THE EMPLOYMENT DECISIONS OF NEWLY QUALIFIED MIDWIVES

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DECLARATION

I declare that this thesis has been composed by myself, and that the study reported in it was my own work.

ACKNOWLEDGEMENTS

I would like to record my gratitude to those who have helped me in a number of ways to complete this work. My supervisors have provided help at different times throughout the study. I am grateful to Margaret Auld for the initial suggestion that this well-recognised problem is researchable and for her ongoing inspiration. Kaye Rowe, in the preparatory stages, introduced me to the reality of research and encouraged me to continue this work. Miss B. Jamieson invariably gave her valuable time for reading and commenting on earlier drafts and ensuring a sound link with the world of midwifery. My initiation into a new way of thinking and questioning was mainly by Annie Altschul. I am deeply indebted to my supervisors in the final stages of the work, Penny Prophit and David Nelson, for their constructive criticism of what must have seemed like endless drafts.

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ABSTRACT

This thesis reports an examination of the problem of non-retention of new midwives in Scotland and the development of a tool to assist managers to control the problem. The objectives of the study are to describe new students' and new midwives' employment intentions, to identify factors associated with continuing midwifery practice and to evaluate the effects of the extension of midwifery training in terms of midwifery employment.

The existence of the problem is established by drawing on published material and research findings. The changes which constitute the context of this problem are considered. The design of the study has certain features in common with concurrent and sequential natural experiments. A self-administered questionnaire was applied to a sample of 501 new student midwives to assess their employment intentions and their views about midwifery. A similar instrument was applied to these students when they completed their training to be midwives. The data collection extended over a period of four years and was completed in 1984. The study focusses on student midwives' changing views on midwifery and employment, and relates these changes to their socialisation into midwifery.

The analysis of the data was complicated by the deteriorating economic climate and the resulting changes in the respondents' perceptions of the labour market. The data provide a profile of student midwives in Scotland, detailing their personal and occupational characteristics. A model of midwifery employment decision making is developed comprising descriptive and potentially predictive elements. The implications of the study are examined and recommendations are made to test the predictive value of the model and include a wide-ranging approach to problems of midwifery identified in this study.

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CHAPTER 1

INTRODUCTION

1.1. The Problem of Retention in Midwifery

This thesis comprises an attempt to study a problem which is of particular significance in midwifery. The problem is the poor retention of newly qualified personnel; it is being studied in the context of certain important changes in midwifery training, nursing and midwifery organisation, and health care organisation. These changes apply not only in Scotland, where the research project was undertaken, but throughout the UK and possibly beyond to the European Community (EEC). It is hypothesised that the poor retention of newly qualified midwives is associated with a change in employment intentions during training and that these employment intentions are influenced by external and other changes.

1.2. Theoretical Framework

The retention of new midwives (also referred to as newly qualified midwives and Completers) in midwifery reflects the accumulation of their employment decisions. Freeman's all-embracing model (1971) of career choice is being used as the theoretical framework for this thesis. In drawing on Freeman's economic approach, it is to be regarded merely as a tool to facilitate the examination of this problem in that, far from limiting the study to purely financial aspects, it permits precise evaluation of a range of variables which may contribute to employment decisions; in Freeman's words (1971:2):

"nonpecuniary factors will be especially important".

Freeman envisages two groups of factors which may affect the career decision. The first group are those which are inherent in the individual, including a range of preferences, abilities and expect-

ations. The second group of factors are those which are controlled externally to the individual and among which Freeman includes wages and job characteristics, those which are fixed by the "market". These two groups of factors, which Freeman considers constitute constraining influences, limit the choices available to the individual, within which the person must select a career which "maximises his utility function".

The "maximisation approach" involves the decision being made by comparison of the current situation and its future prospects, in terms of monetary and non-wage income and the non-monetary value of the work, with other possible career paths. The individual selects the career which offers the greatest benefits or "utility". This thesis assesses the extent to which these processes may be identified in student midwives. The influence of the duration of midwifery training on the employment decision is examined and also whether the outcome of these decisions relates to any personal or other predictors which may be used to aid selection, with a view to improving the retention of new midwives in midwifery.

1.3. Plan of the Thesis

The first Part of this thesis comprises an introduction to the current situation regarding midwifery employment decisions. Chapter Two, on "The Problem and its Background", demonstrates the extent of the problem and serves to illuminate the midwifery environment in which the study has been undertaken. Next, the literature review examines previous research on employment decision making in midwifery and related areas and explores the other developments which may bear upon these decisions. The final chapter in the first Part discusses the issues involved in the design of the study, in the description of

the Research Method.

In the second Part the data provided by the present study are analysed. This analysis is combined with discussion of some areas which influence the interpretation of the data. Thus, after the analysis of the Beginners' data, the meaning of the practice of midwifery is scrutinised in preparation for the analysis of the Completers' data and their views on midwifery practice as demonstrated by their employment decisions.

Part Three comprises material on the Midwifery Employment Decision Model (MEDM), the components of which are those variables identified during the present study. The rationale for a theoretical model is examined first, together with its appropriateness in this context. Discussion of the psychological basis of employment decisions and thus the MEDM is followed by three chapters on its component parts. The scrutiny of the components of the model is arranged in accordance with Freeman's model; first, those factors inherent in the individual, then those more remote from the individual relating to the job itself and, finally, those relating to the labour market.

The final Part of this thesis considers the conclusions and implications of this study, including testing the Midwifery Employment Decision Model.

Throughout this thesis a convention commonly observed in midwifery and nursing literature is used; when referring to midwives or nurses the female pronoun is used, regardless of the gender of the individual.

CHAPTER 2

THE PROBLEM AND ITS BACKGROUND

This chapter begins by demonstrating the existence of the problem of the non-retention of new midwives; it then details the background against which the study of employment decisions of new midwives will be made. The background will include, first, the development to the present time of midwifery education, in order to view the present changes in the context of a continuum, rather than as discrete isolated incidents. Second, the state of midwifery education at the beginning of the study will be described, as reference will inevitably be made to these arrangements when giving an account of the research and in explaining current developments. These developments will be detailed alongside the description of the situation at the beginning of the research; this will permit comparisons to be made between the "before" and "after" organisation of midwifery education. Third, it is also necessary to consider changes which, although not unique to midwives, have certain implications for their employment. The research questions were based on this exploration of the problem.

2.1. The Nature of the Problem

It has long been recognised that the retention of new midwives presents a problem. As early as 1927 the Ministry of Health (1929) demonstrated that the ratio of of qualified midwives to those in active practice was only 4:1. The Lancet (Editorial, 1948) regards the problem as one of selection, stating that of those who took midwifery training "very few meant to practise as midwives". The Editor continues by observing that the large number of midwives lost on completion of training is a major factor in the shortage of midwives. In this section an analysis will be made of whether the problems

identified by the Editor of the Lancet in 1948 still persist.

2.1.1. The Evidence

The Dan Mason Nursing Research Committee (National Florence Nightingale Memorial Committee [NFNMC], 1963) identified the problem of non-retention while preparing for a study which, like the present study, examined the career choices of new midwives. The NFNMC Report discloses that the proportion of new midwives actually practising remains at a fairly constant fifty percent. This Report suggests that many student midwives have no intention of practising, aggravating a then widely recognised shortage.

The scant attention given in midwifery schools to the students' career plans is due to pressure on limited training facilities, an aggravating factor being the large numbers of students, many of whom will never practise (Shegog, 1966). A similarly pessimistic view of midwifery manpower planning is also taken by others. Observing the high wastage rate on completion of training and its marked decrease within five years of qualification, Willcocks and McLachlan (1968) state that the midwifery workforce at any time comprises mainly people who have qualified within the preceding ten years.

In their country-wide survey of nurse staffing, the Scottish Home and Health Department (SHHD, 1974) showed that the majority (57.1%) of qualified midwives in Scotland are working outside midwifery. This is compared with mental illness and mental handicap nursing, in which only sixteen percent and thirteen percent of qualified staff, respectively, work outside their particular field.

The Royal College of Midwives (RCM, 1979) recognises the continuing existence of the problem, attributing non-retention to poor career prospects and an inadequate system of training.

The continuing existence of the problem is demonstrated in Table 2.1.1., which suggests that in the UK a growing majority of new midwives practise. The application of these data to Scotland requires caution as, first, the source of the data is "midwifery training schools", which having no reliable records of practice would tend to overestimate, relying largely on students' stated intentions. Second, the number of new midwives practising in Scotland has been found to be lower than other parts of the UK. Mander (1980) shows that in 1978-9 a majority of new midwives in England and Wales practised (CMB, 1979), while in Scotland the figure was found to be 30.3%. The increasing trend towards midwifery employment, unusual in view of the longstanding existence of the problem of retention, should be considered in the context of the unusual employment environment. The present study will provide empirical data which will indicate whether reservations concerning the RCM material are justified.

Table 2.1.1. Numbers of New Midwives Practising in UK

Year	Midwives Qualifying	New Midwives Practising	%age of New Midwives Practising
1979	2400	1333	55.5%
1980	2428	1459	60.1%
1981	2496	1554	62.3%
1982	2296	1499	65.3%
1983	1444	1013	70.1%
1984	1950	1409	72.3%
1985	1772	1304	73.6%
Total	14876	9571	64.7%

(RCM, 1986:v)

2.1.2. A Changing Picture

Perceptions of the gravity of this problem are influenced by a range of factors, including the health or otherwise of the labour market. In 1980 there was a strong perception of a shortage of midwives (Robinson, 1980). Half a decade later, this perception is less widely held (Langford, 1984).

2.2. Midwifery Training

It is widely accepted (Dickie, 1979; Williams, 1979) that the extension of midwifery training will affect employment decisions. Therefore, having established the continuing existence of the problem it is necessary to scrutinise the context of this change.

2.2.1. Development of Midwifery Training

To view the extension of training as part of a continuum of change the development of training merits attention.

The education of midwives is, in relation to the history of midwives, a recent phenomenon. According to Donnison (1977), who traces the struggle between female midwives and male "obstetricians" resulting in the Midwives' Acts of 1902 and 1915, Scotland was the first country to provide formal midwifery training; prior to this date training had been by apprenticeship or by personal childbearing experience. Formal training began in 1726 when a Chair of Midwifery was created by Edinburgh Town Council. A century later midwifery training was far from generally accepted. This was shown by a report produced by the London Obstetrical Society (LOS) in 1869 (in HMSO, 1949). In answer to the question "Are the midwives instructed?" the reply was negative:

> "Several districts' replies indicate ... gross ignorance and incompetence ...".

The LOS reported that in capital cities midwives were "fairly

competent" but "unequal to any of the obstetric emergencies". As a result of this report the LOS made a diploma available to midwives who exhibited basic expertise, but neither the diploma nor the preparation for it were required for midwifery practice.

The Midwives Acts of 1902 in England and 1915 in Scotland resulted from a variety of pressures which were exerted both from inside and outside midwifery (Donnison, 1977). Public pressure to protect the life of newborn infants, a general desire for a healthy population to "fight popular colonial wars", dissatisfaction among the public about the unnecessary use of instruments by male obstetricians and the desire in various quarters for better educated, higher status midwives favoured the passage of legislation requiring statutory regulation and education of midwives.

In line with both professional aspirations among midwives and developments in midwifery practice, midwifery training was extended in 1916 from three months to six months; in 1938 it was further extended to twelve months for registered nurses and to two years for women who had not trained as nurses. The advent of enrolled nurses in 1962 required a compromise solution and their midwifery training was of eighteen months duration (Myles, 1975).

These arrangements continued until the recent changes were announced by the government departments in 1977 (CMB[S], 1977). The European Community (EEC) Directive (1980) states as the rationale:

> "all discriminatory treatment based on nationality with regard to establishment and provision of services is prohibited ...".

This document continues with a declaration of midwives' rights to freedom of movement to practise in the EEC and the reciprocity of qualifications, providing all sections of the directive are observed.

With regard to the training of midwives the Directive requires a training of at least three years, with a special dispensation reducing it to eighteen months or two years if the student already possesses a nursing qualification. For reciprocal registration midwifery training is to be followed by a period of professional practice which is to include full time practice in all areas of midwifery.

2.2.2. Organisation of Midwifery Training

Changes in the organisation of midwifery training have influenced this study, so they warrant attention.

