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Occularcentrism and the need to 'see' the evidence of impact

Key words: Occularcentrism, CTG machine, research impact, REF 2014 and evidence-based midwifery

We live in a modern world in which seeing is believing and we only believe what we can see. This phenomenon is known as occularcentrism (Jenks, 1995) and it is pervasive, silent and infiltrative. Our modern society values and promotes science and technology, evidenced in the value we place on the visual image or cinematics over and above the phonetics of annunciation that comes to us from the 'word'. This fascination with and dedication to research that provides us with pictures of uterine life is irreversible and we cannot fail to see evidence of it in our everyday practice where women want to see their unborn baby. Midwives eagerly develop their ultrasound scanning skills and families are willing to pay up to £450 for high definition 4D scans. This need for health professionals to display data on screen for others to see is irrefutably commonplace and accepted as standard practice leading to the visual healthcare industry growing exponentially.

I have been observing the slow but steady progress of occularcentrism in midwifery practice since I first started studying for my PhD in 1994. It was at this time that I first became aware of the dilemmas associated with the difference between the pinard, sonicaid and the cardiotocograph (CTG) machine and in my search to make sense of the promotion, desirablility and trust in all things 'high-tech' I noted in my field diary: 'The pinard provided audible evidence but it could only be heard by one person, the sonicaid provided audible evidence and this could be heard by all present but it was time bound and could not be reviewed or "seen" by others. However, the CTG could provide audible and visible evidence and this was accessible and retrievable'.

This was my first introduction to occularcentric power in action and it has to be acknowledged as being integral to the overarching acceptability and continued use of CTG machines by clinical midwives in spite of policies and guidelines for limited usage. The CTG provides us with the evidence that counts for us, for women and for lawyers. Modernity with its rationalism and universality assumes 'visible evidence' is basic and integral to quality service delivery and this particular machine with its unique combination of philosophy, science, art and technology makes it a highly desirable product that rests comfortably with our technologically sophisticated youth of today. The hidden lifeworld of the fetus can now be seen through the visual display properties of the CTG machine. Very soon, we will have a machine that provides visual data of the birthing journey as the baby navigates the mother's pelvis and birth canal into the world (Awan et al, 2009).

This desire to see is changing the landscape of clinical midwifery research and research in general. Evidence-based practice is leading us to demand and expect an 'evidence base for everything' and this requires visual, searchable, demonstrable data to prove benefits and impacts. Research funders have every right to expect to 'see' the evidence of their investment in us as researchers and with the new research assessment exercise known as the Research Excellence Framework (REF, 2014) we need to be prepared to capture the visible evidence of impact on practice.

Seeing the benefits of research demonstrated in impact measures is highly valued, but data collection has been problematic. Translating research from the field or laboratory to the clinical or public setting requires concerted effort by researchers, clinicians, funders and policy-makers and we know it takes 15 to 17 years for the time lag between research expenditure and eventual health gains to be realised and more importantly 'visualised'. The evidence for this statement comes from a recent and highly innovative report produced by the Health Economics Research Group et al (2008) after an economic evaluation was commissioned by the Academy of Medical Sciences, the Medical Research Council and the Wellcome Trust. This report has major implications for healthcare in the UK, including midwifery, as this is the first time we have been able to 'see' the health gains from investment of public and charitable funds in research. The evaluators devised a methodology for estimating the value of this investment, and in their summary, they translate this effect into a meaningful equation: 'The health and GDP [gross domestic product] gains derived from UK public and charitable investment in cardiovascular disease research (over the period 1975 – 1992) is equivalent to an annual rate of return of around 39% (37% for mental health research).' They translate this further by stating the benefits as '30% in direct GDP and 9% indirectly via health gains (Health Economics Research Group et al, 2008: 2). The importance of this report is yet to be realised and it will take years before we have further evidence of impacts in health gains for midwifery, obstetrics and women's health. The REF 2014 may assist in reducing the time it takes for research to demonstrate impact as it measures 'outputs, impact and environment' with respective weightings of 65% for outputs, 20% for impact* and 15% for environment. Impact has been defined by Higher Education Funding Council for England (HEFCE) (2011) as any identifiable benefit to or positive influence on the economy, society, public policy or services, culture, the environment or quality of life.

The REF 2014 guidance section on 'impact' clearly asks institutions for a precise, 500-word, description (case study) of the visible evidence of the specific benefit or impact from the research.

Three specific types of information are required and the following guidance is provided:

One: detailed description and specific evidence of actual benefit or impact including:

* *from the REF 2010 pilot exercise*

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- An explanation of the nature of the impact in terms of its reach and signifigance
- Details of when the impact occurred and
- Evidence of the above including appropriate indicators

Two: explain how the unit's research activity contributed to the impact:

- An outline of what the underpinning research was, when this was undertaken and by whom
- How the research influenced or contributed to the impact
- Any efforts made by the institution to exploit or apply the research to secure the impact
- Acknowledgement of any other signifigant factors or contributions to the impact.

Three: provide references to:

- Key research outputs that underpin the impact- and states how the research was peer reviewed
- External sources that could corroborate the information provided

Impact must be visibly measurable and HEFCE are 'convinced that the value of research must be sold to funders and impact is the way to accomplish this.' The indicators for measuring impact in REF 2014 have been identified as follows:

- Creating new businesses, improving the performance of existing businesses, or commercialising new products or processes
- Attracting R&D investment from global business
- Better informed public policy-making or improved public services
- Improved patient care or health outcomes
- Progress towards sustainable development, including environmental sustainability
- Cultural enrichment, including improved public engagement with science and research
- Improved social welfare, social cohesion or national security.

In March 2011, HEFCE produced an information document entitled *Decisions on assessing research impact* (REF 01: 2011). Under 'attribution and timeframe', it stated:

A To be credited for an impact, the submitting unit must *show* [my emphasis] that it undertook research that made a distinctive contribution to achieving the claimed impact or benefit, that meets standards of excellence that are competitive with international comparators. The submitting unit need not have undertaken all of the contributing research, or have been involved in exploiting the research

B The timeframe for the underpinning research will be up to 15 years between the publication of at least some research output(s) that made a distinctive contribution to the impact, and the start of the assessment period (January, 2008). This timeframe may be extended by a further five years for some UOAs, if the sub-panel makes an exceptional case for doing so (HEFCE, 2011: 1).

The REF 2014 is designed to 'inform the selective allocation of quality-related research (QR) funding to higher education institutes from 2015-16 on the basis of excellence and provide:

- Benchmarking information and reputational yardsticks.
- Accountability for public investment in research and demonstrate its benefits.'

The challenge facing the midwifery research community is to fully grasp the meaning of what counts as evidence and this is becoming more complex as the different value systems compete for representation. The inclusion and exclusion criteria for what counts as evidence requires consideration of the value we attribute to different types of knowledge, for example, knowledge from ethicists, philosophers, scientists, theologians, policy-makers and health economists. I would strongly argue that we will lean towards high visibility evidence. However, the problem with evidence comes from the process of knowledge development and its acceptance by the community to which it belongs. From an epistemological perspective, the basis of knowledge is a justified true belief that is shared by the rest of the community. According to philosopher AJ Ayer (1956), for knowledge to exist in real terms, there must first be a conviction that something is factually correct prior to/irrespective of any proofs or evidence to support it; secondly, this must be tested and proven to be true irrespective of our beliefs or justifications; and, thirdly, it is only after testing from empirical research or logical reasoning that we really come to know the truth. Theoretically speaking, modern midwives have a problem with accepting what they cannot see and those who have 'faith' to believe what they cannot see and actively facilitate the growth of the intuitive senses will be severely challenged in an occularcentric midwifery world.

In conclusion, regardless of whether I succumb to this position or theoretical stance, our future midwifery research endeavours must produce demonstrable, visible, verifiable, relevant, accessible evidence of impacts because we live and work in a midwifery world that must see to believe and believes only that which it sees – the modern world is very much a seen phenomenon (Jenks, 1995: 12).

References

Awan N, Rhoades A, Weeks AD. (2009) The validity and reliability of the StationMaster: A device to improve the accuracy of station assessment in labour. *European Journal of Obstetrics and Gynecology and Reproductive Biology* **145**: 65-70.

Ayer AJ. (1956) *The problem of knowledge*. Penguin: Harmondsworth.

Health Economics Research Group, Office of Health Economics, RAND Europe. (2008) *Medical research: what's it worth? Estimating the economic benefits from medical research in the UK*. UK Evaluation Forum: London.

Higher Education Funding Council for Education. (2011) *Research Excellence Framework 2014*. See: www.hefce.ac.uk/research/ref/REF 01:2011 (accessed 5 June 2011).

Jenks C. (1995) *Visual culture*. Routledge: London and New York.

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Theory for midwifery practice: where the future meets the past

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This is the fourth paper in a series celebrating the contribution of professors to the midwifery profession.

Abstract

In the 16 years between publication of the first and second editions of *Theory for midwifery practice* (Bryar, 1995; Bryar and Sinclair, 2011), there has been an explosion in the theory's development. It is hoped that the second edition will contribute to the ongoing need to refine theory to direct, guide and drive practice. In this paper, I describe the process that led to the publication of the two editions and highlight the differences between the two. Three important themes that run through both editions will be illustrated, namely: the impact of the context of care on practice; the role of the midwife; and the experience of the childbearing woman and her family.

Key words: Theory development, action research, evidence-based midwifery

Introduction

The practice of midwifery is constantly evolving and developing. As part of this process, new and better ways of meeting the needs of the childbearing woman and her family are suggested, tested and refined: theory is applied to practice. Simpson and Weiner (1989: 902 cited in Bryar and Sinclair, 2011: 27) provide a dictionary definition of theory describing it as 'a conception or mental scheme of something to be done, or of the method of doing it; a systematic statement of rules or principles to be followed'. Theories are developed through thinking and reflecting on practice and they inform all aspects of practice. However, we may not be aware that providing thoughtful care depends on the application of thought and theories to that care.

When a midwife undertakes any activity and provides care, that activity is undertaken in the light of the midwife's personal understanding, knowledge and theories. Firstly, the midwife has to have an

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understanding of the need or problem that requires attention. This understanding will be based on previous experience of such needs and what has been previously learnt about such needs (the knowledge base). The midwife will be able to state or define the need. Next, the midwife will have an understanding of the action that might alleviate the problem or reduce the need. Midwives will also have an understanding of their ability or the ability of their colleagues to meet the need (Bryar and Sinclair, 2011: 17).

Theory for midwifery practice (Bryar, 1995; Bryar and Sinclair, 2011) aims to make this process more explicit providing support to the more coherent application of theory to practice, research and service development and the identification and testing of theory from practice. In this paper, the process that led to the publication of the first and second editions of this book will be described and the differences between the two editions will be highlighted. Three important themes run through both editions and will be illustrated:

- The impact of the context of care on practice
- The role of the midwife
- The experience of the childbearing woman and her family.

Introducing a change in midwifery practice

The first edition of *Theory for midwifery practice* was a long-term output or outcome from an action research project at Queen Charlotte's Maternity Hospital in London, which started in the late 1970s and aimed to introduce individualised, continuous care by midwives in the hospital and community midwifery service. In 1979, I was appointed as the first research midwife to work with the midwives on this project at Queen Charlotte's. My post was funded, on a recurring annual basis, for three years by the charitable trust of the hospital.

The project to introduce individualised care at Queen Charlotte's was informed by the nursing process movement, which had been initiated in the mid 1970s in the UK by Professor Jean McFarland in a seminar she held in the nursing department at the University of Manchester. The nursing process aimed to move practice from being task centred and delivered by many different people to the provision of individualised care through care planning with continuity of caregiver. The project was also informed by the reaction of women against the use of routine induction of labour, which had grown in the 1970s and had led to dissatisfaction among women attending the hospital.

The study initiated by staff at Queen Charlotte's and from the University of Surrey aimed to answer the question: 'Can the nursing process help midwives in the care of the pregnant woman, her child and family?' (Bryar and Strong, 1983: 45). An action research approach involving staff and students in all clinical areas was adopted as the means to deliver the project (Hart and Bond, 1995). The action research project made use of the nursing/midwifery process and allocation of women to 'individualise care of the woman, baby and family; identify and act on any problems she had; identify and prevent the development of any potential short or long-term problems; provide continuity of care and advice, either by, or between, individual midwives' (Bryar and Strong, 1983: 46).

The project was initiated by a study morning in which the concept of the project and the nursing process were introduced to staff, many of whom had not used this care planning approach before. Small groups met and nursing/midwifery process assessment tools and care plans were designed, tested in practice and redesigned.

It was at this point that the issue of theory informing midwifery practice was raised for the first time. Any assessment tool should be informed by the theory on which it is based. For example, an assessment tool based on the Neuman Systems Model will differ from one based on a developmental model such as that of Orem (Marriner-Tomey and Alligood, 2006; Bryar and Sinclair, 2011). The midwives were not enthusiastic about using any of the then current nursing theories and the assessment tool developed reflected a bio-medical approach to midwifery practice, reflecting the then culture of the organisation. Discussions at these meetings and observation of practice showed that midwives held different models or theories of practice. While they acknowledged the value of the bio-medical model, many held more holistic, women-centred models or theories, which guided their practice within the constraints of the organisational setting. This was the first intimation of one of the main findings of the evaluation of the project: that many of the midwives held a different personal model of midwifery care to that evident in the wider organisation and that the organisational context impacted on their ability to provide care consistent with their beliefs, values and theories of midwifery practice. This is a theme that is very much present in a number of the chapters in the second edition of *Theory for midwifery practice* (Bryar and Sinclair, 2011) and it is evident that there are continuing tensions in some settings between midwifery beliefs and values and the reality of the care they are able to provide.

The introduction of change involved a process of pilots in all the clinical areas of the hospital and with the community midwives. Many action cycles were undertaken testing out, for example, different ways of allocating women to staff in the antenatal clinic or ways of involving women in their care.

Research realities

I quickly learnt that being a full-time research midwife, undertaking an action research project had its challenges. For example, the action part of the action research started taking off within the first few weeks. Following presentations about the study close to the start of the project, one of the postnatal

ward sisters was so affected by what she heard that she changed her ward from a task-orientated model to a model involving allocation of staff to care for groups of women. This of course had implications for the collection of baseline data.

I discovered that research could be a slow process involving frequent discussions ensuring that everyone knew what was going on and felt involved; that it could be tedious and involved spending a great deal of time at the photocopier copying the many different versions of care plans that we produced. I also learned that it could be daunting but exciting. It could also present unexpected challenges such as the withdrawal of the academic team when the study failed to gain external funding. After this, I was very fortunate to gain support for the ongoing work on the project from Grace Owen, head of the department of nursing at the then Southbank Polytechnic, Sarah Whitfield at St Bartholomew's Hospital and Denise Le Voir (Barnett) at The Royal London Hospital, both then nursing process co-ordinators, and Pat Ashworth, then a lecturer at the University of Manchester teaching nursing process. At Queen Charlotte's, the key people involved in the study were Grace Strong, midwifery tutor and project co-ordinator, Margaret Adams, director of midwifery education and Elaine Ward, director of nursing.

In the third and last year of the project my role became one of an evaluator, evaluating the impact of the changes on care experienced by women. I undertook the evaluation by identifying and interviewing a sample of 21 women in the antenatal clinic and analysing their records at the end of their care; observing care in all the areas of the hospital and community through shadowing and interviewing members of staff and analysing documents generated during the project. To help me make sense of the vast amount of data I collected, I turned to theory. I made use of a framework developed by Silverman (1970): the action approach to organisations. This framework describes the inter-relationship between the knowledge and attitudes in society, the organisational role system, and the values, beliefs and attitudes of those involved in the action, in this case, care of the childbearing woman. This framework helped to identify the factors that contributed and those that inhibited movement towards individualised care, the overall purpose of the project. While many midwives may hold a person-centred care philosophy, actually translating this into practice is affected by the setting in which they work, the way the setting is managed, expectations of women and their families and the wider society. This framework is applicable to all care settings as it takes a whole systems approach to examining practice and is discussed further in Bryar and Sinclair (2011: 75-80).

The study involved all the midwives at Queen Charlotte's who made a huge contribution to it initiating changes, developing the assessment tools and implementing care planning from antenatal care though to discharge by the community midwifery team. I learnt a lot about research from this experience: about the initiation of research, the process of supporting action research, use of a range of research methods, writing up research for publication (Adams et al, 1981; Bryar and Strong, 1983), and the difference in writing up the study as a report for the hospital and as an MPhil. When I look at the smiling pictures of Grace Strong and myself in the *Nursing Mirror* in 1983, I am not sure if we are smiling with happiness or relief that the project, by the time of this publication, was now over.

Theory for midwifery practice: the first edition

In 1985 I was awarded my MPhil by Southbank Polytechnic for the work at Queen Charlotte's and my career then took me away from midwifery into primary healthcare development. Therefore I was surprised to be contacted in about 1992 by Kerry Lawrence, a commissioning editor from Macmillan publishers. She had identified that there was no book available about theory in midwifery and asked me if I would be interested in writing a book on this subject. Professor Jo Alexander had suggested to her that I be approached to write this book drawing on my work at Queen Charlotte's. I had never written a book before and had little idea of the work involved; I had done no serious work on thinking about care planning and the use of theory in midwifery since 1985 but I agreed.

