, do you feel they’re more prepared for labour because of the way you work with them?

R: Yes, and not only that, they’re more prepared to allow you to work with them through it if that makes sense. Not that for example the woman that I hadn’t had chance to do the birth talk with and she ... I felt that she had confidence in me because I knew her so well that I would guide her through it ....appropriately. Not in a directional way oh no you have to be on the bed and with the monitor on but in a way to say come on what do you want to do what’s comfortable for you but when she said I want to get on the floor that was in response to me saying how are you going to get more comfortable,
well I want to be on the floor, but it was … erm… I was saying to her you can do this, you can do whatever you like and she was able to respond to that erm, so that even though she wasn’t, she’s read things and we had talked about things we’ve gone through and but erm yeah I think she was able to get on with it. ((Laughs))

I: You’ve also mentioned a couple of time you’ve come into hospital and the woman’s been on the monitor, do you find there’s a clash of philosophies?

R: I don’t know…….I think there’s still very much a feeling that if a woman’s on a monitor she should be on a bed rather than looking at alternatives even just sitting out on a chair or or standing up, you know, I mean yes I know there’s always a chance that you’re going to lose contact and not get a good monitor but you won’t know that til you’ve tried it will you?... And the situation that I’ve mentioned where I’ve gone in and they’ve been on the monitor sometimes it’s because they’ve been admitted by someone who’s looking after someone else and they’ve just thought well I’ll just put the monitor on and then I’ll come back in a minute.. As far as I’m aware there’s no point in having a monitor on if you’re not going to look at the tracing, there’s no point, you might as well just listen in and walk out again…. Erm so I think that’s what that is, I think probably I think some of the core staff maybe not all of the core staff but maybe some I’ll stress that some ((emphasis)) are midwives who’ve been there a long time are just used to doing things a certain way. I mean we don’t do admission traces these days and if the woman’s midwifery led care you just do intermittent auscultation and I would certainly, because the majority of woman we’re looking after are with the consultants who we work with closely erm … they would trust me to know if I needed a monitor on or not and if I didn’t and they came and questioned me I would be able to justify why I hadn’t done it, just because she’s .. I don’t know... just because she’s come in in spontaneous labour and she’s under a consultant doesn’t necessarily mean she needs to be on a monitor whereas for some midwives maybe because they don’t work with the consultants the way we do actually, yeah that’s possible, because we’ll if the woman’s having a complicated pregnancy we’ll go to clinic with her and we’ll see the consultant with her and we’ll devise a plan of care and whatever so we work with those consultants closely so we feel, I feel more that I could, yeah that they trust me to make the right decisions which might well include someone not having a monitor on unless it was necessary. And if one of the consultants came and said to me why didn’t you have that monitor on I’d say well it was spontaneous labour and everything else was normal, that they would go yeah that’s fine, that’s to do with my relationship with them as well
and maybe that with the doctors too because we work with them in clinic with women that we go with and take in at times and maybe that’s something to do with our relationship and the way we work together in that way.

I: How do you feel if a shift leader challenges you about care?

R: Erm….. They let us get on with it mainly. If anyone did say to me why haven’t you done an ARM? I’d say well why should I?. Erm I know with the woman that was pushing that I haven’t VE’d I know that if xxxxx ((name)) the shift leader had known I was doing that Oh do you no think you should have done it I think you should have done and I would have just said well it won’t change my care at this point in time and that was a phrase someone I heard from someone, why should I do that if it’s not going to change her care at this point in time and that’s something that’s really stuck with me and it does it’s a useful thing to think about, you know, ok so I haven’t done that or if I did that what’s going to change, well nothing would have changed, as I said if there had been no evidence of anything within half an hour then I would have maybe erm had a look .. but….I don’t think there’s been……I think when I was newly qualified I felt I was challenged a few times and gone ohhh ok whatever you say, but now I just feel a bit more…… yeah ok sister …… ((Laughs))

I: Do you think you might ever affect the shift-leaders confidence when you go in as a case-holding midwife?