Prior to the beginning of this study in 1980, midwifery training in colleges of nursing and midwifery in Scotland and in schools in midwifery divisions in England and Wales was supervised by two CMBs; one being responsible for supervision in England and Wales, the other for Scotland. Midwifery training was of twelve months duration for registered nurses in all countries of the United Kingdom, but in England and Wales eighteen month and two year courses existed for enrolled nurses and for women with no nursing qualification respectively. This is but one difference among many between the midwifery training in the countries of the UK. The functions of the CMBs included supervision of training institutions, organisation of examinations, maintenance of the roll of midwives and discipline of midwives. Maintenance of the roll was by the addition or deletion of the midwife's name under the following circumstances: a name was added to the roll when a midwife passed the final examination and was awarded the certificate; the name remained on the roll for as long as she continued to notify intention to practise (notified each year through the local supervising authority, Appendix A); a name could be removed if the midwife ceased notifying intention to practise or if the CMB,

in its disciplinary capacity, decided to remove the name. The name could be restored to the roll if the midwife in the former case resumed practice and notification or in the latter case if the CMB decided that the name should be restored to the roll, allowing the midwife to practise once more.

Single period midwifery training was the only form of training available in the UK after 1968; this had superceded the two part training, in which Part II was primarily community experience and was not essential for midwifery practice in hospital. Community experience in training continues to differ between the countries of the UK; this may be associated with the differing provision of maternity care or the differing aspirations of midwives to independence.

The transition from twelve month to eighteen month training was planned for August 31st 1981 in Scotland and for September 1st 1981 in England and Wales; the transition had already taken place in Northern Ireland. The change was preceded by written guidance to midwifery schools from CMBs about the new curriculum; this was accompanied by a request for the submission for approval of new syllabi. The CMBs' guidance gave considerable freedom for interpretation by the tutorial staff. This freedom was limited somewhat by the perception that the period of training had formerly been too short for the theoretical input and the practical experience required; it may be suggested that this perception may have eased the acceptance of the extension of training. Some midwifery tutorial staff did, however, interpret this change as an opportunity to develop a more "liberal" curriculum.

2.2.3. Other Training in the Midwifery Area

Other forms of training involving the maternity service are referred to during the present study and may affect the employment

decisions of nurses and midwives. At one end of the scale, the basic introduction to maternity care for first level students, obstetric nurse training, may stimulate the nurse to take midwifery training. At the other end of the scale, the possibility of continuing education provided by courses such as the Advanced Midwifery Course, may broaden career horizons sufficiently to encourage the new midwife to continue in midwifery. Because of their potential for influencing employment decisions, these other forms of training merit consideration.

2.2.3.1. Obstetric Nurse Training

In Scotland since 1964 (1972 for males) the most basic experience of midwifery available has been that provided for all students training for the register of nurses. Originally known as "Obstetric Nurse Training" and now "Maternity Care Module" it is of a minimum of four weeks duration. During this experience the student learns of the normal processes of childbearing and of some of the deviations from those processes; students learn to cope with a childbearing emergency and to give simple advice on health education (CMB[S], 1976). It was hoped, when compulsory obstetric experience was introduced throughout the UK in 1979, that it would satisfy the needs of nurses who would otherwise undertake midwifery training only because they considered their general nurse training to be incomplete without it. The present study may indicate whether or not this aim has been achieved.

2.2.3.2. Twelve Week Obstetric Course

Another introduction to midwifery which is available to a smaller number of nurses is the twelve week obstetric course, which is an entry requirement for nurses who have no midwifery qualification wishing to train as health visitors. This short preparation is barely adequate for the important role health visitors play in the care of

the childbearing family.

2.2.3.3. Refresher Courses

Continuing education for midwives has been a statutory requirement since the enactment of the 1936 Midwives' Bill; this education is in the form of refresher courses which are of two types. The first is for midwives in continuous practice, when the employer is responsible for arranging for the midwife to attend an approved refresher course of one weeks duration "at intervals of not more than five years", (UKCC, 1983:21). The educational value of these courses is questionable (Mander, 1986) as mere attendance is required and the subject matter is unlikely to meet the needs of the wide range of midwives who attend.

The second type of refresher course is that which is undertaken when a midwife returns to practice "after having ceased to practise for a period of five years or more" (UKCC, 1983:21). These courses are of variable duration, depending on the circumstances of the midwife. The value of this second type of refresher course is considerable, in that it updates both the theoretical knowledge and practical skills of the midwife. An advantage of these courses is that they ease the transition back into the role of midwife.

2.2.3.4. Advanced Midwifery Course

In 1972 the Advanced Midwifery Course (AMC) was introduced. This is a post basic midwifery qualification which enables midwives to continue their education within their own specialty; it leads to the Advanced Diploma of Midwifery (ADM). The nature of these courses varied considerably, so the statutory body reviewed and revised the arrangements for the AMC in 1983/4. In the process of revision the course was upgraded and extended so that this became the essential

professional qualification for midwives working towards the Midwife Teachers Diploma (MTD).

2.2.3.5. Midwife Teachers Diploma

The Midwife Teachers Diploma, until the advent of the ADM, was the only post basic midwifery qualification available to midwives. It was probably for this reason that the course, essentially for teachers of midwifery, developed a disproportionately large "professional content", that is, the proportion of midwifery theory to teaching theory and practice was larger than might have been expected in a teaching course. Perhaps as a result of this imbalance the MTD became a prerequisite for many senior midwifery posts, despite the fact that no formal teaching responsibility was involved. It is anticipated that the rationalisation of the ADM will make this the appropriate qualification for career midwives and that the MTD may be recognised purely as a teaching qualification. That this development is beginning is evidenced by the move, particularly in Scotland, to the recognition of multidiscplinary teaching courses, following the award of the AMC.

2.2.3.6. Masters' Degree

Unlike the other midwifery courses mentioned in this background, a Master's Degree in midwifery is, at the time of writing, purely hypothetical. A case has been put forward for such a course in the UK, (Ward & Adams, 1979), being well established in the United States (Editorial, 1983). Ward and Adams make a strong case for the continuing education of midwives in the form of such a degree, though they fail to consider the poor career structure for midwife educators, which would certainly be improved by the extension of midwifery into higher education.

2.2.4. Review

The background against which the present study was made comprised changes in various aspects of midwifery, including education. The state of midwifery education has been described.

2.3. Concurrent Developments in Health Care

Having examined the situation and the changes affecting midwifery education at the beginning of this study, this description will be extended to other areas impinging on midwifery, which may have produced an alteration in the nursing/midwifery environment between the Stages of this research and which may ultimately affect new midwives' employment decisions.

2.3.1. Developments in the Role of the Midwife

The midwife's changing role has been attributed to various factors. The lack of community midwifery is blamed for the demise of midwifery skills; this is associated with falling interest on the part of general practitioners, low birth rates and increasing maternity bed provision (Cronk, 1979). Bradley (1981) demonstrates midwives' dissatisfaction with their current role, echoing Cronk's comments and implying midwives' conversion into "obstetric nurses".

The literature suggests that changes in the midwife's role and relationships occur in spite of midwives. The midwife is envisaged as passively accepting such changes (Bradley, 1981; Roch, 1983), which inevitably affect her relationship with medical and other colleagues. The underutilisation of midwifery skills is observed (Maclean, 1980; Pearson, 1982) and attributed to the development of the obstetrician's role (Beak in RCM, 1980). Comparing the evolution of the role of the midwife with that of the nurse, Roch (1983) concludes that, despite the medical threat, the separation of midwifery from obstet-

rics is not feasible due to the need for emergency medical support. This rationalisation of the situation neglects the possibility of limiting such problems by the appropriate organisation of services.

The increasing participation of doctors in normal maternity care has jeopardised the role of the midwife, resulting in "strain and conflict" within the midwife-doctor relationship (Walker, 1972). This concealed conflict exists in the complex interdisciplinary environment of the hospital and Walker suggests that the increasing responsibility of doctors reciprocally reduces that of the midwife, effectively diminishing her role to an "obstetrical nurse".

The conflicts in the midwife-doctor relationship are apparent in certain areas of care, such as management of labour (Bradley, 1981). 84.9% of midwife respondents and 39.9% of doctors considered that theirs is the prime responsibility for decisions concerning care of women in normal labour. Bradley relied largely on the reports of midwives to describe the distribution of responsibility, but these reports were supported by observational studies. This large area of uncertainty regarding responsibility is fertile ground for the growth of the "strain and conflict" identified by Walker.

The Central Midwives Boards (CMBs, 1983) recognised changes in the role of the midwife and patterns of care resulting in the midwife becoming a team member, rather than the independent practitioner traditionally claimed. WHO and EEC (cited in CMBs, 1983) define the role of the midwife in terms of the work and the relationships with other occupational groups. While accepting the changing role and resulting relationships the CMBs exhort midwives to resist changes in the nature of their work to "fulfil the role for which they are trained". It may be that this ambivalent approach of the statutory

bodies fails to clarify a confused and unstable situation.

2.3.1.1. The Midwifery Process

A comparatively new approach may redress the erosion of the midwife's role and make midwifery more attractive to new midwives.

The advent of "the nursing process" has brought a more scientific approach to the provision of nursing care. The use of the midwifery process may redress the erosion of the role of the midwife which has been described already (Ashworth, 1981). It emphasises the importance of individual patient care, and comprises the systematic use of four stages of problem solving - assessment, planning, implementation and evaluation. Roper et al. (1980) discuss this approach in a nursing context, emphasising its logical, step by step sequence. Whitfield (1983) describes the implementation of this approach in midwifery; she briefly mentions how this approach may improve the pattern of care, partly by encouraging questioning of established practices and the implementation of research findings, and partly by ensuring more personal, consistent and comprehensive care for mothers and babies. The problems of the introduction of this system of care appear to centre on the documentation involved - the care plans. The arrival of unaccustomed paperwork causes minor difficulties, but the major problems are associated with staff being uncertain about what they should be writing. Being accustomed to stereotyped phrases such as "satisfactory morning", many staff find particular difficulty in describing the emotional trauma which a new mother encounters. The other serious problem, not unique to this field, is the feelings of insecurity in staff who felt safe and comfortable using the old system, and feel threatened by the new one. Whitfield suggests the demise of "routines" as an example of this phenomenon.

Metcalfe (1981) demonstrates the selectivity with which midwives have accepted the process. Her project was based on the midwifery process, notably the planning of care of the mother/baby dyad on an individual basis using a plan of care; these were written daily by the leader of the team providing care. An important feature of Metcalfe's study was the system of reporting, which was undertaken by the staff actually caring for the mother and baby. Serious organisational problems were encountered due to shifts. Metcalfe evaluated the change on the basis of an observation study and satisfaction reports. The observation study showed only that communication between staff and patients increased significantly using the new system. The findings of the patient satisfaction study were ambiguous, but the staff satisfaction study showed clearly that the staff knew more about the mothers and babies in their care, that team work was better and that the planning of work was improved. Metcalfe demonstrates how the "midwifery process" may be applied in a modified form to the satisfaction of staff, even if the advantages to the mothers/babies have not yet been established.

It is apparent that the concept of the midwifery process has advantages for both consumers and midwives. In considering changes in midwifery practice it is vital to consider whether the midwifery process can contribute to slowing the deterioration in the midwife's role. Ashworth (1981) discusses the ways in which the midwifery process may help midwives to identify those areas of care which are midwifery, in an effort to minimise the huge overlap between midwifery and medical functions described by Bradley (1981) and to re-establish the role of the midwife as something other than an obstetric nurse. Ashworth further argues that the effects of midwives' passivity, in

permitting others to define their role, may be reversed by the midwifery process allowing midwives to reassert themselves and regain their occupational identity.

2.3.1.2. The extending Role of the Midwife

Concurrently with the above developments another phenomenon has been evolving which may influence their role, but has implications for training; this phenomenon is the extending role of the midwife. The midwife's extending role merits examination here as students are aware of this development and the midwives' responses to it.

Maintaining that the extending role of the midwife helps to develop the profession, Burrett (1983) indicates that the syllabus for the extended training supports this view by including the requirement for the instruction and practical experience of student midwives in perineal repair. Burrett describes the teaching of midwives and enumerates the wounds which may and may not be sutured by midwives. This list of prohibited wounds emphasises a point made by certain senior midwives concerning the learning and practice of perineal suturing. The problem results from three factors: first, the large number of student midwives required to gain some degree of proficiency in perineal repair: second, the prohibitions as to the wounds which midwives may repair and, third, current changes in midwifery practice. The outcome is that, though students obtain the appropriate experience to meet training requirements, midwives' and others' attitudes result in a reduction in the number of episiotomies to be repaired. Scottish midwives' attitudes to perineal repair are clearly demonstrated to be frequently ambivalent and occasionally reluctant (Askham & Barbour, 1986:22). These attitudes are related to the tendency to "impose standards well in excess of those required by training". Others'

attitudes to perineal damage are reflected in the falling episiotomy rate and the corresponding rise in the perineal tear rate, further increasing the number of prohibited wounds (Sleep, 1983).

Perineal repair is an example which demonstrates one aspect of care in which the "extending role of the midwife" is merely an extension of the midwifery syllabus, because even practising midwives are unable to maintain their "extended" skills.