I began to plan the book and then in the summer of 1993 we learnt that there would be no more funding for Teamcare Valleys, the primary healthcare project in which I was then working (Marx, 1996). At this point I was very fortunate to gain a post as a lecturer back in Swansea, where I had previously worked, in the School of Health Sciences. My appointment was to the midwifery team headed up by Professor Sheila Hunt, but for the first three months of my appointment, I was given a sabbatical by the head of school, Professor Barbara Green, to complete what became the first edition of *Theory for midwifery practice*.

To get back into the midwifery literature after a break of eight years I had to undertake a great deal of reading and the first edition is essentially an extended literature review concerning the use of theory in midwifery up to the mid-1990s. I wanted to include in the book information on the current theory being used in midwifery, but looking at the literature, I was only able to find work from nurse/midwives in the US. This work by, for example, Reva Rubin and Ramona T Mercer (Bryar and Sinclair, 2011: 63-75) was very interesting and demonstrated work that had been ongoing for decades in developing and testing theory relevant to the care of the childbearing woman. To identify UK work I had a letter requesting information on theory development published in the *Midwives Chronicle* and this generated a small number of responses. Rosemary Methven's work on testing the use of nursing theory in the care of childbearing women was included, but the

work of Jean Ball was the only work on theory building that I was able to find at that time (Bryar and Sinclair, 2011: 80-3).

In quite a short time the book was complete and was sent out by the publishers for review. The reviewers were very kind and the only major suggestion they made was to include exercises at the end of each chapter to enable people to apply the chapters. Finally the book was published in 1995 and I moved from Swansea to the University of Hull to take up a joint appointment as professor of community healthcare nursing practice, working two days a week in the university, two days as professional lead for health visiting and one day as a health visitor in a health visiting team. My time in Hull was very much concerned with practice development and built on my experience in Teamcare Valleys but was informed by my initial experiences of action research in midwifery. With Jane Griffiths at this time I edited a book on practice development in community nursing, which provides examples and tools to help people achieve organisational change, the aim of the original project at Queen Charlotte's (Bryar and Griffiths, 2003).

I stayed in Hull for five years and during that time I met midwives who were making use of the book. The first occasion this happened to me was at a seminar at St George's in London where a midwife came up to me to say that she was using the book in her PhD work. This was an amazing moment. During this time, I was invited annually to contribute to a midwifery theory course at City University London. I also acted as an examiner to some midwifery PhD students, which enabled me to keep in contact with some developments in the field. The book was then translated into German and later into Indonesian so I was aware that it was being used by midwives but my involvement in its use was limited. In 2000, I moved to City University London as a professor of community and primary care nursing, becoming head of my department shortly afterwards. I noticed that there were multiple copies of *Theory for midwifery practice* in the library, many of which were well used and battered.

Theory for midwifery practice: the second edition

In 2005, I was again approached by the publishers to write a second edition of the book. By now it was more than 20 years since I had completed the project at Queen Charlotte's. I had some discussions with Dora Opoku, then head of the midwifery department at City University and agreed to develop the second edition with input from a midwifery colleague who helped direct me to the considerable number of people in the UK, in Australia, New Zealand, US and elsewhere who were developing and testing theory.

It was decided that the book would be in two parts, the first drawing on the original edition outlining issues about theory and the historical context of theory development in midwifery, and the second, chapters to be contributed by people active in the field of midwifery theory development and testing. Potential contributors were contacted and agreed very willingly to write their chapters. The second edition was one of a number of activities I was involved in and time started to pass. One chapter arrived and then others but momentum on the development of the book was difficult to sustain until I had a chance meeting with Professor Marlene Sinclair at a conference of the Academy of Nursing, Midwifery and Health Visiting early in 2009. This meeting galvanised the project and within a few months we had a firm publishing schedule and a date for the manuscript to be submitted to the publishers.

This second edition demonstrates the vast developments in midwifery theory building since the mid 1990s. There are 20 individuals who have written chapters in the second section, but there are many others who could have been included. Following on from the first edition, the second illustrates the application of theory to practice, the testing of theory for practice through research, and the process of generation of theory for practice from practice and research. As with the first edition, the second is concerned with practice – thinking about, influencing and enhancing practice and is concerned with the themes of context, role and women's experiences. Most of the chapters have something to contribute to each of these themes, but some focus more on one than the others.

The impact of the context of care on practice

The impact of the context of care on the practice of midwives was a key finding from the study at Queen Charlotte's (Bryar, 1985) and chapters in the second edition extend our understanding of this area, enabling the development of strategies to bring the organisational context and midwives' models of care into closer alignment. Hunter (2011) in chapter seven, which is concerned with exploring the little discussed realities of doing research, provides evidence of the emotion work undertaken by midwives in managing their work within the organisational setting, identifying in her research midwives who hold models of practice that are 'with organisation' or 'with woman'. The physical characteristics of the birth environment, part of the organisation, are explored in a number of chapters including the discussion by Fahy et al (2011) in chapter ten of *Birth territory theory* and by Walsh of birth centres in chapter eight. Walsh identifies a key point from his chapter which illustrates the importance of context for women: 'Women make assessments of the emotional ambience of birth settings and are drawn to nurturing, caring environments' (2011: 178). In chapter 14, Mander demonstrates, in her discussion of the partnership model in New Zealand, the impact of theories in the wider society on the practice of midwives and thus of the care they provide. The importance of context of health care is now more widely acknowledged in the international Positive Practice Environments Campaign (2010).

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The role of the midwife

The importance of theory on the role of the midwife in providing care for the childbearing woman and her family is the main theme of the first edition and the importance of the role and ways to develop the role is supported by evidence in the second edition. For example, Stockdale et al (2011) in chapters four and five illustrate the contribution of motivation theory to thinking about how midwives support women with breastfeeding through antenatal preparation to the realities of breastfeeding. These chapters provide a fundamental challenge to much of the current thinking and provide useful tools in supporting breastfeeding. Research concerning the importance of technical clinical skills to care of women in labour is discussed by Crozier et al (2011) in chapter 11, while the impact of bullying on midwives and thus on the care they are able to provide is explored in chapter 13. Walsh (2011: 193) concludes that 'care as gift' is the type of practice that midwives should be aspiring to, but this will only be possible where midwives are working in supportive environments that value and care for them.

The experience of the childbearing woman and her family

Much of the early theory development work in midwifery illustrated in the first edition was concerned with the development of the maternal role by women (see Bryar and Sinclair, 2011, chapter three). In the second edition, the focus is on women's experience of care. Schuiling et al (2011), for example, present in chapter nine a research study that tested the application of comfort theory to care of women in labour identifying the importance of physical, psychosocial, social and environmental aspects on the woman's experience of pain in labour. Jones and Kendall (2011) illustrate in chapter six the use of research evidence of women's experiences of breastfeeding to the development of a chair that supports women to breastfeed. In a discussion of decision-making in relation to caesarean section, the role of the woman and her experiences in that process is explored by Kealy and Liamputtong (2011) in chapter 12.

There are clearly strong relationships between these three themes and current research, by among others Downe and colleagues (Bryar and Sinclair, 2011: 83-7), in examining these relationships will take the process of development of theory for midwifery practice onto new areas.

Conclusion

In the 16 years between publication of the first and second editions, there has been an explosion in the development of theory for midwifery practice and it is hoped that the second edition will contribute to the ongoing need to refine theory to direct, guide and drive practice. In 1979, when Queen Charlotte's Maternity Hospital initiated the action research study, they can have had no idea that one impact of the study would be a book on midwifery theory, which 32 years later would be published as a second edition due to the expansion in midwifery theory development in that time. Professor Hugh McKenna asked me at the recent Doctoral Midwifery Research Society Conference in Belfast in 2010 why it had taken 16 years for the second edition of *Theory for midwifery practice* to be published: I hope the above provides some explanation.

Marlene Sinclair and I end the introductory chapter by reinforcing the theme that practice depends on thinking: this book is not a prescription for 'doing' or 'applying' theory. This book is a challenge to you and your thinking about midwifery theory, research and practice. Our message to you is: 'Change the world of midwifery care that you live in by changing the way you think' (Bryar and Sinclair, 2011: 13).

References

Adams M, Armstrong-Esther C, Bryar R, Duberley J, Strong G, Ward E. (1981) The nursing process in midwifery: trial run. *Nursing Mirror* **155(15)**: 32-5.

Bryar R, Strong G (1983) Trial-run continued. *Nursing Mirror* **157(15)**: 45-8.

Bryar R. (1985) *A study of the introduction of the nursing process in a maternity unit*. Unpublished MPhil thesis. Southbank Polytechnic: London.

Bryar R. (1991) *The midwifery process: the introduction of change*: In: Robinson S, Thomson A. (Eds.). *Research in midwifery and childbirth (volume 2)*. Chapman and Hall: London.

Bryar R. (1995) *Theory for midwifery practice*. Palgrave MacMillan: Basingstoke.

Bryar R, Griffiths J. (Eds.). (2003) *Practice development in community nursing. Principles and processes*. Arnold, Hodder Headline Group: London.

Bryar R, Sinclair M. (Eds.). (2011) *Theory for midwifery practice*. Palgrave MacMillan: Basingstoke.

Hart E, Bond M. (1995) *Action research for health and social care: a guide to practice*. Open University Press: Buckingham.

Mariner Tomey A, Alligood MR. (2006) *Nursing theorists and their work (sixth edition)*. Elsevier Mosby: St Louis.

Marx R. (1996) *Providing continuity of care by community midwives*: In: Bryar R, Bytheway B. (Eds.). *Changing primary health care. The Teamcare Valleys experience*. Blackwell Science: Oxford.

Positive Practice Environments. (2010) *Positive practice environments: meeting the information needs of health professionals*. Positive Practice Environments Campaign Secretariat, ICN: Geneva.

Silverman D. (1970) *The theory of organisations: a sociological framework*. Heinemann: London.

Mapping maternity care facilities in England

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Abstract

Objective. To describe the organisation of maternity care at trust and unit level in England.
Methods. All NHS trusts providing maternity care participated in a survey as part of the Healthcare Commission review of maternity care in England in 2007. Data on trusts and numbers of units were also collected in 2009 as part of the Birthplace in England programme.
Results. Models of care provision are limited: in 2007 two-thirds of trusts provided choice between home birth and birth in an obstetric unit only. Geographical variation is substantial, with approximately 70% of trusts in the North-West, Yorkshire and Humberside and London Strategic Health Authority regions having only obstetric units, compared with 50% or less in the South-West and East Midlands. Availability and proximity of specialist facilities for women and babies within trusts varies and is linked with obstetric units. Changes in trust configuration, identified in 2009, have largely resulted from opening alongside midwifery units, then available in a quarter of trusts. Freestanding midwifery units continue to provide care for small numbers of women, commonly in more rural areas.
Conclusions. In 2007, 66% of trusts had no midwifery-led units and this is likely to have limited the choices that women were able to make about their planned place of birth and the possibility of having midwife-led care in non-obstetric unit settings. Recent data suggest that women's options for care may have increased, although capacity and staffing issues, reflected in closures to admissions, may affect these.

Key words: Maternity units, service configuration, evidence-based midwifery

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Introduction

Maternity services in the NHS in England provide comprehensive care for almost all pregnant women. The physical configuration of services at any one time, both locally and nationally, is likely to be a consequence of history, funding, policy and local implementation, as well as the needs of the local population. Some of the drivers for local configuration include geography and transport, trends in birth rates, as well as the provision and location of obstetric theatres, neonatal care facilities and adult intensive care.

The maternity standard of the National Service Framework (NSF) for children, young people and maternity services set out the need for flexible and individualised services that are woman and family centred (Department of Health (DH), 2004). The importance of women being able to make choices about their maternity care has been emphasised in strategy documents (DH, 2007; Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010). It was envisaged that in the future, all women and their partners would be able to choose where and how to give birth, while at the same time being supported in having as normal a pregnancy and birth as possible. The national choice guarantee was that by 2009: 'Depending on their circumstances, women and their partners will be able to choose where they wish to give birth' (DH, 2007: 5). The options for place of birth given, in addition to obstetric units in which birth is supported by a maternity team, were 'birth supported by a midwife at home' and 'birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre.' (DH, 2007: 5).

The teams providing care in hospital based obstetric units include midwives, obstetricians, paediatricians and anaesthetists.

Providers and commissioners are expected to facilitate improvements in maternity services that support high-quality care and to monitor changes as they occur. Changes in both the population of childbearing women and in their birth rates continue to impact on maternity services and the organisations and individuals providing care. These include the number of women giving birth in NHS hospitals in England increasing from 544,468 in 2002 to 642,624 in 2008, while numbers of births at home in England rose from 12,055 to 18,933 over the same period (Office for National Statistics (ONS), 2004; 2009a; 2009b). After standardising to take account of the changing structure of the population, the mean age at first birth in England and Wales increased from 26.3 years in 1998 to 27.5 in 2008. The numbers of maternities to women aged 35 to 39 rose from 89,009 in 2002 to 114,099 in 2008, while the numbers to women aged 40 and over rose from 17,108 to 25,902 over the same period. In 2008, 25% of live births in England were born to women who themselves were born outside the UK, compared to 18% in 2002 (ONS, 2009).

The requirement to comply with the European Working Time Directive has particularly affected medical cover and availability and led to organisational change, which has included some centralisation of medical services into larger units, especially those linked with neonatal units (NHS Confederation, 2004; Royal College of Paediatrics and Child Health and RCOG, 2009). While there is evidence about variation

Box 1. Unit definitions used in maternity care review

Obstetric unit (OU)	An NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available on site.
Alongside midwifery unit (AMU)	An NHS clinical location offering care to women with straightforward pregnancies during labour and birth, in which midwives take primary professional responsibility for care. During labour and birth the full range of diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair.
Freestanding midwifery unit (FMU)	An NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. GPs may also be involved in care. During labour and birth, diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance.

between trusts (Audit Commission, 1997; Healthcare Commission, 2008) and in women's experiences of care (Garcia et al, 1998; Redshaw et al, 2007), the overall physical configuration of maternity services in England and its implications for women's choice has been less well documented. From the late 1940s to 1986, basic data were collected about the location of maternity units, the numbers of beds provided for consultant and GP-led maternity care and the numbers of births in these facilities, in the SH3 Hospital Return.

Since this was discontinued, data collection has not regularly or systematically documented capacity, throughput and changes to the geographical distribution of maternity units on a national basis. This study reports findings from one component of the Birthplace in England research programme, the aims of which were to obtain an overview of the configuration of maternity services and to describe the organisational geography of the care and services available, focusing particularly on intrapartum care.

Methods

Data collection

Collection of data about the configuration of maternity care in England was carried out during 2007 as part of a maternity service review by the Healthcare Commission, now part of the Care Quality Commission (Healthcare Commission, 2008). All 148 acute trusts providing obstetric services and a further four trusts providing midwifery-led services were required to complete an online questionnaire. Nominated leads within each trust were responsible for data return and the data were returned in October 2007. Data on trusts, maternity unit numbers and changes in classification were also directly collected by the Birthplace project team during 2008 to 2009, in order to identify all functioning maternity units and any changes in configuration within trusts. Organisational, policy and aggregated statistical data were returned on a trust and unit basis. No individual data were requested and thus ethical approval was not sought for the survey.

Table 1. Configuration of maternity care within trusts in England in 2007

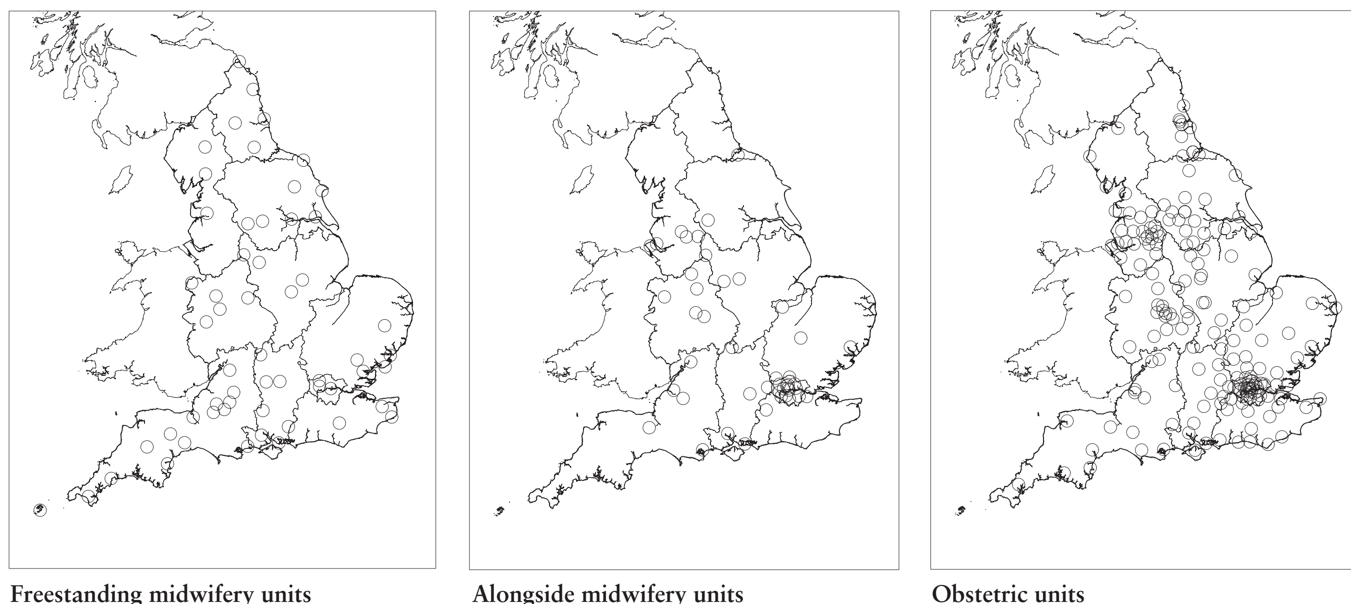
Trust configuration	Trusts n (%)
One or more obstetric unit (OU) only	100 (65.8)
One or more OUs and one or more AMUs	20 (13.2)
One or more OUs and one or more FMUs	23 (15.1)
One or more of all types of unit (OU, AMU and FMU)	5 (3.3)
One or more FMUs only	4 (2.6)
Total	152 (100.0)

Source: Maternity Service Review HCC/NPEU questionnaire (2007)

Survey instrument

The Birthplace Mapping Component Working Group and the Maternity Review Team at the Healthcare Commission together developed the survey instrument to be used with trusts and a formal agreement was made for data to be shared between the Commission and the National Perinatal Epidemiology Unit. The topics covered included details about a wide range of policies

Figure 1. Location of freestanding midwifery units, alongside midwifery units and obstetric units in England



Freestanding midwifery units **Alongside midwifery units** **Obstetric units**

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Table 2. Different types of maternity units with the numbers of women giving birth in England 2006/7 by type of maternity unit

	Number of women giving birth					
Type of unit	**Under 1000**	**1000-2499**	**2500-3999**	**4000-5499**	**5500-6999**	**7000 and over**
Obstetric unit	1	51	81	39	7	1
Alongside midwifery unit	21	4	1	0	0	0
Freestanding midwifery unit	56	0	0	0	0	0
Total	78	55	82	39	7	1

Source: Maternity Service Review HCC/NPEU questionnaire (2007)

and services associated with staffing, facilities, and the organisation of antenatal, intrapartum and postnatal care. Both trust level data and unit data were collected, and where trusts had more than one maternity unit, the data were entered separately. A survey administration manual was provided with guidance and definitions. This included descriptions of the different types of unit. Individual units were identified and categorised based on the definitions developed by the Birthplace Programme as obstetric units (OUs), alongside midwifery units (AMUs) and freestanding midwifery units (FMUs) (see Box 1). Only units able to provide information about the care they provided and their own birth statistics were treated as separate units for the purposes of the study.