R: Ermm…….I think there have been times in the past when we were newer they’d come expecting you to do weird and wonderful things you know having your woman swinging from the lamp, I was going to say chandeliers but we don’t have them ((Laughs)) light fittings or something. And I think because all of us are even before we were known for having women on the floor and on a ball or whatever, it’s just because we’re all together they know where we all are ((Laughs)) Erm ….. I mean sometimes and whoever’s in charge will say oh I expect you’ll have her on the floor well don’t expect me to come in a second, well that’s ok I don’t want you in as second thank you very much ..................So I don’t know , I know one midwife who’s felt quite threatened by us erm and was actually quite unpleasant and did have to be spoken to about it..erm….and I think yeah because we do things differently, because we ask questions, because we don’t do as we’re told it can be a bit frightening sometimes, a bit challenging for them. I mean it’s change isn’t it change is scary ............ and perhaps it’s a way of pointing things out to them that they know are not right …. Like not doing
an admission trace, we shouldn’t be doing that anyway……. but they’re much happier
going along with the status quo and … I think for some of them it’s just comfortable isn’t it they just keep doing the same thing, you don’t have to think about it do you it’s what you’ve always done…

I: The last thing I wanted to ask was how would you identify a confident midwife?

R: Erm…… Ohhhh…….erm someone who’s assertive, someone who asks questions
erm… someone who listens to women erm, someone who can show emotion, I think
that’s quite important ………erm ((laughs))…….erm………………someone who had a
good theoretical, not just theoretical, has a theoretical and practical knowledge, not necessarily experience but has the basics and someone who knows their own boundaries, someone who asks when they’re not sure ..erm.. or they just want clarification, someone who asks rather than guessing … Does that make sense? .. I think that’s something that I learnt far more whereas before I might just collar someone and ask in a corner whereas now I’ll say look I haven’t done this for ages you’ll have to just tell me how to do it.. If the anaesthetist comes in and I say to them ok I’ve not done this for a long time so you’ll need to be very specific about what you want me to do for you erm … for me that’s being confident, rather than just sort of getting everything and hoping for the best … yeah, so… yeah boundaries I think is important, acknowledging your own boundaries ………

I: Well if there’s nothing else you want to say ((R Laughs)) thank you very much

Tape off
Using diaries to explore midwives’ experiences in intrapartum care: An evaluation of the method in a phenomenological study

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ABSTRACT

Aim: Finding appropriate ways of obtaining contemporaneous data in acute settings is an ethical and practical dilemma for researchers. Our aim was to evaluate the use of diaries by midwives in a research study informed by a phenomenological approach.


Method: A phenomenological approach was used to guide a study exploring midwives’ views of confidence when providing intrapartum care. Two methods of data collection were used: diaries and semi-structured interviews. This is a methodological paper reporting on the usefulness of diaries used with participants who were health professionals in a healthcare setting.

Results: Participants completing qualitative diaries provided rich data, recording not only a description of events but also their emotional response to such events. A high degree of self-reflection and analysis was also evident. The participants provided contextual and time-targeted data although remaining focused on the phenomena being explored. Furthermore, the diaries highlighted the data that may not have been uncovered by interviews alone.

Conclusions: Use of diaries for qualitative data collection is feasible and well received by health professionals. Individuals completing diaries were engaged in a reflective process enabling them to address significant events. Hence, diaries may provide benefits to both the researcher and the participant. They proved appropriate to a study requiring an exploration of the lived experience of the participants. Researchers conducting research informed by a phenomenological perspective should consider diaries as a valuable data collection tool.

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INTRODUCTION

Diaries as a data collection method have grown in popularity in both social and health care researches (Jones, 2008). The focus of this paper is to discuss the use of the diary as a qualitative research method in phenomenologically informed research with health professionals. In this paper, we consider the feasibility of the use of diaries in qualitative research, including acceptability to participants, the scope of the diary for capturing relevant events, emotions and self-reflection by participants within it.

In order to do this, a study utilising phenomenologically guided research diaries in a study of midwives’ experience of confidence when providing intrapartum care will be used as an exemplar. This study explored midwives’ views on the meaning of confidence. The study participants were midwives who regularly provided care for women in labour. They were employed at three hospital Trusts within England, each providing different models of care.