2.3.1.3. The Relevance of Midwifery Training

That the role of the midwife is changing has been demonstrated. The extent to which midwifery training is still relevant to this role now merits consideration as students identify any discrepancy. Changes which have already been described are those involving occupation-wide aspects of midwifery, such as the societal and inter-occupational effects which are associated with the reduction in the role of the midwife. The more scientific approach to caring and the extension of the midwife's role now being applied to midwifery may reciprocally re-establish the midwife. Is it possible, though, that in attempting to correct the situation, there may have been an overcorrection?

This phenomenon may be identified in Burrett's example, as it is possible to interpret the extension of the midwife's role as a form of over-training. Strauss (1964) and Singer and Ramsden (1972) discuss the problem of over-training in industry, and emphasise the importance of training personnel to work at the <u>currently accepted level</u> (their emphasis). They go on to state that personnel who have been trained to too high a level, later perform work which could be undertaken by a less highly trained person. It may be questioned whether anticipation of such a frustrating situation influences new midwives' employment decisions. Singer and Ramsden suggest that the solution to the problem

of over-training lies in a detailed analysis of the skills which are required by newly qualified personnel, and ensuring that students are prepared to function at this level, taking into account technological and other developments. The personal experience of this researcher suggests that such an analysis is overdue in midwifery, especially in view of the large number of "midwifery tasks" which are performed by non-midwife and occasionally untrained staff. The work of Gray and Smail (1982) supports the contention that the role of untrained staff in midwifery needs examination if the skills unique to midwives are to be identified.

The relevance of midwifery training was one area which Golden approached in her study of the views of student midwives (1979). Unlike the above example, she reveals that students consider that they are inadequately prepared for certain basic midwifery tasks. Two of these tasks, a home confinement and working in a SCBU (Appendix A, Page 294), are areas in which, for different reasons, it is difficult for the student to gain adequate experience. The two other areas for which, Golden indicates, students consider themselves inadequately prepared are teaching groups of parents and the immediate care of the newborn baby. Golden regards the latter as the more serious deficiency, but it may be suggested that both of these are areas in which in which the midwife may claim to be uniquely appropriate to provide care and that it is areas such as these which need emphasis in midwifery training rather than those such as Burrett's example which the midwife is increasingly unlikely to use. Thus, in considering the relevance of midwifery training there appears to be mis-match between training and occupational needs, varying between over-training and inadequate preparation.

Student midwives are exposed to the declining occupational role. Although certain strategies are being implemented which may correct this decline they are not consistently effective. Awareness of this situation may influence the employment decision.

2.3. 2. Midwives as An Occupational Group

A continuing debate, pertinent in this context and which contributed to the background of the present study, focusses on the nature of midwifery as an occupation discrete from nursing. The relevance of this debate here relates to the question of wastage (Appendix A, Page 294); as if nursing and midwifery are one occupation it may be assumed that the loss of a new midwife to general nursing is merely intra-occupational mobility. If, however, midwifery is a separate occupation, this loss constitutes wastage.

Personal experience causes this author to believe that many midwives regard midwifery as an occupation or profession which is quite distinct from nursing; they cite the fact that, despite their seeming reluctance to do so, midwives are permitted to act independently, that is, without medical supervision in normal situations and that a midwife is permitted to administer certain drugs without a medical prescription. These are not nursing duties (UKCC, 1986b:50).

Further evidence to support the contention that midwifery is a separate entity lies in the historical origins, which (Donnison, 1977) grew out of local women's support systems, and to which were added some elements of folk medicine. Nursing on the other hand evolved from more organised beginnings, being rooted in the church and the military (Baly, 1976:12). The relevance of such history is questionable, as both occupations have undergone vast changes, probably in a common direction. This greater congruity is evidenced by the fact that mid-

wives, like nurses, care for patients, despite the fact that few midwives' patients are ill and, generally, a person must be a nurse before being able to train as a midwife. Further evidence is the names of the statutory bodies (... for Nursing, Midwifery and Health Visiting); this claim may be rendered less valid by the acceptance by midwives of "nurse/nursing" in their job titles, such as the "nursing officer" titles created by the Salmon Committee's report (Ministry of Health, 1966), or, more recently, "Director of Nursing Services".

Such a distinction between nurses and midwives is regarded by some as unnecessary and potentially divisive, arguing that the similarities between the two occupations are of greater significance than the differences. Henderson (1968) provides support for this argument, as her definition of nursing is equally applicable to midwifery:

> "the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities of daily living contributing to health or its recovery".

Coutts (1981) further contributes to the concordance debate by describing the role of the nurse in helping people to adapt to change, regardless of the person's health status. This approach has much in common with the accepted role of the midwife (CMB[S], 1983) "she must be able to give the necessary supervision, care and advice to women". These statements would appear to support the contention made already, that these two occupations are changing in the direction of greater congruity. These changes, however, still have a long way to go and because of this and because of midwives' current enthusiasm to regain their former independence, in this thesis the assumption is made that midwifery is a separate occupation from nursing and that loss from midwifery constitutes wastage.

2.3.3. Male Midwives

Because the advent of males into the midwifery labour force has implications for midwives' employment decisions, it is necessary to consider their route of arrival and likely impact.

2.3.3.1. The Legislation

The heated debate concerning males in midwifery was initiated by the proposals for sex discrimination legislation in the early 1970s. This legislation related to UK entry into the EEC. The movement in favour of male midwives included an unlikely collaboration between male nurses and feminists seeking consistency; the latter regarded males entering "female" occupations as the inevitable corollary of females having the right of entry into "male" occupations (Leader, 1983; Donnison, 1977:199). This movement was strenuously opposed by the RCM, with the support of nursing and medical organisations (Speak & Aitken-Swan, 1982:1). The grounds for opposition included patients' interests, their freedom of choice, and the essential femininity of the midwife's role. The spectre of chaperonage, with its associated staffing constraints and costs, was also raised.

In an attempt at least partly to meet these objections, and to ease the passage of the Sex Discrimination Bill (HMSO, 1975), the then Health Minister, Barbara Castle, suggested the introduction of experimental schemes of training, to be followed by "transitional restrictions" on the practice of qualified male midwives, pending evaluation of the schemes. The experimental scheme in Scotland, which coincided with Stage I of the present study, incorporated an important difference from its English equivalent in that, due to the well established ON course for male student nurses, chaperonage was waived (Speak & Aitken-Swan, 1982:1).

The evaluation of these schemes demonstrated general acceptance of male midwives (Speak & Aitken-Swan, 1982) and resulted in Section 20 of the Sex Discrimination Act (1975) being repealed by an Order in Council in 1983 (Lewis, 1984); thus, midwives' exemption from the terms of the Act was ended and men were permitted to train and practise as midwives on equal terms with women.

2.3.3.2. Males in Midwifery

Throughout the present study the assumption is being made that a large majority of midwives are female. The correctness of this assumption is demonstrated in Table 5.2.1.1. (Page 96), but it may be becoming less valid. Donnison (1977) predicted and Speak and Aitken-Swan (1982:1) identified a low demand by men for midwifery training and initially only small numbers trained and even fewer practised (Leader, 1983); but this may only have been a temporary phenomenon, due to a combination of "transitional restrictions" severely limiting employment opportunities and a large proportion of male student midwives, being non-UK citizens, not practising in this country. That the situation is changing is supported by Lewis (1984), who describes his return into midwifery when Section 20 was repealed and subsequent progress into a Charge Midwife post (1985). The advance of males into midwifery practice may be limited by the requirement that women must be free to choose <u>not</u> to be attended by a male midwife. This element of choice may, by reducing staff flexibility, constrain midwifery managers' employment of male midwives. Problems such as this are more likely to be encountered in areas with large ethnic minority communities than in Scotland. Consumers' changing attitudes, by their acceptance of male midwives, may render this problem less significant.

2.3.3.3. Male Midwives and Employment Decisions

The existence of male midwives is likely to affect the employment decisions and the retention of midwives in two ways.

The first is in the nature of their employment decisions which, (Nuttall, 1983), are different from those of females due to males' limited vulnerability to domestic responsibilities. Other reasons for the difference lie in the nature of males' domestic responsibilities which are traditionally more of an economic provider than care provider. There is unlikely, however, to be a representative sample of male students in the present study to permit conclusions to be drawn on the nature of their employment decisions.

The second possible influence which male midwives may exert on employment decisions and midwifery retention is in association with their effect on the decisions of female midwives. The arrival of men in midwifery may be compared with their presence for longer or shorter periods in other areas of nursing. Nuttall (1983) contrasts the equal proportions of female and male nurses in the most senior nursing posts (DNOs & DNEs) with the small proportion of males entering nursing (6.4% of entrants). A more extreme form of this imbalance is demonstrated by Pollock and West (1984) as a feature of the psychiatric nursing career structure, where, at the level of unqualified staff, the ratio of females to males is 142:1. This ratio is reversed at DNO level to 1:7.

Nuttall discusses the reasons for the female/male ratio of senior nurses in England, suggesting that it is because women's careers are secondary to those of their husbands. She anticipates that male nurse-managers and female nurse-workers will become the norm to which female nurses will feel obliged to conform. Blenkinsop (1982) considers the

effect of this career structure imbalance on the employment decisions of new entrants into nursing. She suggests that, in the absence of suitable role models among senior nurses, new female nurses may be deterred from continuing in nursing.

2.3.3.4. Review

To what extent are the developments in general and psychiatric nursing predictive of the future midwifery career structure? Because men are newly arrived in midwifery and because the same pattern has been repeated in those areas of nursing which they have entered previously, it may be anticipated that male midwives are likely to gravitate towards the senior posts in midwifery, allowing a suitable time for promotion.

2.3.4. National Nursing Structure

The Nurses, Midwives and Health Visitors Bill (HMSO, 1979b) was the somewhat belated result of the Briggs Report (HMSO, 1972). The new central and national nursing structures were being formed at the time the present research began (UKCC, 1981) with a view to taking over responsibility for all functions in March 1983 (UKCC, 1982).

The effects of such changes, if any, on the retention of midwives or on the present research are difficult to assess. It may be that the development of the single professional register may make the movement of Scottish-trained midwives even easier, thus increasing an already established trend (Mander, 1980). Such a development would make the present research more significant, in that more precise methods of selection using predictors of continuing practice would be a relatively easily implemented method of retaining midwives in Scotland.

2.3.5. Local NHS Structure

The publication of the discussion document "Patients First"

(HMSO, 1979a), proposing organisational changes in the provision of health care in England and Wales, resulted in the reorganisation of those services on April 1st 1982 (Barber, 1981). A similar process was completed in Scotland in 1983, retaining a commitment to the team approach to management. As a result of the emphasis on "being responsive to the needs of patients" (HMSO, 1979a:5 para 5), there is considerable variation in the management arrangements between districts. Due to similar variations in unit arrangements, complex communication pathways and associated difficulties developed.

The likely effects of this reorganisation on the retention of midwives and on the present research are difficult to assess. The feeling of dissatisfaction at yet another reorganisation may not be felt by the student and newly qualified midwives, the majority of whom were not employed in the NHS at the time of the previous major reorganisation in 1974. It is possible, though, that such feelings may permeate through from more experienced members of staff to produce dissatisfaction. The effects of the local reorganisation are even more difficult to envisage, as the nature of the reorganisation is subject to local variation, as mentioned above.

2.3.6. NHS Management Structure

The Griffiths letter (1983) proposed a new approach to management in the NHS. Unlike the team approach previously favoured, general management emphasises the need for a "driving force, seeking and accepting direct and personal responsibility for developing management plans" (Griffiths, 1983:12). These principles are reflected in the transition from consensus to corporate management. In applying Griffiths' principles to the Scottish health care system, Coopers and Lybrand (1986:3.4) reiterate the need for authority, lines of manag-

erial accountability and leadership.

The significance of the new management structure was apparent to few nurses or midwives during the time of the data collection of the present study. These changes are an essential component of the midwifery environment which, with the likelihood of any influence in the future, deserves consideration.

2.3.6.1. Implementation

The changes proposed in the Griffths letter (1983) were soon implemented in England and Wales. One of the reasons for this speedy and easy implementation was the widespread assumption that the general managers would be inserted into existing structures which would remain unchanged (Dimmock, 1985a; RCN, 1984; Kings Fund Working Party, 1985).

The delay in implementing these changes at unit level in Scotland has been caused by the need to review the application of general management. The first phase of the implementation of the new structure, the appointment of Area General Managers, was completed by the end of 1985, as planned (SHHD, 1984).

