NEW ZEALAND COLLEGE OF MIDWIVES (INC)

JOURNAL

NZCOM journal goes electronic

Discerning which qualitative approach fits best

What evidence supports the use of free-standing midwifery led units (primary units) in New Zealand/Aotearoa?

Women's Experience of the Abdominal Palpation in Pregnancy; A Glimpse into the Philosophical and Midwifery Literature

Developmental mentoring: New Zealand graduates' confidence grows when their needs shape the relationship

JOURNAL 46
June 2012

NEW ZEALAND COLLEGE OF MIDWIVES (INC) JOURNAL

Guidelines for Contributors to the New Zealand College of Midwives Journal

The NZCOM Journal is published in April and October each year. It focuses on midwifery issues and has a readership of midwives and other people involved in pregnancy and childbearing, both in New Zealand and overseas. The Journal welcomes original research, literature reviews, exemplars/practice stories, audits and research methodology articles. It is important that articles have not previously been published in any form. In general, articles should be between 500-4000 words.

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The reference list at the end of the article should contain a complete alphabetical list of all citations in the article. It is the responsibility of the author to ensure that the reference list is complete. A comprehensive range of examples are provided on the APA website. Two examples are included here.

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Pairman, S. (1999). Partnership revisited: Towards a midwifery theory. *New Zealand College of Midwives Journal, 21* (4), 6-12.

Book

Page, L. (Ed.). (2000). *The new midwifery.* London: Churchill Livingstone.

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Reference

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: American Psychological Association.

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PHILOSOPHY OF THE JOURNAL

- Promote women's health issues as they relate to childbearing women and their families.
- Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- Provoke discussion of midwifery issues.
- Support the development of New Zealand midwifery scholarship and research.
- Support the dissemination of New Zealand and international research into midwifery and maternal and child health.

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EDITORIAL

NZCOM journal goes electronic

Andrea Gilkison & Lesley Dixon

As this issue of the NZCOM journal has gone to print I (Andrea) have had the privilege of being on sabbatical leave from my role as a midwifery educator. As well as a time to undertake research and write for publication, sabbatical is a time to reflect on ones research and where it might lead in the future. The articles in this issue of the journal have given me inspiration and I think that New Zealand midwives can be proud of the midwifery research and scholarship which is taking place across our midwifery community.

As well as reading about research in this journal, midwives can look forward to a further opportunity to hear about the research which midwives are undertaking at the NZCOM biennial conference in Wellington later this year. I seriously hope that as each of the presenters prepares their conference presentations that they will consider writing an article to submit to this journal.

The editorial board and reviewers have been working hard on the format of the journal and assisting authors to get papers ready for publication. Jean Patterson has kindly agreed to join the editorial Board as a sub editor, bringing the board's membership to six. Jean brings great experience as a past editor of the journal and as a researcher. Jean introduces herself in her biography at the end of this editorial. We also welcome four new reviewers to our team; Tomasina Stacey, Paula Cox, Lorna Davies and Sally Baddock, and thank them in advance for their commitment. We would also like to thank our existing reviewers who often work in short time frames to review articles so that they can be ready for publication.

One of the things which the editorial board and the National Committee of the NZCOM have been considering is how best to disseminate New Zealand midwifery research to a wider audience. The NZCOM journal has been published in this paper copy format twice a year since 1989. An electronic version copy is also made available on the College of Midwives website (www.midwife.org.nz) six months following initial publication. The majority of academic journals are now published electronically as well as in print. After careful consideration and discussion about a variety of different options the editorial board and the National Committee have agreed a change of format. From now on as each paper is reviewed, amended, edited and accepted for publication, it will be published electronically for members and subscribers. This will be linked into the redevelopment of the NZCOM website with secure member access which is planned to commence in July this year. At the end of each year (in June) all the papers published electronically in the preceding year will be put together into a printed version of the journal and sent out to members and subscribers. This change provides the benefits of ensuring immediate electronic access to a paper as soon as it is prepared for publication whilst continuing to provide a printed copy for members (although this will be annual). We hope that this new format will be welcomed by our readers.

This issue of the journal brings together several different types of methodology which each explore different aspects of midwifery practice. Liz Smythe's paper explains different qualitative research methodologies and explores the differing philosophies which underpin each of these methodologies along with some practical points to support their use. This paper can help all midwives (not just those planning research projects) to better understand the array of differing (and often complex) ways of 'doing' qualitative research.

The paper on free standing midwifery units (by Lesley Dixon and colleagues) has used a structured literature review to explore and determine the evidence. This way of undertaking a literature review provides a systematic structure for reviewing previously published findings. It maps out and appraises the quality and findings of each study. In contrast David Blee and Elaine Deitsch have used a phenomenological approach when exploring the literature about the woman's experience of abdominal palpation in pregnancy. This article reminds us that for the woman, palpation is more than a fact finding screening tool but may also be filled with meaning. David and Elaine provide an overview of the different interpretations of touch which have been discerned from a variety of differing philosophies.

Our final paper has used a mix of methods which has incorporated both qualitative and quantative data collection tools to explore the mentoring process for a group of four new graduate midwives. Sue Lennox has described a research project which was set up in 2006 (prior to the Midwifery First Year of Practice Programme MFYPP) and which explored how the graduate midwives identified their needs during their first year of practice. With so much attention being focused on new graduate midwives Sue's research has demonstrated the value of mentoring (albeit in a group) in supporting these midwives during their first year of practice.

It is always exciting to be able to publish papers on topics which have such relevance to New Zealand midwifery practice. We would like to thank the contributors for their academic work and acknowledge the importance of this work for all practising midwives. It has the potential to enhance the quality of the work that midwives do on a daily basis as they work with women in their homes, communities and hospitals.

Bio: Jean Patterson, RM, PhD.

I currently teach and coordinate the Postgraduate Programme at the School of Midwifery, Otago Polytechnic in Dunedin. My midwifery practice experience has been largely in rural areas and the sustainability of a viable rural birth option remains my research interest. As a member of the NZCOM Journal Board I am committed to encouraging and supporting new researchers and seeing our New Zealand research and scholarship grow and flourish.

Discerning which qualitative approach fits best

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ABSTRACT

This paper is designed as a teaching tool to assist in choosing the most appropriate qualitative research methodology. Its key aim in providing broad outlines is to distinguish difference between approaches. Assumptions of each methodology are articulated along with the mood of the approach. Examples of interview questions, data and analysis are given to 'show'. References are offered, including links to these.

KEY WORDS

Descriptive interpretive, phenomenology, hermeneutics, critical hermeneutics, narrative analysis, grounded theory. qualitative, action research, midwifery research.

INTRODUCTION

Choosing to do qualitative research is the first decision; the next is 'by which approach?' This paper displays those choices in the manner of a guide who points to the broad distinguishing features to help the person about to travel decide where to spend their time.

It is wise to name and understand one's chosen methodology from the outset of the research for it dictates so much about how to conduct the research. It is also important not to over-inflate expectations, for example, to call one's research 'phenomenology' but to produce something that is 'descriptive interpretive' without following through the phenomenological expectations. To move beyond descriptive interpretive, one needs to explore the assumptions, philosophical underpinnings and nature of analysis that give the specific hallmarks of methodological congruence. There are no half measures in a named methodological approach, although Sandelowski (2000) describes how it is possible to bring a methodological hue. One needs to be wary of taking on a more complex methodology if the study is small and there is limited time available to do the background reading as, for example, in a master's thesis. Engaging with philosophical reading is best done with a guide who is familiar with the key works and can help with the initial understandings of key notions. Reading from the wide variety of qualitative research textbooks is helpful (Green & Thorogood, 2004; Hennink, Hutter, & Bailey, 2011; Lavender, Edwards, & Alfirevic, 2004; Morse & Field, 2002; Thomson, Dykes, & Downe, 2011) although sometimes there is a tendency to assume the methods are the same for each approach, or for the common approach of a discipline to dominate. Once a choice is made, it is important to have access to at least one person familiar with the methodological approach.

This paper takes the stance that 'seeing' is an important step to understanding. It is written as a teaching tool. The data given as examples are mostly imagined. Its prime aim is to show difference to allow distinction from one approach to another, and avoid common confusions. The details of how to do each approach are sketchy. One would need to read further. A particularly useful overview is the paper by Grant and Giddings (2002) which further points the directions and indicates the nature of each different pathway. The approaches included are: descriptive interpretive, phenomenology, hermeneutics, critical hermeneutics, narrative analysis and grounded theory. There are others, such as a Kaupapa Māori approach, case study, a historical perspective, and ethnography, that are not covered in this paper. But the principle remains the same: be very clear about the methodological assumptions that guide and shape the research before embarking on the study.

The topic chosen as the focus for examples is "attending conferences".

DESCRIPTIVE INTERPRETIVE

Descriptive interpretive research is ideally suited to a master's study, or a piece of research contained by time, where the researcher wishes to hear the voices of people, analyse the themes and present a thoughtful overview of results. It does exactly what its name implies: describes and interprets, but has no specific theoretical underpinnings. So, taking an example:

Research question *What do midwives get out of attending a conference?*
Interview question (anything that will elicit answers to the main research question) *Tell me about going to conferences*
Interview data Well I usually try and get to a conference every couple of years. It depends a bit where it is, and if I can get cover. I love the ones where it feels like I'm having a bit of a holiday as well. I'm never too bothered about the speakers. It all goes in one ear and out the other. But there was someone last year who really got me thinking.
Initial analysis Key words representing points that may be raised in other interviews **bolded** *Well I usually try and get to a conference every couple of years. It depends a bit* ***where it is,*** *and if I can* ***get cover.*** *I love the ones where it feels like I'm having a bit of a* ***holiday*** *as well. I'm never too bothered about the* **speakers.** *It all goes in one ear and out the other. But there was someone last year who really got me* ***thinking.***
Later analysis Themes begin to emerge from the common threads, such as: **Finger on the pulse:** going to a conference to stay up to date Conference as 'treat': really enjoy meeting up with people, having fun **Being inspired:** particular speakers can inspire and motivate **Tension of going:** getting time off is never easy **Impact on practice:** things that have changed in practice because of going to a conference
Linking with literature The researcher would link findings with the wider literature to support common insights and to show difference or contradiction. Further, they would highlight findings that seemed not to have been previously published.

Useful References

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health,* 23, 334-340.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3,* 77-101.

Examples of theses

Earl, D. (2004) *Keeping birth normal: Midwives' experience in secondary care settings, a qualitative study.* Unpublished master's thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/simple-search?query=Deb+Spence&sort_by=0&order=DESC&rpp=10&start=10

Murphy, J. (2008). *Strategies older New Zealanders use to participate in day-to-day occupations.* Unpublished master's thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/684

Rigby, C. (2007). *What it's like: How consumer staff members experience working in mental health*. Unpublished master's dissertation, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/711

Rolland, T. (2008). *Exploring physiotherapists' participation in peer review in New Zealand.* Unpublished master's thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/270

Carbines, M. (2003). *Being together and separate: a grounded theory study of the experience of first-time fathers during childbirth.* Unpublished master's thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/281

The strength of a descriptive interpretive approach is its straightforwardness. One asks, listens, and makes sense of the data. The depth of the analysis may vary depending on the 'thinking' of the researchers and the nature of the literature they engage with in unpacking ideas. By the same token, the limits are that analysis may not move beyond what the participants actually said. Further, there is an assumption that 'truth' emerges when several participants talk about the same thing, thus building a cluster of agreement. That may be so, but equally the insightful participant may be the only one to mention a particular aspect. In a thematic approach that voice could be silenced.

PHENOMENOLOGY

Phenomenology, in some ways, is closely linked to a descriptive interpretive approach as it listens and makes sense of data without a prescribed viewpoint such as power or gender. The aim of phenomenology is to reveal the meaning within experience. It is often chosen by novice researchers because of the call to listen to stories. On the other hand, it requires perhaps the most in-depth reading of philosophy of all the approaches (or is it that Heidegger, the key phenomenology philosopher, has written so many books that are all so hard to read?!)

Research question (usually about 'experience' or 'meaning')

*What is the **experience** of attending a conference?*

or What is the ***meaning*** of attending a conference?

Interview questions (Try to elicit very detailed story about what happened in a specific event)

Tell me about deciding to come to this conference? /Tell me about the first session? /Tell me about the best session? /Tell me about a session that disturbed you? /Tell me what else you did?

Interview data

Tell me about yesterday.

I was a bit late, so I ended up sitting near the back and had trouble reading the slides. After the first 5 minutes I felt myself drifting off. I couldn't understand the language. It was all too hard. I caught the eye of someone I hadn't seen for years. She looked as bored as me. When she pointed to the exit, we both snuck out and had a cup of coffee.

Now that was a great conversation. Her group is having the same problems we are about taking their weekends off, but they seem to have found the answer…

Initial analysis

Penny talks of losing interest in the presentation. This was partly because she struggled to see, but neither could she understand the words being used. Heidegger (1995) [full reference below in 'key references'] talks of how we are 'called'. Sometimes our interest is captured; other times it is not. The 'call' to reconnect with an old friend was much stronger; the conversation that followed more useful than the more formal conference presentation. How free are conference participants to heed the call (or not) on their attention? 'They' say it is not polite to leave during a presentation. Does that mean people endure sessions of little interest to them? How easy is it to have one-on-one conversations amidst a busy schedule?

Philosophical assumptions

- Understanding is revealed through our experiences, but we tend to go about in a non-thinking way, thus insights get hidden
- Interpretation reveals and conceals; we only ever come closer to understanding
- Understanding is always in context; Dasein (being-there) is about the things that matter in the moment (or not)

Phenomenological mood/process

Trust the process / Write to understand /Read Heidegger and co /Let the philosophical notions spark questions of the data /Talk, ponder, let the thinking come /Write again, and again…

You have to like writing; you need to be trusting

Where it leads

- To wondering / thinking aloud / saying what usually goes unsaid
- It does not set out to be political, but it can end up that way
- When the story captures attention, a presentation can evoke a deep silence
- To the phenomenological nod
- Perhaps phenomenology speaks as much to the 'soul' as to the 'mind'

Key references

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Examples of theses

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Dickinson, A. (2004). *Within the web: the family/practitioner relationship in the context of chronic childhood illness.*

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Vague, S. (2003). *Midwives' experience of working with women in labour: interpreting the meaning of pain.* Unpublished master's thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/72

Water, T. (2008). *The meaning of being in dilemma in paediatric practice: A phenomenological study.* Unpublished doctoral thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/405

Wright-St Clair, V, A. (2008). *'Being aged' in the everyday: Uncovering the meaning through elders' stories.* Doctoral thesis, University of Auckland, Auckland, New Zealand. http://hdl.handle.net/2292/3080

HERMENEUTICS

Hermeneutics is very closely aligned to phenomenology. The key difference is that while phenomenology calls for a return to the 'things themselves' (Thomson et al., 2011) which puts the focus on eliciting stories, hermeneutics simply seeks to analyse 'text'. Gadamer, the key philosopher one reads if doing a hermeneutic study, was a student of Heidegger's. His work is congruent with Heidegger's philosophical assumptions but expands understanding of the nature of interpretation, understanding, and language. In my own doctoral study (Smythe, 1998), not quite understanding the difference, I ended up with stories from the women as they talked about their birth experience, but from the midwives and doctors I had data that were much more generalised. They had so many stories that they tended to offer me their own analysis rather than a specific story itself. I called the methodology of my thesis 'hermeneutics' to accommodate the more generalised data but it was also strongly phenomenological, with many rich stories, and drew heavily on Heidegger. Do not get too concerned about keeping these approaches separate; they are often combined as 'phenomenological hermeneutics'.

Research question

*What **understandings** do midwives have about attending conferences?*

Interview questions (Draw on the insights of the participants, invite their thinking)

Tell me about going to conferences? What do you get out of them? How do they help your practice?

Interview data

Tell me about going to conferences.

I sometimes wonder about why I spend time and money going to a conference. If I had those 3 days at home I could get so much of my own writing done. But it's funny. You can think you got nothing much out of a conference, but then you find yourself following a line of thought that links back to a reference from something that was said, or maybe a question that was asked, or a great conversation you had one lunch time. And so the next year when the conference comes around again, off you go again. It seems to me that going to conference creates a thinking space that adds value to writing.