Whereas the aim of this paper is to consider the use of diaries as a qualitative research method, the focus of the study was to consider the phenomena of confidence as experienced by the participant. We therefore used a hermeneutic Heideggerian approach as the most appropriate underlying philosophy associated with the study. Heidegger’s phenomenology is concerned primarily with Being-in-the-world, that is, how the individual sees himself in the world (Heidegger, 1962). To consider the being of something is to ask for the nature or meaning of that phenomenon (van Manen, 1990).

Heidegger accepts the pre-conceptions of the researcher as essential for reaching an understanding. This was of particular relevance for researchers conducting the study. As midwives we were steeped in the tradition of the role and the culture. Rather than try to set this aside, as would be required by descriptive Husserlian phenomenology, we accepted that such fore-understanding would be valuable and essential in understanding the meaning in this study.

As this study was primarily concerned with participants lived experience of the phenomena of confidence it was essential to
employ methods of data collection sympathetic to the underlying phenomenological philosophy. Hence, a two-stage approach of participant-completed diaries followed by semi-structured interviews was used.

A literature review of the use of diaries in phenomenological research revealed a lack of evidence relating to their use in studies with health professionals. It was, therefore, a secondary aim of the study to explore and evaluate such diaries in this setting.

Diaries in qualitative research

In the health-care setting, diaries are most frequently used with patients, both to chart the development of illness and also to capture the experiences of those who are ill (Richardson, 1994). Diaries can vary from a very structured format, to a much more open reflective style, with both types being employed to capture data around health and illness. As such, health diaries have been considered and criticized by a number of researchers (Verbrugge, 1980; Ross et al., 1994; Gibson, 1995; Valimaki et al., 2007). They have been found to be an efficient and sensitive tool for data collection (Richardson, 1994).

However, research focused around health professionals has utilised diaries much less frequently. While they have been used, there has been much more emphasis on the structured format. Often such diaries have been used to capture data around professionals working practices or activities (Kakker et al., 1996; McFerran, 1998). Diaries using a more qualitative approach have been used with student midwives to capture their views and feelings during their midwifery training (Begley, 1995; 2002) and their experiences of studying abroad (Greatorex-White, 2008). Ross et al. (1994) explored the use of diaries by nurses in collecting both quantitative and qualitative data concluding that they were a "reliable and effective method of data collection," whereas Symon (2004) describes the use of diaries within organisational research as a "useful and insightful information source."

Advantages of the diary method include the accurate and contemporaneous capture of data (Verbrugge, 1980). In addition, qualitative diaries have the ability to capture thoughts and feelings, especially in intimate or challenging situations. Potential disadvantages include the failure of participants to complete the diary, obtaining irrelevant data, cost and difficulties in analysis (Verbrugge, 1980; Richardson, 1994; Symon, 2004). Literacy can also be a concern in some populations.

While diaries tend to be in paper form other formats can be utilised. These are largely through electronic media, such as dictaphone, word processing packages or e-diaries. Electronic diaries used with patient groups have provided higher levels of compliance than paper diaries when entries need to be completed within a specific timeframe (Stone et al., 2002; 2003; Palermo et al., 2004; Kajander et al., 2007). However, they may be more time consuming (Kajander et al., 2007) and may be difficult to access or complete in some settings.

The diary, as well as being a data source in itself, can be used in conjunction with other methods, such as interview, where it may be used as a memory aid (Verbrugge, 1980). It has been suggested that a diary followed up by interview is one of the most reliable methods of collecting data (Zimmerman and Wieder, 1977; Corr, 1993; Williams 2001) claimed that diaries can be a "secondary supportive" method of data collection and found that they appeared to validate previous interview data.

The study method

In order to explore midwives' views of confidence, consideration had to be given to the appropriate choice of method to be used. As the underlying philosophy was phenomenological it was important to choose a method that would be suited to this approach. It was essential to try to capture midwives' thoughts on a day to day basis. Hence, diaries were chosen as the most appropriate method for capturing an in-depth personal perspective, prospectively and longitudinally. This was followed up with a semi-structured interview which included an exploration of both the diary entries and the midwives' views of the use of the diaries themselves. The interview included open questions such as "how did you find completing the diary?" Diaries also suited the hermeneutical phenomenological approach, in which they allowed the participant to tell their own story in the context of being in the world. This approach allowed for a narrative, uninterrupted by the researcher's questions and enabled data produced to be time situated.