The review of unit functions, the first part of the second phase, has also been completed punctually and the recommendations circulated to Health Boards. Following consultation on the basis of the SHHD discussion document (1986), the final part of the second phase is to be the introduction of a general management function at unit level. The proposed structures are to be submitted by October 1986 and unit general managers in post by April 1987. The SHHD recommendations emphasise the need for integration of services, which should be facilitated by conterminosity. Unlike management arrangements in other parts of the UK, professional input is a basic tenet of the Scottish proposals, and is recommended at health board and unit level. Simplif-

ication of management, together with delegation and accountability, reflect the original Griffiths principles. Strategic and operational management functions are recommended to be allocated to area and unit levels respectively. The "flexibility and perhaps experimentation" advocated by Hunter (1985) may yet materialise in the Scottish context in association with the consultation process. The final phase of the management changes is the strengthening of the management function at unit level, which has no time limit.

2.3.6.2. Implications for Nurses and Midwives

The new NHS management structure is relevant in the present context as the career structure which develops within it may influence the employment decisions of new midwives and nurses and their retention in midwifery and nursing. This influence may be exerted in two ways; which alternative operates depends on the foresight or career planning of the individual.

The first possible effect relates to nurses' and midwives' contribution to senior management. Dimmock (1985b), after tracing the waxing and waning of nurses' management input into the NHS, regards nurses' future in senior management as extremely uncertain. This is a cause for concern in England and Wales because of the lack of a nursing "voice" in policy decision making and because of the limited career opportunities due to a foreshortened nursing career structure. The likelihood of this concern being justified in the Scottish context appears remote in view of the firm recommendation (SHHD, 1984:2) for nursing input at health board and unit level, the latter having line and professional management responsibility. Dimmock expands his argument by anticipating the business model of a Board of Directors to manage local health care; he predicts that any responsibility

allocated to a nurse would be of a general nature. The Board of Directors model (Allen, 1985) depicts the future structure as problem based rather than professionally based.

The second possible effect of the new management structure, also suggested on the basis of the English experience, is the effect on nurses providing care directly. Rogers (1985) anticipates that such nurses may find their caring role limited, as those delegating work to them may be non-nurses, with an inevitably incomplete understanding of nursing. This fear of "domination" by non-nurses is unlikely to be justified in the Scottish context due to the strong nursing input. This anxiety may be transferred, in the case of midwives, to a fear of being managed, if not dominated, at unit level by non-midwives.

Some regard these developments more optimistically, such as Allen (1986) who considers that in a new problem-oriented unit structure nurses would appropriately take responsibility for the provision of hotel functions, regarding this as an opportunity and a challenge! This is an example of the incomplete understanding of nursing mentioned already. Young (1986) adopts a similarly optimistic viewpoint, interpreting the diminution of a senior nursing staff structure as a positive benefit to practising nurses, in that they will become responsible for providing the nursing "voice" rather than their senior colleagues.

2.3.6.3. Review

Thus at the time of writing the changes in the Scottish health service management structure are far from complete. Material relating to the English experience indicates that nurses are concerned about the limitation of their career structure and about the possibility of

nursing instructions being given by non-nurses. The extent to which this concern is justified is difficult to assess at this early stage.

2.4. Other Relevant Developments

2.4.1. Economic Climate

The general perception of an economic recession, which reached the UK at the beginning of the present research, may have had some effect on midwifery retention, although this is difficult to establish. Long and Mercer (1978), in their examination of general factors affecting manpower, maintain that factors as general as the national economic situation should be borne in mind when manpower planning is being undertaken. At the beginning of the present research it was not possible to predict the way in which any economic recession would affect the study, but that there would be some effect was certain; the possibilities of a declining birth rate and of increasing female employment were contemplated, and the former has materialised. It may be suggested that such changes are not wholly attributable to the economic climate or to the associated employment difficulties, and that these are only further unquantifiable variables which should be borne in mind when examining midwifery employment decisions.

The deteriorating economic climate was perceived as affecting midwifery employment, by making fewer jobs available for new midwives (Section 13.1.4., Page 258). It may be that this phenomenon, by reducing the choices available for new midwives has reduced the value of the present study. Even accepting that the number of jobs available has been reduced the value of this study is upheld for four reasons: first, this material provides midwifery managers with a tool to assist them to select midwives who will remain in midwifery, when its use is appropriate. Thus, managers may control midwifery manpower, making the

service less vulnerable to shortages, such as that encountered in 1980. Second, regardless of the state of the job market, employment decisions continue to be made by those completing training. Third, in view of the anticipated demographic changes (Hutt, 1986) the number of young people available for recruitment into midwifery will soon decrease, and one solution to this problem will be improved retention. Fourth, large numbers of midwives are being trained with no prospect of any return to the NHS of the costs of training; such a reimbursement would be in the form of midwifery service. In financial terms this outlay is not a justifiable use of finite NHS resources.

2.4.2. Membership of the European Community

UK membership of the EEC contributed to the immediate stimulus to implement the recent extension of midwifery training. Although certain political factions are committed to the withdrawal of Britain from the EEC, it would be difficult to envisage the reversal of changes such as those recently completed in midwifery education, were such a withdrawal to occur.

2.5. Research Questions

On the basis of this statement of the problem the research questions are formulated. They are as follows:

1. Who undertakes midwifery training in Scotland and why?
2. What are the new student midwives' employment intentions?

    2a. Are these intentions different from the intentions expressed on completion of midwifery training?

    2b. If there are any differences between Beginners' and Completers' intentions, or between intentions and employment, are there any personal or other characteristics which may be associated with these differences?

2c. How do employment intentions develop in association with the extended midwifery training?

3. How do the expressed intentions relate to the employment of new midwives?

4. Are there any changes in employment practice in association with the extension of midwifery training?

5. What are the phenomena which influence a new midwife's employment decision?

6. What are student midwives' views of midwifery training and midwifery?

6a. Does midwifery training meet their expectations?

6b. How do they perceive the value of the midwifery qualification?

CHAPTER 3

LITERATURE REVIEW

The purpose of this section is to examine material written on midwives' employment decisions and the factors influencing or relating to those decisions. As midwifery employment has received scant regard in the past it is necessary to consider research undertaken in the context of other occupational groups, but which is relevant to midwives. Such an approach is not entirely inappropriate as midwives may be considered to belong to larger subgroups of the population, such as nurses, women, or just employees.

This chapter is organised chronologically; thus, the material on the employment intentions and decisions precedes that research into beginners' employment intentions. The factors encountered during training which are likely to affect employment decisions are considered next. Fourth is the employment decision made on completion of training, followed by scrutiny of some of the areas which may be affected by the decision. As midwifery is considered by some to be a secondary career (Appendix A, Page 294) attention will be given finally to the decision to take up midwifery later in life.

3.1. Employment Intentions and Employment Decisions

Previous relevant research on long term career planning suggests that predictors of continuing employment activity are identifiable.

The career patterns of graduate nurses (Jope, 1980) are based on the interaction of three groups of factors in adult life, namely, personal, professional and employment factors. As a result of her work, Jope suggests that nurses' careers generally fall into five discrete stages: full time, part time with first child, cessation of

employment with second child, not on labour market, and resumption of employment on a part time basis. The students in the present study are experiencing the first phase of their careers and this study should reveal the extent to which they anticipate these developments.

The value of research on employment to managers is demonstrated by the work of Cleland and her colleagues (1976). Their study of the factors which affect the decision of married nurses contemplating employment shows the influence of certain aspects of the job, also finance, motivation and family ideology. These authors consider the job content variables, as these are the factors over which nurse managers have control. Of the seven factors which are identified as job content variables, the authors suggest that those which correlate positively and most strongly with employment activity are career desirability, professional behaviour and the economic value of the work. The authors conclude that the general organisation of nursing, nurses' financial remuneration and the attitudes of society to female employment are major influences. Although such conclusions may not be entirely justified by the published data, this research does indicate the scope for managerial intervention.

Certain aspects of Price and Mueller's study (1981) are comparable with the present study. On the basis of the high voluntary separation rate for nurses (58% compared with 17% and 34% for teachers and social workers respectively), Price and Mueller assessed the presence of certain personal and other characteristics in stayers and leavers. The characteristics involved were kinship responsibility, general training, professionalism, promotional opportunity, distributive justice, pay, integration, instrumental communication, participation, routinisation, job satisfaction and intent to stay.

These authors conclude that intent to stay is the best predictor of a nurse continuing in employment. On the basis of these findings they suggest that employing more nurses with certain personal characteristics may produce a more stable work force, or at least reduce voluntary separation from the then unacceptably high level. These desirable personal characteristics include living locally and with young children and also being in the over thirty age group. The present study provides data to examine this conclusion.

The comparison of nurses with teachers and social workers may not be entirely valid as these groups include different, probably higher, proportions of male employees, who provide a stabilising influence and reduce the separation figures (Abel, 1976). Despite the obvious differences between the work of Cleland and that of Price and Mueller, these two groups of researchers emphasise the different career plans which are associated with the changing role of women in relation particularly to marriage and childrearing.

Using an economic approach Freeman (1971), probed the effects of higher education on careers; he maintains that career choice is determined by personal factors interacting with job characteristics, these include financial and other features. Freeman's emphasis on non-wage income is particularly pertinent in the present context as, first, the choice for new midwives is likely to be between midwifery and other NHS employment with similar rates of pay, and, second, the wage component of nurses and midwives income is regarded by many as being disproportionately low (Burslem, 1979), implying that the non-wage component is of greater significance. Wage income only becomes important when all other factors are equal, according to Freeman, but for new midwives pay is perhaps the only factor to be equal, so this is of

limited value in illuminating the decision process. There may, however, be concern about other aspects of midwives' pay.

Incorporating a "black box" approach, Freeman describes the factors which affect the employment decision, the first of which is the effect of past market conditions on the formation of expectations (Figure 3.1.1.). Such expectations control decisions, which in turn affect supply and, hence, the actual state of the labour market, or manpower level, which is also influenced by certain external forces such as the general supply of manpower (Long & Mercer, 1978).

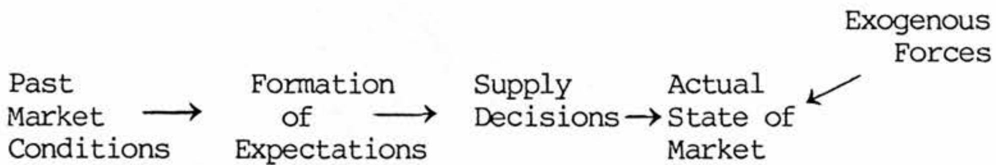


Figure 3.1.1. Factors Affecting Employment Decisions - An Economic Analysis

Freeman suggests an alternative, more complex sequence in which the formation of expectations is studied separately. This involves an element of dissonance following expectation formation, due to the non-fulfillment of those expectations (Figure 3.1.2.). Adjustment to this dissonance, according to Freeman, removes any difficulty and permits an employment decision.

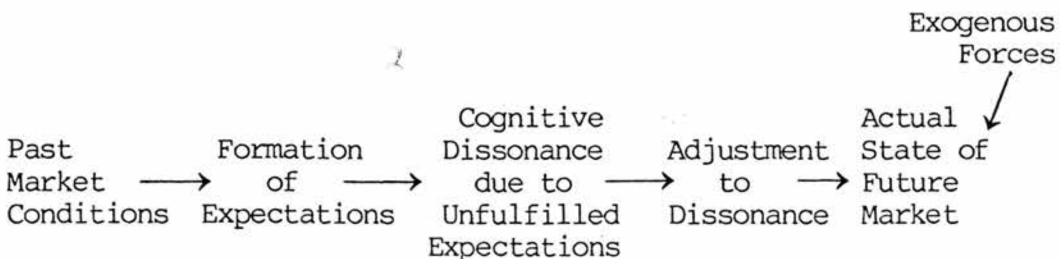


Figure 3.1.2. Influence of the Formation of Expectations on Decisions

It may be that the latter, more complex, sequence is less valid

than the former, as adjustment to dissonance is not a long term solution; according to Festinger (1957) dissonance may be resolved in one of two ways, either by obtaining new, dissonance-reducing information or by the avoidance of dissonance-raising situations, in this context the employment. Were Freeman's suggestion of "adjustment to dissonance" to be accepted, it would follow that the dissonance would continue to exist, though not at a conscious level, and that under certain, perhaps stressful, circumstances, it would reveal itself in feelings of discomfort or anxiety.

Freeman compares the perceived importance of job characteristics to undergraduates and to graduates; similarly, the present study will reveal changes in attitudes to midwifery during training. Undergraduates considered earnings to be the most important characteristic of the job, whereas graduates placed earnings second after national need. This change in priorities indicates increasing idealism in attitudes towards employment during education; this fails to support others' findings (Croog et al, 1968, Section 3.3.1. Page 41).

3.2. Initial Employment Intentions

Early employment intentions reflect the idealist/realist orientation of the individual, which in turn determines their ideal career. Although research suggests that sound knowledge is required for durable career decisions this has been shown to be deficient in certain groups, although others have been shown to possess extensive breadth of vision regarding careers.