Analysis

The data entered were loaded into an MS Access database and data checks and analyses carried out using STATA 10.1 SE and SPSS 15.0. Frequencies and proportions were calculated. The location information was used for geographical mapping with a geographical information system (GIS).

Results

A total of 148 acute trusts providing a full range of maternity care and a further four trusts providing only midwifery-led services returned data. All of these

Figure 2. Regional variation in trust configuration of maternity care (number of trusts) in SHA regions in England in 2007

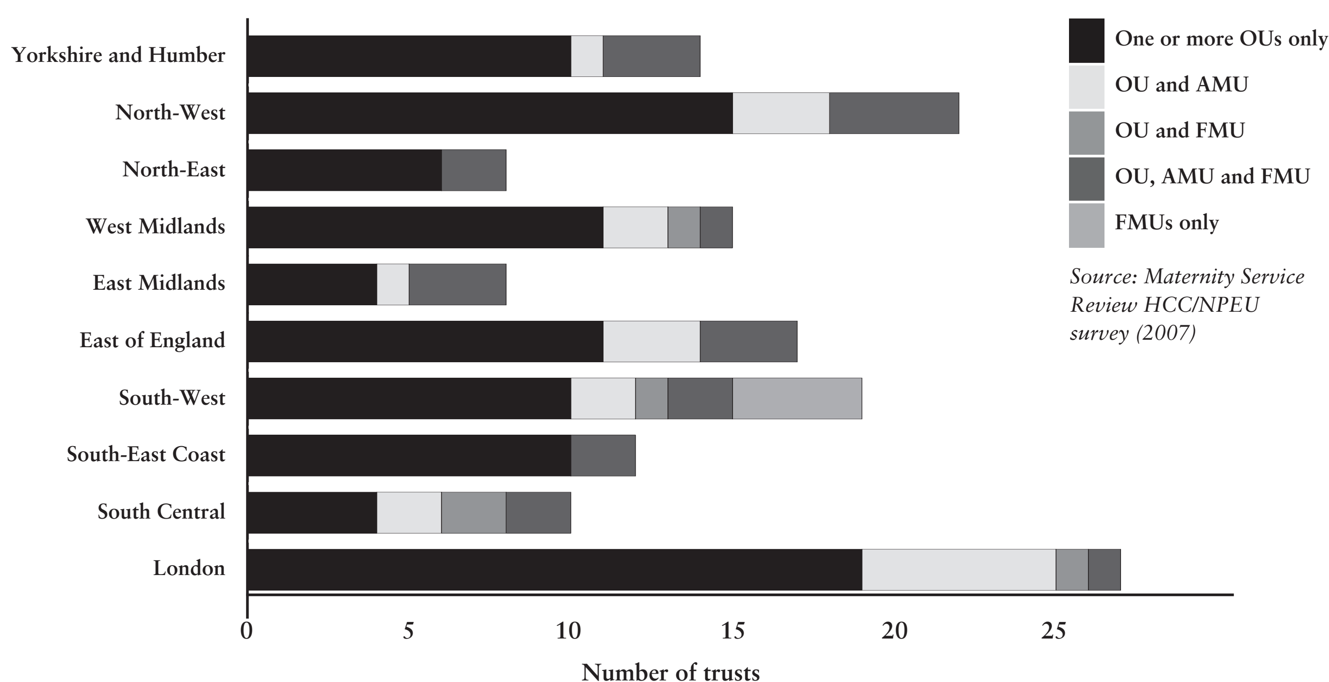

Table 3. Facilities and services associated with each type of maternity unit

Facility or service	Maternity unit type (n %)			Total units (n=262)
	OU (n=56)	AMU (n=26)	FMU (n=180)	
Pregnancy day assessment unit	171 (95.0)	20 (76.9)	16 (28.6)	207 (79.0)
Early labour assessment by a midwife at home	84 (46.7)	15 (57.7)	36 (64.3)	135 (51.5)
24/7 epidural service	169 (93.9)	6 (23.1)	0 (0.0)	175 (66.8)
1 or > obstetric high dependency unit beds	88 (48.9)	0 (0.0)	0 (0.0)	89 (34.0)
Adult intensive care unit on site	167 (92.8)	20 (76.9)	6 (10.7)	193 (73.7)
Dedicated obstetric theatres	178 (98.9)	n/a	n/a	178 (67.9)
Blood transfusion service on site	172 (95.6)	24 (92.3)	6 (10.7)	202 (77.1)
Neonatal unit on site	178 (98.9)	26 (100.0)	0 (0.0)	204 (77.9)

Source: Maternity Service Review HCC/NPEU questionnaire (2007)

were included in the analyses. This reflects an almost complete picture of all the trusts and units providing maternity care in England. Data were not available from one trust that had merged with a larger trust just prior to data collection. Within the trusts, data were provided by a total of 262 maternity units made up of 180 OUs, 26 AMUs and 56 FMUs. AMUs unable to provide their own birth statistics separately from those of the OU at the time of the review were not included as distinct entities.

Configuration of services

The basic configuration of maternity services within trusts falls into five categories (see Table 1). In 2007, two-thirds of trusts (66%) had only one or more OUs delivering maternity services and 84 of these 100 trusts had a single OU. Only 17% of trusts had hospital-based AMUs and only 15% had a combination of OUs and FMUs. Even fewer trusts – 3% – had all three types of unit. Marked differences in the availability of midwifery-led services can be seen within the geographical areas in England covered by individual strategic health authorities (SHAs) and patterns can be seen (see Figure 1). Trusts with FMUs were more common in the South-West and trusts with AMUs were more likely in London, the North-West and the East of England.

Maternity care in an obstetric unit was by far the most common form of provision with more than two-thirds (69%) of the maternity units at this time being OUs, caring for more than 95% of the women giving birth in England in the financial year ending 31 March 2007. AMUs and OUs varied considerably in the numbers of women giving birth (see Table 2), with over a quarter of OUs (29%) having fewer than 2500 women giving birth and a similar proportion (26%) having more than 4,000 women giving birth. Using throughput as a marker, midwifery-led units, both alongside and freestanding are small compared with OUs. The distribution of types of unit also varies considerably between geographical areas (SHA regions), following the pattern of trusts (see Figure 2).

Home birth is one of the choices available, but the proportion of women reported to have given birth at home in England as a whole was relatively small, 2.8% in both 2007 and 2008 (ONS, 2008; 2009b). However, there were marked differences between trusts, for among the 138 trusts reporting on women whose births were planned and completed at home in the year ending 31 March 2007, the numbers ranged from 0 to 368 per trust, with a median of 61. Planned birth at home was more common in trusts with OUs and at least one FMU (mean 131 births, median 124) and in trusts with all three types of unit (mean 142 births, median 142), compared with trusts with OUs only (mean 70 births, median 53).

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Closures

Data were collected on the extent to which units were operational and the days that they were closed to admissions during the year ending 31 March 2007. A small number of units, nine OUs, three AMUs and nine FMUs, reported not being operational during this year, for variable time periods ranging from 12 to 52 weeks. Most maternity units (62%) were not closed at any time, but 39% of OUs, 35% of AMUs and 32% of FMUs did report being closed for a median of four days, 12 days and 30 days respectively, largely as a function of capacity and staffing issues.

Facilities and services

The associated facilities and services varied by type of maternity unit (see Table 3). Pregnancy day assessment units were most commonly associated with obstetric units whereas early labour assessment at home was reported as available by half of all maternity units, most commonly those that were midwife-led. The 24-hour epidural services followed a similar pattern, with almost all OUs (94%) reporting this type of service. Almost all OUs had at least one dedicated obstetric theatre, access to an intensive care unit and a blood transfusion service on site, though only half had one or more high dependency obstetric beds.

It may be that during labour some women and their babies need to be transferred to other units for more specialist services. For FMUs, the nearest OU was a median distance of 17 miles away (mean 18.6), but this distance ranged from five to 70 miles. Several units in one trust were unable to identify the main unit to which women were likely to be transferred, indicating that it depended on different units' available capacity on the day. The median distance from an FMU to the nearest neonatal unit providing high dependency neonatal care was 17 miles (mean 17.5), with a range from five to 54 miles. However, the distance to a neonatal unit able to provide the full range of neonatal intensive care may be greater than this. Seven FMUs in two trusts in rural areas indicated that air transport was used for some transfers.

Planned and reported changes

All participating trusts provided information about recent and planned future changes in provision. Changes in maternity services were planned in trusts with all types of configuration for the three years following the maternity review. Some planned to increase capacity and options for care by opening new units, with 13% planning a new OU, 17% a new AMU and 13% a new FMU. Higher proportions planned to make changes across the board, with 30% increasing delivery bed capacity in maternity care, 48% increasing obstetric medical cover, 45% increasing consultant posts and 54% increasing the funded midwifery establishment.

Recent figures on the numbers of maternity units returned by heads of midwifery suggest some of these changes have now taken place. Between October 2007 and September 2009, three trusts were reported to have merged and one OU closed. There has been an increase in the number of AMUs, and while six FMUs had closed, three had opened. By 30 September 2009, a total of 179 of the 287 maternity units identified were OUs (62%), 51 were AMUs (18%) and 57 were FMUs (20%). Of the 24 'new' AMUs, six were already functioning in this way in 2007 but were unable to disaggregate their data and so were not identified as such. In terms of configuration within trusts the situation at the end of 2009 was one in which fewer trusts had only OUs (52%), more had OUs with AMUs (24%), and there was little difference in the proportion of trusts with OUs and FMUs (17%), those with all types of unit (5%) and those with just FMUs (3%).

Discussion

In terms of places for birth provided by the NHS, care provision and choice, were limited, with most women giving birth in an obstetric unit in which a team of midwives and obstetricians provided care for low- and high-risk women as required. The number of trusts with midwifery-led units was relatively small and there was geographical variation in the extent to which these were available. Specialist facilities for women and their babies are usually linked with obstetric units and proximity to these varied accordingly. Changes in trust configuration since the survey took place suggest that by September 2009, women's options may have increased, resulting from the higher number of AMUs that had become available in a quarter of trusts. FMUs continued to provide care for a relatively small number of women, commonly in more rural areas. While home births were at a low level, 58% of women responding to women's surveys in the same trusts, reported being offered birth at home as an option (Healthcare Commission, 2008). Using national statistics as a data source on numbers of women giving birth and focusing only on the location of maternity units, rather than the configuration within trusts, the distribution of UK maternity units and home births was described in a recent report, which supports the findings reported here (Dodwell and Gibson, 2009).

Changing demographics and national and local policy are major influences on the configuration and provision of care. The current policy agenda, with its focus on choice for women and their families, is a driver for the kind of changes taking place. At the same time, the European Working Time Directive (RCPCH and RCOG, 2009) has impacted on staffing arrangements and cover that may in turn affect women's possible choices. Differences in configurations of maternity provision are also likely to reflect a range of historical and contemporary factors including geography, local champions and innovators, and user group activity.

The present distribution and configuration of care suggests that, over time, trusts have adopted different strategies. Some have moved towards having midwifery-

led units alongside consultant-led units, while others have provided midwifery-led care separately. In some cases, these reflect past provision of 'GP units', in which women booked with a GP for care provided largely by midwives (Smith and Smith, 2005). Other arrangements include FMUs that are closed unless required by a woman in labour (Lewis and Langley, 2007). The shift from a model of commissioning maternity services with 'block maternity contracts' with acute trusts, to contracting a maternity service for a local population within a managed clinical network may mean that commissioners of these services may have more options and greater flexibility in contracting for maternity services. Based on needs assessments of the local maternity population, commissioners can contract services from more than one provider, for the whole or part of the care pathway. While this may improve the quality of services, it also makes for more complexity in monitoring the effects of changes in configuration and provision. Cross-boundary movement of women for different phases of care similarly increases the uncertainties associated with planning and providing maternity services.

Planning individual women's care necessarily involves taking into account accessibility and proximity to any specialist services that may be required, in addition to their reproductive history and health. The characteristics and needs of the local population more generally, and the way in which maternity care has been provided have historically influenced the way that maternity care is configured at present. The changing birth rate and inward migration have affected some services markedly, particularly those in the south and in London.

With the birth rate increasing by 2% per year in the capital, which also has the highest regional vacancy rate for midwives (Healthcare Commission, 2008), capacity issues are a considerable challenge, as is the cultural and social diversity of the population evidenced in the broad range of ethnicity and languages used. The numbers of units of all kinds within a region reflect the number of births, with London and the north-east at the extremes (ONS, 2009a).

Conclusion

In 2007, 66% of trusts had no midwifery-led units and this is likely to have limited the choices that women were able to make about their planned place of birth and the possibility of having midwife-led care in non-obstetric-unit settings. Data from the end of 2009 suggest that women's options for care may have increased, although capacity and staffing issues, reflected in closures to admissions, may affect these.

Undertaking the survey was a challenge, especially in collecting data from trusts whose information systems were ill-equipped to access or supply them. Routine collection of basic data of the kind collected in the survey could enable monitoring of changes in configuration over time and monitoring of the effects of these changes. The data presented provide an overview of how care is provided, a context for the development of perinatal or maternity networks and a baseline against which to compare future configuration, developments and organisational change, both locally and in England as a whole.

References

Audit Commission. (1997) *First-class delivery: improving maternity services – England and Wales*. Audit Commission: London.

Chief nursing officers of England, Northern Ireland, Scotland and Wales. (2010) *Midwifery 2020: delivering expectations*. HMSO: London.

Department of Health. (2004) *National Service Framework for children, young people and maternity services: maternity standard 11*. HMSO: London.

Department of Health. (2007) *Maternity matters: choice, access and continuity of care in a safe service*. HMSO: London.

Dodwell M, Gibson R. (2009) *Choice of place of birth*. NCT: London.

Garcia J, Redshaw M, Fitzsimons B, Keene J. (1998) *First-class delivery: a national survey of women's views of maternity care*. Audit Commission: London.

Healthcare Commission. (2008) *Towards better births: a review of maternity services in England*. Commission for Healthcare Audit and Inspection: London.

Lewis M, Langley C. (2007) I'm giving birth up the hill: will you come? *Midwives* **10**: 428-9.

NHS Confederation. (2004) *Survey of models of maternity care: towards sustainable WTD compliant staffing and clinical network solutions*. NHS Confederation: London. See: www.rcog.org.uk/files/rcog-corp/uploaded-files/survey_of_models_maternity_care.pdf (accessed 3 June 2011).

Office for National Statistics. (2004) *Birth statistics: review of the registrar general on births and patterns of family building in England and Wales, 2002. Series FM1 no 31*. HMSO: London.

Office for National Statistics. (2009a) Report: births in England and Wales, 2008. *Population Trends* **138**: 85-9.

Office for National Statistics. (2009b) *Birth statistics: review of the registrar general on births and patterns of family building in England and Wales, 2008. Series FM1 no 37*. HMSO: London.

Redshaw M, Rowe R, Hockley C, Brocklehurst P. (2007) *Recorded delivery: a national survey of women's experience of maternity care 2006*. National Perinatal Epidemiology Unit: Oxford.

Royal College of Paediatrics and Child Health, RCOG. (2009) *Children's and maternity services in 2009: working time solutions*. Royal College of Paediatrics and Child Health and RCOG: London.

Smith LFP, Smith CP. (2005) UK childbirth delivery options in 2001-2002: alternatives to consultant unit booking and delivery. *British Journal of General Practice* **55(513)**: 292-7.