The purpose of the diary was two-fold to collect data and to focus participants' mind on the issue of confidence prior to a subsequent interview. This approach is similar to that described by Verbrugge (1980) in her review of health diaries. Corr (1993) considers that the diary⁄and interview method is one of the most reliable methods of obtaining information. In this detailed questions about diary entries are asked at interview. Zimmerman and Wieder (1977) describe a similar approach as a means of ensuring consistency in the data collected. Hence, in our study, analysis included triangulation of data from both the diary and interview.

The diary, and an explanation of its use, was provided to the midwife at the time of consent. A list of five broad questions, such as 'why did you feel confident today?' was provided within the diary as a guide and participants were asked to record anything else that they felt was relevant to them within the concept of confidence. The questions were deliberately wide in order to encourage participants to express themselves freely within their diaries. However, for practical purposes, it was necessary to give some guidance to avoid the risk of failure to complete the diary due to large amounts of irrelevant data (Symon, 2004). Participants were requested to complete the diary for a period of 10 days when they were providing intrapartum care. There was no obligation to make an entry for every shift as the aim was to capture events around confidence that were significant to the midwife involved. Hence, all entries were self-selected. The timing of completion of the diary and the quantity of data recorded was left to the choice of the midwife.

Relevant ethical approvals for the study were gained prior to recruitment (COREC reference 06/Q5/150/162).

Setting and sample

The study involved recruiting a purposive sample of midwives providing intrapartum care at three hospital Trusts in England, in 2007. Midwives were approached by an initial letter of invitation to take part in the study. They responded either by telephone, e-mail or face to face contact. Written consent was obtained from midwives willing to participate.

Analysis

Many approaches to hermeneutical phenomenological analysis are broad, focusing on themes emerging from the text, for example that of van Manen (1990). Although this approach was appropriate for the study as a whole, the issue of the text, as written in the diaries, required further consideration. On initial examination and reading of the texts it became apparent that the manner in which the text was constructed would give meaning and understanding to the narrative itself. The participants used various devices, such as punctuation, grammar and presentation.
to add tone and meaning to the text. Unlike interview, where visual aids to interpretation occur, such as the participant’s body language, changes in tone and silence, the physical text of the diary alone is all that is available from which to gain understanding. Ricoeur (1981) distinguishes between text as written by the respondent (language) and that which is initially verbal, and subsequently transcribed into text (discourse). Text as written, is free of the author who cannot be questioned or challenged to reach an understanding. For hermeneutic understanding to be reached Schleiermacher (1986) believed both grammatical and psychological interpretations of language have to take place. Although Gadamer (1989) criticised the psychological interpretation proposed by Schleiermacher, grammatical interpretation remains crucial to understanding. In order to understand and interpret the diaries it was important to consider how they were written in their entirety.

The diaries were analysed in their original format, as written. Transcription was initially carried out, but the original texts were returned to as the essence of the data appeared to lose substance in the transcription. It was impossible to recreate the textual presentation and layout in transcription.

In order to analyse the texts, the critical narrative analysis approach, devised by Langford (2007) was utilised. This critical hermeneutical phenomenological approach was based on the work of Ricoeur. Although in larger prescriptive terms of analysis, we felt that the focus on the textual tone and narrative suited analysis of the diaries as a research tool. A six stage approach is described by Langford as a method of analysis of data. Stage one involves a critique of the illusions of the subject, where the researcher considers their prejudices and forestructures of understanding and engages in a reflexive position. As described earlier, we were aware of some of our pre-conceptions. In order to interpret the text it would have been inappropriate to bracket these preconceptions out and instead we used a reflexive approach. Stage two involves identifying narratives, narrative tone and rhetorical function. This was particularly crucial in respect of the diary data, as many grammatical devices had been employed in order to add tone to the narratives. Stage three concerns identities and identity work in an attempt to identify the person/self brought into being by the narrative. Stage four revolves around identification of themes emerging from the text. Here a process similar in manner to that described by van Manen (1990) was utilised. Stage five requires a critique of the text. In particular, it is at this stage that the researcher composes the hermeneutic circle. Within hermeneutical Heideggerian phenomenology it is impossible to understand the whole without understanding the parts. Various stances have been taken with regard to the circle itself (Crotty, 1998). Geenellos’s (2000) describes the process of interpreting parts of text in relation to the whole and the whole in relation to the parts. Others see the circle as a process of sharing of culture and language between participant and researcher (Lennard, 1989). Indeed in entering the circle, it is essential to be aware of our fore-understanding and tradition that we bring with us (Gadamer, 1989). In analysing the diaries, elements of both approaches to the circle were appropriate.