A study of the career motivation of 325 nurse graduates in the UK examined motivation to nurse, reason for degree, personal career, attitude to the short (postgraduate) course and attitude to the experimental course (Bendall & Pembrey, 1972). The authors discuss the

differences between intentions and reality in their consideration of career paths (ideal) and career routes (actual); this differentiation raises the question of what happens to the former to produce the latter. Three of the sample left nursing after qualifying, all to work in another of the "caring professions". This finding serves to further weaken the argument propounded by Freeman, that there is a once and for all career decision, as it is likely that for these people the move away from nursing is at least their third occupational decision. The first was to enter university, the second to begin a nursing course and the third on completing the nursing course.

The role conflict, recounted by Bendall and Pembrey, which the nurse graduate experiences is applicable to other carers. They suggest that if the "moralist" nurse perceives the "system" as illegitimate she may either rebel by withdrawing from nursing or may persevere in spite of the perception of its illegitimacy, to become an innovator, changing those aspects which she regards as unsatisfactory. Alternatively, the nurse with a less moralistic, more expedient approach may perceive the system in the same way but be prepared to work within it and to adopt a ritualistic approach. This sequence is consistent with that described by Festinger (1957), in which individuals resolve dissonant situations in different ways, depending on their own personalities and may explain some of the loss from midwifery.

In a survey of 139 college students, Greenhaus and Simon (1976) examined their attitudes to their chosen careers. Those who considered their chosen career to be ideal exhibited high levels of self-esteem and attached great importance to their choice of career. Idealisation of the chosen career showed a strong positive correlation with the students' perception of the career offering intrinsic satisfaction.

Greenhaus and Simon were, however, unable to compare these attitudes to the career which actually developed; such an extension of the work might have revealed whether those with ideal career perceptions were satisfied or disillusioned by their work. The present study attempts to reveal the perceptions of new students regarding midwives, rather than the occupation itself as Greenhaus and Simon did; this is a less direct method of assessing the same factor. The present study will also attempt to reveal whether the student midwives' perceptions of midwifery change in association with training.

Comparing the career aspirations of two groups of student nurses, Loree and Leckie (1977) describe the knowledge needed for a person to select a career. This includes an understanding of their own life situation, a knowledge of what the career involves and a knowledge of how to enter the chosen career. The knowledge described by these authors requires a considerable level of maturity, which may not always be present in those making career decisions. In the present study this knowledge should present little difficulty, as obstetric nurse training has been compulsory for all student nurses since 1979. A study undertaken involving medical students suggests that this knowledge may be deficient. Attempting to illuminate the choice of medical specialty, the career intentions of medical students were sought at intervals during the course (Martin and Boddy, 1962), although no attempt was made to identify the feelings and attitudes on which these intentions were based. Many of the respondents had unrealistic employment intentions, particularly with regard to their promotion through the medical hierarchy. The authors conclude that the respondents' intentions, particularly regarding consultant posts, bore little relation to the staffing requirements in the areas in which

they intended to work.

A study of the characteristics, attitudes and opinions of "neophyte" nurses in the USA and UK aimed to make comparisons between graduate nurses in the two countries, rather than to probe their employment intentions (Kramer, 1967). American nurses were shown to have a greater breadth of vision with regard to their careers than do their British counterparts, seeing far more opportunities both in terms of the work itself and in terms of the environment in which it is undertaken. This contention may support the findings of Glaser (1963) that American nursing is unique in its lack of a hierarchy; it may be suggested that the existence in other countries of a rigid nursing hierarchy, such as that described by Glaser, prevents nurses from appreciating the opportunities which exist outside. The present study may show the extent to which this sense of hierarchy exists in Scotland and whether midwifery training is seen as a prerequisite for ascending through it.

3.3. Factors in Training Influencing Employment Decisions

The factors which have been identified as operating during training to influence the employment decision may be peculiar to midwifery or of a more general nature.

3.3.1. General Factors

The values and orientations of students, which develop during socialisation in training, influence the eventual employment decision.

In studying the occupation and career perceptions of student nurses, Loree and Leckie (1977) discuss the orientation of the nurse in terms of a humanitarian or caring personality as against a professional or bureaucratic personality. These roles are learned during basic nursing education, at the same time as the student begins the

process of socialisation into nursing. They describe the learner as an interested observer who is contemplating entry into nursing and maintain that congruity between the student's self perception and how she perceives the work environment is necessary if the student is to continue in the occupation for which she is training. Citing the work of Powell (1972), they regard the possible orientations as either humanitarian or professional; the latter indicating greater possession of technical skills. This work raises the question of whether student midwives entering training with strong humanitarian ideals are unaware of the large technical and bureaucratic component of midwifery (Gray and Smail, 1982); and, on being brought into contact with reality by their training encounter difficulty in reconciling their ideals with reality. This gives rise to the dissonance mentioned by other writers, such as Freeman and Festinger and which is resolved in the ways stated by these authors.

In a Japanese school the value orientations of student nurses were examined in relation to religious identity and career decisions (Croog et al., 1968). These characteristics were assessed at the beginning of training and on completion. The earlier observations show the students to be more idealistic (52% of the Christians showed this characteristic, whereas only 23% were in the "pragmatic" group). The other main religious group, the Buddhist-Shintoists, showed more pragmatism early in training (64% were pragmatic and 18% were idealistic). When the researchers re-examined the students' value orientations on completion, they found that both groups had become more pragmatic and less idealistic in their views. This suggests that changes in value orientation are associated with socialisation into nursing and reflect the difference between the students when starting training and the

group to which they aspire, that is, nurses. This work supports Festinger, as Croog demonstrates one method of reducing dissonance between the individual's attitudes and those of the group she wishes to join; that is, by obtaining new dissonance-reducing information and ideas which result in greater congruity or confluence between the two sets of attitudes. Croog _et al_. suggest that such a great degree of personal adaptation to achieve occupational socialisation may be unacceptable to those with strongly held idealistic views. As described by Cotter (1982) these are nurses in whom dissonance-reducing mechanisms are inadequate, resulting in the persons withdrawal from the unsatisfactory environment, that is, the employment.

3.3.2. Variations in Practice

Although the present study does not probe this area the effect of the training environment is clear from a study of the career intentions of medical students, which attempted to correlate the medical school or area of practice with the career plans (Martin and Boddy, 1962). The authors identify strong positive correlations, indicating the influence of the educational background on career intentions. Though not sought in the present study, Golden (1979) has demonstrated the great variation in practice between different maternity units, so, on the basis of the work of Martin and Boddy, it may be assumed that these variations influence new midwives' employment decisions.

3.3.3. Conditions of Work

Certain aspects of the environment in which nurses and midwives work have been shown to influence the employees' view of the job, and thus the employment decision to continue.

3.3.3.1. Conditions of Work - Hierarchy

The nursing hierarchy as a component of the system (Section

3.3.3.2., Page 45) is significant due to its perceived effect on junior grades and their retention. Manpower data indicates that the Scottish midwifery service is over-endowed with managers compared with other areas, supporting the perception of imbalance, which is aggravated by perceptions of staff shortages at other levels.

Reference has already been made to the perception of the "system" within nursing as legitimate or otherwise (Bendall & Pembrey, 1972). This "system" is examined in detail by Menzies (1961) and Revans (1964), who conclude that the nursing hierarchy is a crucial component of the system. The problems caused by this hierarchy to a nurse at its base are vividly, if subjectively, described by Cotter (1982) in her account of her reasons for leaving nursing. Cotter identifies two main factors which prevent what she considers to be appropriate nursing care, and suggests that these two factors aggravate each other. The underlying factor is the shortage of nurses, which is aggravated by the unsupportive attitudes of senior nursing staff. Cotter is an example of the idealist nurse described by Croog et al., or Bendall and Pembrey's moralist nurse, who perceives the system as illegitimate.

Comparing US and other countries' hospitals, Glaser (1963) recognises the vigour of nursing hierarchies outside America, suggesting that Americans' competitive personalities prevent the evolution of rigid hierarchical structures. The presence of a nursing hierarchy, similar to that described by Cotter and Glaser is identified in midwifery in Scotland (Gray and Smail, 1982). Referring to the effects of societal changes on nurse employment, they show the significance of the three-fold increase in the numbers of unqualified staff, which changes the role of nurse or midwife from practitioner to supervisor.

Gray and Smail reveal the large numbers of nursing staff in administrative grades in midwifery, compared with other grades of nursing, 13.9% of midwives are administrators, whereas only 9.8% of nurses in general nursing are in administrative grades. On the basis of these data, which demonstrate the existence of a strong nursing hierarchy in midwifery, it is necessary to question whether this is due to deliberate policy or to a genuine shortage of midwives providing patient care.

Gray and Smail maintain that the proportion of nursing, including midwifery, staff in Scotland working in maternity units fell from a peak of 10.9% in 1966 to 8.6% in 1979, but this does not establish the existence of the shortage described by some authors (Burslem, 1979). An attempt was made by Robinson (1980) to ascertain the existence, extent and effects of shortages of midwives in England and Wales. Although Robinson maintains that she achieved her aims and described both the effects and extent of midwife shortages, she does not really establish their existence, but only the perception of their existence by staff working in certain areas, this perception usually relating to "establishment levels". The distinction between real and perceived shortages may be irrelevant as they are likely to produce similar effects on staff, and thus indirectly on patient care.

3.3.3.2. Conditions of Work - Support Systems

The perception of an unwieldy nursing hierarchy has been shown to aggravate the unsupportive nature of nursing relationships.

The problem of a high level of student nurse attrition was the starting point for a major study by Revans (1964) on staff relations within hospitals. Drawing comparisons between inter-staff relationships and staff-patient relationships. He identifies the major problem

of projection of an individual's own shortcomings on to other people. Partly due to this phenomenon, termed "parataxis" (misconceptions about what others are supposed to know and do), the problem of a lack of a support system is identified at all levels, which in turn produces a cycle of projection of shortcomings.

Examining the coping mechanisms used in nursing to defend against anxiety, Menzies (1961) found high levels of tension, distress and anxiety. She links this with the tendency of nurses to undertake post-certificate training, but the nature of this link is not entirely clear. It may be that, as a learner, the nurse is exempt from the anxieties and obligations of qualified staff. According to Revans, however, poor interpersonal relations exist at all levels, including between learners and others. One of the coping mechanisms identified by Menzies is "ritualisation" of tasks to eliminate the need for decision making; this is one of the possibilities available to the expedient, or non-idealist, nurse experiencing role conflict. Menzies further describes "ritualisation" as a hazard of unresolved diss-onance; incomplete reduction of dissonance (Freeman's "adjustment to dissonance") may result in secondary anxiety which has long term effects, but the effect on employment decisions is more short term.

3.3.3.3. Conditions of Work - Salary

In a discussion of the effects of the extension of midwifery training on the recruitment of student and qualified midwives in the South East Thames Region, Johnson (1981) anticipates that, unless extra training is recognised in the form of extra remuneration, it will become even more difficult to attract staff into the midwifery field. By drawing on the work of Burslem (1979), this argument may be taken a stage further, as he draws unfavourable comparisons between

the salaries of midwives and those of their health visitor colleagues. The present study should reveal whether dissatisfaction exists among new midwives.

Surveying the opinions of midwifery teachers, Dickie (1979) reveals their attitudes to the extension of training. In addition to disclosing certain fears concerning resources being made available to implement the extension of training, Dickie demonstrates certain misgivings concerning recruitment to the longer training. At the time of writing, these fears have not proved to be well founded, but the long term effects of the extension on recruitment to midwifery training remain to be seen.

3.3.4. Occupational Socialisation of Midwives

The process of occupational socialisation should be completed during training as it occurs when a person joins a new occupational group, it is defined by Merton <u>et al</u>. (1957) as:

> "... the processes by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short, the culture - current in the groups of which they are, or seek to become, a member. It refers to learning social roles".

Incomplete socialisation is one reason for non-retention; this is discussed by Williams (1979) who anticipates the extension of midwifery training, suggesting that the twelve month course is too short to permit the majority of student midwives to achieve socialisation. The result is that, on qualifying, the student has not reached the stage of identification with the work and pride in the occupational title which Becker and Carper (1956) regard as essential to complete socialisation. Williams predicts that occupational socialisation is more likely to be achieved by more student midwives with the extension of midwifery training. This more complete socialisation, she believes,

would improve the retention of new midwives.

3.3.4.1. Features of Occupational Socialisation

The characteristics of socialisation, with particular reference to the student's passive/active contribution, may be related to student midwives.

Occupational socialisation progresses over a variable time period and involves a number of component processes occurring simultaneously. These processes have been described with differing emphases.