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An exploration of the importance of emotional intelligence in midwifery

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Abstract

Background. Recognition of the importance of emotional intelligence (EI) dates back as far as Aristotle (350BC). More recently, the notion of emotional intelligence features in social psychology literature; it has also been embraced within personnel management and is now beginning to appear in nursing, medical and midwifery journals. Emotional intelligence involves possessing the capacity for motivation, creativity, the ability to operate at peak performance and the ability to persist in the face of setbacks and failures. EI refers to the ability to recognise our own feelings and those of others and it enables us to manage emotions effectively in ourselves and in our relationships.

Objectives. The objectives of the paper are to define EI and to present an original framework for reflection on the significance of this attribute in midwifery (see Figure 1). This framework illustrates the impact of emotional intelligence on practice, particularly in relation to improving the quality of care delivered to women, and enhancing our relationships with colleague.

Method. Midwives are constantly responding to change and challenges within maternity services. This paper examines how EI can assist midwives in dealing with pressures that involve delivering the government reforms, providing choice to women and facing current issues within the midwifery workforce.

Conclusion. EI refers to midwives' ability to recognise our own feelings and those of others. Midwives need to develop self-awareness and not avoid addressing emotional issues in midwifery practice. Raising the profile of EI in maternity care will enhance the effectiveness of midwives and strengthen the capacity to deal with pressures and develop effective relationships with colleagues and women (Hunter, 2004).

Key words: Emotions, intelligence, recognition of feelings, understanding of emotions, empathy, communication, effective working, evidence-based midwifery

Introduction

Emotional intelligence (EI) is featuring more prominently in health service literature and its importance is now being acknowledged in practice (Cadman and Brewer, 2001; Carrothers et al, 2000; Gould, 2003; Akerjordet and Severinsson, 2008). 'It is generally accepted that very little of our lives is governed by logic alone. It is rather our emotional world that motivates our decisions and actions' (Freshwater and Stickley, 2004: 91).

EI and failure to understand emotional issues can have significant negative outcomes on the health and well being of midwives (Gould, 2003; McMullen, 2003; Hunter, 2004). In spite of family friendly policies and Agenda for Change (Department of Health (DH), 2004), this has barely been acknowledged within the midwifery profession.

The aims of this paper are to define EI, to generate insight into the importance of EI in maternity care particularly in relation to meeting the challenges of today's maternity services and to enhance the reader's understanding of the need to develop EI in student midwives.

Defining EI

EI refers to our ability to recognise our own feelings and those of others and encompasses managing emotions effectively in ourselves and in our relationships. It also involves possessing the capacity for motivation, creativity and the ability to perform at an optimal level when completing tasks. It provides the ability to persist in the face of setbacks and failures (Steiner, 1997; Goleman, 2004). Interest in EI, dates back to Aristotle in 350BC when it was suggested that EI was crucial to the ability to make wise judgements (Thomson, 1976). Aristotle in the Doctrine of the Mean said that emotions can be good only if expressed to the right degree in the appropriate circumstances and towards the appropriate person (Thomson, 1976). The concept of EI has re-emerged in social psychology literature and particularly more recently within neurobiological sciences where intelligence and emotions have been studied as components of cognitive, physiological and behavioural responses of individuals to particular life events (Salovey and Meyer, 1990; Bar-On, 2006; American Psychological Association (APA), 2007; Akerjordet and Severinsson, 2008). Within nursing literature EI has become prevalent but Bulmer Smith et al (2009) caution that the concept is sometimes poorly defined, overrated and has not been measured. In healthcare, there is an acknowledgement of the value of EI and the impact of reflective practice, which both influence organisational work and the building of

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caring patient relationships. These ultimately lead to more patient-centred care (George, 2000; Mann, 2005). Within management, EI is thought to contribute to the development of transformational leadership skills. It has also been used as a predictor of job performance, team working and effective communication and is widely used as a tool for personnel training and hiring of staff (Akerjordet and Severinsson, 2008; Jordon, 2009; Joseph and Newman, 2010).

A recent review by Akerjordet and Severinsson (2007) reported that few articles on EI were set within an epistemological tradition and that further study was needed to expand empirical and philosophical knowledge. Theories of EI do, however, exist and on examination of the literature three main theories and definitions have emerged. Salovey and Mayer (1990) defined EI-like academic intelligence as an ability that can be learned and occurs when an individual can perceive, appraise and express emotions. Goleman (1995) viewed EI as a set of skills and personal competences all which demonstrate elements of motivation, self-awareness, self-regulation, empathy and success in human relationships. Bar-On (2006) conceptualises EI as being similar to a set of personality traits and abilities.

The importance of EI has been repeatedly highlighted by Goleman (1995; 2004) who argues that EI is an important social skill that is essential to the process of empathy. EI, therefore, can be defined as a multidimensional concept representing core abilities, which identify process and manage emotions and enable individuals to deal with life events and be more successful in personal relationships (Akerjordet, 2009). This is particularly relevant to midwifery. Hunter (2006) and Walsh (2007) state that meaningful positive relationships are vital. The development of EI ensures that feelings are acknowledged and not dismissed or suppressed (Goleman, 2004). As a consequence of this, there emerges an enhanced understanding of self and others and this helps develop more insight into the complex situations that professional relationships bring within midwifery practice.

EI and the intellect

There is a need to explore the nature of EI vis-à-vis general intelligence. Intelligence is normally associated with intelligence quotient (IQ) (Goleman, 2004). EI differs, but also complements intellectual intelligence. Emotional and intellectual intelligence are situated in different parts of the brain (Goleman, 1995; Bardzil and Salaski, 2003; Moriarity and Buckley, 2003; McQueen, 2004). This is further supported by evidence from LeDoux (1998), who demonstrated that there are specific areas in the brain where emotional processing takes place. Goleman (2004) suggests that the process of learning EI is different from learning intellectually, which takes place in the classroom and where information and understanding is stored in the memory banks of the neo-cortex. This is not so with EI which, as Hunter (2009) claims, is needed for the development of emotional awareness. Combining the management of emotions with self-awareness is essential for the development of EI (Jordon and Troth, 2004). Begley (2006) highlights the difference between learning theoretical material and learning to exercise practical wisdom and make sound judgements in practice. Theoretical subjects can be taught in the classroom, while practical wisdom including competencies in EI requires experience and exposure to good role models and exemplars. Midwives, therefore, need to lead by example and nurture EI in students. This involves approaching clients and colleagues in a positive manner, listening to them attentively, transferring information more effectively and giving skilful feedback to other team members (Goleman, 2004).

Furthermore Strickland (2000) and Goleman (2004) claim that EI is more important than intellectual intelligence, since people with high levels of EI demonstrate higher levels of interactive skills, are more co-operative and work more collaboratively in a group. Hunter (2009) argues that Goleman's (2004) views on EI are 'simplistic' because they do not demonstrate a research evidence base. Hunter (2009) promotes the thinking of Fineman (2003) who refers to 'emotional sensitivity', which relates to responsive leadership, intuition and the process of emotional expression. In spite of the debate surrounding what EI is, however, Hunter (2009) acknowledges that it is essential for effective midwifery practice, since midwives need to recognise their own feelings, the feelings of others and they need to be able to articulate their feelings in a meaningful way. Work by Hunter and Deery (2005) suggests that midwives who failed to acknowledge the importance of emotions in midwifery tended to take an approach that can be described as 'affective neutrality'. This involves the development of coping strategies, becoming professionally detached, avoiding emotional issues and focusing on practical tasks. These traits paint the picture of the midwife as a cold automaton and they do not facilitate a woman-centred approach to midwifery practice.

EI in midwifery practice

Midwives and the acknowledgement of emotions in practice

Hunter (2005) refers to 'social norms' regarding displaying emotions and acknowledges that there are times when it is not considered appropriate in midwifery to display emotions. This supports the Aristotelian approach that emotions must be expressed in the appropriate circumstances. For example, traditional midwifery and nursing training programmes encouraged midwives and nurses to conceal their emotions and work behind a professional façade which protected them from the emotions of patients (Menzies, 1960). This is illustrated in the following extracts from Way (1962): 'Sympathy with the patient is a dangerous virtue, meaning as it does, to suffer with someone' (Way, 1962: 13) and 'Patients will, if you let them... tell you all their problems and monopolise your time' (Way, 1962: 16). This implies that it would be a weakness on the part of the practitioner if time was spent engaging with clients at this level (Begley, 2006).

Historically, midwifery care was community based until the Peel Report (Department of Health (DH), 1970) recommended that hospital facilities should be available to 100% of women giving birth. This brought about significant

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changes to the delivery of maternity services (DH, 1970) leading to medical control of childbirth, greater use of technology and led to midwives working in a fragmented manner with their skills being underutilised (Mander and Reid, 2002). The results of control and medicalisation when birth was moved from the family setting to institutions were that midwives were inclined to become distant and detached from the women they cared for (Donnison, 1988; Currell, 1990). Hunter (2005) acknowledged the importance of emotional support in the mother-midwife relationship and its impact on the quality of care that a woman receives. She states that the evidence suggests that the support women receive from midwives today, particularly in conventional hospital based midwifery as opposed to community settings, varies in quality. The reason for this, it has been suggested, is that the working environment in hospital is driven by the needs of the service. In contrast to this the community offers a normal approach to childbirth where midwives can manage emotions more effectively.

In recent decades, concepts which incorporate involvement and commitment on the part of the midwife are now more highly valued in health care. Concepts such as the named midwife, integrated midwife-led schemes of care, continuity of care, working in partnership with women and midwives as a first point of contact all emphasise the need for effective communication and the importance of the midwife-woman relationship (Kirkham, 2000; Wiggins and Newburn, 2004; DH, 2007; Scottish Government Health Directorates, 2010).

EI and emotional labour

In midwifery practice, therefore, EI is acknowledged as an essential attribute of the effective practitioner. While EI enhances the experience of the woman, it must be acknowledged that it can have a negative impact, such as burnout, on the midwife.

Emotional challenges have the potential to lead to psychological damage (Hunter, 2004). Hunter and Deery (2005) both examined the emotional aspects of midwifery using Hochschild's (1983) theoretical framework of emotional labour (EL) and reported that midwifery was highly emotional work. They identified the lack of recognition and the lack of significance that is placed on emotions in the workplace. This refers not only to emotions that are displayed by midwives but in many cases those which they experience but do not disclose. Hochschild (1983) defined EL as the 'induction or suppression of feelings to sustain the outer appearances that results in individuals feeling cared for in a convivial safe way' (Hochschild, 1983: 7). Hunter (2004) reported that midwives who were struggling and unable to provide women-focused maternity care found the emotional work of midwifery difficult and they required support in managing their emotions. It is not being suggested that EL and EI are similar concepts, but McQueen (2004) states that the mental processes involved are similar. Reflecting on the work of Menzies (1960) and Way (1962), it is understandable that in the past practitioners were discouraged from being emotionally involved since remaining aloof offers a certain degree of protection from such EL.

Incongruent emotions

Vitello-Cicciu (2003) highlights another area of stress and unhealthy emotions within the workplace. That is when practitioners force themselves to feel the expected emotion, for example, when stressed and busy midwives pretend to feel joy and satisfaction in their work in order to display a positive image to women in their care. Vitello-Cicciu, (2003) claims this 'incongruence or dissonance' between what the practitioner actually feels and what they are expected to feel evolves into EL. If these emotions are not managed, they can result in burnout and psychological illness. This in turn is reflected in the quality of care, since burnout in health and nursing staff is linked with reports of patient dissatisfaction (Lester et al, 1998).

EI and the delivery of maternity services

Recruitment and retention

Deery (2005) indicates that midwives not only display positive emotions of empathy and caring to women, but are sometimes required to suppress negative emotions that may emerge from areas of stress in the workplace. This may well be either directly or indirectly contributed to by insufficient staffing levels as a result of problems around recruitment and retention (NMC, 2009). The midwifery profession is still facing a staffing crisis with a reduced number of registered midwives and many are now due to retire (NMC, 2009). Levels of staffing within maternity services is particularly relevant as it is evident that maintaining adequate staffing levels impacts on both quality of maternity services and on the level of satisfaction experienced by mothers (Hatem et al, 2008).

Increased birth rate

For the seventh successive year in England and Wales there has been an increase in the birth rate; in 2008, there were 701,711 live births compared to 690,013 in 2007 which indicates an increase of 2.7% in one year (ONS, 2010). This has been compounded by the fact that there is a continued rise in the proportion of births to mothers born outside the UK 24% in 2008 compared with 14% in 1998 (ONS, 2010). This has led to difficulties in how midwives work due to problems that exist around communication where English is not the woman's first spoken language. Added to this is the fact that non-English-speaking women including black African, asylum seekers and refugees were six times more likely to die than white women (Centre for Maternal and Child Enquiries (CMACE), 2007). Midwives working in such highly charged and stressful environments need to develop an understanding of what Hunter (2004) refers to as 'emotion work' in order to address the issues brought about by increased pressures within the service.

Bullying

If we are to address the needs of an already stretched workforce we need EI to manage relationships with

colleagues (Sandall, 1997; Elliott, 2004). At all levels, we need skill in dealing with conflicting emotions in the workplace as there is evidence that 'horizontal violence' and bullying is a reality among midwives and student midwives (Leap, 1997; Ball et al, 2002; Gillen et al, 2009). The research by Gillen et al (2009) reported just 27% of student midwives considered leaving in the first three months due to poor interpersonal relationships. Keeling et al (2006) highlights the detrimental effect that bullying has on the emotions and EI of the victims. It leads to stress, long term physical health problems and a bullying culture which will compound problems related to recruitment and retention of midwives. Fineman (2003) claims that midwifery leaders are required to display leadership qualities which are emotionally responsive to dealing with stress caused by bullying within the workplace. This will assist in creating a safe environment where midwives can feel supported and where their emotional needs are being recognised (Hunter, 2009).

EI is needed for transformational leadership

The NHS and maternity services are constantly undergoing change and reform. Successive UK governments have made huge demands on healthcare staff. Documents such as *The new NHS: modern, dependable* (DH, 1997); *Making a difference* (DH, 1999); *The NHS plan: a plan for investment, a plan for reform* (DH, 2000); and recently *Front line care report by the Prime Minister's commission on the future of nursing and midwifery* (DH, 2010) have exhorted the NHS to improve and meet the needs of consumers and provide a patient-focused service.

In the four regions of the UK many fundamental challenges have emerged regarding maternity services. Issues such as a lack of health awareness, unhealthy lifestyles, family wellbeing, parenting skills, mental health problems, socially complex pregnancies and language and cultural diversity affect the health and wellbeing of many women in pregnancy (CMACE, 2007). In order to meet the demands of change and reform, effective transformational leadership throughout the profession is needed (Elliott, 2004; Coggins, 2005; Ralston, 2005). Evidence supports the link between EI and effective leadership.

Goleman (2004) argues strongly that EI and leadership are interdependent and describes EI as the 'Sine qua non' of leadership. Bass (1990) stated that those with high EI demonstrate personal and social competence that complements transformational leadership. Without EI, therefore, midwifery leaders will fail to be effective in meeting the needs of women, inspiring colleagues and implementing government reform.

Dealing with current pressures within the workforce

Bardzil and Slaski (2003) implemented a model of service quality competences based on EI and staff who were given training in self-awareness for one day per week over a period of four weeks. Those staff were followed up at six months and 18 months and were found to have developed and maintained increased awareness of emotional processes. Goleman (2004) and Slaski and Cartright (2002) state that organisations which develop the EI of their staff will reduce the negative aspects of work life, for example, stress, low morale and poor mental health and also promote a service orientated climate that is more effective. This research is unquestionably useful, but requires further exploration in terms of the environment and measure of EI (Bardzil and Skaski, 2003). It has also been reported that midwives who work together in teams to achieve clearly defined goals will feel better supported. As Carter and West (1999) found, midwives who worked in effective teams had lower levels of stress than those who did not. Yost and Tucker (2000) examined the EI of teams and found that a higher level of EI in teams related to greater team success.

Midwives can further deal with workplace pressures by developing emotional awareness. Hunter (2004) states, that in light of her previous research (2002), EI is the key component in managing EL. This can be achieved in midwifery practice by the process of perceiving, identifying and integrating emotions into thought processes, which will result in a deeper understanding of emotions and consequently more effective management of emotional situations (Salovey and Mayer, 1997). Hunter (2009) further suggests that midwives can develop their emotional awareness by developing an insight into their own personal feelings and the feelings of others, by attending counselling and assertiveness courses. She also highlights the pivotal role of supervisors of midwives in supporting midwives through emotional aspects of practice. Deery (2005) reported that group clinical supervision could be effective in developing an increased self awareness in midwives and facilitating support to meet the emotional demands of their role.

Midwives can learn to be emotionally intelligent

Studies have shown that it is possible to learn EI skills (Muller-Smith, 1999; Goleman, 2004) and although emotional skills are learned in childhood, they can be developed and changed in later life (Dulewicz and Higgs, 2000). Indeed, EI can develop with age and experience (Mayer et al, 1999). Competencies discussed by Muller-Smith (1999) are self-awareness, involving emotional awareness, self-assessment and developing self-confidence. Bardzil and Slaski (2003) argue that these are essential for attitude and behaviour changes and also for enhancing social skills.

As noted earlier, the development of EI, unlike intellectual intelligence, requires experience and is enhanced by mentors and good role models (Begley, 2006). Sometimes young or inexperienced midwives lack this insight into the needs of women. This problem can be overcome by using literature to nurture insight into issues facing others. For example, Seamus Heaney's poem (1969) *Elegy for a stillborn child* can draw us into the emotions of a couple who have experienced the loss of a child. Literature is 'a window through which we can see into the experiences of others' (Begley, 2003: 129).