Findings

Diary composition

The 12 midwives who participated returned completed paper diaries. It was interesting to note that although all had been given the option of completing an electronic diary, none did so. The paper diaries themselves gave a personal feel to the data. Dobson (2002) suggests that physical writing, rather than electronic, keeps us in touch with what we write. Midwives may have preferred this personal aspect, due to the intimate and emotional nature of the phenomena under exploration.

The number and length of diary entries varied (between two and 10), but overall they were very detailed. Although two of the returned diaries recorded only two entries, the quality of the data was good and both were several pages long. In evaluating the diaries Vallimaki et al’s (2007) classification was used. This divides diaries into four classifications by content: message, reporting, descriptive and reflective. All the diaries were reflective to some degree, with midwives expressing their emotions and feelings as well as having a descriptive, story-telling aspect to them. None of the diaries contained entries which could be described as message or simply reporting.

Each diary was unique in terms of grammatical style and presentation. However, for the majority a three stage pattern of diary keeping emerged. Firstly they provided a description of the event. Secondly the emotions experienced around the event were described. Thirdly the participant reflected on both the event and the emotions experienced. This involved both evaluation and analysis where midwives critically appraised the event. Some participants then considered or devised strategies for their future management of such situations. This approach provided greater insight into the effect of the event as experienced by the participant, as well as the participant’s own self-interpretation of their experiences within the diary.

As researchers we were particularly interested in the context in which events occurred. There was a concern that as the diaries were written some of this contextual data would be lost. However, that was not the case. The participants provided diaries that were rich in context and the culture in which they were written.

Keeping a diary

In order to evaluate the use of qualitative diaries as an appropriate method of data collection with health professionals, both diary and interview data were utilised.

One midwife who commented at interview that she found the diary process a positive experience had made the following note in her diary, following a period of reflection:

Maybe should just believe in self. (It) is helpful writing diary! 1.7

At interview most midwives indicated that the act of completing a diary was helpful in that it did help them to focus on the phenomena being explored:

I suppose subconsciously it does make me more aware ... because you know you're gonna be writing about it later on. 1.1

The diary also acted as a memory aid for the follow-up interview, with midwives referring to it during the interview. However, the act of completing it alone enabled midwives to direct their thoughts to the phenomena under exploration. This was the case even for participants who made a fewer entries:

I was thinking about all the things I wrote down but didn't really write them down more just stored them in my head ... incidents that I thought we could talk about. 1.3

The time required to keep a diary was a concern to the researcher, as there was a risk that any long term commitment would become onerous, and hence would not be completed. With this in mind 10 working days were considered appropriate for
completion of this phase of the study. The difficulty of such a commitment was echoed by one of the participants:

"I struggled with it just because of time really." 1.3

This concern may be significant for studies with health professionals who are likely to be completing a diary within a pressured working environment, which may lead to the task being abandoned more readily. However, a diary also permits flexibility in allowing the participant to complete it outside of the workplace. In this study the majority of participants did complete their diary after their shift had finished. This was due to both the time constraints and the recording of incidents associated with emergency situations. Clearly this impacts on the contemporary nature of diary keeping. However, the personal nature of the phenomenon under investigation was unlikely to be captured contemporaneously in any other way. It is also likely that the immediacy of events and feelings may be lost by other methods such as later interview (Zimmerman and Wierdel, 1977).