Measuring the socialisation of student and pupil nurses, Heyman et al. (1983) describe certain aspects of occupational socialisation. They assessed the attraction, identification and congruence of learners to/with what the authors term "medical roles". Heyman demonstrated not only an increase in the aspects already mentioned, but also a decrease in the learners' identification with certain "low status non-medical" occupations. In terms of their definition of socialisation - "psychological closeness and more psychological distance from alternative low status occupations" - these authors demonstrate increasing socialisation during nurse training, but they admit their inability to identify the cause. It may be assumed that such changes are due to nurse training, but as they confess "the changes could theoretically be due to maturational or testing factors" or, it could be added, any number of extraneous variables.

A subjective report of "professional socialisation" is presented by Davis (1975). This is apt as he defines socialisation as a passive process. Davis describes the socio-psychological processes by which the students' self perceptions change - or rather, are changed - to those which nursing ascribes to itself.

Davis discusses the six stages of occupational socialisation,

which he terms "doctrinal conversion", during which the student moves from the lay imagery of the beginner to the "institutionally approved" imagery of the graduating student. Davis' first stage is "initial innocence" with the emphasis on doing tasks to help people, this stage passes slowly, and reluctantly the student moves into the second stage which is "labelled recognition of incongruity". During this stage the student is, sometimes painfully, aware that the long and firmly held views about what constitutes nursing are no longer valid. The conflict engendered during the second stage is resolved to some extent in the third stage. This is "psyching out", during which the student becomes worldly wise, identifying desirable rewards and having the ability to manipulate the system to obtain these rewards. The fourth stage is the observable behaviour resulting from the knowledge gained during the third stage; "role simulation" is when, in spite of continuing doubts and misgivings about what nursing really is, the student demonstrates the behaviours of which the training institution is known to approve. These four stages pass rapidly and are followed by two stages in which the previous four are consolidated. These comparatively slow final stages are "provisional and stable internalisation".

Melia (1981) studied the occupational socialisation of student nurses, illuminating the active/passive debate and demonstrating some differences from Davis' study. She initially uses Simpson's passive definition of occupational socialisation - "the conversion of the layman to the finished product by the influence of the system" (1979). Her work suggests that student nurses play a more active role in their socialisation, an important difference from Davis' observations. She goes on to describe the techniques which the students first learn and

then use, to manipulate the system. These techniques are manoeuvres, similar to the stages detailed by Davis, which the students use to achieve certain goals which they identify; these goals include: "getting the work done", "learning the rules" and "doing nursing and being professional". The manoeuvres which the students learn to use are: "coping with the dark", which enables the student to care for the patient in the absence of adequate knowledge about the patient and about the information which has been given: "fobbing off" is another manoeuvre which is used when the student lacks knowledge, or is working under instructions not to impart knowledge. "Fobbing off" involves evading direct questions or telling a "wee white lie".

It is clear from Melia's (1982) examples that these nurses are being socialised into being students. The extent to which these manoeuvres will be appropriate when the nurse is qualified is not addressed. It may be suggested that these manoeuvres should not be necessary for the staff nurse to use, due to her ability to control the difficult situations, such as patient teaching/information giving; this suggestion would support the contention that such manoeuvres are only part of the socialisation to being a student nurse, which may not be valid, because, as mentioned by Melia (1982:333) the nurse may not actually be in control of the information given to a patient:

> "If a consultant does not wish a patient to be told the diagnosis, then the nursing staff are not in a position to ignore this decision".

So, on the basis of these examples it may be deduced that the manoeuvres learned by student nurses will be used by them when they are qualified nurses. The socialisation of students may, therefore, be socialisation into the student role, but this is not irrelevant to the qualified nurse, as additional socialisation is superimposed on the

pre-existing knowledge on qualifying. Davis indicates that there may be "further revisions, transformations or even regressions in the student's doctrinal identity" (1975:130) depending on a wide range of contingencies.

Thus, occupational socialisation begins during training, due to the activity of the learner, but the knowledge gained is appropriate to other grades.

3.3.4.2. A Problem of Occupational Socialisation - Professional Status

A certain phenomenon currently occurring in midwifery may hamper the socialisation of student midwives, inevitably affecting their employment decisions and retention. This is the changing professional status of midwifery.

In considering the position of midwifery a description of the ultimate occupational category provides a benchmark with which it may be compared. Carr-Saunders and Wilson (1933) provide this benchmark in their scrutiny of the characteristics of the classical professions, law and medicine. Describing the relations between the classical professions and other occupational groups, they state that the former possess defined characteristics and that:

> "all around them on all sides are grouped vocations exhibiting some but not all of these features".

It must be assumed that midwifery is one of the vocations which are "grouped around".

During their "prolonged and specialised intellectual training" these professionals, develop a sense of responsibility for their practice. Illsley (1980:60), however, disregards the need for lengthy training for the acquisition of professional status; stating that these, along with ethical codes and the predominance of clients' interests, are of value only in their ability to persuade the public

of professional status.

During training the professional is imbued with a technique which is unique to that profession; the technique may be founded on either scientific or institutional (human) knowledge, but the practice of the technique is inseparable from the body of theoretical knowlege on which it is based. Carr-Saunders and Wilson compare nurses and midwives with doctors, veterinary surgeons and dentists; the latter, it is claimed, study a wide area, more or less directly related to their subject, whereas midwives "are concerned only with the applications of science". The midwives' case is strengthened by their direct personal contact with their clients, which imbues the relationship with a greater responsibility. This relationship is devalued if money fails to change hands, that is when the practitioner is salaried. This feature, the authors admit, is comparatively minor when compared with others, such as technique.

Katz (1969) endorses the view of the importance of the technique and body of knowledge, applying it to semi-professionals, such as nurses. The legitimacy of the distinct body of knowledge and, thus, the professional contribution of those holding it, must be recognised by coterminous groups. Katz offers a grim picture of the occupational status of nurses. The proximity of "physicians and hospital administrators" decreases the likelihood of nursing gaining recognition, as these groups are unlikely to recognise or legitimate nursing. To Katz' catalogue of unlikely legitimators may be added, in the context of midwifery, the plethora of lay groups, whose area of expertise and knowledge overlaps with that of midwives; in the same way as much midwifery knowledge is common to, and derived from, medical sources.

Having considered the significance of a unique body of knowledge,

it is necessary to examine the source of such knowledge. Greenwood (1966) discusses the importance of theory construction (via systematic research) to a professional group. He details the necessity of theory development, which will provide a valid base on which techniques or practice can be built. Whether this unique, research-based body of knowledge exists in midwifery is doubtful; it might even be suggested, as has been implied in the last paragraph, that midwives use medical knowledge in preference to developing midwifery theory.

Greenwood then goes on to describe the uncomfortable role of the researcher-theoretician, who evolves in every profession; the discomfort being due to their difficult position straddling the chasm between the "division of labour", by which is meant the separation of service oriented practitioners and theory oriented educationalists. This separation has been well documented in the case of nursing (Melia, 1984; Macguire, 1961; Hunt, 1974; Bendall, 1973).

A final and crucial feature which serves to define professions, against which the occupational status of midwifery may be measured, is the degree of control or power exhibited by each occupational group. Freidson (1977) discusses the role of occupational monopoly and dominance in relation to the future of professionalism. He states the orthodox view of the ability to control one's own work as an indicator of professional status - more autonomy indicating higher status. Freidson extends this orthodox view by adding the ability of professionals to control the market or the access of clients, and the political implications. In addition to internal power, influence in the wider political arena is necessary, either by overtly political activity of members of the group or by the ability of members to influence those outside the occupation who do wield political power.

Freidson continues by suggesting that those occupations in which there is control by a dominant profession, or control by the state, are unlikely to break free of such controls in order to exert power themselves and establish themselves; they are "bound into occupationally subordinate positions" (1977:25).

3.3.4.3. Professionalisation of Midwifery

Discussion of the characteristics of professions, inevitably raises the question of whether and to what extent midwifery manifests these characteristics.

The place of power in professional status is pertinent to midwives as they have, in former times, exerted such power (Donnison, 1972). Controlling the market was a salient feature of the midwives who practised privately, before the establishment of the NHS. This characteristic may be re-emerging, as exemplified by the increasing proportion of midwives on the statutory bodies, and also by the increase in the numbers of self-employed, independent midwives. Freidson's pessimistic assessment of the relationship of certain occupations with the state and with other dominant professions may counterbalance the optimism engendered by these emerging phenomena.

It may be concluded that claims to professional status by midwives are not, at least in sociological terms, well founded. It cannot be denied that midwives are certainly contenders for professional status, as demonstrated by the frequent references to them in the literature. This notion of a contender for professional status is reminiscent of the analogy of various occupations being "grouped around" the classical professions, sharing some, but not all of their characteristics. This analogy suggests that although the ultimate professions are being described, there are other occupational groups

showing varying degrees of professionalism. Such groups are undergoing a process of change in their occupational status, which is known as professionalisation. This process is a continuum on which the various professional groups are moving in relation to professional status, the movement being in either direction (Goode, 1966). Early twentieth century midwives may be regarded as moving away from professional status, losing both political power and control over their own market.

Certain features of nursing have been attributed to its changing professional status. Nursing in USA is demanding increasingly high educational standards as a method of attaining professional status (Glaser, 1963). This process is contrasted with the situation in other countries, in which the higher occupational status is being achieved by increasing bureaucratisation. Illsley (1980), citing the the UK situation, endorses the views expressed by Glaser. The work of Menzies (1961) and Revans (1964) certainly supports the existence of more bureaucratisation within nursing, but these authors suggest that its value is to increase the personal self-esteem of the nurse, rather than increasing the professional status of the occupational group.

The significance of a well-defined administrative structure is examined by Mercer (1981), exemplifying occupational therapists and physiotherapists. The professionalisation of these groups relates to their comparatively recent release from medical domination. Their new found autonomy is now being threatened by a new and even less appropriate external occupational group - the lay administrators. Although Mercer fails to include nurses in his 'sample', this summary of the history and future of the professions supplementary to medicine is remarkably similar to that of nurses.

A more recent development which serves to reinforce the anxieties

for the future expressed by Mercer is the Griffiths (1983) proposals. It may be argued that the introduction of general managers, possibly from outwith the health care system, poses a further threat to the professionalisation of many groups within the NHS; the extent of this threat is uncertain at the time of writing.

Further anxiety is engendered by Griffiths' frequent reference to "clinicians", who, it may be assumed, are the "doctors" who are also mentioned; this may be contrasted with Griffiths' almost total neglect of nurses or nurse-managers. If, as has been suggested by Glaser (1963), Illsley (1980) and Mercer (1981), administrative power does contribute to professionalisation, then Griffiths' proposals and their implementation constitute a serious bar to any development of the occupational status of nurses and midwives. It is necessary to concede that the changes advocated by Griffiths refer only to England and Wales; the equivalent document detailing the proposals for the Scottish health service (Weeple, 1984) although receiving less publicity took a firmer line in favour of non-nursing contributions to health service management at the "grass roots" level (Weeple, Section 7). The increased nursing input into top level management may have compensated for this omission (Weeple, Section 3).

The rationale for this examination of occupational socialisation relates to the difficulty of completing occupational socialisation in an occupation which is undergoing professionalisation. This is due to the new members' inablity to perceive the occupation as either professional or non-professional (Bucher and Strauss, 1961). It is for this reason that a study of occupational socialisation and professionalisation is necessary when considering new midwives employment decisions.

3.3.4.4. The Future of Professions

The evolution of professions and midwives' claims to professional status are apparent to the new midwife making the employment decision. For this reason it is necessary to consider the desirability and future of these institutions and the emergence of another group with a similar effect in maternity care.

Contemplating the likely directions for professions' development, Freidson (1977) considers the implications of the recently increased availability of professional status. He questions the value of the term itself as it has long ceased to describe the individual's work. That control over one's work is an essential feature of a professional has been mentioned already; this feature is used by Freidson to suggest the decline of professionalism. He maintains that increasing specialisation creates professionals who are more interdependent - that is, less able to control their own work. He cites the example of the pharmacist and the physician needing to cooperate to provide appropriate drug therapy for a patient. Large multinational corporations and the national health service are examples which provide good supporting evidence to this argument; in both, the number of people who work independently and could, therefore, claim professional status, is few. Freidson also draws on the decline in self-employment, particularly in health care, as evidence of "deprofessionalisation".

Deprofessionalisation is defined as "the loss to professional occupations of their unique qualities", such as knowledge monopoly, public belief in the service ethic, work autonomy and authority over the client (Haug, 1973). Like Freidson, Haug considers that increasing specialisation poses a threat to professionalism, but for a different reason. As greater specialisation requires the possession of narrower

and deeper knowledge, reliance on non-human memory stores increases. Dependence on technology, particularly computers, means that knowledge is no longer monopolised by professionals, but is available to anyone who has the ability and opportunity to seek it. Haug believes that the information technology explosion has undermined the traditional client/ professional relationship by enabling the client to become better informed, more questioning and, inevitably, more critical of professional services. She continues by summarising the disadvantages of the traditional system of professional power, and then predicts changes in the balance of power amounting (in her words) to a "tug-of-war". In such a conflict, she anticipates that the term professional will become obsolete or even pejorative "a symbol of an earlier, pre-modern era" (1973:208).