(Note: this is not about a specific conference, but she draws insights from having gone to many conferences. That's the key difference of hermeneutic data)

Initial analysis

Helen ponders on the value of going to a conference when time to 'write' is so precious. She sees that the worth is often not so much in the presentations themselves as in all the conversations that flow around them, both within her own thinking and with others. Gadamer (1982) [full reference below]talks of the play of conversations. They are never planned. We are drawn into them, and in the moment our thoughts respond. We may never have thought to ponder a certain question until it is thrust our way.

Philosophical assumptions

- Understanding is always interpretive
- One's cultural historical horizon means 'my' understanding is always unique
- I need to begin by being open to my own biases
- Such openness enables me to be drawn into thought by different understandings
- Language is always slippery
- As a researcher the interpretation is always my own

Hermeneutic mood/process

- As for phenomenology but with more emphasis on possible meanings of language
- Always striving to 'see' own pre-understandings
- Work between the hermeneutic circle of parts and whole

Key distinguishing factor from phenomenology

Is not necessarily focused on 'story'

Closely supported by Gadamer. May or may not include Heidegger.

Where hermeneutics leads

- To a more 'thought-full' level of interpretation
- To more questions, more thinking
- It unpacks, reveals, and offers, fresh insights that others may 'think-along'…
- Data tend to be presented first in both phenomenology and hermeneutics to allow the reader to 'think-along' with you rather than to be 'told'.

Key references

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Van Manen, M. (1990). *Researching lived experience.* London, Ontario: The Althouse Press.

Examples of theses

Gilkison, A. (2011). *Implementing a narrative-centred curriculum in an undergraduate midwifery programme: a hermeneutic study.* Unpublished doctoral thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/1375

Bree, C. (2003). *Lesbian mothers: queer families: the experience of planned pregnancy.* Unpublished master's thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/51

Fleck, K. (2008). *Finding the shadows in the mirror of experience: an ontological study of the global-co-worker.* Unpublished master's thesis http://aut.researchgateway.ac.nz/handle/10292/468

Kohut, S. (2005). *Tensions in the toolbox: the meaning of Western acupuncture for New Zealand physiotherapists.* Unpublished master's thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/18

CRITICAL HERMENEUTICS

A critical lens is just that, a lens imposed on top of another methodological approach. The critical lens brings a specific interest in 'power', but the approach dictates the way of doing the research. Similarly one can bring a feminist lens. Or one could link critical with another methodology, such as ethnography. I have stayed with a critical hermeneutic approach (i.e. one that seeks to interpret the meaning of 'text' with a specific interest in issues of power) as that is the one with which I am most familiar.

Research question

How do conferences shape understanding? **Or** *How do conferences impact professional practice?*

Or *How is the content, process and access to conferences determined?*

Interview question

(Trying to uncover what shapes/influences/dictates)

- How did you get to come to this conference?
- What do you know about how it was organised?
- How impactive did you think the key note speakers were?
- Do you think there was a particular agenda, message, mindset?
- Was there anything from this conference that might make you change the way you practise?

Interview data

Can you think of how a particular event shaped our understanding?

I remember the year Caroline Flint was the key note speaker. It was just before we got autonomy. She asked if we knew how many health professionals a woman sees during her childbirth experience, and then lined up an outrageous number of people and said "that many"! We were all horrified. Looking back, that fed into our notion that to be a true midwife, 'you' had to be the 'one' to be there for the woman, no matter what.

Initial analysis

Chris looks back to see the shaping that took place as midwives moved into independent practice. They were shamed into thinking the fragmented nature of practice was dreadful (as perhaps it often was) and at the same time sold a notion of continuity of care that seemed to be reliant on the 'one'. What funding structures were set in place to hold the notion of the individual mode of practice? What beliefs currently exist about the midwife's responsibility whenever possible to be 'the one'?

Philosophical assumptions

- Everything is a social construction
- There are always 'people' with vested interests who seek to shape the behaviours of others
- Revealing the nature of power/shapers can explain the nature of how things are

Critical hermeneutic mood/process

- It is not enough to simply listen to stories or opinions
- You need to get behind what is said to reveal how shaping happens
- You need to expose the 'interests' that seek to shape in particular ways
- You are always looking for power/dominance/oppression and taken-for-granted acceptance of 'how the world is'
- Same hermeneutic process of reading/writing/thinking/re-writing

Where it leads

- Key shapers are revealed which show how we are somehow pawns in a much bigger play
- The taken-for-granted-ness that allows the vested interests of others to hold sway is seen
- Questions are asked as to how it could be different
- The agenda is political – towards change

Key references

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Examples of theses

McAra Couper, J. (2008). *What is shaping the practice of health professionals and the understanding of the public in relation to increasing intervention in childbirth?* Unpublished doctoral thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/323

Mathias, L. (2009). *The shaping of decision-making in governance in the New Zealand Public Healthcare Services* Unpublished doctoral thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/720

A critical approach is not to be taken lightly. Revealing how power is at play, how people's social worlds serve the interests of those who hold power, and how subtle shaping dictates behaviours in a way people are often unaware of, can be disturbing. The researcher may be left feeling vulnerable. The participants may see their world in a new light which they may or may not appreciate. Furthermore, the 'powerful' may not appreciate having their power made so visible. While the intention is to generate positive change, there is always the potential for repercussions. Nevertheless, the very nature of oppression calls for an emancipatory spirit of commitment to change.

NARRATIVE ANALYSIS

Narrative analysis seeks to discern insights related to 'how' stories are told. It is perhaps the approach that most often gets chosen without full appreciation of what it entails. Researchers say "I want to hear their stories". What they do not always realise is that narrative analysis focuses more on the manner in which the stories are told than the meaning within the story itself (that is what phenomenology does). This is a very important distinction to make.

Research question

How is the story about going to conference told?

Or *What kinds of stories are told about going to conferences?*

Interview question (You simply want to get them telling stories)

Tell me about going to conferences.

Interview data

Tell me about going to the conference?

I was so busy trying to get everything done to get away to the conference. And it wasn't cheap! When I got there, I was exhausted. But I went to nearly every session. I took copious notes so I could feedback to the others. There were lots of things we need to think about. How would you keep up with all the new evidence if someone didn't get to all the conferences? And I made a point of going around all the stands one lunch time and got all the flyers. There is so much new equipment on offer. Boy, I was tired when I got home, but I had so much to take back to my colleagues.

Initial analysis

Nancy tells her story as a person who has made sacrifice to be the one who attends the conference. She goes feeling a responsibility to the others who could not go. She works hard at ensuring she rewards them with information on her return. Even though she is exhausted, still there is a sense in the way she tells her story that she is the heroine. It is such efforts that help keep practice current. She pats herself on the back. Her heroic efforts are so worthwhile.

= a Quest narrative, meeting the challenge head on and becoming the heroine of her own story.

Philosophical assumptions

- We shape our stories in ways that holds meaning in itself
- It is not so much the content of the story that we are interested in, but the manner of telling
- e.g.: Frank's Illness narratives: Restitution, Chaos, Quest

Narrative analysis mood/process

- It is about listening 'behind' what is said to hear the manner of telling
- Examining how the plot unfolds
- The analysis is about what is revealed by the nature of the telling

Where it leads

- Helps us understand the human experience
- Reveals how culture influences the act of story telling
- Challenges us to consider how the preferred cultural tale shapes the way we give voice to our experience

Key references

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Lieblich, A., Tuval-Maschiach, R. & Zilber, T. (1998). *Narrative Research: Reading, Analysis, and Interpretation.* Thousand Oaks, CA: Sage.

Riessman, C. K. (2008). *Narrative Methods for the Human Sciences.* Los Angeles CA: Sage.

Frank, A. W. (2000). The standpoint of storyteller. *Qualitative Health Research, 10,* 354-265.

Examples of theses

Wilson, J. (2007). *There's no meaning in chocolate: a narrative study of women's journeys beyond the disruption of depression.* Unpublished thesis, Auckland University of Technology http://aut.researchgateway.ac.nz/handle/10292/329

Narrative analysis, like any of the approaches, is best understood by reading good examples. Before you begin such research make sure you are clear that it is about more than simply listening to stories.

FOUCAULDIAN DISCOURSE ANALYSIS

Whereas Gadamer drew our attention to language, and philosophers such as Marx, Habermas and Freire revealed the manner in which power shapes our taken-for-granted social worlds, Foucault moved beyond such understandings to suggest that it is discourse, the way we construct our reality through language, that creates social reality. Further, discourses are always at play, contesting power. The quest of Foucauldian research is therefore to identify the different discourses and how they engage (and contest) with each other.

Research question

What are the discourses at play regarding midwifery conferences?

Or *How is midwifery constructed at midwifery conferences?*

Or *What midwifery practices are more dominant?*

Interview question

There may not be an interview, it may just be analysis of texts

But examples of Interview questions would be:

What drew you to this conference? / What did you get out of it?/ What insights did it give about your practice?/ Did it affirm the understanding you have of yourself as a midwife? /How did it convey the relationship you have with other health professionals?

Text data

Opening Address to the ICM 29th Triennial Congress by Bridget Lynch "Look at where we are, where we sit now, and what we have achieved. This Congress shows what midwives can do when we are united, when we set a goal, and when we work together." Acknowledging global and bilateral partners, Bridget continued, "We cannot do our work alone; we count on the support of our partners nationally and globally. This Triennium has seen global partnership that hasn't been seen before with ICM. I would like to especially recognise our partners SIDA - SIDA has put us on this road. Two midwives in particular …have worked passionately to bring the Swedish government to recognise the vital importance of midwifery and to commit development funds specifically to strengthening midwifery capacity globally."

Initial analysis

There is a strong discourse of global responsibility for childbirth in this passage. The language used: "work together" "united" "we cannot work alone" "partners," signifies this is about collective action. The use of the word "global" signifies this is about every country. There is a sense that a lack of midwifery capacity is every country's responsibility, especially those who are already strong and have access to resources. A global discourse makes it difficult for any member country to step back from such discussions. Further, the collective voice gives a much more powerful message. Midwives take advantage of the ICM conference to gather together their global voice and make statements that have more power because of their collective nature. Thus the knowledge (much discussed at this conference) of alarming maternal and infant mortality rates is reaffirmed on the agenda of global health matters that require the attention of global leaders. The global discourse is about ensuring affluent countries take some responsibility for working towards improved global maternal and infant health.

A marginalised discourse could emerge from a developing nation that did not want global organisations to assume the responsibility for reshaping their maternity service. A discourse of autonomy, of national rights, of the value of local knowledge, could resist in situations where global funders expected the right to determine how funds would be spent.

Philosophical assumptions

- There is no 'given' reality; everything is constructed by discourse
- Power is held within discourses
- Power is always at play
- The marginalised positions can still enact power
- There is usually a dominant discourse which exerts a strong shaping force on what is considered 'right'
- If there is no choice there is 'resistance'

Discourse analysis mood/process

- Always attuned for the different discourses
- Always looking for power at play
- Explores how discourses came into being, and the subject position they offer
- There are multiple truths; difference is how things are
- Need to expose the discourses and their power positions

Where it leads

- Lays out the different discourses
- Reveals dominant discourse, competing discourses, marginalised discourse
- Shows the constructed nature of understanding and reveals power at play
- Shows how people (midwives/women/obstetricians) are positioned in discourse

Key references

McHoul, M. & Grace, W. (1995). *A Foucault Primer: Discourse, Power and the Subject.* London: Routledge.

Mills, S. (2003). *Michel Foucault.* London: Routledge.

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Examples of theses

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Sye, J. (2008). *A fine balance.* Unpublished master's thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/387

Barrington, J. (2008). *Shapeshifting: prostitution and the problem of harm: a discourse analysis of media reportage of prostitution law reform in New Zealand in 2003. A fine balance.* Unpublished master's thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/471

GROUNDED THEORY

Grounded theory, of all the interpretive methodologies, has its origins most closely related to positivism. Its aim is to build data gathered from the phenomena of the study, to explain the processes which occur within the phenomena. It seeks to capture the complexity of actions/strategies that are employed within the phenomena of study. The process of data analysis is aimed towards conceptualisation with increasing abstraction. As with many of the qualitative methodologies, different approaches to Grounded theory have emerged, yet with all:

1. Theory is built from data gathered from the phenomena of study
2. The theory is explanatory of processes which occur within that phenomena
3. The aim is to capture the complexity of actions/strategies that are employed within the phenomena of study
4. In order to develop theory, the grounded theorist uses
   a. Concurrent data collection/data analysis
   b. Data analysis that is aimed towards conceptualisation with increasing abstraction
   c. Codes/concepts developed from initial data analysis which guide the direction of future data collection (theoretical sampling)
5. Memos are used to demonstrate the analytic and decision making processes used in the development of theory

But the principle remains the same: be very clear about the methodological assumptions that guide and shape the research before embarking on the study.

Glaserian grounded theory was the original, from which other variations have developed	
Glaserian	**Charmaz/Strauss/Schatman** type approaches
Research question Aims to discover the problems as identified by the participants and find out how they manage solutions to those problems. E.g. *What is the main concern/problem for midwives attending a conference? and how do they manage that?*	**Research question** 'Midwifery conferences': What all is involved here? **Or** What's happening here?
Interview question (No pre-planned question apart from the opening one) *What is the main problem for you re attending a conference?* – then closely follow what the participant says with prompts	I**nterview question** (No pre-planned question apart from the opening one) *Tell me about going to a midwifery conference* – then closely follow what the participant says with prompts
Interview data Q: Tell me about going to a midwifery conference R: *We know the main ones well in advance but whether we can go or not depends on all sorts of things.* Q: Tell me about that. R: *There are two issues really - getting funding and getting off work to go. Both are just as difficult ....* Q: Some participants have spoken about the funding problem. Tell me more about that. R: *There is funding there but it is a competitive process and the fact that it is there doesn't mean we can go. If I really want to go I would have to pay myself - if I could get the time off work. Etc, etc.*	Q: Tell me about going to a midwifery conference? R: *Well first you have to get chosen to go* Q: Who gets chosen? R: *There's a competitive process for funding* Q: So how does that work? R: *I'm never quite sure. They try to share it around I guess*
Initial analysis Coding; open coding while the researcher identifies emergent ideas. Becomes selective coding once key concepts are identified, e.g. funding and work release.	**Initial analysis** Code: Competing: Against whom? Under what conditions? How do you miss out? Or opt in?

Philosophical assumptions:

- The underlying main concern and the core category will emerge with consistent use of the method.
- The social organisation of a group exists and can be discovered; and
- The concerns of the participants rather than those of the researcher are the focus of the research (Glaser, 1998, p. 44-45).

Philisophical assumptions: pragmatism

Theoretical underpinning: Symbolic Interactionism

- We are interactive, meaning-making, human beings
- We all have patterened ways of being, that are reptitive
- You keep interviewing until the processes revealed are well grounded in deep, rich data

Grounded theory mood/process

- Start with a blank slate
- Analysis: concurrent data collection and analysis. Memos are used to record analytic thinking and methodological decisions in relation to the developing theory
- Code data –who, what, where, why,
  - o Because? Look for the conditions that shift action
  - o Build codes into categories. Codes/concepts developed from initial data analysis guides the direction of future data collection (theoretical sampling)
  - o Through a process of constant comparative analysis
- Through a process of analysis build a conceptual model that explains processes and actions

Where it leads

- Reveals action and conditions that shift action
- Develops a succinct conceptual model
- The 'process' described may be generalisable to similar contexts

Key references

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Morse, J. M., Noerager-Stern, P., Corbin, J., Bowers, B., Charmaz, K & Clarke, A. E. (2009). *Developing grounded theory: The second generation.* California: Left Coast Press.

Strauss, A. (1987). *Qualitative analysis for social scientists.* New York: Cambridge University Press.

Examples of theses

Nayar, S. (2009). *The theory of navigating cultural spaces.* Unpublished doctoral thesis, Auckland University of Technology. http://aut.researchgateway.ac.nz/handle/10292/733

Grounded theory is akin to investigative research where one keeps on asking questions to solve the puzzle. Once 'solved' the resultant theory is presented in a very succinct model, which is likely to be transferable across other situations. Grounded theory perhaps has the most disciplined rigour of the qualitative approaches, allowing the research process to end with an hypothesis.

ACTION RESEARCH

For those who want a more active, involved approach, action research is an option. As implied, it involves the researcher being directly involved in some sort of 'action'. Some action research works from the stance that the researcher must first be invited into a community and support the people in whatever the people want to be researched. At the other end of the participatory continuum, a researcher can take an idea to a group and request their active participation. When using an 'action' approach for a thesis, it is usually wise for the researcher to maintain some degree of control for their thesis has timelines and scholarly requirements.