Indeed it could be said that the data provided was still of time situated. Some participants chose to write extra entries as they considered issues, not just following a shift. One did so, entailing the entry 'Thoughts over the weekend' (1.7). Although not physically engaged in the process of work, the comments could be taken to be recorded contemporaneously as the participant reflected upon the issues. Entries such as these add a spontaneity to the diary keeping, similar to that of the personal, unsolicited diary. The open format of the diary may have contributed to this style.

The participants in this study were self-selected and, as a result, motivated to complete this type of study. It is important to consider the issues surrounding a long term commitment to diary keeping. This includes the environment in which the study is being carried out and as well as the commitment and motivation of the participants.

Choosing what to include

The selection of events chosen for the diary entries was considered in the interview stage of the study. The initial extract had been wide allowing freedom for the participant to record what they felt was important to them, as rated to the exploratory nature of the study. This self-selection of incidents by the participant provided an important insight both into the phenomena being explored, and the individuals lived experience of it.

When questioned about their reasons for choosing the events recorded, midwives commented that they excluded shifts when 'nothing happened'. As a result, some also found it took them longer than they expected to record the requested number of entries.

The concern that the open format of the questions placed at the front of the diaries would lead to a large amount of irrelevant data was unfounded. One participant commented about the need for questions as prompts:

"If it was a particularly bad shift or whatever I didn't need prompting kind of thing I'd just write about what happened." 1.1

It is interesting to note that many participants recognized bad shifts and this in itself prompted a diary entry. When diaries were reviewed later, some midwives expressed surprise that they had actually recorded what they termed as ‘good’ or positive events as frequently or more frequently than ‘bad’ or negative ones, indicating that they had an overall negative perception of the events they recorded.

The intimacy of the diary did vary between participants; however, all appeared very open and honest in their entries. Furthermore, this was validated by interview data. The participants were aware that any diary handed back to the researcher would be read, therefore, it was expected that some more sensitive data may have been excluded. One midwife recorded very detailed and emotional data and commented at interview how she felt about this:

"I found doing the diary quite embarrassing really ... what I wrote was very self-centred." 1.4

However, this did not overly act as a barrier to the diary keeping process for this midwife, who produced one of the most intimate and detailed diaries received.

Personal feelings and emotions did appear to be readily recorded in the diary by many of the participants, often with greater emphasis than when discussed at interview. The personal and private act of writing (Dobson, 2002) may make it easier to write about personal feelings and emotions. However, the passage of time from the recording of the event to interview may have served to reduce the immediacy and awareness of the emotion. In addition, the mere act of recording may have enabled the participant to come to terms with the situation and consider it less important. However, some participants did feel that the diary entries brought back their emotions of the time and discussed these readily at interview.

Midwives frequently alluded to the events that had taken place outside of the diary period; sometimes it was what was not said that was interesting, where midwives hinted at issues without detail. An entry by a midwife described an interaction with her colleagues:

On this occasion, positive responses all the way. 3.3

She gave no further explanation of this in the diary but was able to talk about previous experiences at interview. Clearly these past experiences had an impact upon her present feelings and future expectations.

It is important to have a method of exploring such issues further and the subsequent interview phase of the study provided this. At interview participants were often able to verbalise issues which had only been hinted at in the diary. The impression was that participants were more likely to discuss certain issues face to face, often where this involved talking about the actions of other people. The act of verbal disclosure of such details may somehow seem less tangible than recording them in a written format. Writing in itself these ideas or views in a more concrete manner. Once written, the writer loses control of the text, it gains what van Manen (2002) terms textual autonomy. As such the text is then open to scrutiny and criticism. By handing over a written document the individual loses control of it and may feel vulnerable. In addition, the participant cannot know what the reader's reaction will be. In an interview situation, however, the participant may make an assessment regarding the trustworthiness of the interviewer and make decisions regarding disclosure based on this. They may also pick up cues regarding the interviewer's reaction to the matter under discussion.

As midwives work in a particularly litigious area of healthcare, they may be justifiably wary of committing particular views to paper, particularly where the involvement of others is evident. One midwife commented about her consideration of how to write the diary:

I suppose it made me think ... about what I can write about, you know how to word it ... without it coming across as being either too critical or ... 1.1

This participant appeared concerned with both how she portrayed others and also how she herself was judged by what she had written.