This method of facilitating the development of EI is particularly useful in educating students for practice (Begley,

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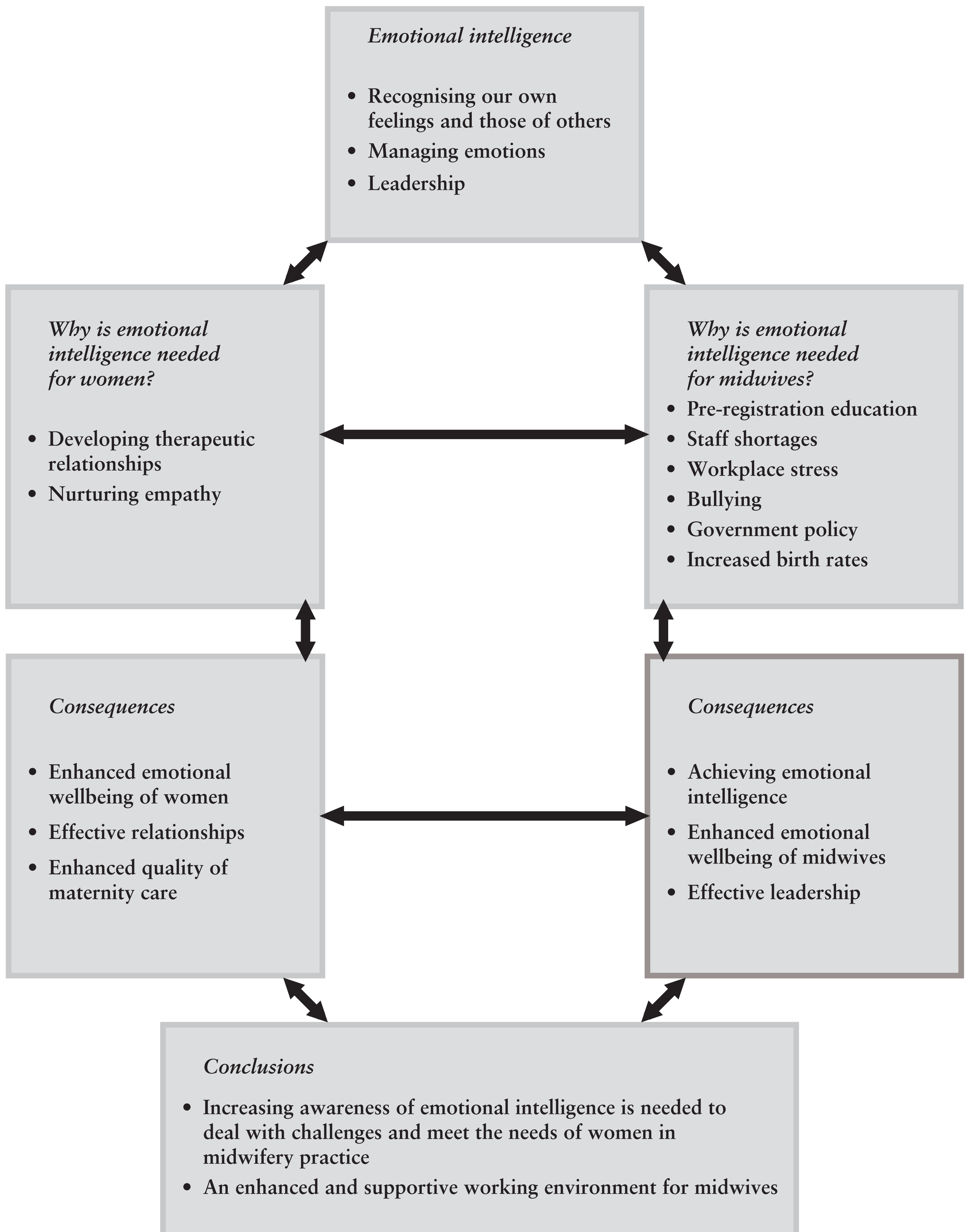
Figure 1. Patterson's and Begley's original framework for reflection on EI in midwifery



2010). Many midwives feel inadequately prepared for the interpersonal and emotional roles that sometimes occur in their practice (Henderson, 2001; Hunter and Deery, 2005). Gould (2003) suggests that we should set up opportunities for women's birth stories to be heard in multidisciplinary forums, and that we need to look at re-skilling in areas of communication developing EI so as to deliver care that is more sensitive.

Testing of EI

There is, of course scepticism in relation to the nature and importance of EI. It has been suggested that EI can be explained by personality traits and cognitive abilities (Landy, 2005). However, several tests that employ self-report devices and psychometric measurements that will quantify psychological qualities have been developed to measure EI (Akerjordet and Severinsson, 2007). The Bar-On Emotional Quotient Inventory (EQ-i:S) (2002), a self report questionnaire is a test that is recognised internationally to measure EI. The EQ-is comprised of a list of non-cognitive competences, or personal qualities that demonstrate an individual's ability to cope with environmental pressure.

This test was used in a study by Fletcher et al (2009) to measure EI in third year medical students following EI training. The intervention group demonstrated significantly higher change in EI than the control group (Fletcher et al, 2009). The test was reported to have a sound theoretical base, good psychometric properties and it has been used in many international studies, demonstrating construct and predictive validity (Bar-On, 2006; Benson et al, 2009).

The Bar-On (2002) EQ-i:s was also used in a cross-sectional study to measure EI in 100 baccalaureate nursing students. The aim was to evaluate the differences in EI in students across a four-year pre-registration programme (Benson et al, 2009) and all the nursing students in this study were found to have a level of EI that enabled them to establish effective interpersonal relationships and to function under pressure. However, there was a statistical difference (p=<05) in scores between students in year one and year four in interpersonal skills and stress management with scores being higher in year four students than year one.

The Mayer-Salovey-Caruso EI test (2003) (MSCIT) can also be used in measuring. This tests abilities such as how individuals correctly identify emotions, how they cognitively use emotions and how emotions are managed. Validation of the test occurs by comparing the responses to expert opinion, which are supported by views from the general public using focus groups.

EI and pre-registration midwifery education

Nurturing emotionally intelligent midwives for the future is challenging and it could be said that traditional pre-registration midwifery programmes which focused on the teaching of practical skills and knowledge within the class room failed to enhance this essential attribute. These models of learning promoted surface learning rather than deep learning (Entwistle and Ramsden, 1993). Pre–registration programmes are now based on critical social theory and feminist epistemology, which promotes a reflective holistic approach and includes interpersonal skills training and personal development (Freshwater and Stickley, 2004). However, Hunter (2004) states that this is not sufficient to address the complex emotions which may arise in practice. Communication is an essential skill which was introduced into midwifery training following the review of pre-registration midwifery education by the NMC (2006). It will be interesting to assess if achievement of this competency as an essential skill in training will assist to prepare midwives to deal with emotional issues in practice. Hunter (2009) endorses raising the profile of emotional awareness in pre-registration midwifery programmes by incorporating role play, theatre and drama within a supportive environment. The introduction of these, in addition to appropriate literature and poetry (Begley, 2006) into programmes would facilitate the exploration of a range of emotional issues that may arise in practice. This method of engaging the emotions and nurturing insight has proved successful in nursing students (Begley et al , 2010).

Bulmer Smith et al (2009) insisted that methods of nurturing EI need to be included in pre-registration curricula. Students need to understand the emotional nature of practice, they need emotional skills to be competent in practice and they need EI to deal with stressful working environments. Akerjordet (2007) recommends that EI is integrated into nurse education by means of a transformatory learning model which focuses on both emotional and rational development. Freshwater and Stickley (2004) state that it is not enough for the rational mind to attend to practical and technical tasks as the rational mind does not 'intuitively sense the needs and emotions of the person at the receiving end of care' (Freshwater and Stickley, 2004: 93).

For example, Freshwater (2003) suggests that communication skills, if taught separately from emotional interactions, then become similar to any other technical intervention and emotions are ignored and unrecognised. Other attributes highlighted within the model are the development of empathy and its relationship with good client outcomes, the development of unconditional positive regard and its association with therapeutic healing and also developing an understanding of oneself through self reflection. These attributes can assist the midwife in creating therapeutic relationships with others (see Figure 1). In addition to this Akerjordet (2007) suggests, that students will become more emotionally intelligent if they are given opportunities to develop their own professional identity among other disciplines through the process of multidisciplinary learning.

Conclusion

EI appears to be crucial for midwives in the maternity care setting for the following reasons:

- EI refers to our ability to recognise our own feelings and those of others and encompasses managing emotions effectively in ourselves and in our relationships.
- In order to support women and provide women-centred care, midwives need to develop self awareness and

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become emotionally intelligent and not avoid addressing emotional issues in midwifery practice

- Raising the profile of EI in maternity care will enhance the effectiveness of midwives and will impact on the quality of care that women and their families receive (Hunter, 2004)
- Increasing EI will provide added support for midwives within the work environment, by strengthening the capacity to deal with workplace pressures and develop effective relationships with colleagues and women (Hunter, 2004).

EI needs to be acknowledged and included innovatively in pre-registration curricula. As educationalists, we have a responsibility to potential employers and the general public to prepare midwifery students for not only the clinical and theoretical demands of practice, but also the emotional challenges which arise in complex life situations which exist in midwifery practice (McQueen, 2004).

Scepticism in relation to EI in maternity care undermines the quality of care and does not lend itself to effective engagement with women or colleagues. Midwives who are emotionally intelligent will become accustomed to managing emotions in practice enhancing both the mother and midwife experience.

References

Akerjordet K, Severinsson E. (2007) Emotional intelligence: a review of the literature with specific focus on empirical and epistemological perspectives. *Journal of Clinical Nursing* **16**: 1405-16.

Akerjordet K, Severinsson E. (2008) Emotionally intelligent nurse leadership: a literature review study. *Journal of Nursing Management* **16**: 565-77.

Akerjordet K. (2009) Emotional intelligence: Part 1: the development of scales and psychometric testing. *Nursing and Health Sciences* **11**: 58-63.

American Psychogical Association (APA). (2007) *APA dictionary of psychology*. Library of Congress Press: Washington.

Ball J, Curtis P, Kirkham M. (2002) *Why do midwives leave?* RCM: London.

Bar-On R. (2002) *BarOn emotional quotient inventory (EQ-i): short technical manual*. Multi-Health Systems: Toronto.

Bar-On R. (2006) The BarOn model of emotional-social intelligence. *Psicothema* **18**: 13-25.

Bardzil P, Salaski M. (2003) Emotional intelligence: fundamental competencies for enhanced service provision. *Managing Service Quality* **13(2)**: 97-104.

Bass B. (1990) *Bass and Stodgill's handbook of leadership: theory, research and managerial applications*. Free Press: New York.

Begley A. (2003) *Creative approaches to ethics: poetry prose and dialogue*: In: Tschudin V. (Ed.). *Approaches to ethics*. Butterworth Heinemann: London.

Begley A. (2006) Facilitating the development of moral insight in practice: teaching ethics and teaching virtue. *Nursing Philosophy* **7**: 257-65.

Begley A. (2010) On being a good nurse: reflections on the past and preparing for the future. *International Journal of Nursing Practice* **16(6)**: 525-32.

Begley A, Glackin M, Henry R. (2010) Tolstoy, stories, and facilitating insight in end-of-life care: exploring ethics through vicarious experience. *Nurse Education Today* **9**: 907.

Benson G, Ploeg J, Brown B. (2009) A cross-sectional study of emotional intelligence in baccalaureate nursing students. *Nurse Education Today* **30(1)**: 49-53.

Bulmer Smith K, Profetto-McGrath J, Cunnings G. (2009) Emotional intelligence and nursing: an integrative literature review. *International Journal of Nursing Studies* **46(12)**: 1624-36.

Carrothers R, Gregory S, Gallagher T. (2000) Measuring emotional intelligence of medical school applicants. *Academic Medicine* **75(5)**: 456-63.

Cadman C, Brewer J. (2001) Emotional intelligence: a vital prerequisite for recruitment in nursing. *Journal Nursing Management* **9(6)**: 321-4.

Carter A, West M. (1999) *Sharing the burden – teamwork in healthcare settings*: In: Firth A, Cozens J, Payne R. (Eds.). *Stress in health professionals*. Wiley: Chichester.

Centre for Maternal and Child Enquiries. (2007) Saving mothers lives: reviewing maternal deaths to make motherhood safer 2003-2005. Centre for Maternal and Child Enquiries: London.

Coggins J. (2005) Strengthening midwifery leadership. *RCM Midwives Journal* **8(7)**: 310-3.

Currell R. (1990) *The organisation of midwifery care*: In: Alexander J, Levy K, Roach S. (Eds.). *Midwifery care: antenatal care: a research-based approach*. MacMillan Press: London.

Deery R. (2005) An action-research study exploring midwives' support needs and the affect of group clinical supervision. *Midwifery* **21(2)**: 161-5.

Department of Health. (1970) *Domiciliary midwifery and maternity bed needs: report of the sub-committee (chair: Sir John Peel)*. HMSO: London.

Department of Health. (1997) *The new NHS: modern, dependable*. HMSO: London.

Department of Health. (1999) *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health care*. HMSO: London.

Department of Health. (2000) *The NHS plan: a plan for investment, a plan for reform*. HMSO: London.

Department of Health. (2004) *NHS pay modernisation in England: agenda for change*. HMSO: London.

Department of Health. (2007) *Maternity matters: choice, access and continuity of care in a safe service*. HMSO: London.

Department of Health. (2010) *Front-line care: report by the prime minister's Commission on the Future of Nursing and Midwifery in England*. HMSO: London.

Donnison J. (1988) *Midwives and medical men (second edition)*. Historical Publications: London.

Dulewicz C, Higgs M. (2000) Emotional intelligence: a review and evaluation study. *Journal of Managerial Psychology* **15(4)**: 341-68.

Elliott M. (2004) Cultivating tall poppies. *RCM Midwives Journal* **7(9)**: 384-5.

Entwhistle N, Ramsden P. (1983) *Understanding student learning*. Croom Helm: London.

Fineman S. (2003) *Understanding emotion art work*. Sage: London.

Fletcher I, Leadbetter P, Curran A, Osullivan H. (2009) A pilot study assessing emotional intelligence training and communication skills with third-year medical students. *Patient Education and Counselling* **76(3)**: 376-9.

Freshwater D. (2003) *Counselling skills for nurses, midwives and health visitors*. Open University Press: Buckingham.

Freshwater D, Stickley T. (2004) The heart of the art: emotional intelligence in nurse education. *Nursing Inquiry* **11(2)**: 91-8.

George J. (2000) Emotions and leadership: the role of emotional intelligence.

References continued

Human Relations **53(8)**: 1027-55.

Gillen P, Sinclair M, Kernohan W, Begley C. (2009) Student midwives' experience of bullying. *Evidence Based Midwifery* **7(2)**: 46-53.

Goleman D. (1995) *Emotional intelligence*. Bloomsbury Publishing: London.

Goleman D. (2004) *Emotional intelligence*. Bloomsbury Publishing: London.

Gould D. (2003) Emotional intelligence. *British Journal of Midwifery* **11(4)**: 203.

Hatem M, Sandall J, Devane D, Soltani H, Gates S. (2008) Midwife-led versus other models of care for childbearing women. *Cochrane Database Syst Reviews* **4**: CD004667.

Heaney S. (1969) *Elegy for a stillborn child*: In: Heaney S. *Door into the dark*. Faber and Faber: London.

Henderson A. (2001) Emotional intelligence and nursing: an under-appreciated aspect of caring work. *Nursing Inquiry* **8(2)**: 130-8.

Hochschild A. (1983) *The managed heart: commercialization of human feeling*. University of California Press: Berkeley, California.

Hunter B. (2002) *Emotion work in midwifery: an ethnographic study of the emotional work undertaken by a sample of student midwives and qualifed midwives in Wales*. (Unpublished PhD thesis) University of Wales: Swansea. In: Hunter B. (2004) The importance of emotional intelligence. *British Journal of Midwifery* **12(10)**: 604-6.

Hunter B. (2004) The importance of emotional intelligence. *British Journal of Midwifery* **12(10)**: 604-6.

Hunter B. (2005) Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery* **21(3)**: 253-66.

Hunter B. (2006) The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery* **22(4)**: 308-22.

Hunter B. (2009) *The emotional context of midwifery*: In: Fraser D, Cooper M. (Eds.). *Myles textbook for midwives*. Churchill and Livingstone: London.

Hunter B, Deery R. (2005) Building our knowledge about emotion work in midwifery, combining and comparing findings from two different research studies. *Evidence Based Midwifery* **3(1)**: 10-5.

Jordan P.(2009) *An examination of the impact of emotions and emotional intelligence on organizational change and organizational learning*: In: Kumar K. (Ed.). *Organizational change*. ICFAI University Press: India.

Jordan P, Troth A. (2004) Managing emotions during team problem-solving: emotional intelligence and conflict resolution. *Human Performance* **17(2)**: 195-218.

Joseph D, Newman D. (2010) Emotional intelligence: an integrative meta-analysis and cascading model. *Journal of Applied Psychology* **95(1)**: 54-78.

Keeling J, Quickley J, Roberts T. (2006) Bullying in the workplace: what it is and how to deal with it. *British Journal of Midwifery* **14(10)**: 616-20.

Kirkham M. (2000) *How can we relate?*: In: Kirkam M. (Ed.). *The midwife-mother relationship*. Macmillan Press: London.