Research question

How can we plan a conference that more effectively meets the needs of practitioners and impacts practice?

Plan

Who will I work with? How will we determine what practitioners need? How will we find a way of meeting those needs? How will we evaluate success?

Data

A record of 'action' with scholarly discussion incorporated

Philosophical assumptions

- Cyclical: a problem is defined, an action is planned and the action is then performed and evaluated (Usually two or more cycles in a study)
- Responds to the emerging needs of the situation
- Involves participation and collaboration
- Is about a group rather than individuals
- Its aim is to make a difference to practice

Action research mood/process

Pragmatic, better to 'do' than just talk about it, make change happen.

Needs good project management skills

Where it leads

- A change that has already taken place within the research process, with recommendations for how similar change can be enacted

Key references

Coghlan, D. & Brannick, T. (2005). *Doing action research in your own organization* (2nd ed.). London: Sage.

McNiff, J. & Whitehead, J. (2006). *All you need to know about action research*. London: Sage.

Reason, P. & Bradbury, H. (2006). *Handbook of action research.* London: Sage.

Stringer, E. (2007). *Action Research* (3rd ed.). California: Sage Publications.

Stringer, E. (2008). *Action research in education*. (2nd ed.). New Jersey: Pearson Prentice Hall.

Examples of theses

Go to http://aut.researchgateway.ac.nz/ and search for Roz Sorenson, Heather Donald and Andrea Thompson. Their theses are nearing completion.

DISCUSSION

Making the choice of qualitative research methodology is something that seems to just happen. It is my experience that most of us are drawn more toward some methodologies than to others. In reading a paper such as this, it is likely that each reader felt their interest sparked by some approaches and not by others (Smythe & Spence, 2012). Consider the mood of the process as suggested by these descriptions:

Phenomenology is very contemplative and is written in an almost poetic manner, striving to capture understanding that most often stays between the lines. There is a great deal of overlap and merging between hermeneutics and phenomenology, but to be phenomenology it must be grounded in stories of specific experiences. Hermeneutics invites data that can be more about what the participants 'think'. Both approaches call for a love of writing for much of the analysis involves the art of writing to 'see' what one is thinking. A narrative analysis may have stories that are very similar to phenomenological data, but rather than unpacking 'meaning' the research will be intent on perceiving the manner in which the stories were told. For example, is the teller positioning themselves as the heroine or the victim? The researcher stands back to consider what is going on rather than immersing themselves closely in the lived experience. A critical lens is political; the aim of the research would be to reveal power play that shapes, enables or constrains, and from such insights to work towards change. It may take moral courage and tenacity to engage in such a journey, for it is likely that someone has vested interests in maintaining the status quo. Participants are seen as co-participants; the research done in a collaborative, empowering manner. Yet there is also the potential for the deep satisfaction of being part of making empowering change. Foucauldian discourse analysis also explores questions of power, but without necessarily bringing the personal quest of being involved in emancipatory change. Such an approach rather assumes there is always power, it is always at play, and seeks to deconstruct the text to reveal how language (discourses) positions that player and contests power. It requires a keen ear to hear and distinguish the discourses. A grounded theory approach requires both attention to close detail and the ability to conceptualise. There is a beginning stage of doing line by line analysis, coding and categorising. Then one needs to rise above the detail to conceptualise the basic social processes towards generating a theory. It is very satisfying to unveil the findings in a one page conceptual model. Grounded theorists liken the process to detective work, and often are people who delight in jigsaw puzzles. For some the action research methods fit their personality of wanting to make things happen. They are 'doers' who have no wish to produce a lengthy piece of writing. They are much more interested in getting on with what needs to be done, and bring great organisational skills to the process.

It is my experience that most of us are drawn more toward some methodologies than to others.

Recognising the depth of philosophical reading required (or not) for each approach is another important consideration. For example, neither Heidegger nor Foucault is easy to read. My own copy of Heidegger's 'Being and Time' ended up looking like a multi-coloured rainbow. It seemed that each time I went back to try to make sense of what he was saying, I had a different coloured highlighter pen in my hand. On each reading I saw something that had previously passed me by. The understanding came slowly, over time. But such insights, as those gained from other philosophers, richly informed my analysis and enabled me to see meaning in the data that would otherwise have escaped my notice. Philosophical reading is essential if it underpins the approach, and in such cases is always a valuable investment of time. What seems 'hard' in the beginning phase makes the later analysis so much easier.

The best guide to any methodology is to access a thesis that has used that approach. The methodology chapter will unpack the philosophical underpinnings, and the methods chapter will show you how that researcher went about enacting the approach. It is a good idea to practise the style of writing with some pretend data to sense the fit with one's normal way of engagement. If the writing comes with ease, proceed. If not, there is value in talking to someone who has used the methodology. One grounded theorist, for example, can sense another. Some people find it difficult to remove the lens with which they ordinarily see the world. For example, they are always drawn to see the issues of power. Choosing an 'already there' lens brings an ease to the process; one's thinking is able to follow along in an effortless manner.

CONCLUSION

If the harmony of person-methodology-topic-supervisor all comes together in a synergistic manner, methodological congruence is a long way towards being already there. Nevertheless, a key question of any research, and one that needs to be asked again and again, is: "am I still holding true to the chosen approach?" Before that can be answered, the researcher needs to be very clear about the theoretical assumptions underpinning the chosen methodology, and ensure the appropriate methods flow out of such understanding. From my own personal experience and from students whom it has been my privilege to walk alongside, at the end the phrase is often echoed "it was the best thing I have ever done". One learns as much, if not more, about 'self' as the topic of the research. One looks back in awe at the writing that has emerged, polished and insightful. One should not be faint-hearted at the thought of beginning such a journey; but a 'right' beginning is the first step to a great experience. Getting it 'right' means being very clear about the methodological tenets one is adopting, and holding them as a beacon to light the journey.

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PRACTICE ISSUE

What evidence supports the use of free-standing midwifery led units (primary units) in New Zealand/ Aotearoa?

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ABSTRACT

Background: Free-standing midwifery led units (FMLUs) (known in New Zealand as a primary maternity unit), provide midwifery led care for low-risk women in local, family friendly environments which are generally some distance from an obstetric unit (OU) (known in New Zealand as a secondary or tertiary facility). The majority of women in New Zealand/ Aotearoa choose to give birth in an OU and reasons for this choice may be related to safety concerns.

Aim: To identify, compare and critically evaluate published studies on FMLUs to determine the evidence that contributes to safety and may be useful for the New Zealand/Aotearoa maternity context.

Method: Five databases were searched using the search terms: place of birth, midwife-led, primary unit, maternal outcomes, neonatal outcomes. The primary outcome of interest was place of birth and the impact on mortality or morbidity rates for maternal and neonatal health. Secondary outcome measures were intervention rates during labour.

Findings: Three studies were found which compared maternal and neonatal outcomes for low risk women planning to birth in free standing midwifery led units or obstetric units. These studies found less augmentation during labour and higher rates of normal birth in FMLUs. Low-risk women who planned to birth in an OU had higher rates of epidural anaesthesia, instrumental birth, cesarean section and episiotomy rates. Neonatal health appeared to benefit with no differences in mortality rates but higher Apgar scores at 5 minutes and lower rates of admission to a neonatal intensive care unit for babies when birth was planned at a FMLU.

Conclusion: There is strong and consistent evidence to support FMLU birth as a safe option for women experiencing a low-risk pregnancy.

KEY WORDS:

Free standing midwifery led units, midwife-led, primary unit, maternal outcomes, neonatal outcomes

INTRODUCTION

There are many choices for parents when a pregnancy is confirmed, one of which is deciding on where to give birth. In New Zealand/Aotearoa women have the choice of giving birth at home, in a free standing midwifery led unit (FMLU), known in New Zealand as a primary maternity unit, or an obstetric unit (OU) known in New Zealand as a secondary or tertiary maternity unit. However, there are some regions of New Zealand that do not have free standing midwifery units (FMLUs) so women's choice is reduced to either home or an Obstetric Unit (OU). In 2009 there were 52 primary maternity units (FMLUs) in New Zealand most of which are situated in rural or provincial towns although there are several situated within main cities but are still free standing and separate to an obstetric unit (Hendry, 2009; Ministry of Health, 2012a). A primary unit is defined as:

> *"A community-based birthing unit, usually staffed by midwives. Primary birthing units provide access for women assessed as being at low risk of complications for labour and birth care. They do not provide epidural analgesia or operative birth services" (Ministry of Health, 2011a, p. 31).*

Primary units are midwife led units which are physically separate (and often some distance) from obstetric units. For this paper the term FMLU will be used to replace primary unit so as to support consistency with international language. FMLUs provide midwifery led care for women who are well and healthy considered low risk and suited to birthing environments that are relaxed and home like. They are also more likely to be close to women's homes, therefore community based with familiar surroundings, which may have cultural significance for many families/ whanau. It has been argued that midwives need to support and utilise FMLUs because women are more likely to birth normally in these units (Skinner & Lennox, 2006).

Despite this encouragement, many of the FMLUs in New Zealand are reporting low bed occupancy levels whilst OUs are full and often oversubscribed (Canterbury District Health Board, 2012). In 2010, 12.5% of women who had a midwife Lead Maternity Carer (LMC) who was also a

member of the Midwifery and Maternity Provider Organisation (MMPO) gave birth in a FMLU (primary unit) compared to 46.9% in a secondary unit (OU) and 35.4% in a tertiary unit (OU) (New Zealand College of Midwives & Midwifery and Maternity Provider Organisation, 2011). So whilst FMLUs are often available and provide an option for women to birth in their local community, the majority of women in New Zealand are actually giving birth in an obstetric unit. It is not known what role midwives play in the choice of birth place for women.

The choice of birth place is clearly not just dependent on availability but is often a deeply personal decision influenced by both rational and non-rational considerations. These can include influences such as culture, tradition, perceptions of safety, media, fear, previous experiences and the views and expectations of family/whanau and friends (Houghton, Bedwell, Forsey, Baker, & Lavender, 2008; McCourt, Rance, Rayment, & Sandall, 2011). The majority of research exploring choice of birth place has focused on why women choose to give birth at home. There is currently little research exploring the reasons why women do not choose to give birth in FMLUs in New Zealand or whether midwives promote their use.

In the United Kingdom there are a similar range of settings for women to consider when choosing a place of birth. These settings are home, FMLUs alongside midwifery led units (AMLU) and obstetric units (Redshaw, et al., 2011). Alongside midwifery led units are situated within or on the same site as an obstetric unit but care provision is led by midwives. These options are not fully available in all regions with FMLUs more available in the South West of England than elsewhere.

UK research has found that women's view on place of birth is influenced by safety, previous birth experiences, the influences of friends, family and doctors, social class and cultural values (McCourt, et al., 2011). Drivers for choosing hospital birth were access to epidural for pain relief and not needing to be transferred during labour if there was a problem. Women reported being prepared to travel up to two hours from a rural location to their preferred place of birth, and often associated consultant led (obstetric) units with increased safety (Pitchforth, et al., 2008). Often women were unaware of different options and considered that giving birth in an obstetric unit was the norm and a safe environment (Houghton, et al., 2008).

With so many women giving birth in an obstetric unit despite the availability of FMLUs in New Zealand it is likely that women are basing their decisions on similar concerns about safety as in the UK. What is the evidence that supports increased safety of obstetric units when compared to free standing midwifery led units? There have been several structured reviews examining the outcomes and cost effectiveness of FMLUs to ascertain the benefits and harms of these units (Henderson & Petrou, 2008; Stewart, McCandish, Henderson, & Brocklehurst, 2004; Walsh & Downe, 2004). These reviews found that in general women who birthed in FMLUs were more likely to birth normally with less intervention, but that there was a lack of conclusive evidence about neonatal mortality and morbidity. The reviews recommended more research be conducted using robust study designs that would support confidence in the reliability of the findings and in order to provide information to women about the safety of all birth place settings.

The Birthplace in England Collaborative Group have recently published the results of a large well conducted prospective cohort study involving 64,538 women aimed at comparing the perinatal outcomes, maternal outcomes, interventions during labour and the costs for the various options of birthplace in the United Kingdom (Birthplace in England Collaborative Group, 2011). The authors conclude that women planning birth in a FMLU experience fewer interventions than those planning birth in an OU with no impact on perinatal outcomes. This research is being used to provide evidence based information to women and support for low risk women to give birth in free standing midwife led units in England.

The maternity model of care in England, whilst similar to that of New Zealand, also has some differences. The authors of the Birthplace England study caution that their findings may not apply to countries where care is provided differently. So what are the similarities and differences between the UK and New Zealand? Both countries have midwives providing primary care in the community, both have fully funded maternity services, both support choice for women and both provide a choice of birth place which includes FMLUs for intrapartum care. In New Zealand women have universal access to the same midwife from antenatal care through the labour and birth and into the postnatal period. In England this type of continuity of care is less common and universal access to a known midwife is not the usual practice. This means that when transfer of care between units is necessary the women do not generally have a midwife stay with them and continue care in the obstetric unit. This continuity of care may have an impact on birth outcomes.

The choice of birth place is clearly not just dependent on availability but is often a deeply personal decision.

We considered it timely to critically review the evidence relating to the safety of FMLUs and to consider the relevance of those findings to the New Zealand context. Previous reviews of studies published prior to 2004 reported limited evidence on perinatal morbidity and mortality and poor study designs (Stewart, et al., 2004; Walsh & Downe, 2004). Our focus was to identify research studies that have been published since 2004 and in which outcomes could be considered transferrable to or are from the New Zealand context. Our research questions were: What is the evidence of safety for FMLUs and how does this evidence fit the New Zealand context? This paper provides the results of a structured literature review which aimed to identify, compare and critically evaluate published studies on FMLUs to determine the evidence that contributes to safety and may be useful for the New Zealand maternity context.

METHOD

The primary objective of this structured literature review was to assess the elements of maternity care that contribute to safety for the woman and baby. Therefore the search strategy was designed to find all research studies on maternal and/or neonatal outcomes for births planned for free standing midwifery led units. Specific outcomes included interventions during labour, mode of birth, maternal morbidity such as Post Partum Haemorrhage (PPH), 3rd or 4th degree tears and episiotomy, perinatal mortality and morbidity such as stillbirth and neonatal mortality, Neonatal Intensive Care Unit (NICU) admission and low Apgar score

Search Strategy

The authors identified five databases to be searched to ensure a comprehensive review of the literature. Meta-searches of four databases were undertaken Cinahl, Embase, Medline and Pubmed. An additional database Scopus was searched separately. Key words used were place of birth, midwife-led, primary unit, maternal outcomes and neonatal outcomes. Identified studies were also hand searched for further references. Results were restricted to English language, peer reviewed papers and for the years 2004 to 2012.