Haug (1973) also considers an inevitable development associated with deprofessionalisation; citing Pearl and Reissman (1965), she examines the contribution of lay workers who are "preferably from the clientele". The lay worker phenomenon involves a multitude of lay groups which provide, on either a national or a local basis, a wide range of services to childbearing women. Lay groups are envisaged by some professionals as a threat to their status on the grounds that their monopoly of knowledge is being compromised. The alternative response by "professionals" to lay groups (Haug, 1973:208) has also been observed by this writer. Haug reveals how "the cream of the paraprofessionals" is absorbed into the orthodox system. The lever for such an elevation is the desire of the lay workers for acceptance by the system. Haug mentions, perhaps inadvertently, that such elevation is controlled by the traditional professionals, thus reinforcing their own control.

The insitutionalisation of paraprofessional work does little to improve the service offered to clients. Institutionalisation has been witnessed by this writer in the case of the lay groups providing services to pregnant women. These groups, perhaps in association with their growth, have developed a hierarchy similar to that encountered in nursing and midwifery.

3.4. Employment Decisions on Completing Training

The large-scale effects of these decisions are scrutinised after consideration of the feasibility of this decision.

3.4.1. Midwifery and Comparable Areas

The employment decision has been shown to be influenced by personality and the work environment. Because of the manpower implications the role of managers in attracting personnel is crucial.

Matching personality characteristics to job characteristics is, according to Singh and MacGuire (1971) of prime importance in career counselling. Personality characteristics may be assessed by seeking the most important reasons for the individual's choice of career, rather than using complex psychological tests. Singh and MacGuire do, perhaps inadvertently, reveal a weakness of such an aid to career counselling; they discuss the effects of nurse training on personality development, indicating that personality is not static, but that its development is a dynamic process affected by a range of variables. It may be that this aid to career choice is of short term value, in employment decision making, rather than the longer term career choice which they purport to discuss.

Inappropriate career decisions are associated with incorrect self-perception (Singh and MacGuire, 1971), resulting in mismatch between occupation and personality. This supports the contention of

Loree and Leckie (1977), that understanding one's own life situation is necessary for sound career decisions. Singh and MacGuire fail to consider the individual's perception of the chosen career.

The Dan Mason Nursing Research Committee (1956) examined nurses' attitudes when, like the present study, they were newly qualified. The nurses were dissatisfied generally with three aspects of nursing; these were salaries, poor hours of work and poor human relationships, although it is not made clear whether there is any correlation between dissatisfaction and employment decisions. This work demonstrates the reluctance of nurses to leave nursing, despite considerable dissatisfaction. The marked loss due to domestic commitments suggests that these were "acceptable" reasons disguising "unacceptable" motives.

The existence of this deception is supported by the work of Cunningham (1979). Her study of staff nurses and their reasons for leaving suggests that they give what they regard as "acceptable" reasons for leaving, which are not necessarily genuine. Threats to what they perceive to be appropriate standards of nursing cause them to leave in order to preserve their own standards. This accords with the arguments of other authors, such as Cotter (1982) who maintains that nurses leave for "idealistic" reasons.

An account of manpower planning in occupational therapy, (Blunt, 1981) demonstrates that this profession supplementary to medicine shares a problem encountered in midwifery in Scotland. This is the problem of retaining qualified occupational therapists (OTs) in view of their short working lives. The duration of the working lives of midwives, unlike that of OTs has been well documented (Moores, 1980). Blunt decribes the health region under discussion as a "net exporter" of OTs to the extent that 67% of OTs trained there practise outside

the region. This situation is comparable with midwifery in Scotland (Mander, 1980) where, in a single year, 69.7% of new midwives failed to practise in the country where they trained. 35% of these indicated their intention to practise in another country.

Bringing an economist's insight, Altman (1970) considers the significance of the employment decision on completion of nurse training. Altman states that retention of trained staff is crucial if profits are to accrue to the training institution, but he fails to indicate how this retention may be achieved. One of his reasons for a "home grown" policy is that induction programmes are unnecessary for such staff, thus reducing recruitment costs. This indicates one value of being able to retain staff. Altman's economic analysis of the benefits of retaining newly trained staff considers the savings in the costs of induction programmes, but omits to consider the non-financial benefits of retaining them, in terms of the existence of a stable work force. Although his arguments are applied to individual institutions in the USA, they are relevant in national terms in the context of the present study. This is because the technical (nursing and midwifery) and social characteristics of other countries, even within the UK, may be sufficiently different from those of Scotland to justify the recommending the retention of "home grown" midwives.

Considering the employment decision following a period of "time out", Cleland et al. (1973) describe the role of the employer in attracting nurses back into employment. They conclude that employers should experiment with methods of attracting recruits, to discover the "package" which is most successful in their area.

3.4.2. Effects of a Predominantly Female Work Force

The short term, possibly inconstant, pattern of women's

employment is well-documented, but responses are variable.

The changing role of women as a form of identity stress is exacerbated by socialisation into nursing (Davis & Oleson, 1963). Conflict between the extension of her role as a woman and the increasing conformity of becoming a nurse are a cause of the dissonance which has already been discussed. They associate this conflict with poor rates of retention. The scant attention paid to extra-occupational factors, such as the women's movement, is regretted, attributing this disregard to the inability of managers to control such factors.

It is possible that certain factors are not amenable to action by employers, Price and Mueller (1981), cite the presence of children and increasing age are factors associated with taking up nursing employment. These factors, along with non-labour income, may also prevent the nurse taking up employment. It may be concluded that the supply of nurses to the labour market is affected by the factors which affect all women, and that no action on the part of employers can affect these "women factors".

The intractibility of "women factors", regretted by Davis and Oleson (1963) is refuted by Cleland _et al_. (1976). They perceive these factors as a challenge to managers, rather than an insoluble difficulty, stating:

> "Nursing must recognise low labour force paticipation as a problem to be solved, rather than an inevitable association with a woman's profession".

3.5. Areas Affected by the Employment Decision

The significance of the employment decision to the employer or the organisation may be measured in financial or other terms.

3.5.1. Manpower/Wastage

The non-financial costs of turnover include a lowering of morale,

reduction of efficiency, and the need to recruit/train replacements (DHSS/NHS Subgroup, 1975). Depending on the occupational status of midwifery with regard to nursing, the non-retention of new midwives may be considered to be turnover or wastage (See Appendix A).

In his well-known investigation of relationships in a hospital, Revans (1964) examined the problem of turnover. He concludes that there is a strong negative correlation between duration of staff employment and the duration of patient stay, suggesting that the turnover rates in midwifery should be very low.

Engleman (1977) discusses the problems of manpower planning in medicine, addressing the twin problems of ensuring the correct supply of manpower in terms of both quantity and quality. Using population forecasts to estimate future demand for, and supply of, midwives would be appropriate, as the birthrate is one of the variables which directly affects the quantity of work for midwives and, eventually, the supply of suitable recruits.

An assessment of midwifery manpower planning is made by Moores (1980). He observes that recruitment to midwifery is unrelated to the demand for midwives, but depends on the number of training places available; this applies to recruitment to midwifery training. In this respect Scottish midwifery differs from that in England and Wales, in that the statutory bodies for England and Wales determine the number of training places in each school and, thus, throughout the countries. In Scotland each training institution decides how many student midwives will be employed, limiting the possibility of national planning.

Moores continues by discussing estimation of workload and staffing requirements, and devises a pupil (now student) midwives' survival curve. This may, he suggests, be computerised and used to

predict future training needs. This would appear to present a satisfactory solution to midwifery manpower difficulties, but it fails to take into account the fluctuation in demand and the prediction of that fluctuation. Moores observes that the investment in midwifery training is disproportionately large, compared to the total numbers employed, supporting the need for better selection of student midwives.

A study comparing the attitudes of stayers and leavers to their work, as well as personal and other characteristics, showed no significant differences between stayers' and leavers' characteristics. Seybolt et al. (1978) did find that the leavers were less satisfied and more frustrated with their work. Seybolt and Walker (1980) recommend the use of an attitude survey as a means of reducing turnover, this recommendation is based on the findings of Seybolt's earlier study; the main recommendation of which is that two directional communication should improve staff perception of their own work and reduce turnover. No data are given on the implementation of this method of using an attitude survey or of its effect on turnover.

3.5.2. Economic Effects of the Employment Decision

Moores (1979) attempted a cost-effectiveness analysis of general nurse training, with limited success in the absence of an agreed product (Williams and Anderson, 1975), other than trained nurses. This analysis, however, provides a valuable discussion of the costs of general nurse training, with some indication of the measures which would assess the effectiveness of a training programme. Moores' observations of general nurse training may apply to midwifery and his statement "a trainee ... is no longer a cheap commodity" is even more relevant since the extension of midwifery training. Moores does not consider the costs of students who, like so many student midwives,

never use the skills in which they have been trained; this omission may be due to the small numbers to whom it applies in general nursing.

An economic analysis of the costs of graduates training to work in primary care provides a detailed breakdown of all costs, allocating fixed and variable costs (Stern et al., 1977). Teaching costs vary according to the teaching methods used (group or individual) also the stage of development of the programme, new programmes being more expensive than established ones. Costs are lower if a student has had work experience prior to joining the course; whether this applies to student midwives is difficult to assess, but the present study may reveal the extent to which training costs are reimbursed by practice. The entrepreneurial nature of health care in USA, where Stern's study was undertaken, makes an economic analysis feasible when care is provided on a "fee for service" basis, as opposed to the "free at the point of receipt" principle on which the UK health service is based.

3.6. Midwifery as a Secondary Career

Midwifery as a secondary career has certain attractions, it has been defined as:

> "a career which a woman takes up or resumes after interruption of employment". (Seear, 1971)

Employing women as midwives after the completion of their child-bearing/rearing career is recommended as one method of achieving a more stable work force (SHHD,1974) on the basis of a countrywide survey of hospital nursing staff, their personal and employment characteristics. This recommendation would appear, on the basis of the work of Gray and Smail (1982), to have been implemented. These authors report that, using 1959 as the index year in which the number of part time workers in midwifery is regarded as 100, the index number rose to 878 in 1979. The equivalent increase in mental illness and mental

handicap nursing being 331 and 598 respectively. These data do not reveal the hours worked, but if these part time midwifery staff each work only a small number of hours, no increase in the number of midwifery/hours being worked results. The employment stability of these workers might become less significant than the poor continuity of patient care.

The work of Jope (1980) on the career patterns of graduate nurses demonstrates the interrupted nature of these careers. The final stage of the career pattern sequence is part time employment, a factor which, according to Gray and Smail (1982) is already being utilised by nurse managers.

3.7. Summary

This literature review has shown that a variety of factors are associated with the decision to leave or continue in employment. The literature suggests that the problem of retention is amenable to managerial intervention, probably by utilising predictors of continuing practice, although organisational difficulties also require attention. These difficulties include the non-wage returns to the employee and the conflicts associated with working in a hierarchical organisation experiencing staff shortages. During training the student is socialised into midwifery, but this process may be incomplete due to professionalisation of midwifery. Manpower factors associated with the majority of midwives being female may be interpreted as advantageous or challenging, but are likely to become inceasingly significant.

CHAPTER 4

THE RESEARCH METHOD

This chapter on the method begins with a discussion of the concepts which influenced the design. This is followed by a critical examination of the techniques, the rationale underlying their use and their implementation. The final parts of this chapter comprise a scrutiny of the method and the pretest, concentrating on any limitations which may have affected the research.

When undertaking a research project such as this, it is essential that the researcher should adopt a flexible approach to its design. Inevitably, there will be some aspects which will be identified as less than perfect, some of which will require amendment during the course of the research. An example in the present study is the item requesting the educational qualifications, in which many Stage I respondents confused CSEs and SCEs and which was rectified in Stage II. Other aspects with which the researcher may be dissatisfied may be less amenable to correction. These aspects are discussed in this chapter after the description of the method, alerting the reader to problems encountered and facilitating replication.

4.1. Concepts influencing the Research Design

4.1.1. Evaluation

> "Evaluation is ... assessing the worth or value of an object or activity" (Goldberg & Connelly, 1982)

Though evaluation is regarded by some health care planners as an integral component of the planning process (Bennett and Lumsdaine, 1975), the "Guidelines for the Extension of Training" (CMB[S], 1977) omitted any form of evaluation to follow this momentous change. This omission tends to support the view stated in the Perrin Report (DHSS,

1978) on the management of resources in the NHS:

"evaluation is more frequently recommended than practised".