Landy FJ. (2005) Some historical and scientific issues related to research on emotional intelligence. *Journal of Organizational Behavior* **26**: 411-24.

Leap N. (1997) Making sense of horizontal violence in midwifery. *British Journal of Midwifery* **5(11)**: 689.

LeDoux J. (1998) Emotional memory systems. *Behavioural and Brain Research* **58(1-2)**: 69-79.

Lester M, Harvey P, Frizzle C. (1998) The correspondents of nurse burnout and patient satisfaction. *Social Science of Medicine* **47**: 1611-7.

Mander R, Lindsay R. (2002) *Midwifery power*: In: Mander R, Flemming V. (Eds.). *Failure to progress*. Routledge: London.

Mann S. (2005) A health-care model of emotional intelligence. *Journal of Organization and Management* **19**: 304-17.

Mayer J, Salovey P. (1997) *What is emotional intelligence?*: In: Salovey P, Sluyter D. (Eds.). *Emotional development and emotional intelligence: implications for educators*. Basic Books: New York.

Mayer J, Caruso D, Salovey P. (1999) Emotional intelligence meets traditional standards for intelligence. *Intelligence* **27**: 267-98.

Mayer J, Salovey P. Caruso D. (2003) Measuring emotional intelligence with the MSCIT. *Emotion* **3**: 97-105.

McMullen B. (2003) Emotional intelligence. *British Medical Journal* **326(7381)**: S19.

McQueen A. (2004) Emotional intelligence in nursing work. *Journal of Advanced Nursing* **47(1)**: 101-8.

Menzies L. (1960) A case study in the functioning of social systems in the defence against anxiety. *Human Relations* **13(2)**: 95-121.

Moriarty P, Buckley F. (2003) Increasing team emotional intelligence through processes. *Journal of European Industrial Training* **27(2)**: 98-110.

Muller-Smith P. (1999) Yet another workplace crisis. *Journal of Peri-Anesthesia Nursing* **14(4)**: 217-20.

NMC. (2006) *Consultation for review of pre-registration midwifery training: competencies and content*. NMC: London.

NMC. (2009a) *Analysis of LSA reports to the NMC (2008-2009)*. NMC: London.

Office for National Statistics. (2008) *Live birth statistics*. See: www.statistics.gov.uk (accessed 3 June 2011).

Ralston R. (2005) Transformational leadership: leading the way for midwives in the 21st century. *RCM Midwives Journal* **8(1)**: 34-7.

Salovey P, Mayer J. (1990) Emotional intelligence. *Imagination, Cognitation and Personality* **9(3)**: 185-211.

Sandall J. (1997) Midwives burnout and continuity of care. *British Journal of Midwifery* **5(2)**: 106-11.

Scottish Government Health Directorates. (2010) *Multi-professional: keeping childbirth natural and dynamic (KCND) programme*. Scottish Government Health Directorates: Edinburgh.

Slaski M, Cartright S. (2002) Health performance and emotional intelligence: an exploratory study of retail managers. *Stress and Health* **18(2)**: 63-8.

Steiner C. (1997) *Achieving emotional literacy*. Bloomsbury Publishing: London.

Strickland D. (2000) Emotional intelligence: the most potent factor in the success equation. *Journal of Nursing Administration* **30(3)**: 112-27.

Thomson JAK. (Trans.). (1976) *The ethics of Aristotle: the Nicomachean ethics (re-issued)*. Penguin Classics: London.

Vitello-Cicciu J. (2003) Innovative leadership through emotional intelligence. *Nursing Management* **34(10)**: 28-32.

Walsh D. (2007) *Improving maternity services. Small is beautiful – lessons form a birth centre*. Radcliffe Publishing: Oxford.

Way H. (1962) *Ethics for nurses*. Macmillan: London.

Wiggins M, Newburn M. (2004) *Information used by pregnant women, and their understanding and use of evidence-based informed choice leaflets*: In: Kirkam M. (Ed.). *Informed choice in maternity care*. Palgrave Macmillan: Basingstoke.

Yost C, Tucker M. (2000) Are effective teams more emotionally intelligent? Confirming the importance of effective communication in teams. *Leadership Quarterly* **11**: 243-74.

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Midwifery research by midwifery researchers: challenges and considerations

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Abstract

This paper will discuss some of the challenges that may be encountered by midwifery researchers when conducting research where the research setting is familiar or study participants are known to the researchers. The paper identifies some of the key challenges that should be considered such as researching in a familiar culture, perception of participants, sample selection, finding space in the setting and interview dynamics. Examples are provided from three previous qualitative research projects conducted by the authors in educational and clinical settings with both pre-registration and post-registration midwives. Each of the key issues will be discussed highlighting specific issues relevant to each with further consideration of how these issues may impact on progress of the project, data collected and subsequent findings. Finally, these will be drawn together with recommendations for future research conducted by midwives or where the setting or participants are known to the researchers. Although the paper is focused on midwifery research, the issues raised may bear relevance in other areas where the setting or participants are known to researchers.

Key words: Qualitative research, role conflict, insider research, evidence-based midwifery

Introduction

Increasingly midwives are involved in both the planning and conduct of research projects where the focus is to facilitate further understanding of the profession, midwifery practice or education. Sometimes these are small scale projects incorporated into a programme of further academic study, for example at MSc level or may involve a larger project undertaken with the aim of leading to PhD qualification as more midwives choose this career pathway. Although not limited to qualitative research, often these types of project employ a qualitative approach, which for many reasons is advantageous, but may also present challenges for the researcher. Qualitative research seeks to further and deepen our understanding through capturing rich data from participants about their experiences, perspectives and emotions on a particular subject (Morse, 1991). Given the nature of qualitative research where often the quality of the data depends significantly on the skill of the researcher and the relationship with the participant, it is evident this may present some difficulty if the researcher is studying their own professional culture or as such conducting 'insider research' (Field, 1991). When the researcher is conducting research where the setting is familiar, for example in a clinical area or educational setting, it is pertinent for midwifery researchers to have an awareness of potential limitations with such an approach.

This paper will focus on combined experiences of the authors while conducting three separate projects. The aim of the first project (study one) was to gain further understanding of the perspective of midwives in relation to the provision of Down's syndrome screening in Northern Ireland (NI). In-depth interviews were conducted with midwives in a clinical setting in NI who were involved in offering Down's syndrome screening tests to women. Further details of the methodology and results are reported in McNeill et al (2009) and McNeill and Alderdice (2009). The second study (study two) was conducted with midwifery students undertaking a pre-registration programme at Queen's University Belfast where the aim was to elicit the experiences and perceptions of students who had been involved in caseload midwifery (Nolan 2010a; 2010b). Caseload midwifery was innovatively introduced into the pre-registration programme where midwifery students had responsibility (under supervision of a registered midwife) for the care of a small caseload of women during pregnancy, childbirth and the postnatal period. A SWOT (strengths, weaknesses, opportunities and threats) analysis was carried out on two cohorts of direct-entry students to ascertain if the learning outcomes of the module were being achieved.

The teaching team was particularly interested in determining if responsibility for 'caseload' midwifery during

pre-registration education was an effective model in assisting students to relate theory to practice and ultimately generate autonomous practitioners (Nolan, 2010a). Focus groups were used to examine student perceptions and explore their experience further. The final study (study three) referred to was a before and after case study of a group of registered midwives undertaking further education in relation to screening. Focus groups were used to examine perceptions of antenatal screening, in particular Down's syndrome screening, before and after the course was completed to identify any change. A brief description of the methodology for each of the research studies used as examples is outlined below, in order to provide context for some of the challenges presented in the paper.

Study one

The aim of this study was to explore the perspectives of midwives who were involved in offering Down's syndrome screening tests to women and used a focused ethnographic approach. Muecke (1994) identifies two different types of ethnography – mini and maxi. Maxi type traditional ethnographies are grounded in academic anthropology, which recognises there are several schools of thought about ethnography but generally all agree that it is a longitudinal study over time and emerges from the 'local context' (Muecke, 1994: 187). Mini ethnographies are those with a specific focus and aim to answer a question. They are referred to by Muecke (1994) as health sciences ethnography, of which the purpose is to 'improve cultural appropriateness of professional practice' (Muecke, 1994: 200). Health sciences ethnography is where the researcher has a specific question or topic and therefore particularly relevant to the application of ethnography in midwifery or nursing research. Health sciences ethnography is a type of 'rapid ethnographic appraisal' (Muecke, 1994: 198), which has been described using several terms; mini ethnographies (Leininger, 1985), microethnography (Germain, 1986) or focused ethnography (Morse, 1991). There has been an increase in the use of focused ethnographies in midwifery and nursing research mainly due to the applicability of findings that may be used to improve practice. In focused ethnographies, the number of subjects is limited and the objective is to secure data from people who have knowledge and experience relevant to the area of study (Muecke, 1994) and therefore deemed appropriate to use in relation to this project. In addition, this study evolved from a primary study investigating inequalities in antenatal screening (Alderdice et al, 2008) and therefore the topic area was known to the researcher, which facilitated insight into the direction further research should take. This is in keeping with the principles of focused ethnographies, which differ from traditional ethnographies in that the topic is specific and apparent before the study starts (Morse and Richards, 2002).

Study two and three

Study two and study three both used focus groups as a data collection method. Focus groups are a useful method to explore not only what participants think but the reasoning behind their thinking (Morgan, 1988). Barbour (2005) highlights in her paper reviewing the use of focus groups in medical education that they can be useful to elicit the student perspective, helpful to study change, provide access to the hidden curriculum or aspects of student learning that are not easily evaluated and have a valuable contribution to help understanding of problematic areas in practice. The focus groups conducted in each of these studies consisted of six to eight participants who were all students (pre and post registration). In study two, a SWOT analysis was also used, where midwifery students undertook the analysis using flip-charts. This method of data collection aims to isolate the key issues that will be important in developing future trends, trends that subsequent planning will address (Mercer, 1996). The findings of the analysis have influenced subsequent delivery of the module along with impacting on curriculum planning. In study three, the aim was to generate discussion in the focus groups about antenatal screening and more specifically Down's syndrome screening. Down's syndrome screening could potentially be viewed as a sensitive subject, particularly in NI where the law on termination of pregnancy differs from the UK. Jordan et al (2007) used focus groups to research sensitive issues in NI and found it 'illuminated locally culturally appropriate ways of thinking and talking about the sensitive issues' (Jordan et al, 2007: 16) and therefore offered a valuable approach. Focus groups were undertaken with students at the start of semester one and on completion of the module at the end of semester two.

Challenges in conducting midwifery research

Familiar culture

There is some debate around midwives and nurses doing qualitative research in their own setting (Morse and Field, 1996). The risk of nurses and midwives conducting research within their own environment is that they may not be aware of normative behaviours and the importance or relevance of such, which as a result, may be taken for granted. Analysis of the data may also be affected as the familiarity with the setting may limit the depth of analysis. In one of the projects outlined previously, the setting was a maternity unit where one of the authors had been employed prior to undertaking a research position. The setting and staff were familiar therefore highlighting the challenge of seeing beyond the familiar and striving towards objectivity. In the other projects, both researchers were employed within the educational institution used as a setting and were involved in the planning and organisation of courses highlighting the potential for bias in the interpretation of results. Research conducted in a familiar area is often termed as 'insider research', which Kanuha (2000) defines as 'research populations, communities and identity groups of which the researchers are also members' (Kanuha, 2000: 439). Asselin (2003) suggests that one of the main problems of familiarity with the setting is that the researcher is unable to 'see' objectively and thus events, conversations or observations may be undervalued in the data analysis. Aamodt (1981) counteracts this notion by suggesting that although the researcher may be conducting

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research in their own community, it does not necessarily mean they are a native of that community due to the sub-cultures occurring within cultures.

Perception

The perception held by clinical midwives of midwifery researchers can often present challenges within a project. Clinical areas are generally busy and often understaffed, so midwifery researchers may feel guilty that colleagues have limited flexibility and many demands on their time and yet at times the researcher role requires observation, sitting still and watching events unfold. Morse and Field (1996) highlight the importance of defining yourself as a researcher and not a clinician, which helps to avoid role conflict. In study one, there were many times the researcher was sitting around waiting in the recruitment phase and was aware of some undercurrents or tension. Although staff would not have expected help or assistance in busy times, the underlying perception of a midwife doing research or collecting data was that it was not really 'proper' midwifery and therefore raised questions over what type of work research actually was. It may also be difficult for colleagues to accept the researcher in a role different to that of a clinical one. At this time, one of the authors had left full-time clinical practice behind when the project started and was still perceived as a midwife and not a researcher. This was similar to observations reported by Simmons (2007) in her study of nurse consultants within the organisation where she was employed as a manager.

Simmons (2007) reported that during interviews, respondents would sometimes assume she knew about events or happenings because she was also a manager in the setting. In addition, this may create some role conflict for the researcher where he or she may wish to help colleagues in a busy period or when participants move between identifying with the researcher as a midwife and data collector, for example, during interviews in study one, when colleagues would say to the researcher 'you know what I mean' referring to knowledge she held as a midwife who had practised in that clinical area. Walker (1997) refers to the 'borderlands'; a metaphorical description of the tension experienced between the roles of academic and practitioner, and although Walker was both, she was neither simultaneously. This is a similar experience to that of the authors of this paper in that we were both midwives and researchers inhabiting the 'borderland' area when conducting research in familiar areas or with participants known to us. In study two and study three, it may have been difficult for students to distinguish between their lecturer as a teacher and as a researcher, which subsequently may have affected the dynamics of power in the relationship when collecting data. Ryan et al (2011) highlighted in a recent paper how the blurring of boundaries in researcher-participant relationships can create dilemmas and challenges for researchers and practitioners. Feminist theory can provide a critique of the subservient relationship between obstetrics and midwifery leading to the development of more women-centred care (Wickham, 2004; Wilkinson, 1999). The application of similar principles to research with midwifery students could facilitate empowerment and confidence to challenge the imbalance of power that can exist when their teacher and researcher is the same person. Ultimately, this has the potential to lead to a student-centred approach in teaching and research and hence redress the aforementioned imbalance. In addition, it is possible that midwives being observed in practice or asked questions about their usual practice may perceive the researcher has an agenda to undercover problem areas, potentially highlighting substandard practice, which may lead to a slight defensiveness. In addition there is the potential that behaviour may change under observation or events recounted in the manner the participants perceives acceptable to the researcher; often referred to as the Hawthorne effect (Pope and Mays, 1995). Sheridan (2010) however reported in an observational study of midwives that research was seen as positive and as a mode to highlight good practice, also supported by Kirkham (1989). One way to overcome this problem is for the researcher to be very clear about the purpose of the study and the aim of data collection. It is also important to reassure participants that 'finding fault' with practice was not the aim of the project nor would it be reported in the findings, but rather the focus was to explore current practice and gain further understanding about the 'how' and 'why'.

Finding space

An initial phase of ethnographic studies is 'finding space' (Morse and Field, 1996). This was particularly difficult in both stages of study one. In the primary study, when women were recruited from the antenatal clinics in hospital, it was not possible to have an identified room for interviews and the researcher relied on one being empty or unused while the antenatal clinic was running. This was sometimes frustrating as women may have consented to the study, but then had to wait for a free room to conduct the interview, impacting on the time that they had freely given to participate. A similar situation occurred with the midwifery interviews in the second phase of study one, although these generally took place when the clinic was less busy. Finding space is important as the researcher needs a space to conduct interviews, write field-notes and observe. In addition, the researcher is dependent on the availability of participants and, as a result, lack of space may impact on the recruitment of the study if there is no room free when the participant is ready.

In study one, midwives were given the option of where they preferred the interview to take place, either in an office that was separate from the clinic or in a free room within the clinic. The majority of interviews occurred within the clinical setting due to convenience, as they often were slotted into a less busy time in the clinic or at lunchtime. On reflection, interviews generally were smoother with fewer interruptions and participants were more relaxed away from the clinical area, maximising the opportunity for a 'better' interview. In study two and study three, the students were given no choice of space or venue as it was convenient to use the allocated classroom. The association of the classroom with formal

teaching, learning and assessing may have influenced the responses students gave and therefore limited the depth of data obtained. To counteract the formality of the classroom setting, refreshments were provided, which enabled students to relax and converse prior to the start of the focus group. Ideally the focus groups would have been conducted in a neutral environment and outside of official 'university time', which may have facilitated optimal responses from the participants, however in reality, compromises are often a necessity.

Herzog (2005) suggests that little attention has been given to the interview location in existing literature and that in reality the location should be considered as integral to the findings in relation to the social context of the interview. The usual approach is to facilitate participants and enable them to choose a location and time which is convenient for them (Warren 2002), however often this is not possible with the confines of all research projects. It is more difficult to facilitate participant choice of location for focus groups due to logistics and organisation of the groups however the choice for individual interviews should lie with the participant.