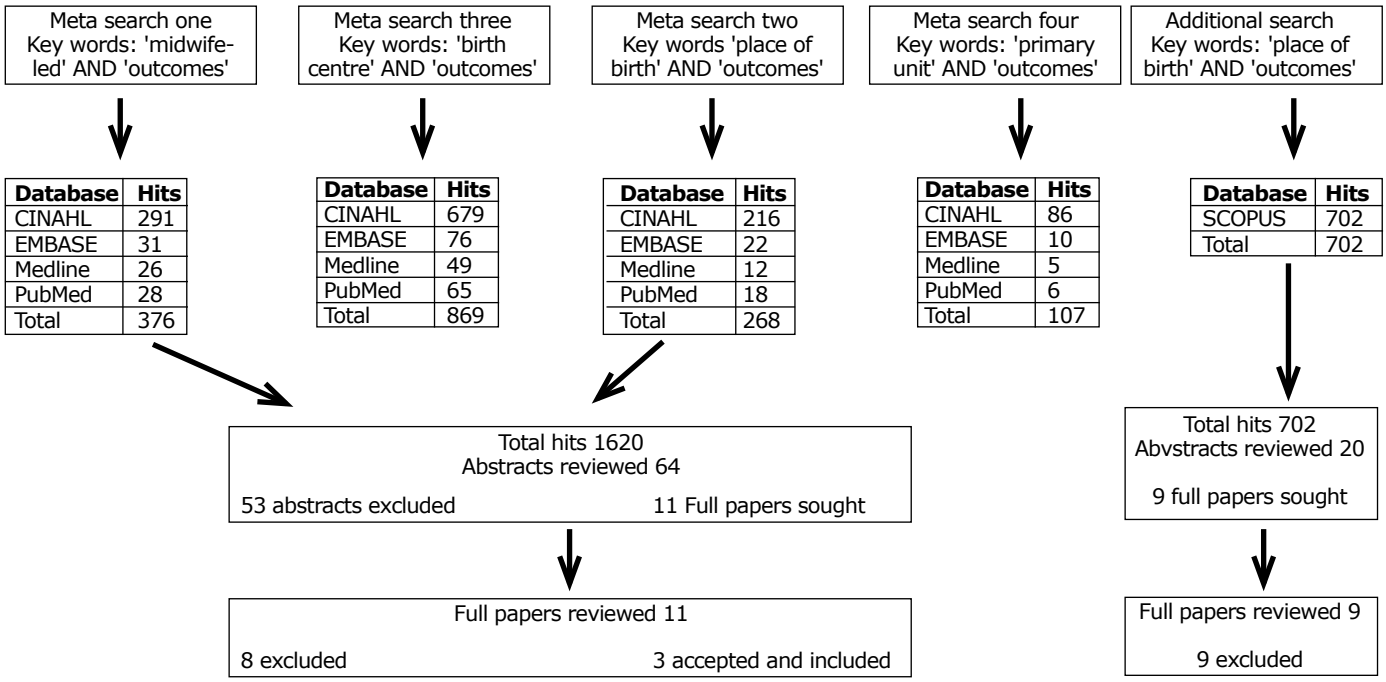
RESULTS

The search resulted in 2322 hits with 84 full abstracts reviewed and 11 full texts retrieved and assessed (figure 1). All identified studies were assessed separately by two authors then discussed together. Studies were selected if they provided maternal or neonatal outcomes.

Excluded Studies

Eight studies were excluded; six of these described outcomes for alongside midwifery units in Ireland, Norway, China, and Australia (Begley, et al., 2011; Bernitz, et al., 2011; Cheung, et al., 2011; Eide, Nilsen, & Rasmussen, 2009; Laws, Tracy, & Sullivan, 2010; Tracy, et al., 2007).

Figure 1 Flowchart detailing literature search for place of birth paper



A further two described outcomes for midwifery led care as opposed to place of birth (Table 1) (Maassen, et al., 2008; Symon, Winter, Inkster, & Donnan, 2009).

Included Studies

Three studies were included which met our search objectives (Table 2). This review has included one prospective cohort study from the UK, a prospective cohort study from Denmark and a retrospective observational study from New Zealand (Birthplace in England Collaborative Group, 2011; Davis, et al., 2011; Overgaard, A Moller, Fenger-Gron, Knudsen, & Sandall, 2011).

Findings

Overview and Quality assessment of included studies

Birthplace in England Study

The aim of the Birthplace in England study was to compare perinatal outcomes, maternal outcomes and interventions during labour by planned place of birth at the start of labour for women with low risk pregnancies (Birthplace in England Collaborative Group, 2011). It was a prospective cohort study involving 64,538 eligible women who were classified as low risk. This national study collected data for women who gave birth in one of the following places: at home, in a FMLU, an ALMU or an OU. Data was collected between April 2008 and April 2010. The results found no significant differences in the adjusted odds (1.00 OU, 1.59 Home, 1.22 FMLU, 1.26 AMLU) of the primary outcome (a composite of perinatal mortality and intrapartum related morbidities) for any of the non-obstetric unit settings compared with obstetric units (Table 3). Interventions during labour were substantially lower in all of the non-obstetric settings (these included homebirth, FMLU & AMLU). There were differences between nulliparous and multiparous women's outcomes depending on place of birth. Nulliparous women who planned to birth at home had an increased odds ratio (OR 2.80, 95% CI 1.66-4.76) for the primary outcome when compared to nulliparous women who planned to birth in a FMLU (OR 1.40, 95% CI 0.76-1.96). Additionally transfers from non-obstetric unit settings were more frequent for nulliparous women.

This study was able to compare outcomes by the woman's planned place of birth at the start of labour and had high participation rates from all the maternity units and hospitals in England. It also had a large sample size with sufficient statistical power to detect clinically important differences in adverse perinatal outcomes. Selection bias was minimised owing to a high response rate and there was the ability to compare groups that were similar for identified clinical risk. A weakness of the study was the use of a composite of perinatal outcomes, both mortality (perinatal death) and morbidity (neonatal encephalopathy, meconium aspiration syndrome etc) outcomes were used. This was because of the low rate of events for individual perinatal outcomes, but putting these two outcomes together may have concealed important differences between planned places of birth. The generalisability of the findings to other settings is problematic as models of maternity care may differ.

Danish Study

The objective of the Danish study was to compare the perinatal and maternal morbidity and birth interventions in low-risk women who planned to give birth either in one of two FMLU or in two OU's (Overgaard, et al., 2011). This was a prospective study involving a cohort of 839 low risk women who planned to give birth in a FMLU. Participants in the study were matched for age, ethnicity, parity and other factors and compared to a control group of 839 low risk women who gave birth in an OU (Overgaard, et al., 2011). The results indicated no increase in perinatal morbidity (poor Apgar scores, admittance to NICU, asphyxia) but significant reductions in caesarean section and increased likelihood of spontaneous vaginal birth for women with low- risk pregnancies who planned to give birth in a FMLU (Table 4). As a prospective cohort study this research had rigorous processes and well defined criteria to ensure that the outcomes for low-risk women were provided. The research was carried out in the same region so there was reduced risk of cultural or regional variances. A complete set of data was obtained and the cohorts were matched and adjusted to reduce the influences of confounding factors. However, the risk of confounding by unknown factors persists because of the study design.

New Zealand study

The New Zealand study was a large retrospective cohort study describing mode of birth according to birth place settings and intrapartum and perinatal outcomes using data extracted from the Midwifery and Maternity Provider Organisation (MMPO) database (Davis, et al., 2011). The MMPO is an organisation which supports self employed LMC midwives to manage their practice. It assists midwife members with payment claims and collects summary data based on the clinical information submitted by midwives. The database provides national data collected prospectively for a large number of women who birth in New Zealand. In this research study the cohort involved 16,453 low- risk women who gave birth between 2006 and 2007 and who planned to birth at home, in a FMLU (primary unit) or in an OU (secondary/tertiary unit). The results demonstrated that low-risk women planning to birth in a secondary or tertiary hospital had a high incidence of cesarean section,

Table 1 Excluded studies

Authors and country	Study design	Sample size	Inclusion / exclusion criteria	Outcome measures	Main findings	Reason for exclusion from review
Begley et al 2011 Republic of Ireland	Randomised trial intention to treat analysis	1653 women randomised 1101 to MLU (Midwife Led Unit), 552 to CLU (consultant led unit	Comprehensive exclusion criteria to determine risk factors including demographic characteristics, medical, gynaecological and obstetric history	9 key maternal and neonatal outcomes including caesarean birth, induction, episiotomy, instrumental birth, Apgar score<8, PPH, breastfeeding initiation, continuous EFM, augmentation of labour	No significant difference in seven key maternal and neonatal outcomes. MLU women significantly less likely to have continuous EFM and augmentation of labour	Alongside midwifery led unit
Bernitz et al 2011 Norway	Randomised controlled trial	1111 low risk women randomised to special unit, normal unit or midwife led unit	Low risk at onset of labour defined by inclusion criteria matching selection criteria at the MLU	Primary outcome was operative delivery rate. Secondary outcomes were augmentation, pain relief, PPH, sphincter injuries, intrapartum transfer, Apgar score<7, metabolic acidosis and transfer to NICU	No significant differences in operative delivery rates, PPH, sphincter injuries or neonatal outcomes. Significantly less augmentation, epidural analgesia in MLU.	Alongside midwifery led unit
Cheung et al 2011 China	Retrospective cohort study plus questionnaire survey	226 women accessing MNBU matched with 226 controls accessing standard care	Term women with singleton cephalic pregnancy, no complications of pregnancy or significant medical problem and a normal CTG trace were included	Mode of birth and model of care	Vaginal birth rate of 87.6% in MNBU (Midwife-led Normal Birth Unit) compared to 58.8% in standard care unit	Alongside midwifery led unit
Eide et al 2009 Norway	Prospective non randomised observational study	252 women in MLW and 201 women in CDW (Conventional Delivery Ward). Allocation was alternated between MLW and CDW	Low risk women who met the criteria for delivery in the MLW (Midwife Led Ward) who did not have a preference were allocated to either MLW or CDW. Women requesting epidural were excluded	Maternal intervention rates, caesarean section and instrumental birth rates.	No significant difference between emergency caesarean and instrumental rates. Higher incidence of episiotomy, epidural analgesia, pudendal nerve block and nitrous oxide in the CDW. Higher incidence of opiate and non-pharmacological pain relief in the MLW	Alongside midwifery led unit
Laws et al 2010 Australia	Retrospective analysis of population database	822,955 mothers and 836,919 babies. 2.7% (22,222) of these women intended to birth in a birth centre	Women aged 20-34 yrs, who had a singleton baby of >2500g. Women who had hypertension or diabetes (pre-existing or gestational) were excluded	Maternal and neonatal outcomes including method of birth, onset of labour, episiotomy, third fourth degree tear, Apgar score, admission to NICU	Lower rates of intervention and adverse perinatal outcomes for women in birth centres. No significant difference in perinatal mortality for low risk women at term.	Alongside midwifery led unit
Maassen et al 2008 The Netherlands	Retrospective analysis of national database	107,667 low risk women; 87,817 in primary care with midwife, 19,850 in secondary care with obstetrician	Inclusion and exclusion criteria as assessment of risk clearly defined	Primary outcome: rate of operative deliveries	Significantly lower rates of operative vaginal birth, caesarean section in primary care group. Significantly lower rates of primiparous caesarean section in primary care group. Significantly higher rates of spontaneous vaginal birth for multiparous and primiparous women in primary care group	Comparison of model of care (midwife verses obstetrician) not place of birth
Symon et al 2009 UK	Retrospective matched cohort analysis	8676 women; 1462 cared for by independent midwives (IMA) matched with 7214 cared for by NHS midwives (NHS)	All women cared for by independent midwives in UK between 2002-2005	Primary outcome: rate of unassisted vertex delivery. Secondary outcomes; live birth, perinatal death, onset of labour, gestation, use of pharmacological analgesia, duration of labour, apgar scores, admission to NICU and infant feeding	IMA mothers were significantly more likely to have an unassisted vertex birth but were also more likely to experience a stillbirth or neonatal death. Exclusion of high risk pregnancies made this a non significant difference. The low risk IMA perinatal mortality rate is comparable to other low risk studies. IMA mothers were more likely to have a spontaneous onset of labour and use less pharmacological pain relief	Comparison of model of care not place of birth
Tracy et al 2007 Australia	Retrospective population based study	1,001,249 women of whom 21,800 gave birth in a birth centre	All women who gave birth in Australia between 1999-2002. Multiparous and primiparous women analysed separately	Perinatal outcomes including stillbirth and perinatal death	Perinatal death rate was significantly lower in birth centres than in hospitals irrespective of parity	Alongside midwifery led unit

Table 2 Included studies

Authors and country	Study design and sample size	Inclusion / exclusion criteria	Outcome measures	Main findings	Comments
Birthplace in England Collaborative Group 2011 UK	Prospective cohort study 64538 women Cohorts were by planned place of birth; home, standalone MLU, alongside MLU, stratified sample of obstetric units	Singleton pregnancy at term included planned caesarean section or caesarean section prior to labour were excluded	Composite primary outcome measure of perinatal mortality and morbidity. Secondary outcomes were maternal morbidities, interventions and mode of birth	No significant differences in primary outcome for any non obstetric setting compared with obstetric units. Nulliparous women who planned a home birth had higher odds of primary outcome	Sub analysis was conducted to differentiate between low risk and higher risk pregnancies
Overgaard et al 2011 Denmark	Retrospective matched cohort study 839 low risk women intending FMLU birth matched with 839 low risk women intending obstetric unit birth	All women who were admitted to FMLU in labour between 2004 and 2008. Controls were matched to individual obstetric and social characteristics	Perinatal and maternal morbidity and interventions	No differences in perinatal morbidity. Significantly reduced incidences of maternal morbidity, birth interventions and increased likelihood of spontaneous normal birth for women intending FMLU birth	Four units were compared two FMLU and two obstetric units
Davis et al 2011 New Zealand	Retrospective cohort study 16453 Low risk women	Low risk women defined by range of medical and obstetric criteria	Mode of birth, intrapartum interventions, neonatal outcomes	Higher risk of caesarean section, assisted modes of birth and intrapartum intervention for women planning to birth in secondary or tertiary unit plus higher risk of neonatal admission to NICU	Data collected from MMPO database

Table 3 Maternal and Neonatal Outcomes for the Birthplace in England study

Birthplace in England Collaborative group 2011						
	FMLU		CI 99%	OU		CI 99%
Mode of birth	N =11280	%		N = 19688	%	
Spontaneous vaginal birth	10,150	90.7	(89.1-92.0)	14,645	73.8	(71.1-76.4)
Ventouse birth	321	2.7	(2.0-3.5)	1535	8.1	(6.4-10.1)
Forceps birth	365	2.9	(2.3-3.7)	1307	6.8	(5.4-8.4)
Intrapartum caesarean section	405	3.5	(2.8-4.2)	2158	11.1	(9.5-13.0)
Interventions during labour						
Syntocinon Augmentation	878	7.1	(6.0-8.5)	4549	23.5	(21.1 – 26.2)
Epidural	1251	10.6	(9.1-12.3)	5817	30.7	(27.5-34.2)
Immersion in water	5253	45.7	(35.6-56.3)	1836	9.1	(6.4-12.6)
General anaesthesia	61	0.5	(0-3-0.8)	285	1.5	(1.1-1.8)
No active management of 3rd stage	2568	22.1	(15.8-30.0)	1188	6.1	(4.6-8.1)
Maternal morbidity						
Third of fourth degree tears	259	2.3	(1.9-2.9)	625	3.2	(2.7-3.7)
Episiotomy	995	8.6	(7.3-10.1)	3780	19.3	(17.4-21.4)
Neonatal mortality & morbidity composite	**N = 11,199**		**Per 1000 (95% CI)**	**N = 19551**		**Per 1000 (95% CI)**
Overall cohort	41		3.5 (2.5-4.9)	81		4.4 (3.2-5.9)
Without complicating conditions at start of labour	N= 10,571		N=15676			
	35		3.2 (2.3-4.6)	48		3.1 (2.2-4.2)

**neonatal composite outcomes were: stillbirth after start of labour care, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus or clavicle*

assisted births and other interventions when compared to women planning to birth at home or in a FMLU (Table 5). Additionally, women planning to birth at home or in a primary unit had less incidence of the baby being admitted to a neonatal intensive care unit.

The observational research design of this study increases the possibility for selection bias and there is a possibility that confounders (such as Body Mass Index (BMI) and socio-economic status which were not defined) could have had an influence on outcomes. Additionally, when there are multiple comparisons being made from a large database it is possible that some results may reach significance by chance. However, the level of significance for many of the outcomes this study measured were at the level of 0.001 or less thereby reducing chance outcomes to one in a 1000. The study was not powered to detect differences in perinatal mortality.