In actually completing the diaries all the participants were showing a degree of trust in the researchers, particularly given the sensitive nature of the phenomena under exploration.
Capturing emotions

The language used by the midwives to describe experiences reflected their emotions. The grammar and other techniques used gave emphasis to their descriptions of events. Techniques such as the use of capital, punctuation or understating tended to be used to emphasize extremes of emotion, both negative and positive. In this way the diaries were able to capture the intense emotions and feelings experienced by the midwives. As researchers reading the diaries, they clearly did evoke a feeling of the emotions experienced by the writer. This was both in the way entries were written and the language used. Occasionally the strength of feeling was evoked by the obvious pressure of the pen on the paper.

One midwife describes how when reading her entries the emotions felt at the time of writing returned:

"It was what I felt at the time and it was a bit cathartic... I read it back this morning and, the way I'd written it, I went back to how I felt at the time and I got the same anger or same frustration from reading it."

Some of the diaries written over a whole shift were able to capture changes in the midwife's feelings of confidence. The midwife would often describe a sudden change of emotions based on the occurrence of a single event. The ability of the diary to capture and record the individual's feelings at a given time point was confirmed by the interview data. One midwife noted at interview that she thought what she had written may be "pretty" raw, but it was clearly significant enough to record at that time. It is likely that this incident or emotion may not otherwise have been revealed at interview and highlights the importance of diaries in capturing unfolding emotions. In addition, the mere act of creating a narrative may help reduce an incidents significance, enabling the individual to resolve the issues around it.

Writing, in itself, allows an individual to organise their thoughts and feelings into a coherent structure. As a result the emotional effects of the experience can then become more manageable, giving the individual a sense of control (Pennelake and Saegl, 1995). Pennelake (1997) suggests that individuals will readily write about even very traumatic events if given the opportunity to do so. The fact that some midwives recorded what they perceived as mostly negative events is a testament to this. By writing on paper the individual is able to distance themselves from the subjectivity of their immediate experience allowing them to reflect in a more objective manner (van Manen, 1990). In addition writing about emotional events is associated with reduced mood and better physical and psychological health (Pennelake, 1997). The diary may therefore be more than a simple tool of data collection. It can provide the individual with a safe outlet for their emotions, giving them the space for reflection and subsequently the means to develop strategies for coping with similar events in the future.

Reflection

The majority of the participants used the diary as a reflective journal, indicating that it made them look back and analyse their behaviour:

"When I sat down and did it, it made you think about your actions... how you felt."

The reflective approach employed by the midwives provided an important insight into their reaction to events and also revealed plans as to their possible future behaviour as a result of the event. Some commented that they found this process of reflection helpful. One participant felt that such a reflection had changed some of her previously held views about herself and also the behaviour of others. Another participant reflected at length on aspects of her own behaviour and its effects on others, reaching a decision about her own future actions:

"So that's what I've decided. I'm going to be more supportive."

The mode of recording reflection varied from use of formal sub-headings to a more fluid style evident within the text. It was also spontaneous, as we had not requested that they keep a reflective journal, only that they recorded pivotal incidents and their emotions and thoughts about them. In reflecting upon their diaries the participants often made their own comments regarding their interpretation of events. This indicated an ongoing level of involvement in the diary writing deeper than the mere recording of detail.

Reflection is considered an essential element of midwifery practice with midwives being considered reflective practitioners (National, 2005). As such reflection is regarded as part of their everyday practice. Although reflection is generally utilised in relation to learning and skill development, the participants here used reflection to consider both events and their emotional response to these events. Despite the differences in style, the participants tended to follow a similar approach to reflection. This is comparable with some of the more straightforward models of reflection, such as that described by Gibbs (1988). This is a circular process which begins with the individual describing the event. This is followed by a description of thoughts and feelings around the event, then an evaluation of the event. Analysis and conclusion follows this, resulting in an action plan for future similar situations.