Sample selection

Purposeful sample selection is often used when conducting research with the aim of selecting participants who will best inform the study. In each of these projects, purposeful sampling was used. Morse and Field (1996) advocate that two principles should guide qualitative sampling: appropriateness and adequacy. Participants should be appropriately selected in that they have the knowledge or experience to contribute to the topic under investigation. Adequacy of sampling is evidenced by the amount of data generated to enable description and further understanding of the research topic. The midwifery students in study two were selected with the purpose of exploring their experiences of caseload midwifery, however, they may have felt that they had little choice but to participate, considering that the research was being carried out by one of their lecturers. This was also similar to the context of study three, where students may even have felt that it might be in their interest to become involved, as participation in the study could be seen by staff as a sign of motivation and commitment. It was clearly explained to all students that participation was voluntary and there was an option to withdraw at anytime. Written consent was obtained following written explanations of the reasons why the projects were being carried out. While it is hoped that this facilitated informed consent, acknowledgement needs to be made of the fact that inability to freely consent could have occurred. In study two and study three, all midwives were invited from a defined clinical or educational setting and it is recognised that while it was appropriate to select this group, all were known to the researchers. It is possible that participants may have been reluctant to decline based on a previous relationship with the researcher(s) and may have felt it was impolite not to participate. To overcome this difficulty around sample selection, it is recommended that at the outset it is very clear to those invited that this is a research project, participation is voluntary and withdrawal is always an option. An open and friendly attitude by the researcher when known to the participants is vital to ensure that individuals do not feel coerced into the study and that they will not be judged or penalised for not being involved.

Interview dynamics

The context of an interview and interaction of the interviewer with the interviewee has the potential to affect or influence the data generated. In each of the research projects referred to here, the participants for the most part were known to the researchers. This situation may present several problems. In study two, there was a high level of familiarity between the researcher and the students and while this may have been valuable in the building of trust and relationships, it could also have influenced the discussion and responses. In the focus groups, flip-charts were used to list the strengths, weaknesses, opportunities and threats of caseload midwifery, which facilitated open sharing of ideas. However, some students potentially could have felt intimidated as anonymity within the group was not possible. While this method of data collection facilitated open sharing of ideas from the researchers' perspective, some students may have felt the level of confidentiality was threatened and therefore were possibly less willing to share their experiences. In study one, midwives who participated in in-depth interviews were for the most part known to the researcher. McEvoy (2002) suggests that interviews with colleagues are 'framed in the context of an ongoing relationship' (McEvoy, 2002: 52). This was evident throughout the interviews, as often midwives were reluctant to discuss contentious issues around the provision of Down's syndrome screening. As the researcher was a midwife known to participants, midwives may not have felt at liberty to discuss personal feelings given the relationship with the researcher and therefore may have 'held back' from disclosing sensitive information. Although in some cases the previous relationship may affect interviews negatively, in other cases, a shared background or familiarity may have assisted in extending the depth of discussion within the interview. The other potential issue when interviewing colleagues is that it may be difficult to discuss aspects of practice that do not meet required standards or conform to policies and guidelines. Interviewees may not raise these issues within an interview with a colleague, or alternatively, if they are raised and the researcher as a professional recognises substandard care, she/he is presented with an ethical dilemma regarding the information. It is challenging to interview colleagues and keep the interview focused in relation to the area of interest – this is largely influenced by the skill of the interviewer. It is essential for researchers to undergo training, particularly in qualitative data collection methods or communication skills and perhaps undertake a trial run with colleagues or friends before starting the study. McEvoy (2002) suggests there are specific aspects which need to be considered carefully when interviewing colleagues including the perspective of the interviewer, the dynamics of the relationship with the participant and the impact of disseminating findings which emerge. It is clear from the research used as examples in this paper that an important element was to consider the nature relationship with each group of participants carefully and the potential impact it might have on the data collection and analysis before starting data collection.

Conclusions

Despite the challenges outlined, it is clear there are benefits to researching within a familiar professional culture. Practical benefits such as access to the field or previous relationships and rapport with participants may assist in the progress of the study, however it is essential to maintain the delicate balance between subjectivity (from group involvement) and the objectivity required to see the environment as it is. The key argument against doing 'insider' research is the high risk of bias, which must be acknowledged as a legitimate risk. However there are measures that can be integrated into the design of the research project to ensure the risk is minimised and thus enhance the credibility of the study. These may include having a colleague review the data analysis process ensuring openness and transparency, member checking with participants and developing a critical awareness of the dual role between researcher and midwife. There are also particular advantages relating to the applicability of insider research to advance or improve clinical practice. To achieve this, a robust methodology, facilitating credible findings is essential alongside recognition of limitations and a critical self awareness. In summary it is vital to consider and develop an awareness, at an early stage the nature of the relationship between the researcher and participant and between the research setting and the researchers considering how this will impact on the emerging data and progress of the project.

References

Alderdice F, McNeill J, Rowe R, Martin D, Dornan J. (2008) Inequalities in the reported offer and uptake of antenatal screening. *Public Health* **122**: 42-52.

Aamodt A. (1981) *Neighbouring: discovering support systems among Norwegian-American women*: In: Messerschmidt DA. (Ed.). *Anthropologists at home in North America: methods and issues in the study of one's own society.* Cambridge University Press: Cambridge: 133-52.

Asselin ME. (2003) Insider research: issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development* **19(2)**: 99-103.

Barbour R. (2005) Making sense of focus groups. *Medical Education* **39**: 742-50.

Field PA. (1991) *'Doing fieldwork in your own culture'*: In: Morse J. (Ed.). *Qualitative nursing research: a contemporary dialogue*. Sage: California: 91-104.

Germain C. (1986) *Ethnography: the method*: In: Marshall PL, Oiler CJ. (Eds.). *Nursing research: a qualitative perspective*. Appleton-Century-Crofts: New York: 147-62.

Herzog H. (2005) On Home Turf: interview location and its social meaning. *Qualitative Sociology* **28(1)**: 25-47.

Jordan J, Lynch U, Moutray M, O'Hagan MT, Orr J, Peake S, Power J. (2007) Using focus groups to research sensitive issues: insights from group interviews in nursing in the Northern Ireland 'troubles'. *International Journal of Qualitative Methods* **6(4)**: 1-19.

Kanuha VK. (2000) 'Being' native versus 'going' native: conducting social work research as an insider. *Social Work* 45(5): 439-47.

Kirkham M. (1989) *Midwives and information-giving during labour*: In: Robinson S, Thomson AM. (Eds.). Midwives, research and childbirth (volume one). Chapman and Hall: London.

Leininger M. (1985) *Ethnography and ethnonursing: models and modes of qualitative data analysis*: In: Leininger M. (Ed.). *Qualitative research methods in nursing*. Grune and Stratton: New York: 33-71.

McEvoy P. (2002) Interviewing colleagues: addressing the issues of perspective, inquiry and representation. *Nurse Researcher* **9(2)**: 49-59.

McNeill J, Alderdice F, Rowe R, Martin D, Dornan J. (2009) Down's syndrome screening in Northern Ireland: women's reasons for accepting or declining serum testing. *Evidence Based Midwifery* **7(3)**: 76-83.

McNeill J, Alderdice F. (2009) The perspective of midwives involved in offering serum screening for Down's syndrome in Northern Ireland. *Journal of Clinical Nursing* **18(20)**: 2888-96.

Mercer D. (1996) *Marketing (second edition)*. Blackwell: Oxford.

Muecke MA. (1994) *On the evaluation of ethnographies*: In: Morse JM. (Ed.). *Critical issues in qualitative research methods (first edition)*. Sage: California: 187-209.

Morgan DL. (1988) *Focus groups as qualitative research*. Sage: London.

Morse J. (1991) *Qualitative nursing research: a free-for-all?*: In: Morse J. (Ed.). *Qualitative nursing research: a contemporary dialogue*. Sage: California: 14-22.

Morse JM, Field PA. (1996) *Nursing research: the application of qualitative approaches*. Chapman and Hall: London.

Morse JM, Richards L. (2002) *Readme first for a user's guide to qualitative methods (first edition)*. Sage: California.

Nolan A. (2010a) Caseload midwifery for students in Northern Ireland: part 1. *The Practising Midwife* **13(8)**: 27-9.

Nolan A. (2010b) Caseload midwifery for students in Northern Ireland: part 2. *The Practising Midwife* **13(9)**: 26-8.

Pope C, Mays N. (1995) Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* **311**: 42-5.

Ryan K, Brown S, Wilkins C, Taylor A, Arnold R, Angell C, van Teijlingen E. (2011) Which hat am I wearing today? Practising midwives doing research. *Evidence Based Midwifery* **9(1)**: 4-8

Sheridan V. (2010) Organisational culture and routine midwifery practice on labour ward: implications for mother-baby contact. *Evidence Based Midwifery* **8(3)**: 76-84

Simmons M. (2007) Insider ethnography: tinker, tailor, researcher or spy? *Nurse Researcher* **14(4)**: 7-17.

Walker K. (1997) Cutting edges: deconstructive inquiry and the mission of the border ethnographer. *Nursing Inquiry* **4**: 3-13.

Warren CAB. (2002) *Qualitative interviewing*. In Gubrium JF & Holstein JA. (Eds.). Handbook of interview research: Context and method (pp83–101). Sage: Thousand Oaks, London, New Delhi.

Wickham S. (2004) *Feminism and ways of knowing*: In: Stewart M. (Ed.). *Pregnancy, birth and maternity care: feminist perspectives*. Books for Midwives: Edinburgh.

Wilkinson S. (1999) Focus groups – a feminist method. *Psychology for Women Quarterly* **23(2)**: 221-44.

The combined use of diaries and interviewing for the collection of data in midwifery research

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Abstract

Background. This paper discusses the combined use of diaries and interviewing for the collection of data, using examples from a PhD study that explored the feelings, perceptions and experiences of women in relation to their perineum following childbirth.
Method. A midwife-led antenatal clinic in the south of England was used as a base for the recruitment, which began following ethics approval from the local research ethics committee and NHS trust. Women were asked to keep a diary for ten days following the birth of their baby and describe what affect their perineum had on being able to carry out daily living activities. The same women were then invited to explore in more detail via interview the experiences they had described. Using a grounded theory approach, women were initially recruited by means of purposeful sampling, but as important issues emerged recruitment continued using theoretical sampling. Sample size was determined when theoretical saturation was reached, which was achieved after 14 women – six primiparous and eight multiparous – were recruited to the study.
Results. The diary: diary-interview gave women the opportunity to write about their experiences at the time they were happening, as well as enabling expansion of those experiences at a later date, through the interview process.
Recommendation. The diary: diary-interview is a useful research approach for seeking a more profound understanding of the experience of individuals in a healthcare setting.

Key words: Midwifery, qualitative research, diary: diary-interview, grounded theory, perineum, evidence-based midwifery

Background

Diaries and interviews are well-established methods for collecting data in the field of health and social research (Jones, 2000; Jacelon and Imperio, 2005). Both methods can be used where detailed information about an event or experience is being studied. Each method has its own advantages and disadvantages that need to be taken into account when deciding on the most appropriate method of collecting data in order to answer the research question. A less known approach, discussed by Zimmerman and Weilder (1977) is combining the diary and interview, which is known as the diary: diary-interview.

Midwifery is a practice-based profession where women, their babies and families are at the centre of care that midwives provide (Fraser and Cooper, 2009). It is therefore important to ensure that their voices and experiences underpin midwifery research, knowledge and evidence-based practice.

In my PhD study (Way, 2007), women were asked to record how their perineum felt following the birth of their baby and if this had an impact on their ability to carry out daily living activities, such as walking and sitting. The profile of women recruited included six who had given birth to their first baby; three women to their second baby and one each to their third and fourth baby respectively. Out of the 11 women, eight had a spontaneous birth while the other three had an assisted vaginal delivery; four had an intact perineum, four sustained a tear of varying severity and three has an episiotomy. The women kept the diary for the first ten postnatal days, which matched the minimum number of days a midwife must attend women following the birth of their baby (NMC, 2004). This timeframe met the parameters of the PhD study, to provide a basis for appropriate information-giving and planning of care for women in the postnatal period.

Activities of daily living (ADL) such as passing urine, walking and defecation were identified by Kempster in 1987 as being highly relevant for determining the impact of perineal pain and discomfort on new mothers and were used in this study because of their continued relevance today. Recent studies investigating and exploring perineal pain while undertaking ADL continue to evidence substantial problems for women (Steen, 2005; Williams et al, 2005), indicating the importance of this phenomenon and the need for more in-depth, sustained enquiry. In order to understand how these experiences may affect women following the birth of their baby, a grounded theory approach was used that utilised diaries and interviews as the method of data collection. Grounded theory is an exploratory approach that builds a complex, holistic view from the reports of participants with the ability to detail their experiences (Glaser and Strauss, 1967; Strauss and Corbin, 1998). The data collected reflects 'real life' or social context and when analysed, explanations are developed based on complexity, detail and context.

Grounded theory as a research approach is gaining popularity with midwives (Spendlove, 2005; Roberts, 2008; Fenwick et al, 2009) and is an important means by which women's views are heard and can be taken into account when working in partnership with women in order to meet their needs. It is more structured than other forms of qualitative research such as phenomenology or ethnography as it focuses on generating a theory from the research data (Rees, 2003) rather than generally seeking to describe or explain the phenomenon under question. The main theoretical idea that emerged from this study and derived directly from the data is that if women are able to successfully adjust to their new and often unexpected reality after the birth of their baby, and begin to reclaim their selves and their world, then they experience a return to their normality (Way, 2007).

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Sampling strategy

Initially, women were 'purposefully' selected to provide information about the area being studied (Speziale and Carpenter, 2007). This meant that the selection of women was based on the researcher's first-hand experience about who was most likely to achieve a vaginal birth rather than a caesarean section. Charmaz (2006) identifies that the initial decision regarding sampling is the only one that can be pre-planned, since the selection of all other data sources is controlled by the emerging theory. As important issues emerge, theoretical sampling takes priority (Glaser and Strauss, 1967; Coyne, 1997). This provides the greatest opportunity to gather the most relevant data about the phenomena under investigation (Strauss and Corbin, 1998).

Recruitment

Initially, women were selected on the basis that they were planning to have a vaginal birth, regardless of them experiencing a straightforward pregnancy or one where they had complex needs. Personal contact was made with each woman to explain the use of the diary. It was also hoped that this contact would encourage women to complete it once started. A number of factors influencing response rates are cited in the literature related to diaries. Best response rates are achieved by personal recruitment and delivery of the diary, and regular follow-up and personal collection. This ensures good initial acceptance rates and increases the likelihood of the diary being returned (Corti, 1993; Gibson, 1995).

After recruiting four women to the study and analysing their diary entries, several themes began to emerge. Women who already had children described their experience as 'better than before'. It was also noted that although all the women had been classified as having 'minimal' perineal trauma in the record of the birth written by midwives, the pain the women experienced was variable. These emerging issues led to a more focused sampling of women who were having their first baby and women who sustained a greater degree of trauma to see if their experiences differed.

Data analysis

Grounded theory differs from other research methodologies in that consideration of the literature does not happen until data analysis starts and categories begin to emerge resulting in the literature becoming another source of data that is incorporated into the main body of the study (Bluff, 2006). This approach enables the simultaneous collecting, coding and analysing of the data in order to decide what data need to be collected next. It is known as the constant comparative method of data analysis. At this point, the literature becomes another source of data that is incorporated into the main body of the study. Reference to the literature continues throughout the research study, which means ultimately the literature is extensively reviewed. Data collection, literature review and analysis are therefore linked from the beginning of the research and interact simultaneously. According to Glaser and Strauss (1967), this constant comparative method focuses on generating and plausibly suggesting numerous categories, properties and hypotheses from within the data.

Early in the research process, each diary and interview were analysed enabling codes to be identified, which Strauss and Corbin (1998) refer to as substantive codes, so called because they come from the substance of the data. Each code was compared to all others for similarities, differences and general patterns (Strauss and Corbin, 1998). Similar codes were then linked together to form categories. This forming of categories moves the data to a more abstract level, generating further categories to explore in more detail with the participants. As a result, questions were generated from the data and one event was compared with another. Therefore the data were modified as directed by the advancing theory (Charmaz, 2006; Holloway and Wheeler, 2010). For example, after reviewing the analysis of several diaries, it was noted that women were describing some of their experiences as being unexpected such as Anne (second baby normal birth, first degree tear) and Brenda (first baby, normal birth, intact perineum):

"Worried that going for a wee (passing urine) would still sting and be uncomfortable, but to my surprise it didn't sting at all" (Anne).

"I feel surprisingly well today" (Brenda).

These accounts led to the instructions in subsequent diaries being updated in order to ask the women to comment if the experiences they were writing about had been expected. After the change to the diary instruction, further women who were recruited wrote about unexpected experiences that led to the category, 'experiencing the unexpected'.

Data collection, diary-keeping

Diaries were chosen as a method for collecting data as one of their advantages is that it provides the opportunity for the participant to write about their thoughts and feelings as near to an event as possible, so they do not have to rely on memory to recall past experiences (Holloway, 2008). This was relevant to my study as it took into account the wish to understand events that women experienced as they happened, rather than recalling an event that may have lost significance several months later. The diary also provides the researcher with an unobtrusive way of tapping into intimate areas of people's lives that may otherwise be closed (Polit and Beck, 2004). It was evident from the content of the diaries such as described by Sarah (first baby, forceps delivery, episiotomy) that women were not constrained in their writing, describing experiences such as sex, dreams and thoughts about their femininity:

"Keep having dreams that my husband had left me and slept with another woman. Really not good stuff. We laugh about it, but really not being able to use my equipment (have sex) plays in my mind while I sleep" (Sarah).

Diaries can be structured where participants are typically asked to monitor and measure the effect of certain interventions at particular times of the day (Sharp and Tishelman, 2005) or record specific information in relation to some aspect of an event or experience (Gonzalez and Lengacher, 2007). Alternatively, the diary may be completely unstructured where the participant is asked to record an item when it occurs detailing their thoughts, opinions and feelings at the time (Bowling, 2009). Clayton and Thorn (2000) argue that having any structure to a diary may reduce the spontaneity of the participant's diary

entries. Therefore, the decision was made to use unstructured diaries with an initial introduction about how to use the diary.