OUTCOMES

Maternal outcomes

Interventions during labour

The Birthplace in England study found women had less intervention during their labour and birth when they planned to birth in a FMLU compared with women who planned to birth in an OU (Table 3). The results included women whose planned place of birth changed during labour. They found reduced rates of syntocinon augmentation,

Table 4 Maternal and neonatal outcomes for the Danish study

Danish Study (Overgaard et al., 2011)	FMLU n = 839 women		OU n = 839 women		RR 95%	P Value
Mode of birth	N	%	N	%		
Spontaneous vaginal birth	796	94.9	751	89.5	1.06 (1.03-1.09)	0.000
Instrumental birth	25	3.0	61	7.8	0.4 (0.3-0.6)	0.000
Caesarean section	19	2.3	34	04.0	0.6 (0.3-09)	0.04
Interventions during labour						
Augmentation	69	8.2	154	18.6	0.5 (0.3-0.6)	0.000
Epidural (pain relief)	35	4.2	85	10.3	0.4 (0.3-0.6)	0.000
Water tub for pain relief	269	32.1	197	23.5	1.4 (1.2- 1.6)	0.0001
Maternal morbidity						
Third and fourth degree tears	19	2.3	24	2.9	0.8 (0.4-1.4)	0.5224
PPH > 500 mls	29	3.5	68	8.1	0.4 (0.3-0.7)	0.0001
PPH > 1000mls	11	1.3	14	1.7	0.8 (0.4-1.7)	0.6900
Perinatal morbidity						
Neonatal asphyxia	27	3.2	41	4.9	0.7 (0.4-1.1)	0.1143
Apgar score <7 at 5 minutes	5	0.6	5	0.6	1.0 (0.3-3.4)	1.0000
Admission to NICU	28	3.3	42	5.0	0.7 (0.4-1.1)	0.1143

Table 5 Maternal and Neonatal outcomes for NZ planned place of birth study

Planned place of birth in New Zealand (Davis, et al 2011)	Primary Unit (FMLU) n = 2873		Secondary unit (OU) n = 7,353		Tertiary Unit (OU) n = 4,095		P value for tertiary unit
Mode of birth	N	%	N	%	N	%	
Spontaneous vaginal birth	2,722	94.7	6,216	84.5	2,979	72.7	
Ventouse birth	34	1.1	352	4.8	304	7.4	
Forceps birth	24	0.9	161	2.2	201	4.9	
Caesarean section	91	3.2	622	8.5	610	14.9	
Interventions during labour	**Ref**		**Adjusted RR (95% CI)**				
Augmentation	1.0		1.91 (1.73-2.10)		1.87 (1.68-2.08)		**0.001**
Artificial Rupture of Membranes	1.0		1.49 (1.34-1.65)		1.51 (1.35-1.70)		**0.001**
Pharmacological pain management	1.0		1.49 (1.36-1.64)		1.64 (1.47-1.82)		**0.001**
Maternal morbidity							
Perineal trauma – level not stated	1.0		0.83 (0.76-0.91)		0.91 (0.82-1.02)		**0.098**
Episiotomy	1.0		1.88 (1.54-2.30)		2.91 (2.37-3.57)		**0.001**
PPH >1000mls	1.0		1.20 (0.80-1.81)		1.39 (0.90-2.16)		**0.138**
Neonatal outcomes							
Apgar score <7 at 5 minutes	1.0		1.39 (0.87-2.22)		1.58 (0.95-2.61)		**0.077**
Admission to NICU	1.0		1.40 (1.05-1.87)		1.78 (1.31-2.42)		**0.001**

**Relative risks adjusted for age, parity, ethnicity & smoking*

reduced rates of epidural and general anaesthesia and increased use of water immersion and non active third stage. The Danish study also reported lower rates of oxytocin augmentation and epidural anaesthesia and increased use of water for pain relief for low-risk women who planned to birth in a FMLU (Table 4). The New Zealand study found significantly higher levels of intervention for women who birthed in a secondary or tertiary unit. The primary unit was used as the reference point in the analysis. The tertiary units had an adjusted relative risk of 1.87 (CI 95% 168-208 P < 0.001) for augmentation during labour as well as increased risks for artificial rupture of membranes and pharmacological pain management (Table 5).

Mode of birth

The England birthplace study reported higher rates of spontaneous normal vertex birth (90.7%) for women who planned to birth in FMLUs and higher rates of operative births for women who planned to birth in an OU (Table 3). The Danish study also reported higher normal birth rates (94.9%) and lower operative births for women who planned birth in a freestanding midwifery led unit (Table 4). The New Zealand study similarly found higher rates of vaginal birth for low-risk women who gave birth in a primary unit (94.7%) compared to low-risk women birthing in secondary units (84.5%) and tertiary units (72.7%).

Maternal morbidity

Maternal morbidity outcomes for each study varied with some overlap between studies. The Birthplace England study reported reduced rates of third and fourth degree tears for women who planned to birth in a FMLU. The Danish study also reported reduced rates of third and fourth degree tears and PPH although the differences between units for PPH of more than 1000mls were not significantly different (Table 4). The New Zealand

study found that the adjusted relative risk of episiotomy for women who planned a tertiary unit birth was 2.91 (CI 95% 2.37-3.57) times that for a woman planning a primary unit birth. For PPH of more than 1000mls, the adjusted relative risk for a woman planning a tertiary unit birth was 1.39 (CI 95% 0.90-2.16) times that of a woman planning a primary unit birth.

Neonatal outcomes

The UK birthplace study reported on the perinatal mortality and morbidity for the whole cohort as 4.3 per 1000 (CI 95% 3.3 – 5.5). This included outcomes such as stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus or clavicle as an adverse event. For women without any complicating conditions at the start of labour, the rate of adverse events was 3.1 per 1000. Differences between the FMLUs and the OUs reduced when this restriction was applied to the cohort (Table 3).

The Danish study found no difference in perinatal morbidity between infants of low-risk women who intended to birth in a FMLU compared to OUs (Table 4). There was one neonatal death in the total cohort which was due to a severe diaphragmatic hernia not detected on ultrasound screening.

The New Zealand study was not powered to detect differences between place of birth and perinatal mortality but did report on Apgars of less than 7 at five minutes and admission to NICU (Table 5). For women with low-risk pregnancies who planned to give birth in a tertiary unit the adjusted risk ratio of having a baby with an Apgar of less than 7 at five minutes was 1.58 (CI 95% 0.95- 2.61) times that of a woman with a low- risk pregnancy planning to birth in a FMLU. The risk of admission to a NICU for a baby of a woman with a low-risk pregnancy who planned to birth in a tertiary unit was 1.78 (CI 95% 1.31-2.42) times that of a woman planning a FMLU.

Transfer to an obstetric unit

Both the Birthplace UK study and the Danish study reported on transfer rates between free standing midwifery led units and obstetric units (Table 6). There were variations in the rate of transfer between the studies but similarities in transfer rates for nulliparous women. The New Zealand study did not report data on transfers.

Table 6 Transfer rates for Danish and Birth in England studies

Transfers from freestanding midwifery led unit	Birthplace in England	Danish Study
Overall transfer rates	21.9%	14.8%
Before the birth	16.5%	11.5%
After the birth	4.8%	3.2%
Nulliparous women	36.3%	36.7%
Multiparous women	9.4%	7.2%

DISCUSSION

This literature review has been structured in a systematic way so that findings which are central to the issues could be rigorously and systematically mapped out and critically appraised. A clearly identified question and search strategy was utilised. Differing quantitative research designs were included as it was considered that randomised control trials may not be feasible for this research issue. Two well designed prospective cohort studies and an observational study have been included in this review. Well designed cohort studies can provide several advantages. They can demonstrate causal associations, provide direct calculation of the incidence of risk and allow different and sometimes uncommon outcomes to be assessed.

The aim of this review was to compare and critically appraise published studies on FMLU's to determine the evidence that may be transferrable to the New Zealand maternity context. The three studies identified by this review have demonstrated similar and consistent outcomes. This review has appraised data on a total of 14,998 women and their babies, who planned to birth in a FMLU, of which 19% (n=2,877) were from the New Zealand maternity context. It was found that when low-risk women planned to birth in a FMLU there was less augmentation of labour and increased rates of spontaneous vaginal birth when compared to women who gave birth in an OU. There was a concomitant reduction in the rates of instrumental birth, caesarean section and episiotomy when compared with outcomes for low-risk women who planned to birth in an OU. Neonatal health appeared to benefit with no differences in mortality rates but higher Apgar scores and lower rates of admission to a neonatal unit for babies when birth was planned in FMLU. Thus there would appear to be substantial health and safety benefits for low-risk women and their babies who plan to birth in FMLU.

The New Zealand context

Can the results of this review be generalised to the New Zealand maternity context? There are clearly some similarities and differences between the New Zealand maternity system and those of Denmark and England. In New Zealand women are universally able to access continuity of care from a LMC midwife or her backup (Ministry of Health, 2011a). The woman meets the midwife LMC when first pregnant and all antenatal care is provided in the community by the midwife. This enables the development of a relationship with the woman and her family/whanau which includes intrapartum care planning and provision. Additionally, when a woman requires transfer to an obstetric unit the midwife will often accompany the woman and continue to provide care. Having a midwife who knows the woman may enhance and support increased safety because the midwife has an in-depth knowledge of the woman, her obstetric, medical and pregnancy history which can be shared with other health professionals when required. This model of care enhances satisfaction with maternity services. The recently published consumer satisfaction survey indicates that LMC midwifery care achieves the highest level of satisfaction (Ministry of Health, 2012a).

This model of care is not universally available in either Denmark or England although continuity of care is considered important in England with the following commitment statement made in 2007 by the Department of Health (Department of Health, 2007).

> *… every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth* (p5).

The maternity service in the UK is striving to support continuity of midwifery care for the antenatal and postnatal periods but universal access to full continuity involving the provision of intrapartum care is not available except for women planning a homebirth (National Childbirth Trust, 2008). In Denmark maternity care is more fragmented with provision of antenatal and postnatal care in the community by midwives with hospital midwives providing intrapartum care. The free standing midwifery units were considered innovative for the Danish maternity situation and were closed during the study period by the Danish National Board of Health owing to concerns that a new model of care had been introduced without sufficient evaluation (Overgaard, et al., 2011). Yet the move to and centralisation of births to obstetric units has occurred with little evaluation in many countries.

Although the model of maternity care is different in each country midwifery care is the key determinate of the differences between the obstetric units and midwifery led units. Midwifery led care is often considered a 'social' model of care and characterized by a philosophy that views birth as a physiological and social process (National Childbirth Trust, 2011; New Zealand College of Midwives, 2008; Wagner, 1994). Care provision within midwifery led units will often follow this philosophy of care with a focus on emotional and psychological support as well as physical care (National Childbirth Trust, 2008; New Zealand College of Midwives, 2008; Smythe, Payne, Wilson, & Wynward, 2009). FMLUs offer welcoming family friendly environments which support the woman and her family by providing a range of options such as different positions for labour, alternative non-pharmacological approaches to help women cope with pain and positive reinforcement (National Childbirth Trust, 2008; Smythe, et al., 2009). Women reported more satisfaction with FMLUs in the UK stating that they had a greater sense of freedom, more privacy and autonomy and were more likely to be able to walk around (National Childbirth Trust, 2008). They were also more able to control who came into the room as well as control the lighting, set up and temperature of their environment. This philosophy of woman-centred care is the key similarity in the care provision in FMLU's.

There has been a move within the United Kingdom to increase choice for women by providing increased access to midwifery led care and more availability of midwifery led birthing facilities (Department of Health, 2007). In 2007 only 2% of women in England gave birth in a FMLU (Birthplace in England Collaborative Group, 2011). The proportion of trusts providing FMLU in the UK has subsequently increased from 18% in 2007 to 24% in 2010. In a recent survey of 121 women in the UK 62.8% of respondents reported that they would choose to have their baby in a FMLU

because of the homely environment, accessibility and ability to use water for labour (Rogers, Harman, & Selo-Ojeme, 2011). The main reason given among those who would prefer to birth in an obstetric unit were concerns about safety. The results of the Birthplace in England research are being used to provide women with evidence to facilitate their decision making about place of birth (Birthplace in England Collaborative Group, 2011).

An issue that has been highlighted by this review is the differences in transfer rates between England (21%) and Denmark (14.8%). It is unclear why this is but these differences could be caused by a variety of influences such as differences in labour care and management, distance from an obstetric unit or confidence levels of the midwives or mothers. Both studies that reported this outcome measure found a higher rate of transfer for nulliparous women. The level of transfer in New Zealand was not reported in the New Zealand study that was used but overall transfer rates are reported in the NZCOM/MMPO annual reports. The report for 2010 found that approximately 16% of women transfer from a primary unit during labour (New Zealand College of Midwives & Midwifery and Maternity Provider Organisation, 2011). Higher numbers of multiparous women (14.6%) give birth in a primary unit than nulliparous women (9.5%).

New Zealand has a set of referral guidelines recently updated, which outline the criteria for referral to secondary/tertiary services along with process maps that provide pathways to support transfer during intrapartum care (Ministry of Health, 2011a). These guidelines are designed to support national consistency whilst also ensuring that the woman, her baby and family/whanau remain at the centre of any discussions and decision-making. These long standing national guidelines may have an influence on the rates of transfer as they are used nationally to support decisions about place of birth and transfers from primary to secondary/tertiary services. Transfer rates may also be influenced by geography/rurality.

The results of this review indicate benefits for both maternal and neonatal health when low- risk women plan to give birth in a FMLU. We would argue that the results of this review are transferrable to the New Zealand context.

Midwives need to discuss and share these findings with women and their families/whanau. Information resources need to be designed that support decision making and choice for women and which take into account the outcomes for each birth place setting.

IMPLICATIONS FOR FURTHER RESEARCH

More research is needed in New Zealand exploring the choices of place of birth. Who and what influence women's decision making about birth place setting? There is also a need for a specific prospective study of maternal and perinatal outcomes (as per the Birthplace in England study) for planned place of birth for all settings and which is powered to detect differences in neonatal outcomes. This will provide more specific evidence for the New Zealand maternity sector and provide detailed information on outcomes, transfer rates and the safety of primary units for low risk women.

CONCLUSION

There is now strong and consistent evidence that women with low- risk pregnancies who plan to birth in a FMLU are more likely to have a normal birth, have less intervention during labour and experience low levels of perinatal mortality and morbidity. Giving birth in an obstetric unit increases the likelihood of intervention during labour and subsequent morbidities for the low- risk mother without any improvement in perinatal outcomes. The similarities in outcomes of the included studies in this review add to the midwifery knowledge base and provide important evidence indicating that the optimal place of birth for low-risk women is in a FMLU. These units provide low key individualised care for women in a calm and comfortable environment.

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PRACTICE ISSUE

Women's Experience of the Abdominal Palpation in Pregnancy; A Glimpse into the Philosophical and Midwifery Literature

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ABSTRACT

This paper describes a literature review which was undertaken following a personal narrative in which abdominal palpation during pregnancy was experienced. When a midwife touches a woman's abdomen, the woman is both touched, and touches; perhaps for a moment at least, their worlds are intertwined. The aim of this paper is to try to come a little closer to understanding women's experience of abdominal palpation in pregnancy. The literature reviewed has been drawn from midwifery, philosophy, sociology, and critical feminism. The opening vignette is one woman's experience of abdominal palpation. It is her story of recounting experience, and un-packing the meaning of that experience, that steers and drives this work.

Some literature explicitly addressed the experience of touch for the pregnant woman; much of the reviewed work did so only obliquely, by inference, or by chance. This gave the opportunity to divide the literature into three clusters or categories: Touching at a Distance, Touching the Edges and Exploring Touch.

KEY WORDS:

Pregnancy, Abdominal Palpation, Touch

BACKGROUND:

Abdominal palpation in pregnancy is a routine procedure performed by midwives. Over the course of a pregnancy, and certainly from 20 weeks gestation, many palpations may be performed (National Institute for Health and Clinical Excellence, 2008, p. 112). The purpose of antenatal palpation is as a screening tool which reveals which pregnancies require further investigations (Bharj & Henshaw, 2011; Griffiths, Pinto & Margarit, 2008; Grigg, 2010).

A typical set of hand-held antenatal notes carried by women in New South Wales, Australia, includes written and graphical records of several abdominal palpations. Brief coded inscription and abbreviations offer clinical clues related to fetal position, engagement, movement and growth to the next professional (whether midwife, general practitioner or obstetrician) in timely ordered expressions of surveillance. Midwifery texts and education emphasise the need for abdominal palpation skills and thoughtful interpretation (Bharj & Henshaw, 2011; Grigg, 2010). The woman who bares her abdomen for inspection and touch during each abdominal palpation is not revealed in those notes. The experience of abdominal palpation itself appears invisible, the woman silenced.

This literature review which follows one woman's personal narrative, explores the notion of women's experience in an attempt to unveil the moment of palpation for her, to reveal her as far more than inscription, code, or abbreviation. The purpose is to explore how the phenomenon of the women's experience of abdominal palpation during pregnancy is described within the literature. The woman's personal narrative is set in the Australian outback and provides an insight into the teaching of 'touch' in a group setting. Whilst this is an unusual way of teaching, (and not one commonly used or advocated in New Zealand) the experience itself provided a rich description of the differences between individuals and how their 'touch' can feel to women.