It is apparent that reflection on both the events and their emotional response to them is a method that the participants used in dealing with emotional events. It is widely accepted that midwives undertake emotional work in their professional role (Hunter, 2005). This concept was defined by Hochschild (1983) as the ‘management of feeling to create publicly observable facial and bodily display’. In doing this midwives must outwardly control their emotions. Health professionals frequently work within stressful and emotional situations. The act of writing a diary may, therefore, provide them with an outlet for their emotions. Rather than ignoring stressful situations, it may allow individuals to confront them and reach a resolution. It may also explain why the majority of midwives recorded what they perceived mostly as negative events. The use of qualitative diaries for reflection, such as in this study, may therefore provide an unexpected benefit to the participant in the form of a personal debriefing and resolution of issues.

Conclusion

This study has highlighted the advantages and usefulness of the diary method in phenomenological studies. The diary is particularly suitable for studies involving the exploration of the lived experience of the individual participant. It is a personal document and as such can capture the very personal emotions and feelings as experienced by the participant. Where there is a wide remit, the self-selection of incidents for inclusion in the diary can provide extra illumination to the data. In a phenomenological study such as this, the use of a diary was particularly useful in identifying areas for exploration within the interview. This added to the participant led approach rather than the interview being led by the researcher with preconceived ideas.

The feasibility of using diaries in this study and with this population was evident. Compliance with the method was acceptable and the data collected relevant to the study phenomena. They were both acceptable to participants and produced rich data. As documents, diaries are time situated and can provide an insight into events as they occur. In particular, strong emotions that may be later discounted can be evidenced by diary data.
A further important and unexpected advantage of using qualitative diaries in this way is that they may provide an added benefit for the participant. In this study, participants evolved the diaries into reflective journals where they were able to consider their reactions to events and their emotional response to them. Clearly, they had moved beyond mere data capture for the researcher and the documents had become more personal.

Although there was no definite intention to elicit reflective diaries, the majority of participants provided diaries in this format. As research diaries, the participants were asked to focus on a particular aspect in completing the diary, then they showed from a purely reflective diary. Midwives are experienced in the skills of reflection and adapted these to suit the research diary format. However, if such diaries are to be used with participants who do not have inherent knowledge of reflection, then it may be prudent to consider providing a simple reflective model as a guide. A number of models are available, however, any model chosen should be straightforward to follow as anything too complex is likely to detract from the phenomena under investigation and may result in a failure to complete the diary. A model such as Gibbs (1988) could suit this purpose. Not only would this provide a focus for the participants, but also it could help provide consistency which may subsequently assist data analysis.

This privacy element to the use of a diary may be important in providing a useful outlet for emotions. In particular, the participants had to maintain a professional profile in the working environment. Here, diaries could have been used as an outlet for the personal feelings and emotions that they were unable to express to others or within their professional environment. The advantage of using the diary in this way, both to record emotions and to reach resolution, may provide reciprocal benefits for the participant and the researcher. This potential use of the diary is an area that would benefit from further research.

The practicalities of a diary study with this population also did not prove to be a problem. Some of the potential disadvantages highlighted, such as cost, difficulties in analysis and co-operation of participants (Verbrugge, 1985; Richardson, 1994) did not arise. As professionals, all the participants had a high standard of literacy and the motivation needed to complete the diary. The cost of the diary element of the study proved to be minimal and considerably less than conducting an interview. In addition, analysis of the diaries using phenomenologically guided methods provided rich data.

There are also some limitations to the use of qualitative diaries which must be addressed in designing a study using the diary method. The time required to complete the diaries and personal motivation of the likely participants must be considered if adequate data is to be obtained. It may be unrealistic to expect study participants to record contemporaneous data, but recording data at the end of each day may be acceptable. Whilst the diaries themselves can be a rich source of data, the lack of direct interaction with the writer can leave researchers with the feeling that they require further explanation. Hence a mixed methods study or diary followed by interview study may enable clarification or pruning of issues. Decisions regarding data analysis of qualitative diaries should take into account the construction of the diaries themselves. The tone and presentation can provide an important insight into the narrative and it is important that this is not lost to analysis.

This paper set out to discuss the use of qualitative diaries using a phenomenological approach in a study with health professionals. All methods have limitations, and the diary method is no exception. However, diaries can be especially useful in phenomenological settings and is important to consider the lived experience of the participant. In particular, they are able to capture the emotions of the participant at a given time point.

The use of the diary as a reflective journal may also provide an added personal benefit to the participant.

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