Meth (2003) argues that instructions about how to complete a diary may be difficult to understand, so it was crucial to the quality of the recorded information that the instructions to the women should be carefully prepared (Streubert, 2011). Initially, it was difficult to write the instructions to give a minimal amount of information while using a 'reader-friendly' language not loaded with professional jargon. Language often used by midwives and doctors can be controlling, giving an air of power and often not understood by members of the public (Phipps and Fletcher, 2010). Medical words such as perineum were necessary for women to understand the study, so trying to explain where the perineum was and what the study entailed was a challenge. After talking with several colleagues and women who were not midwives, the following was used: 'When you gave birth to your baby, your birth canal and surrounding area would have been stretched. It may also have torn or had to be cut. Every day, for ten days from the birth of your baby, please describe in your diary how this makes you feel. Please also describe if this is affecting your daily activities in any way. Daily activities include tasks like walking, sitting, eating, sleeping, as well as caring for your newborn baby.'

The women were encouraged to record whatever was important to them, even if they felt it might not be what was wanted. When analysing the diaries, it was clear the women were not inhibited in their writing or the amount they wrote at any one time.

Thought was given to the length of time it can take to complete a diary. Bowling (2009) identifies that it is only practical to use the diary method with a small number of committed participants to try and ensure completion rates are high. Pittman et al (1997), in preparation for their study to evaluate maternity care, also had concerns about asking women to keep a diary because of the commitment required. However, anecdotal evidence gained from local midwives before they started their study, found that mothers, especially first-time mothers, often kept their own diaries. After an initial pilot study, Pittman et al (1997) identified that diary-keeping by the women was not a problem.

To try and ensure that keeping a diary was not onerous for the women, especially as they had just given birth, careful consideration was given to the style of the diary to be used. It was attractive and the chosen colour green, not pink or blue which is often connected to the gender of the baby. It was A5 in size to make it easier to handle but was large enough to ensure good print size and spacing for instructions.

All women who started using the diary wrote in it for the required ten days and were collected personally, by arrangement, at their convenience. All diaries had been collected by day 15 following the birth. When collecting the diary, a date was agreed to return for the interview.

Ownership of the diary and what should happen to it after the data had been analysed was considered as part of the ethics in undertaking the research. As the women were encouraged to see the diary as their own, recording their own problems in their own words, it was appropriate the diary was returned to them after the content had been analysed. This was in keeping with other studies such as Podkolinski (1996) and Pittman et al (1997).

There are disadvantages to using a diary for example, certain groups in society may find it difficult to participate, such as those where English is not their first language, are visually impaired or have poor literacy skills. This means that participant samples and results would not adequately represent these groups (Furness and Garrud, 2010). This is acknowledged as a limitation in my study.

Combining the diary with interviews

After analysing several diaries, it became apparent that greater depth and clarity from their content was needed and this could be achieved by using interviews as an additional research tool. Combining these two methods is known as the diary: diary-interview, explored in detail by Zimmerman and Wieder (1977) and discussed more recently by Clarke and Iphofen (2006). The combined approach is identified as being mutually supportive and can provide a rich source of data (Jacelon and Imperio, 2005). To illustrate this point Fran (third baby, normal birth second degree tear) wrote in her diary soon after the birth of her daughter, Abby: 'The bath felt nice to be clean.'

Reference to bathing and being clean occurred several times in the diary, but with little explanation as to why this was important to her. By following up this experience with an interview, further clarity was able to be given. Fran explained that bathing so early after giving birth had not happened following the birth of her previous two children. This enabled Fran to talk about her experience of feeling considerably more normal compared to when she went home previously. Being clean and feeling normal were explored in further interviews as well as the literature related to the cultural significance of being clean. Scott and Henley (1996) for example identify that washing extends beyond being just a physical task, but is a means of ensuring social acceptability and the person being comfortable with the way they present themselves. This led to the coding of 'wanting to be myself again'.

The interview is one of a number of different data collection tools used in qualitative studies and range from unstructured, semi-structured to highly structured techniques. The more unstructured the approach, the more likely the information gathered is from the perspective of the participant, whereas the more structured the interview, the more likely this is to reveal information from the perspective of the researcher (Steen and Roberts, 2011). As the aim of the interview was to explore in more detail entries in the women's diaries to aid understanding and clarity of their experiences, a semi-structured interview approach was used. The interview started with a general question: *"Tell me about..."* then questions extracted from the analysis of the diary were used as a prompt if the women did not spontaneously talk about the issues in more detail. During the interview, the women were able to refer to their diary, so it acted as an 'aide memoir' for events that were difficult to recall accurately or were forgotten. It was recognised that women could be preoccupied much of the time with caring for their newborn baby and that recall could be coloured by the new role and responsibilities women had.

Early transcribing of the interview allowed for preliminary

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analyses of the data, which identified initial codes. These then formed the basis of the meeting with subsequent women, asking them to expand on experiences previously identified. This meant that the early interviews tended to be less structured, enabling flexibility and encouraging the interests and thoughts of the women to be expressed and heard (Holloway and Wheeler, 2002). Using a grounded theory approach meant that further analysis of subsequent diaries, interviews and the literature also had an influence on the questions asked resulting in the direction and questioning in the interviews becoming driven by the emerging categories. For instance, as the analysis progressed there was an interest to understand further the idea of 'returning to normal', and so some of the questions were related to this, asking women to expand on their perception of normality.

Georgina's diary entry day nine (fourth baby, normal birth, intact perineum): *"Everything feels nearly back to normal until I go out and I find I am walking quite gingerly and slowly. At least the bleeding has stopped. The only things I have avoided is lifting the baby bath and hoovering at the moment."*

Researcher: *"What sorts of things were normal to you? Can you explain what normal was?"*

Georgina: *"Pause (um), being able to do things, really (um), um, before I was pregnant I think, yes. Because you do, I suppose you slow down in your pregnancy and then after the birth, you slow down even more. But there again having the swollen area, it does make you rest, whereas I tend not to rest very much."*

By being able to explore this theme further in the interviews led to the core category, 'striving for normality'.

Each interview took place within two weeks of collecting the diary. It was hoped that this limited interval would enable women to recall events that would be useful to explore in more depth. This however, did mean that early analysis of the diary was important in order to be prepared in time for the interview.

The researcher needs to think about the most appropriate venue for the interview to take place, taking into account the needs of the participant as well as the safety of the researcher. Interviewing in the women's homes could result in unavoidable distractions such as a crying baby or telephone call. However, the need for the women to care for their babies was viewed as a priority and, in order to facilitate this approach, interviews in the home were offered to the women. This meant the women, if they wished, could have their baby with them to reduce any anxiety that may arise in trying to find someone else to baby-sit. The home was also seen as a safe environment for the women where they would hopefully feel relaxed and comfortable to talk. At the start of the interview, it was emphasised to the women to feel free to stop at any time if they needed to give attention to their baby. On several occasions, women would be breastfeeding at the start of the interview, or would be cuddling and settling the baby ready to put them down to sleep. This did not distract from the interviews and in some cases prompted discussion from the women about carrying out daily living activities such as feeding and sitting comfortably.

Personal safety needs to be taken into account, particularly when interviewing in people's homes. Tod (2010) identifies that it is standard practice for the interviewer to inform an identified person of the location and time of the interview, which was duly done.

Discussion

This paper has discussed the use of the diary and follow up interview – known as 'diary: diary-interview' – as an approach to collecting data about women's feelings, perceptions and experiences in relation to their perineum following childbirth in the early postnatal period. It was known that diaries can be used as an intimate journal that gives account of thoughts and feelings, which had resonance with the topic area under study. It is evident from the literature (Thompson et al, 2002; Bick et al, 2009) that perineal pain and discomfort can give rise to commonly reported adverse symptoms related to urination and bowel movements, topics that women may not wish to discuss freely, but may consider writing about in a diary. The advantages of collecting data in this way has been that women can initially record information at the time it happens, rather than having to rely on recall at a future date. The interview provided an opportunity to explore the descriptions women had written about in the diary in more depth. The diary: diary-interview facilitated women to tell their stories from a perspective that was important to them, as well as adding to the information collected from the diary by using interviews. This approach has not been fully recognised in the midwifery profession as a means of collecting data for research purposes.

Women in my study appeared to welcome the opportunity to write about their birth experience, as well as using it as a tool to reflect on their journey of recovery during the early postnatal period. This was an unexpected outcome of using the diary and women were able to recognise for themselves the changes their body had made after the birth and the progress they had made towards recovery over a short space of time. For example, Amanda (first baby, normal birth, second degree tear) acknowledged in her diary:

"Generally I'm really happy that everything is healing so much quicker than I expected and I just get on with things without a real thought – I couldn't have imagined that ten days ago."

Hall (2001) suggests that where birth has historically been a social event that included group participation of the women in the community, storytelling may not have been necessary as everyone would have known by being there, what had happened. Since birth has become an isolated event, women are now using different mediums to let people know about the events that took place during the birth. It was not the remit of the study referred to in this article, to explore the importance of the need for women to retell their experience of birth and there is literature that documents the advantages and disadvantages of such a process (Hammett, 1997). However, the use of diaries may be considered as another method to help facilitate women's understanding of their experience.

This PhD study demonstrated how useful the combination of diaries and interviews as a data collection tool appeared to be, when exploring women's experiences of daily living activities following birth and may have the potential to be used in other healthcare settings.

References

Bick D, MacArthur C, Winter H. (2009) *Postnatal care: evidence and guidelines for management (second edition)*. Churchill Livingstone: London.

Bluff R. (2006) *Grounded theory*: In: Cluett ER, Bluff R. (Eds.). *Principles and practices of research in midwifery (second edition)*. Elsevier: Edinburgh: 153-70.

Bowling A. (2009) *Research methods in health (third edition)*. OU Press: Berkshire.

Charmaz K. (2006) *Constructing grounded theory: a practical guide through qualitative analysis*. Sage: London.

Clarke C, Iphofen R. (2006) Issues in phenomenological nursing research: the combined use of pain diaries and interviewing. *Nurse Researcher* **13(3)**: 62-74.

Clayton AM, Thorne T. (2000) Diary data enhancing rigour: analysis framework and verification tool. *Journal of Advanced Nursing* **32(6)**: 1514-21.

Corti L. (1993) Using diaries in social research. *Social Research Update* **2**. University of Surrey: Guildford.

Coyne IT. (1997) Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing* **26(3)**: 623-30.

Fenwick S, Holloway I, Alexander J. (2009) Achieving normality: the key status passage to motherhood after caesarean section. *Midwifery* **25(5)**: 554-63.

Fraser D, Cooper M. (2009) *The midwife*: In: Fraser D, Cooper M. (Eds.). *Myles textbook for midwives (15th edition)*. Churchill Livingstone: London: 3-19.

Furness PJ, Garrud P. (2010) Adaptation after facial surgery: using the diary as a research tool. *Qualitative Health Research* **20**: 262-72. See: http://qhr.sagepub.com/cgi/content/abstract/20/2/262 (accessed 3 June 2011).

Gibson V. (1995) An analysis of the use of diaries as a data collection method. *Nurse Researcher* **3(1)**: 66-73.

Glaser B, Strauss A. (1967) *The discovery of grounded theory: strategies for qualitative research*. Aldine De Gruyter: New York.

Gonzalez LO, Lengacher C. (2007) Coping with breast cancer: a qualitative analysis of reflective journals. *Issues in Mental Health Nursing* **28(5)**: 489-510.

Hall J. (2001) *Midwifery, mind and spirit*. Books for Midwives Press: Oxford.

Hammett P. (1997) *Midwives and debriefing*: In: Kirkham M, Perkis E. (Eds.). *Reflections on midwifery*. Bailliere Tindall: London: 135-59.

Holloway I. (2008) *A-Z of qualitative research in health care (second edition)*. Wiley-Blackwell: Chichester.

Holloway I, Wheeler S. (2002) *Research in nursing (second edition)*. Blackwell Science: Oxford.

Holloway I, Wheeler S. (2010) *Qualitative research in nursing and healthcare (third edition)*. Wiley-Blackwell: Chichester.

Jacelon C, Imperio K. (2005) Participant diaries as a source of data in research with older adults. *Qualitative Health Research* **15(7)**: 991-7.

Jones RK. (2000) The unsolicited diary as a qualitative research tool for advanced research capacity in the field of health and illness. *Qualitative Health Research* **10(4)**: 555-67.

Kempster H. (1987) Perineal care: 'confused, battered and unwanted'. *Community Outlook* **June**: 8-10.

Meth P. (2003) Entries and omissions: using solicited diaries in geographical research. *Area* **35(2)**: 195-205.

NMC. (2004) *Midwives rules and standards*. NMC: London

Phipps B, Fletcher G. (2010) *The potential of service user groups to support evidence-based midwifery*: In: Spiby H, Munro J. (Eds.). *Evidence-based midwifery: applications in context*. Wiley-Blackwell: Chichester: 151-66.

Pittman A, Bailey V, Whynes D, James V. (1997) Nottingham's pregnancy diary: a method of evaluating maternity care. *British Journal of Midwifery* **5(10)**: 630-7.

Podkolinski J. (1996) *Women's experiences of 'support' in the postnatal period*. Dissertation (MSc). Southbank University: London.

Polit D, Beck CT. (2004) *Nursing research: principles and methods (seventh edition)*. Lippincott Williams and Wilkins: Philidelphia.

Rees C. (2003) *Introduction to research for midwives (second edition)*. Books for Midwives: Edinburgh.

Roberts T. (2008) Understanding grounded theory. *British Journal of Midwifery* **16(10)**: 679-81.

Scott J, Henley A. (1996) Meeting individual cultural and religious needs in a multiracial society. *British Journal of Midwifery* **4(6)**: 287-9.

Sharp L, Tishelman C. (2005) Smoking cessation for patients with head and neck cancer. *Cancer Nursing* **28(3)**: 226-35.

Spendlove Z. (2005) To suture or not to suture? Decisions, decisions, decisions. A grounded theory study exploring the decision-making of midwives regarding management of perineal following spontaneous childbirth. *Evidence Based Midwifery* **3(1)**: 45-50.

Speziale H, Carpenter D. (2007) *Qualitative research in nursing: advancing the humanistic imperative (fourth edition)*. Lippincott Williams and Wilkins: London.

Steen M. (2005) 'I can't sit down' – easing genital tract trauma. *British Journal of Midwifery* **13(5)**: 311-4.

Steen M, Roberts T. (2011) *The handbook of midwifery research*. Wiley-Blackwell: Chichester.

Strauss A, Corbin J. (1998) *Basics of qualitative research techniques and procedures for developing grounded theory (second edition)*. Sage: London.

Streubert H. (2011) *Designing data generation and management strategies*: In: Streubert HJ, Carpenter DR. (Eds.). *Qualitative research in nursing: advancing the humanistic imperative (third edition)*. Lippincott Williams and Wilkins: Philidelphia: 33-56.

Thompson JF, Roberts CL, Curries M, Ellwood DA. (2002) Prevalence and persistence of health problems after childbirth: associations with parity and method of birth. *Birth* **29(2)**: 83-94.

Tod A. (2010) *Interviewing*: In: Gerrish K, Lacey A. (Eds.). *The research process in nursing (sixth edition)*. Wiley-Blackwell: Chichester: 345-68.

Way S. (2007) *Women's experiences of their perineum following childbirth: expectations, reality and returning to normality*. Unpublished thesis. Bournemouth University: Bournemouth.

Williams A, Lavender T, Richmond D, Tincello D. (2005) Women's experiences after a third-degree obstetric anal sphincter tear: a qualitative study. *Birth* **32(2)**: 129-36.

Zimmerman D, Wieder D. (1977) The diary: diary-interview method. *Urban Life* **5(4)**: 479-98.

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References

RCM. (2007) Guidelines for authors. *Evidence Based Midwifery* **5**(**1**): 35.

Sinclair M, Ratnaike D. (2007) Writing for *Evidence Based Midwifery*. *Evidence Based Midwifery* **5**(**2**): 66-70.

News and resources

***Evidence Based Midwifery* – call for themed-issue papers**

The editors of *Evidence Based Midwifery* are inviting contributions for a themed issue on theory. Subjects sought include: demonstrating theory development, theory testing, theory application, concept analysis or philosophical analysis relevant to midwifery knowledge, practice or education. The submission deadline is 30 September and any authors interested in contributing their paper should contact: emma@midwives.co.uk

ICM's standards for regulation now available online

The full set of International Confederation of Midwives (ICM) global standards, competencies, and MACAT tool is now available from the ICM website. The *ICM global standards for midwifery regulation* (2011) were developed in response to requests from midwives and other stakeholders to promote regulatory mechanisms. The ICM said its essential competencies and the global standards for regulation and education provide a professional framework that can be used by midwifery associations, regulators, educators and governments to strengthen the midwifery profession and raise the standard of midwifery practice in their jurisdiction. To access the set, visit: www.internationalmidwives.org

Book now for the 2011 RCM annual conference

This year's RCM annual conference will take place on 15 and 16 November in Brighton. To book you place and join around a thousand midwifery professionals, visit the RCM website and follow the annual conference link. The deadline for submitting a paper for consideration has now passed. More than 140 papers have been submitted for consideration in the conference programme.

New research group launched by RCM Communities

RCM Communities, an online, member-only professional networking resource, has launched a tenth member group, aimed at researchers. This virtual meeting place is designed for users to share ideas and advice, post the latest resources and contribute to discussion. To sign up, visit: http://community.rcm.org.uk

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