Highlighting vignette – Hilary's Story

In 2004, in the seemingly never-ending dusty-soft hazy intense summer heat of Central Australia, my pregnant wife (Hilary) graciously consented to working closely with the latest nurses who were 'going remote'. A few were midwives; most were not. Over the intense two-week course they were to practice palpation under the watchful gaze of two experienced midwifery lecturers.

Hilary lay on a couch, slightly on her left side, and a sheet was placed over her feet, up to her chest; she was wearing a simple summer dress. She pulled her dress up above her rounded abdomen, and allowed herself to be palpated.

The group ranged from postgraduate nurses in their early 20s, to mature-aged, experienced registered nurses in their 50s. Hilary was not anxious or nervous; she was relaxed and revealed her usual peaceful calm. Keen to protect and ensure her comfort and dignity, the teachers wanted their charges to learn or revise palpation; after all, it's always good to know at the beginning of labour if the fetus is breech if you are in remote, outback Australia and awaiting the Royal Flying Doctor Service plane to arrive. The midwifery lecturers demonstrated palpation with respect and professional competence, and would invite the nurses to do likewise.

Somehow I'd imagined a clinical, hands-on, learning opportunity that would be embraced by the nurses. In fact, as Hilary later relayed to me, this was rarely the case. Some nurses would hang back, nervous as foals. With encouragement from both Hilary and the two slightly bemused midwifery teachers, a nurse might came forward, perhaps hesitant and needed cajoling. The nurses and midwives were gentle, respectful, and kind, but anxious. Hands were a mixture of soft, warm, cool and slightly rough; touch was fearful, gentle, confident, shaking, light as an evening's soft breeze, thoughtful, considerate, wondering and even in the case of the Remote Area Nurses who were also midwives, knowing.

It seems that the moment of palpation can be steeped in interpretation and experience for the woman and for the midwife.

There was intense quiet, almost silence; some gentle instructions could be heard above the hum of the air-conditioning. Afterwards, a younger nurse who was also a midwife came forward as Hilary was just leaving, and thanked her. Spontaneously and with moist eyes she embraced my wife and hugged her. Another of the nurses in his mid-30s was a New Zealander going out to the Tanami desert for the first time. This man picked up on my wife's citizenship (greenstone fish-hook), breached his shyness and told her the feel of our baby moving beneath his fingertips was amazing.

Describing these experiences to me later, Hilary made one of those casual, throwaway remarks that end up quietly metamorphosing into something bigger. You can, she reflected, tell a lot about a person from their hands.

Interpreting the Experience

Hilary's narrative of the touch of hands and 'knowing' the nurses through their hands seemed predicated on spontaneous knowledge, the essence of those moments, but through Hilary's prism of experience, too. As a (male) midwife, I had probably given the woman's experience of palpation fairly little thought until then, but was willing to learn, think, and be challenged; "Unless we spend time looking back to see who we are, how we have been shaped, and therefore what we bring to a particular encounter, then we have missed a vital step towards being open to the 'other'" (Smythe, 2007, p. 401).

Paul Ricoeur (1913 – 2005) asserts that the meaning of experience is always mediated through cultural, religious, historical, political and scientific interpretations (Kearney, 2005). Like Smythe, Ricoeur suggests that such hermeneutic interpretation firstly provides a basis for an'ethic of hospitality' (ibid, 2007, p. 155), in which we take responsibility in imagination and in sympathy for the story of the other. Interpretation, as Hilary's narrative illustrated, is also based on pure intuition, or essence – the touch of hands, 'knowing' those nurses through their hands. Investigating this essence is phenomenology, described by philosophers such as Husserl, Heidegger, Levinas and others. Rather than being in opposition to each other "there exists between phenomenology and hermeneutic interpretation a mutual belonging" (Ricoeur, 1975, p. 85). In trying to find further meaning in Hilary's story, and by inference in the experience of other women, the literature search began.

Literature search and review strategy

The review process was guided by integrative review methods (Whittlemore and Knafl, 2005). Integrative reviews are broad and allow for inclusion of experimental and non-experimental research, theoretical and empirical literature, peer reviewed and grey literature. An extensive search of the literature involved using multiple databases and search engines including EBSCO Host (Health and Psychology), SOCIndex, Medline, CINAHL and PSYCHINFO. Keywords used for search purposes included 'experience' 'touch', 'abdominal palpation', 'pregnancy', and 'antenatal' with Boolean operators. Limitations were set to studies on humans and in the English language.

The search found no studies which specifically addressed the woman's experience of abdominal palpation during pregnancy. Some papers occasionally had a sentence, a hidden kernel, that included the woman hidden within a text, and was pounced upon with delight. A variety of midwifery textbooks were also searched. Again, very little information was sourced that related to women's experience of abdominal palpation. By both necessity and choice, the search was widened to include grey literature written by two women who have greatly influenced midwifery practice: Ina May Gaskin (2002) and Sheila Kitzinger (2005), before moving on to philosophical literature pertaining to touch.

This review of the literature focused on the words experience and woman. All the literature pertaining to abdominal palpation that dismissed, ignored or neglected these keywords was placed to one side. Literature that was selected for consideration included three widely used midwifery textbooks (Fraser & Cooper, 2009; Macdonald & Magill-Cuerden, 2011; Pairman, Tracy, Thorogood & Pincombe, 2010), the work of Gaskin, 2002 & Kitzinger, 2005, and then texts sourced from sociology, critical feminism and philosophy (Butler, 1989; Derrida, 2005; Iragaray, 1983, 1985; Merleau-Ponty 1964; Ricouer, 1975; van Manen 1999, 2001, 2002;).

What's going on here?

Returning to the woman's narrative again, set in that small room in Central Australia; the touchers touched, and are touched; all is feeling, all is colour; 'something else' seemed to be going on. If the rationale for abdominal palpation is under-pinned by assessing uterine size and fetal well-being, then all is fine. Yet the woman's narrative seemed to suggest a different understanding – a kind of primordial, ancient, instinctive, pre-reflective experience for both woman and practitioner; a moment of humanity and science entwined.

'What's going on here?' became an important question in seeking to understand (doubtless influenced by the introductory narrative) that for the woman something primordial, ethereal, even strange might be taking place at the moment of palpation. This moment surely deserves careful contemplation and reflection. Is there an essence of treasure hiding which might reveal itself – or remain hidden? In Imaginarer Lebanslauf, Rainer Rilke talked of God stepping out from his hiding place (Snow, 2009 p. 567), but perhaps this experience will remain hidden from view and go about being whatever it is, quite silently (Harman, 2011).

It could be argued that at the moment of palpation the clinical practitioner may come to exist only in dominant modes of seeing, knowing and being (Murray, 2008), as the sovereign, powerful human subject (Foucault, 2003, p. 149), brought into being by the reductionist requirements and discipline of antenatal care. For a few moments perhaps, the fetus becomes the fixed reference point and the emphasis on the woman may fade and recede until she is in the visual and experiential nowhere; her physical presence seems silenced.

Yet, introduced by the beginning narrative; constructed by experiences, by listening to women and by reading, it seems that the moment of palpation can be steeped in interpretation and experience for the woman and for the midwife. This phenomenon of experience was the priority for this literature review. It "is only in the direct and unmediated relation to the other that we can gain a glimpse of the meaning of the caring encounter" (Levinas, cited by van Manen, 2002, p. 7).

Three clusters were identified on reading and consideration of the literature which alluded to the woman's experience of abdominal palpation during pregnancy. The first cluster, entitled: Touching at a Distance, grouped papers into those that included the woman's experience incidentally or by inference only. Second, Touching the Edges included the literature that chose to examine the woman's experience. Finally, Exploring Touch included literature that specifically addressed touch.

Touching at a Distance

In commonly used midwifery textbooks, students are not encouraged to look much beyond the clinical aspects of palpation. Gibson, a senior midwifery educator, provides an effective introduction to the literature that silences both woman and experience when she states: "The mother should be in a semi-recumbent position, with an empty bladder, arms by her side and abdomen should be relaxed" (Gibson, 2008, p. 22). Gibson pays heed to the National Institute of Clinical Excellence (NICE) guidelines on antenatal care (2008), although the woman's experience of the procedure is not revealed. In an Australasian textbook, Grigg (2010) acknowledges that palpation is a two-way sharing of information and that the midwife must ask about and listen to the woman's experience of her baby's growth. In this textbook the woman's experience is considered in the context of her baby's growth, but her experience of the palpation appears not to be considered. Bharj and Henshaw (2011) offer attention to privacy, comfort and respect during the palpation and Viccars (2009) considers the woman's comfort. A logical progression of 'actions', a sense of temporally ordered routine, pervades all three midwifery texts, revealing the interaction to be methodical and socially recognizable as part of the process of getting things done in a specific manner.

Contrast this to Barclay, Aiavao, Fenwick and Papua's (2005) celebration of traditional birth attendants in Samoa which reminds us of what we lose when we prioritise to bio-medical modernity:

> *A major part of the traditional midwife's work is to feel fetal parts and their place in the uterus. They do this during the gentle massaging they do throughout pregnancy. (p. 26).*

Other literature dismisses the need for touch and palpation altogether. Webb (2009) argues that midwives should be using ultrasound rather than their hands to assess the fetal position. Griffiths, Pinto and Margarit (2008), in a survey of 250 participants, admit that symphysial–fundal height measurements measured by their medical and midwifery colleagues are often inaccurate. These papers comment on clinical accuracy rather than any human element, and diminish the importance of touch.

This category of touching at a distance has described literature which considered the woman's experience of abdominal palpation only incidentally or by inference. In contrast, the next category; touching the edges, explores how women experience abdominal palpation.

Touching the edges

German phenomenologist Hermann Schmitz considered why touch is important and proposed and defended his ideas that the felt body is the *feeling body* (Schmitz, Mullan & Slaby, 2011). For Schmitz et al, categories of bodily feeling include narrowness, broadness, tension, swelling, intensity, rhythm and direction, desire, pain, fatigue or vigor. Joy, sadness, love and hate can be differentiated and classified into the broader sensation of feeling; thus a midwifes' touch of a woman's abdomen reflects back to her own emotions, perceptions and awareness of the atmosphere of the space where the consultation takes place. The feeling body is 'an absolute location of subjective orientation' (p. 3), whilst every encounter with the felt body will differ within the context of the space in which the midwife and woman meet. The notion of the feeling body brings to the forefront, the importance of considering the reciprocity of the toucher and the touched. This reciprocity is what Merleau-Ponty (1964) described as the crossing over of the touching and the touched, which he referred to as chiasm (the symbolic and / or actual place where the toucher and the touched meet at an interface of intermingling).

Wynn (2002) argues that touch should be as intertwining between midwife and woman as the little touches the woman herself gives – adept as she has become at finding, meeting and being touched by her baby, touching back, playful, emotional, in love. In a paradigm of procedural abdominal palpation; in a busy antenatal clinic for example, the intertwining between woman and midwife may either not exist or be broken quickly. Hilary's experience which was un-pressured, un-hurried, gentle, and thoughtful, gives heed to the chiasm Merleau-Ponty spoke of.

Kitzinger dedicates an entire section in her book, *The Politics of Birth* (2005) to touch. Clearly she sees the touching of pregnant women to be an issue of power, control and potential abuse. Kitzinger (2005) relates the story of a woman's experience of abdominal palpation as: "they pull your knickers down and then they dig in"(p.68). In this story, you can almost see the tears in the woman's eyes and hear the powerlessness in her voice. Kitzinger makes the call to deconstruct the language of touch. Deconstruction is steeped in the language of power, it "counteracts the associated repression of the other in nature, in ourselves, in other persons and other peoples' and 'patiently advocates letting the other be in it's otherness" (Derrida, cited in West, 2007, p.186). In any face-to-face encounter between midwife and woman (the other), the woman stands as 'other' than the midwife, as potentially the vulnerable partner (as Kitzinger's story reveals). The midwife may have the power of sheer presence, whilst the woman stands against her as a plea for acknowledgement, permission, assistance and concern (Levinas, cited by Morgan, 2011, p. 68). For Levinas, the 'other' is "'infinitely transcendent"' (Levinas, 1969, p. 194), our relationship with the other an ethical encounter where we place her at the centre of her world.We are called by un-limited responsibility to consider the experience of the woman, to place her at the centre of her and our world (Levinas, 2009).

Levinas's philosophy of an ethical stance towards the face of the other came about after his experiences of the holocaust, and for midwives he challenges us to never sleep, to be the night watchwomen and men, to be perpetually vigilant at and of any encounter where the woman is vulnerable (Manning, 1993).

Ina May Gaskin describes touch as sometimes something that can become unconscious amid the noise and chatter of the world; a lesson she re-learnt after having her finger, then hand, held by a tiny Capuchin monkey (2002, p.10).

Lorna Davies' (2010) research discussion turns on its head the notion of abdominal palpation as merely an assessment, observation, and reductionist procedure. Midwife participants in Davies' study spoke of their wonder during the abdominal palpation encounter with the pregnant woman:

> *'…way more than fetal surveillance. It is also about connection with the baby's energy, how the baby responds to touch, the vitality in babies [sic] positioning.. for me it is very much about connection.'*
>
> *'..window to the womb'*
>
> *'..learning to "see" with my hands. My fingertips are sensitive radars that can imagine the position of the body'* (p.40).

Midwives are in a privileged position to touch a woman, and to have such a sacred position is a wonder in itself. Irigaray takes to task the mainly male philosophical framework that considers perception of the human body as being the same, whether male or female: there are fundamental differences between men and women such that their descriptions, explications and

These papers comment on clinical accuracy rather than any human element, and diminish the importance of touch.

How women experience the hands of the midwife during the moments of palpation may touch on the spiritual and etheral.

analysis of otherness differ totally (Cimitile & Miller, 2007, p. 248). A male midwife thus will experience the woman's body in different ways compared to his female colleagues - according to Irigaray;

> *It is evident that the corporeal morphology of the feminine and the masculine are not the same, and it therefore follows that their way of experiencing the sensible and constructing the spiritual is not the same (Irigaray, cited by Cimitile & Miller, 2007, p. 250).*

For Irigaray (1985), a pregnant woman is a 'mystery beyond metaphor' (p. 228), 'indefinite, infinite, form is never complete in her (p. 229); Irigaray returns us to an elegiac sensitivity of woman as other, of abdominal palpation being so much more than mere clinical assessment.

Spencer (2004) offers her unique gaze into women and traditional midwives of Southwest Mexico (Zapotec), the US (Navajo), and Japan, drawing more from a contemporary research base (the Touch Research Institute in Miami, Florida) and allowing a less abstract, more practical discourse to be revealed. Spencer states 'with women' means to be with through touch, not simply 'being there' and sees a place in midwifery only for women. Underpinning her work is a great sense of the timelessness and historicity of pregnancy.

Judith Butler (1989) takes up Foucault's analysis of the body describing the body as not a natural surface or a passive medium for culture, but as already a cultural sign. Gender, according to Butler, is culturally constructed. Bigwood (1991, p. 68) reminds us of what we might 'see' when we palpate – a 'mothering-body' that shows up 'female bodily wisdom and fleshy openness that inter-twines with a mother's personal and cultural life'. Yet that same beautiful woman may repress her mothering body and describe herself, "No longer nice to look at. Knocked-up, taken, unappealing. In the eyes of others, before being a person, I am first and foremost pregnant" (Bigwood, 1991, p.61).

While the category Touching the Edges explored literature that alluded to the woman's experience of abdominal palpation, the final category, Exploring Touch examines the literature which deliberately explored touch, and thereby informs the reader how pregnant women might experience abdominal palpation during pregnancy.

Exploring Touch

Many midwives close their eyes when performing a vaginal examination, and very often when palpating a pregnant woman's abdomen. Closing one's eyes is not usually something taught by midwifery teachers but seems to happen spontaneously. Nishizaka, a sociologist, suggests that the closing of eyes at these moments (a phenomenon observed by her of Japanese midwives) serves to indicate to the woman that the touch, the palpation, belongs to, is located in, some field other than the visual. By cutting off access to vision, the most basic perceptual field, another, more complicated field is brought forward. Nishizaka's (2007, 2011) work on referential practice is a revelation in its careful consideration of hand gestures, body posture, verbal expression and timing (vision, touch and talk). Here, Merleau-Ponty's notion of intercorporeity when midwife touches woman and woman touches midwife (the world of each is open to the world of the other) becomes vibrant and resonates with warmth and colour.

A caress rather than a palpation would rightly belong to the world of eroticism and have no professional place within our paradigm; and yet Levinas exposes the palpation as emphasizing a subject-object hierarchy that perhaps we need be aware and wary of. The palpation is subject-oriented, limited, constrained (Paterson, 2011). In contrast, the caress has no *object* in touching, the caress offers an ethical sensibility palpation can never have, can never possess the other, can never own the relationship (Oliver, 2007). Levinas's move here is worth a moment of consideration, re-orientating us by ethical sensitivity and sensibility to the other, to the woman.

Arguably, a midwifes' palpation can never be a caress. Derrida would draw us to the notion of tact; knowing how to touch without touching (2005, p. 68), and exploring the *limit* of touch; "To touch with tact is to touch without touching that which does not let itself be touched" (p. 292). Touching as tact breaks with the immediacy and self-presence (transcendental idealism) of the moment of palpation. Derrida attacks the absoluteness of touch as being something tangible; between woman and midwife may be a touch, but touch itself is a kind of spacing or interruption or limit – you cannot touch touch (ibid, 2005). Derrida and Levinas explore an ethical and philosophical limit of touch which offers much to midwifery.

When we are at a farmers market, and we pick up a melon, we 'know' by touch its quality. By its heft, mass, 'give', and contours, we come to evaluate and –possibly - to choose it. It is a very perceptive mode of knowledge (Coffeen, 2010). Midwives can rightly ask, how much of our instinctive, primordial, ancient haptic knowledge are we using when we palpate a woman's abdomen? Van Manen (1999) reveals the (dia) gnostic and pathic touch we employ at work to be professional and non-professional. Professional touch relates to diagnostics, non-professional to soothing, caring, and even meeting. Van Manen considers Merleau-Ponty's notion of self reflection; the palpated woman aware of the palpating hand, and aware of her own body. In another work, and apposite to the experience of the vulnerable woman lying down, belly exposed while a midwife stands over her, van Manen draws on the ethics of Levinas: "The other is already given to me as an ethical event in the immediate recognition of his or her vulnerability or weakness" (2001, p.7).

CONCLUSION AND IMPLICATIONS

From a simple story and a throwaway remark, this exploration of literature turned to philosophers, social theorists, academic midwives and others in order to get a little closer to understanding the experience of abdominal palpation, and thus the experience of touch. Most of the accessed literature explored *touch at a distance* whereby, if the woman's experience of touch during abdominal palpation was considered, it was only by inference. *Touching the edges* was the term used to denote literature that included the woman's experience but there was limited midwifery literature to review that shed light on the woman's experience. Some midwifery literature relevant to abdominal palpation negated or did not consider touch while some midwifery literature touched or hinted at experience. It was revealed that the most useful literature for exploring the concept of touch, came not from the midwifery literature but rather the philosophical literature and it was reviewed because it explored touch carefully, albeit not always with a midwifery focus.

How women experience the hands of the midwife during the moments of palpation may touch on the spiritual and ethereal, and that experience may be filled with meaning. Touch needs to be introduced into midwifery curricula where it is not already. The concept should be given more importance and emphasis during clinical teaching, especially in relation

to midwifery practices such as abdominal palpation where it may not be fully considered. The importance and meaning given to touch needs to be ingrained into the consciousness of all of us who work with women.

The experience of touch, of palpation, needs to be considered wherever woman and midwife meet; the midwifery body of knowledge is limited, and needs to be expanded by future midwifery research. While the reductionists may display a disregard for what belongs to the realm of the spirit (Harrison, 2009), the pregnant woman, the privileged depository of the secret of truth, (Irigaray, 1983) must always be considered to be at the centre of touch during abdominal palpation.

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Developmental mentoring: New graduates' confidence grows when their needs shape the relationship

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ABSTRACT

Background: The transition from student midwife to practising midwife can be supported using the developmental mentoring approach. Aim: This paper describes a research project that explored group mentoring with four new graduate midwives and four experienced midwives. Methods: This longitudinal project used mixed methods to collect data over a period of one year. Data included three in-depth interviews with each participant along with quantitative data from contact logs, self-assessed confidence scales and analysis of practice outcome data. Findings: the four new graduate midwives were able to clearly identify their needs and how those needs could best be met. The most valued aspect of the mentoring support was the ability to discuss practice experiences with the mentors and to hear and learn from all the group members (both other graduates and mentors) during the group meetings. Conclusion: The developmental mentoring approach used in this project was strongly based on a philosophy of supporting the new graduates as competent novices. This approach enabled the new graduates to identify their own needs and decide how to have them met (Lennox, Jutel, & Foureur, 2012). The project appeared to support the new graduates to develop as confident and safe practitioners.

BACKGROUND

The New Zealand maternity system is midwifery-led and depends upon a supply of safe and well educated midwives. This change to midwives taking full responsibility again occurred in 1990 and in the last 21 years midwives have become the predominant lead carers for women having babies in New Zealand (Guilliland & Pairman, 2010; Hendry, 2001). The changes have impacted the maternity system as a whole and in particular the way in which midwives are educated (Pairman, 2006). Undergraduate midwifery programmes aim to graduate practitioners who are competent to care for women during pregnancy, labour and birth and for up to six weeks after the birth on their own responsibility; to provide care in both community and in hospital settings; to recognise problems; to work with and refer to other practitioners as needed (Te Tatau o Whare Kahu Midwifery Council of New Zealand, 2010). The experience of beginning practice is an area that has received increasing international and national interest over recent years (Clements, 2012; Rhéaume, Clément, & LeBel, 2011; van der Putten, 2008).The experience of entering practice was initially described by Kramer(1974)as 'reality shock' and more recently 'transition shock' which is "the most immediate, acute and dramatic stage in the process of role adaptation for new nurses" (Boychuk Duchscher, 2008; 2009, p. 1111). A New Zealand feminist phenomenological study found that new graduate midwives "enter a liminal phase for a short period where they are 'betwixt and between'" and yet at the same time, fulfil, and appreciate their responsibilities as autonomous practitioners (Kensington, 2006, p. 161).

A mentoring approach whereby the new graduate chooses an experienced midwife as a mentor is the model used in New Zealand to support new graduates to make their transition (New Zealand College of Midwives, 1996, 2000, 2008). In this approach the mentor's role is to assist the new graduate to identify her own learning needs, to help her critically reflect on practice, and to be available as a support throughout her transition year. This mentoring approach has also been used as the foundation of the Midwifery First Year in Practice programme-an initiative that was commenced and funded by the Ministry of Health in 2007(Ministry of Health, 2007). There have recently been some calls to introduce an intern-type model for the first year whereby all new graduates would be required to spend the first year, or part thereof, in a hospital-based programme such as is the case for junior doctors (Cameron, 2010 ; Te Tatau o Whare Kahu Midwifery Council of New Zealand, 2011). A research report by Berridge, Sharpe, & Roberts (2007) on new graduate doctors strongly suggested that new graduates' confidence and competence were directly related to the quality of the support they received. The transition time has regularly been shown to be stressful for new graduates of many disciplines (Rochester, Kilstoff, & Scott, 2005; Scott & Yates, 2002).

Stress has been identified as inevitable for new practitioners however according to international evidence the perception of support increases new graduates' self-confidence(Boychuk Duchscher, 2008; Newton & McKenna, 2007; Oermann & Garvin, 2002; Oermann & Moffitt-Wolf, 1997). International studies also underline the limitations imposed on new graduates in hospital settings where "disenfranchisement and marginalisation of new graduates continues…[to] impact recruitment and retention of graduate nurses [internationally nurses includes midwives] and patient safety"(Morrow, 2009, p. 278). There appear to be factors embedded in the culture of the hospital work environment which have been identified in a number of studies that undermines a sense of safety for new graduates; fear of making mistakes, interactions with doctors and lack of support (Rhéaume, et al., 2011). Bullying both internationally and nationally has also been identified as a significant problem in nursing and midwifery(Ball, Curtis, & Kirkham, 2002; McIver, 2002; McKenna,

Smith, Poole, & Coverdale, 2003).Therefore descriptions of effective professional development support models for new graduates in practice need to be shared.

The needs of new graduate midwives during this potentially stressful transition time and how these needs are met is an issue that requires exploring. This paper describes research that examined a group mentoring model and provides a close examination of a developmental mentoring approach. It is based on a recent in-depth study of the mentoring of new graduate midwives conducted in New Zealand (Lennox, 2011). It is the most intensive study of mentorship of new graduate midwives undertaken so far. It provides detailed evidence about the appropriateness of a developmental mentoring approach within the New Zealand context and in particular for midwifery, but has been supported by studies from other disciplines as well (Chiles, 2006; Clark, 2004).

Developmental mentoring is a method of support that is well-established in a number of different settings; it is an adult-to-adult learning relationship, where the needs of the mentee frame the purpose of the relationship through individual negotiation and the increasing accomplishment of the mentee (Knowles, 1973, 1980). The developmental mentoring model is a partnership established with an end purpose in mind, such as to encourage confidence in a particular occupation or position. The purpose of the mentoring relationship is to enhance the mentee's development by inspiring the mentee to a greater understanding of their role (Theobald & Mitchell, 2002). The plans and processes for achieving this end are purposely put in place by mutual dialogue and negotiation (Darling, 1984). The learning process is shared: the mentee is learning about a role or increasing her expertise, and the mentor is learning about the process of stimulating developmental changes (Clutterbuck, 2009; Daloz, 1986, 1999).

The developmental mentoring approach underpinned the study presented here. This paper explores the needs of four new graduates as they transitioned to confident midwife. It reveals how their transition was achieved through a unique group mentoring project. The following questions are explored to examine the question of what new graduates need and how their needs are met:

1. Why did the new graduate midwives in this study think they needed mentoring?
2. How often and why did the new graduates call on mentor support?
3. How did the new graduates get support, information and advice?
4. What aspects of mentoring did the new graduates find most valuable?
5. Did the new graduates gain confidence during their mentoring year?
6. Is there evidence that these new graduate midwives practised safely?

The response of the new graduates has provided rich descriptive data that can be used to understand the graduate perspective on mentoring and support the adoption of the developmental approach as a means of supporting health professionals in their practice transitions.

SETTING UP THE GROUP MENTORING PROJECT

The group mentoring project was carried out in 2006, prior to the introduction of the Midwifery First Year in Practice (MFYP) programme in New Zealand. The project was prompted by a shortage of individual mentors for new graduate midwives in the region. In response to a request from four final year midwifery students, four senior midwives proposed a group approach to mentoring, as none was able individually to be a mentor. The group approach involved the ability to call on any one of the four mentors who established a twenty-four hour seven day a week (24/7) roster. In addition, the group held weekly meetings of all eight, new graduates and mentors to focus on discussing issues arising from the new graduates' practice. The detailed arrangements for contact and for how the meetings would operate were agreed between the group participants. The weekly meetings were held in the home of one of the new graduate midwives; were conducted over a shared meal and were of two hours duration. A structured meeting format was agreed that saw the group begin with a 'round' of greetings and presentation of what issues each mentee wanted to discuss that day. One of the eight volunteered at each meeting to facilitate the conversation to ensure that everyone was heard and to keep the meeting to time. The meeting closed with another round of reflections on the issues discussed and the learning that had occurred.

THE GROUP MENTORING STUDY

All eight participants agreed to take part in a research project carried out by one of the four senior midwives (Sue Lennox). The primary aim of this study was to describe the new group mentoring model in detail, and to explore whether group mentoring supported the new midwives to gain confidence. A secondary aim was to explore how the group mentoring model enabled the experienced midwives to support and pass on practice knowledge and wisdom to the new graduates.

METHOD

As the mentoring project was a unique opportunity to explore various dimensions of new graduate mentoring, a naturalistic study evolved within a pragmatic paradigm, using a mix of both qualitative and quantitative data collection methods. Data were collected opportunistically as the project evolved, as this suited the practice context. The focus of the study was mapping the new graduates' development of confidence, their concerns and their needs. Also of interest were the mentors' responses to the new graduates' concerns and their evaluations of their own roles and responsibilities (the subject of a future article). The research involved collecting data on contacts made between new graduates and the mentors, audio-recording the weekly group meetings, interviews of each of the eight participants, three times over the course of the year, completion by the new graduates of a visual analogue scale of confidence, and a collation of data about the births that the new graduates attended during the course of the year. Quantitative data were analysed using simple descriptive statistics and qualitative data were subjected to thematic analysis (Braun & Clarke, 2006; Graneheim & Lundman, 2004). Ethical approval was granted by the Human Research Ethics Committee of Victoria University of Wellington.

RESULTS

This section presents results from the data analysis according to the six questions listed earlier. Illustrative quotes from interviews have been used throughout and are identified according to which of the four new graduates was the source (New Graduate 1 (NG1) - New Graduate 4(NG4)).

1. Why did the new graduate midwives think they needed mentoring?

It was clear from the first interviews (undertaken prior to graduation) that although the soon-to-be new graduates saw the mentors' experience as potentially helpful, they also saw themselves as competent, responsible professionals upon registration. The soon-to-be new graduates were tentative but excited about their new role and keenly aware that they wanted mentor support to be available, in the background. The new graduates were each clear that they wanted an adult relationship with their mentors and not to be 'mothered': *"I don't expect you to be there holding my hand 24 hours of the day"* (NG1, 1st Interview).The new graduates believed the mentors' experience was the most important reason for seeking mentoring and would play a part in their becoming safe practitioners.

> *But it's having that support, having that experience there and I think it is essential to be a safe practitioner … [to have an] experienced mentor during that transition. It's a big jump, it's huge and it's just having that process there* (NG4, 1st Interview).

This new graduate also said that mentoring was connected to safety: *"I want safety, really good outcomes for my women" (NG4, 1st Interview).* Another reflected that the mentors would provide the new graduates with *"… someone to bounce ideas off and challenge me" (NG2, 1st Interview).* They

thought the role of mentors would be to guide and to help them to understand midwifery more fully. In particular, as students they knew that there were aspects of practice to which they were blind, such as how it felt to be on a pager and to be fully responsible for their own caseload.

> *But I haven't been on the pager [as a Registered Midwife] you know what I mean and there are things that you don't get exposed to as a student. Everything that you have experienced as a student helps you in developing your practice but there are things that you don't necessarily get confronted with until you are out in practice. And having that support to say, "hello this is something new to me …"* (NG4, 1st Interview).

They were aware that starting practice would involve a great deal that was new to them. Their responses suggested that once registered, they were prepared to take responsibility by asking for support should they need it; that they anticipated there would be situations they could not predict; and that when these occurred, they expected the mentors to be responsive and supportive. The interviews clearly showed the new graduates did not want or expect the mentors to attend births unless the new graduate asked. It was expected that other midwives would fulfil this role. Therefore the mentors would be unlikely to be with them if an unexpected emergency occurred, but that they saw the mentors' role in this situation was one of debriefing and support following the event.

> *I don't see you actually coming to that [an emergency] but …more as ringing once it's over. That's what I see [the mentor] asking, what do you think you did wrong or do you think I did that right or have I done the documentation okay or whatever. I think that would be quite good really to come back as a group [for reflection].* (NG1, 1st Interview).

The ability to call a mentor at any time was emphasised throughout the first interviews. The new graduates' appreciated that being able to call anytime was important but so too the opportunity to review and debrief their practice experiences in order for them to learn from these. NG4 and NG1 were aware that the year ahead would provide a big learning curve:

> *Yes definitely [it] is really important and that I know that I can call and not feel hesitant about calling. But to be able to come and sit down and, and discuss something and to debrief and look how I could have done it differently or how I would like to do it and how I can achieve it …* (NG4, 1st Interview).

The importance of not being hesitant about calling a mentor was underlined throughout the year by the new graduates. The importance of mentors "being there" to provide them with the reassurance they need, is reinforced in the comments below:

> *Somebody who's going to be there for me next year when I'm out as a new grad to help me find… need anything clarified, any problems that I need answered, basically just to be there …* (NG1, 1st Interview).

The sense of security provided by the notion of mentors being available 24/7 to receive calls is obvious in the quote below even a year after graduation:

> *Well at the beginning it was the [on-call availability] 24 hours seven days a week. ... I have to admit [that] it was [my] knowing that [the mentors] were available if [needed] to actually be physically present* (NG1, 3rd Interview.)

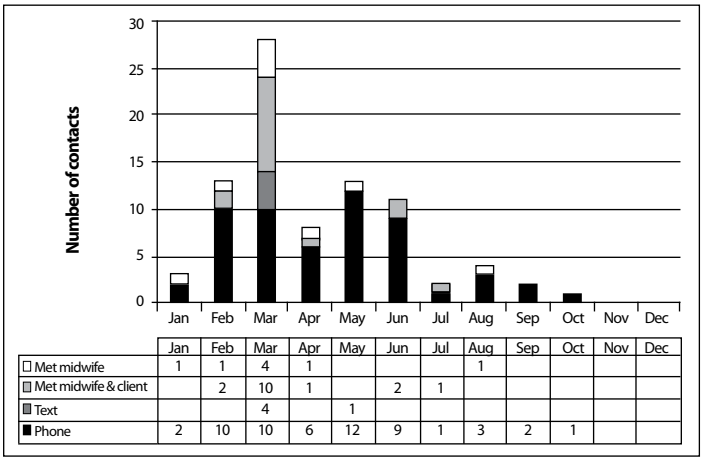
In response to a question about the effectiveness of the on-call mentoring system, one new graduate said:

> *I don't know if I have ever had a moment where that [calling the mentor] hasn't answered my question. I have had moments where I have thought maybe I need to think about this more because I have been encouraged to think about it more… I have never felt like I have come away with nothing* (NG2, 2nd Interview).

2. How often and why did new graduates call on mentor support?

Findings are presented from the analysis of the logs that mentors kept of their on-call and face-to-face contacts with new graduates during the year, outside of the weekly meetings. As shown in Figure 1, mentors recorded 85 contacts with the four new graduates: 56 (66%) contacts were phone

Figure 1: Number, type and frequency of contacts between mentors and new graduates over a year



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Met midwife	1	1	4	1				1				
Met midwife & client		2	10	1		2	1					
Text			4		1							
Phone	2	10	10	6	12	9	1	3	2	1		

calls, 5 (6%) were text messages; on 8 (9%) occasions the mentor and midwife met without seeing the client, and on 16(19%) occasions they met together with the client.

Most of the contacts occurred in the first six months, with only 9 contacts from July onwards and with the last contact being a single call in October. Of the 16 contacts that involved the mentor being with the new graduate and her client (mostly at a birth), ten (62%) occurred in March. On average there were 3.1 contacts (2.6 by phone) for each of the weeks when there were contacts, with the busiest week of the year having 17 contacts recorded (including 4 texts and 5 phone calls).

Of the total number of calls, 46% were generated by one of the four new graduates. Two others generated 20% each, and one of the new graduates generated only 2% of calls. Eight per cent involved more than one new graduate and 4% were as a result of the mentor calling. While the new graduate who generated most contacts had twice as many phone contacts as the other two, she met face to face with a mentor less often.

The number of contacts between individual mentors and new graduates ranged from 11 to 27. Actually meeting in person with the new graduate (with or without her client) ranged between one and nine times.

Mentors recorded a brief description of the reason for each contact. These descriptions were found to fall into the following categories:

- Advice – where the new graduate was asking for information or advice
- Assistance – where the new graduate was asking for the mentor to give assistance (usually to attend a birth)
- Giving information – where the new graduate was giving the mentor information, often in terms of keeping her updated about a client
- Discussion – where the new graduate wanted to be able to discuss a situation and usually her feelings about it without needing advice or assistance
- Mentor initiated – there was one contact where a mentor phoned a new graduate to ask about a client's progress.

In summary, mentors were contacted by new graduates several times a week in the first half of the year, but there was considerable variation between new graduates in the numbers and types of contact they initiated. Two thirds of the contacts involved only a phone call for advice or information, while about a fifth involved the mentor meeting with the new graduate and her client (usually at a birth) and providing either background or face-to face clinical support. In the second six months, there were far fewer contacts and a greater proportion were contacts where the new graduate was seeking a discussion rather than asking for information, advice or assistance.

3. How did new graduates get support, information and advice?

The new graduates not only acted as responsible professionals with their clients, but also took responsibility for seeking the support that they

needed. Once mentor availability was assured, then the new graduates began to discriminate when, and whether to call and who was the most appropriate person needed at the time (a new graduate peer, mentor or senior midwife, obstetric registrar or consultant). They spoke of the need to think out the issues before asking for help from anyone. The ability to be proactive and seek expert opinion was balanced by the recognition that there were skills to knowing when and whom to call, and to think about why the calls were being made, in order to be clear about what they wanted.

One new graduate described how she rang one of her peers first and then decided which calls were appropriate for mentors or for other services.

> *When I haven't been sure I have … called the midwives in the group first to see if they know because that's what we are going to be doing anyway and if they don't know I will contact a mentor. If it has been something that I had been questioning [such as the need] for referral I have just rung the hospital and been pointed in the right direction.* (NG4, 2nd Interview)

In the quote above *"…called the midwives in the group…"* refers to the other new graduates. Their group of four was an important source of support and strength to one another throughout the year(Darwin & Palmer, 2010; Johnson, 2007; Ritchie, 1999). Asking for help was not a reflex action for any of the new graduates; they thought about the reason for calling, whom and when to call, what to say and to whom. Sometimes the new graduates were challenged by hospital personnel who thought the mentors should have been contacted for particular information, rather than bothering hospital staff. One detailed how she had told them this was not the mentor's role, and she was within her rights phoning as a registered practitioner to ask for such information:

> *So sometimes it has been a little bit difficult ... when I first rung up about something they said "this isn't where you're supposed to ring, who are your mentors" and were quite aggressive and I said to them "well actually I need to find out for myself what I need to do."* (NG4, 2nd Interview)

Contacting and communicating with others, then, is a key developmental milestone, but knowing who, when and why to call is only a beginning step. Later the learning appeared to be about knowing why certain information is appropriate for one person and not another, and how to give that information in a particular way. Consulting with doctors was mentioned as a time for finding the right words and form for communicating effectively. One new graduate found practising beforehand with other midwives at the hospital worked well:

> *You have to put it in a coherent order…I actually do it in my head – what I am going to say to the consultant or registrar – before I go and say it… I will talk to the shift coordinator if it is a particularly good one or another midwife…I like pretty much like all of the midwives that work there.* (NG2, 2nd Interview)

Another midwife described how taking responsibility for being clear when consulting with doctors was part of being "the midwife":

> *That's something I have to learn to do. I found it hard to do especially being new and finding the right words and all that kind of stuff. And feeling vulnerable in that position but knowing I have to do it because I am the midwife.* (NG4, 2nd Interview)

What information was appropriate for one colleague was not necessarily required by another; it depended on the role that person held and what it was the new graduate wanted from the dialogue, for example, for the shift coordinator on duty in the hospital:

> *I mean…they just want to know what's going on; they just want to check in. Not give them heaps [of information] but just let them know that you're progressing well and there are no problems basically.* (NG4, 2nd Interview)

When seeking a consultant opinion however, she was *"…more clear, I give a history, I say what's going on and say that I would like…if I am consulting I am usually wanting them to see the woman" (NG4, 2nd Interview).* This new graduate understood there was more to communicating than finding the right form or the right words to use. She described how she sought to collaborate and develop effective inter-professional relationships:

> *I really try not to get defensive inside myself; I think it is really easy just to get defensive. But I am really aware of the fact that I want these people to be on my side, you know that I can communicate with them and have them on board with me. So I have been really aware about building those relationships and communicating with people. It becomes easier to do that you know with some of the obstetricians I have been making the effort, I have gone to some of the [antenatal] consultations – the woman with the anencephalic baby – and had discussions with the obstetrician, so they know I am there… so that they know that I exist, that I'm a midwife in the community and that I am proactive about things that I need to be proactive about.* (NG4, 2nd Interview)

Her confidence and self-awareness after only six months in practice show a level of sophistication in working with the system to achieve respectful and collaborative inter-professional relationships.

4. What aspects of mentoring did new graduates find most valuable?

When the new graduates and the mentors were asked what it was about the group mentoring model that was most important, they all identified the regular group meetings as the key ingredient. Mentoring as a group was a unique aspect of this model. The new graduates felt that they were heard at the meetings, and as everyone focused on their particular story, it helped them reflect on the experience and distinguish what they might do differently, or not, if they met the situation again. As one new graduate reflected:

> *…meetings [are] great and just having to say, well what to think about this, this and this, this is what I have done but what do you think? I look forward to them, I look forward to Mondays. I look forward to seeing what other people have been doing. I've found it helpful.* (NG2, 2nd Interview)

The experiences of their colleagues discussed at the group meetings added to their own meaning, so that their learning during those meetings was potentially quadrupled, as all four new graduates met and shared their different practice experiences:

> *Yes it's good to meet and discuss and even when I don't have anything to discuss it's good to hear what other people have got and you are learning from that.* (NG1, 2nd Interview)

This signals the amount of new graduate learning which occurred whilst listening to one another's stories and the group discussions that inevitably followed (Cooper, 1995). This silent learning at the group meetings was acknowledged in the interviews. *"It's quite scary sitting back and listening to what's going on this year. Really scary and also knowing that that could have been me in all those situations… you do learn from other people's things"* (NG3, 3rd Interview). Listening to others meant the new graduates were processing different views and opinions and sorting out what learning should take priority for them.

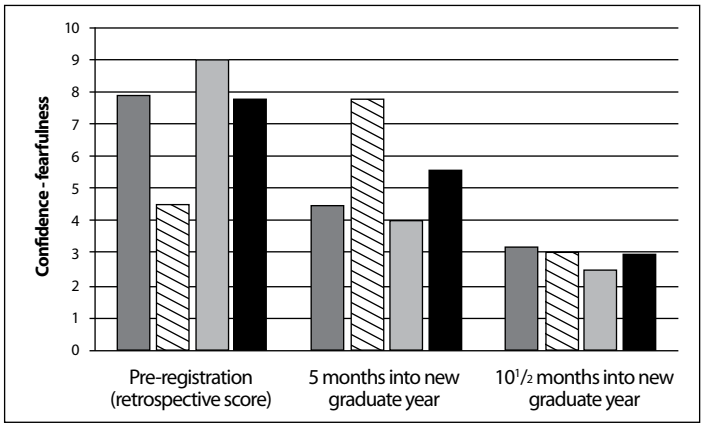
The new graduates recognised that their mentors had different ways of approaching practice problems, and instead of finding this confusing, they seemed to relish the freedom it gave to make their own choices about what they would take or leave:

> *…yeah the group process has been good too because everybody's actually had their own thoughts on that subject and I can then digest what everybody said and then you cement [your own thoughts] "ok so you have said that, that's that person"…I take on what everybody says and then I think "ok, alright, and so that was fine but really it is more that [person's approach] I want to take on board this time and maybe next week it [will be] more that [person's approach]."* (NG1, 2nd Interview)

Or even more simply expressed as: *"It is quite interesting having a group I have found I have learnt lots"* (NG4, 2nd Interview).

The new graduates and the mentors came to meetings voluntarily, as there was no compulsion to attend. Sometimes the new graduates had been up all

Figure 2: Visual analogue scores of the four new graduates over the mentoring year



(from 1=confident to 10=fearful) (each bar represents one of the new grad midwives – the bars are not labelled to protect the identity of the midwife)

night at a birth but felt the need to come to the group meeting anyway, as a resource for affirmation and feedback.

I had been up since four that morning and then I had visits in the hospital, I was knackered but I came to the meeting because I really wanted to discuss it

[Researcher asks] So you are actually finding these meetings helpful?

Oh yeah, they are. I really wanted to go home and sleep but I came to the meeting to discuss it, just to kind of…as a new practitioner everything is new, you know, it was the first time I had dealt with this woman who had a VBAC (vaginal birth after a prior caesarean). (NG3, 2nd Interview)

5. Did new graduates gain confidence during their mentoring year?

Although these new graduates viewed themselves as being competent at the start of the mentoring year, they realised their inexperience and were not confident practitioners. Their ratings on the confidence scales show that they assessed themselves as being quite fearful at the start of the mentoring year and gaining confidence during it (Figure 2).

The new graduates were asked at their second and third interviews to score their confidence on a 10-point visual analogue scale (from 1= confident to 10= fearful). At the half-way point (second interview), they also retrospectively estimated what their confidence had been as students looking ahead to the new graduate year. Figure 2 indicates that after a five month period of mentoring, three of the new graduates felt they had more confidence than at the student pre-registration stage; after ten and a half months, the level of confidence far outweighed their fears.

6. Is there evidence that new graduate midwives practise safely?

The women the new graduates cared for had similar rates of normal births and caesarean rates (67% normal birth rate, 25% caesarean rate) when compared to women cared for by other self-employed midwives in this district (65%normal birth rate, 25% caesarean rate). This was despite having a higher percentage of first time mothers in their caseload which can affect outcomes because first time mothers may have more interventions than mothers who have previously given birth. This reassurance is in line with the national statistics collected by Midwifery and Maternity Providers Organisation (MMPO) about new graduate outcomes and reported in the New Zealand College of Midwives Midwifery News (Dixon, 2010, p. 18).

LIMITATIONS OF THE STUDY

This study is limited to the experiences of these four new graduate midwives in New Zealand and cannot be generalised to other new graduate midwives. The new group mentoring worked well for this project, which may have been due to setting up of carefully considered structures prior to the start of the project. The characteristics of the mentors may also have had an effect on outcomes making it difficult to replicate this study to other settings.

The role of a participant researcher has both benefits and drawbacks. There is potential for a power differential between the researcher and the researched which may affect the feedback received during the research. However, as van der Putten (2008, p. 356), another participant researcher found the participants in this study appeared relaxed about sharing their experiences with the researcher.

DISCUSSION

In order for New Zealand to retain a midwifery-led, high quality, maternity service, the experience gained by midwives in their first year of practice is pivotal. This research has followed the progress of four new graduate midwives in their first mentoring year. The regular audio recorded mentoring meetings held throughout the mentoring year contributed to an understanding of the new graduates' concerns, needs and experiences, as they occurred. In addition this study has recorded the new graduates and mentors reflections about their year through a series of in depth interviews.

Developmental mentoring as provided by this group appears to offer the variety of support needed by new graduates in their first year of practice. The first identified need for the new graduate in this study was the ability to access an experienced midwife for respectful dialogue and support at any time. Each of the new graduates acknowledged the ability to call a mentor when they needed to as extremely important. The new graduates acted in ways that could be described as autonomous from the start. In that they sought the most appropriate person to whom to make a referral, telling them what they needed by using the right words and style of communication to achieve their ends. They learned early that being clear about the purpose of their discussion encouraged appropriate intervention and support and that the converse was also true. In this study the new graduates developed critical thinking skills at the weekly meetings where they were free to discuss their thoughts and to challenge or be challenged (Mezirow, 2003). The group meetings were scheduled according to the new graduates' wishes and 31 such meetings were held over the year. The capacity of a group of midwives to model respectful practice conversations was clearly appreciated. The new graduates showed they were intent on developing cooperative and collaborative practices as autonomous and responsible health professionals working within the scope of practice.

The New Zealand midwives' scope of practice and model of care ensures that the ICM definition of a midwife is fulfilled (International Confederation of Midwives, 2005). In Australia there is a perception that relatively autonomous models of midwifery practice based on one to one, continuity of care for women can only be provided by experienced midwives. However Davis et al (2011)argue that the continuity of care model of maternity care is also appropriate for new graduates so long as these graduates are well supported. When considered together with the evaluation of the Midwifery First Year in Practice programme, this present study reinforces the veracity of that argument (Lennox, 2011; Oliver, 2008).

CONCLUSION

Mentoring provides the framework for supporting new graduates through the transition from new graduate to confident practitioner by. This research has found that new graduates were clearly able to identify and articulate their needs when new to practice. By choosing mentors with whom they could negotiate support these new midwives were provided with the security they needed to develop their practice confidence. One of the ways of becoming a confident and reflective midwife is to begin practice well supported and with time for dialogue with a mentor about recent and anticipated clinical scenarios.

This paper describes research about a group mentoring project which comprised four new graduate midwives and four experienced midwives. This group model of mentoring support during their first year appears to have supported the graduate midwife to develop confidence and may encourage self-governance. The findings from this study suggest that mentoring by experienced midwives enables the graduate to identify and actively seek the support she needs from appropriate professional sources to help her develop as a safe and competent practitioner.

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