These conflicting recommendations and practices raise the question of why evaluation is considered to be so necessary? Five reasons are given for this view: as already mentioned, evaluation is a planning tool, to assist decisions about the deployment of scarce resources, including finance as well as personnel. The second reason is the assessment of the effectiveness of the programme, particularly its impact on the client or consumer. This reason may be extended to relate to the third reason for evaluation, that of economic analysis - the cost-effectiveness of the programme. The fourth reason is to act as a "brake on the new", that is, preventing changes with long term consequences being implemented because of the whim of fashion. The last and probably the most important reason is that evaluation permits monitoring of the system or process under investigation (Goldberg & Connelly, 1982).

The subject of the evaluation may be a person, a programme, a product or an institution. In the context of the present study the evaluation is of a programme (the extended midwifery course). Goldberg and Connelly state that the problems inherent in programme evaluation, especially one involving a human being acquiring new skills, are that they verge on person evaluation. This invidious evaluation is fraught with the problems associated with personality assessment and to these must be added the occasional inconsistencies in any programme, when a:

> "generally effective and viable institution may turn out an unfortunate product ... the black sheep of a good family or college"
> (Bennett & Lumsdaine, 1975:4).

It must be accepted that the reverse may also occur. Thus, programme evaluation raises a range of problems, perhaps explaining why it tends

to be avoided.

Another feature which may also contribute to this tendency is the need for clearly formulated objectives with which to compare the programme. Although the need for such objectives is neglected in much of the work on evaluation, Abramson (1974:23) considers these to be vital to the assessment of the effectiveness of a programme: "for adequate evaluation the goals must be stated very specifically" and that the development of such goals is essential to the planning process. The possibility of evaluation in the absence of clearly stated objectives is also considered. Others state unequivocally the need for "evaluative criteria" against which success or failure of a programme may be measured, but the need to develop these criteria prior to the implementation of the programme is not mentioned (Goldberg & Connelly, 1982; Bennett & Lumsdaine, 1975). Thus, it is necessary to conclude that the "objectives" are not necessarily synonymous with "criteria of measurement" and that, despite evaluation not featuring in the original plan, the programme may still be evaluated with validity.

A further conclusion which may be drawn is that in assessing the success of a programme, different criteria may be selected as measures of outcome. As in Abramson's example (an antenatal programme) a multiplicity of aims are set to be achieved, the extension of midwifery training was expected to achieve various aims, although the only aim stated by the official guidelines was that of achieving reciprocity with other E.E.C. states. Despite this dearth of aims the achievement of the other expectations may be measured to assess the extent to which they have been met and, indirectly, the success of the extension of training. An expectation held widely by midwives was that retention

in midwifery would improve (Williams, 1979); this is the evaluative criterion being used in the present study.

4.1.2. Experiment

Stage I of this research project compared the employment intentions of a group of students at predetermined times (prior to and on completion of midwifery training), a process subsequently repeated using a different group of students to further compare the two groups and evaluate the extension. The similarities between the design of the present study and that of the classical experiment soon became apparent. In view of the power of the experimental approach, these similarities deserve scrutiny, to assess the extent to which the present study may be regarded as experimental and claim the associated power. The comparison of the Beginners' and Completers' data draws on this concept (Chapter 8, Page 164).

4.1.2.1. Strengths of the Experiment

> "The controlled experiment is a powerful design for testing hypotheses of causal relationships among variables. Ideally in the experimental design the experimenter throws into sharp relief the explanatory variables in which he is interested, controlling or manipulating the independent variable (x), observing its effect on the dependent variable (y) and minimising the effects of the extraneous variables which may confound his result". (Riley, 1963:612)

Claims of the strength of the experiment are made on the grounds of certain features, such as its ability to demonstrate not only the existence of causality but also its direction (Simon, 1969:237). In the classical experiment changes in the dependent variable <u>must</u> be caused by the manipulation of the independent variable. The scrutiny of the factors associated with a situation, leading to the identification of variables, is a crucial prerequisite which lends further rigour to the experiment. The correct measuring tool, to assess changes in the presence, absence or quality of the dependent variable,

is vital to the experiment, although all too often it is the weak link in the research design (Fox, 1982:182). In the research setting, power is increased by identifying and controlling extraneous variables to avoid any inconsistency in the data due to their inconstant effects.

Manipulation is essential to the experiment, but the concept of control is less clear, some even regard the two as synonymous. Manipulation is the more active process, whereas control is the measures taken to prevent any spontaneous alteration in the variables other than the dependent variable. The "Hawthorne effect" demonstrates manipulation in the absence of control.

4.1.2.2. Experiment in the Present Study

The midwifery training study, running twice, constitutes the first of the experiments in the present research; the independent variable is midwifery training and the dependent variable, the employment decision. The second experiment is the evaluation of the extension of training, which constitutes the independent variable, using the employment decision as the dependent variable. In this experiment (Figure 4.1.2.2.) Stage I (twelve months) is the control group and Stage II (eighteen months) the experiment group.

Figure 4.1.2.2. The Extension of Training Experiment

	Before		After
Control	Stage I Beginners		Stage I Completers
Experiment	Stage II Beginners	Extended Training	Stage II Completers

An important limitation in regarding the present study as experimental

is the absence of either control or manipulation by the researcher, making it comparable with a natural experiment.

4.1.2.3. The Present Study as a Natural Experiment

Natural experiments are defined in terms of the researcher's lack of control:

> "some force clearly unrelated to the dependent variable causes the variation in the independent variable". (Simon, 1969:121)

Lack of control is a major disadvantage of "real life" experiments:

> "One samples situations instead of producing them." (Anderson, 1969:24)

In the present study manipulation was by the statutory body. Anderson accepts the possibility of the manipulation being by a third party in the context of the natural experiment, endorsing its applicability here. The changing employment situation is particularly significant as an extraneous variable and illustrates the lack of control; it constitutes a historical variable due to its general environmental effect and a maturational variable due to its effect on student midwives' perceptions (Campbell & Stanley, 1968:7). The literature suggests that natural experiments, by precise matching, may overcome problems due to extraneous variables and ensure "meaningful conclusions" (Fox, 1982:176). Matching in the present study is near perfect, as the respondents act as their own controls.

4.1.2.4. Review

The conclusion which must be drawn is that the present study fails to meet the rigorous criteria of the true experiment, but that it corresponds with the definition of the natural experiment. Any claims to the strength of the experimental approach must, therefore, be moderated accordingly.

4.1.3. The Longitudinal Study

In attempting to relate changing employment decisions to other factors, particularly personal characteristics, the longitudinal approach is most suitable. One advantage of a longitudinal study is its ability to reveal certain differences between short term and long term findings - "Sometimes the long run actually reverses the short run direction" (Simon, 1969:149). A longitudinal design was, therefore, planned to reveal any changes in employment plans and practice. To facilitate even more extended observation the possibility of following the career patterns of the two groups of respondents was incorporated (Section 14.4.1.1., Page 288).

4.1.4. Replication

Replication, a "major characteristic" of scientific research (Simon, 1969:20), is defined as "repeating it with all of the essential elements of the original study retained" (Fox, 1982:82). The difficulties which social scientists encounter in achieving replicability, compared with the ease with which their colleagues in the physical sciences achieve this, are attributable to the less precise nature of the measuring tools used in social science research.

The question arises of whether replicability is even possible in social science research. On the grounds that in research involving human beings, no two groups can ever be identical, the basic criterion for replication is challenged (Fox, 1966:258). This argument is solved by a better definition of the sample used in the replication; while it may not be identical, it must be drawn from the same population using the same sampling technique. Replication is facilitated by reducing the need for interpretation of observations, as judgements greatly limit the objectivity of the work by introducing observer bias.

Replicability is doubly significant in the present study. First, to permit further studies in the same area, to check on the findings of the present study and demonstrate whether the present study has included any unidentified idiosyncrasies or artifacts. Although certain features of the present study are hardly replicable, other aspects could easily be reproduced.

Second, an attempt has been made to replicate the findings of certain earlier studies. The work of Golden (1979) and the National Florence Nightingale Memorial Committee (NFNMC, 1963) probed the views of students and midwives respectively. These studies have certain features in common with the present study, such as their focus on career intentions and the respondents' views about midwifery and midwifery training. Selected items from these questionnaires are being used and although this limited form of replicability does not reach the standard set by Fox it is hoped that useful comparisons may be made.

4.1.5. Generalisation

The comparisons with earlier studies, particularly the work of Golden (1979), should indicate the extent to which it is possible to generalise from the present study to other populations, England and Wales in Golden's case. Generalisation permits the extension of the implications of the data at hand to a broader population and it estimates the situation among other groups without incurring the costs involved in questioning every individual. The possibility of generalising the findings of a research study such as the present one to a wider population depends mainly on the nature of the sample and the extent to which it is representative of the population from which it is drawn and the one to which the work is to be generalised. In the

present study the data will be scrutinised to compare them with those produced in Golden's study and statistical tests applied to ascertain whether the population of student midwives in Scotland is part of the same population as those south of the border. Such an examination will determine the extent to which generalisation is possible.

Simon pleads for more generalisation by researchers, as he regrets their "supercautious" fear of overgeneralisation, possibly on the grounds of "jumping the rails and drawing unfounded inferences" (1969:28). This caution results in perfectly valid research being disregarded by practitioners because the researcher has been over critical of minute individual differences in the respondents.

4.1.6. Review

Evaluation, experiment, replicability and generaliseability have been identified as being significant in the design and implementation of this longitudinal study. The research method will now be examined.

4.2. Research Method

4.2.1. Research Approach

Having examined the extent to which this study may be regarded as an experiment (Section 4.1.2., Page 70), comparison with the survey demonstrates other features. A survey illuminates a current situation, as opposed to providing historical or retrospective data. The survey is further categorised according to the degree of judgement or comparison which is involved, this is useful in the present study as aspects of all three types of survey are identifiable. A descriptive survey makes "no judgements, no statements of quality, no evaluations; it only describes" (Fox, 1982:37). This description is a significant part of the present study as it not only facilitates generalisation but also provides much needed data on the characteristics of student

midwives in Scotland.

The comparative survey, which involves collecting two or more sets of data and making a comparative judgement, has certain elements in common with the analytical survey, which seeks to study the factors which determine the outcome of a process (Abramson, 1974). The common element is the study of the influences on a particular event. In the present study data are being collected at different times from different groups of people who have a common characteristic (student midwives). The outcome which is being observed is the decision regarding employment and personal and other characteristics are to be related to this outcome. The third type is the evaluative survey, discussed in Section 4.1.1. (Page 67).

As the present research involves features of descriptive, analytical and evaluative survey technique, it may be assumed that these are not discrete categories.

4.2.2. Survey

4.2.2.1. Design of the Survey

The longitudinal technique was chosen because a change in the expressed employment intentions is anticipated; if such a change is to be examined objectively it is necessary to avoid errors due to imperfect recall by the respondents.

The alternative approach would have been a cross sectional survey, which was used in the pretest of the present study. This technique may be preferred on the grounds of the considerable saving in time and that there is no possibility of the respondents becoming "test-wise" (Fox, 1982:167). This researcher considers that any deficiencies in the longitudinal approach are more than balanced by the benefits of the consistency of the sample, the lack of which

presented a major problem in the pretest (Mander, 1980). Statistical efficiency is facilitated by the virtually perfect consistency of this sample (Simon, 1969:286). Consistency, however, is not absolute due to general changes in all people over time. The most obvious example of this phenomenon in the present study is the changing employment situation associated with the economic recession, and its effects on midwifery employment. Another threat to consistency encountered in the present study is loss of participants to the study. The reduction in absolute numbers when students discontinue training is a minor problem in midwifery (Table 8.1.1., Page 165 & Mander, 1983). Of greater significance here is the loss to the study when students lose interest in this research or are over-exposed to others' research.

A trend study is a specific type of longitudinal survey, which applies to the Stage I/Stage II comparison. It is necessary to emphasise that although the same population is studied, the members of that population will inevitably change; this point is illustrated thus:

> "a trend study of attitudes among students at state university will reflect a different population of students each time a survey is conducted". (Babbie, 1973:63-4)

This example is fortuitously comparable with the present study, in which it is impossible for a student midwife to be sampled in both Stage I and Stage II. Trend studies' major disadvantage is their long period of data collection.

The comparison of beginners' and completers' views constitutes a panel study, because it comprises the collection of data over a period of time from the same <u>sample</u> of respondents. This involves repeating the questioning of all members of the panel, in an attempt to identify and analyse the characteristics of respondents who did or did not

change their minds about the topic, the "switchers" and "non-switchers" respectively. Of particular interest in the present study are the students who change their employment intentions during training, irrespective of the direction of change. A "turnover table" may be used to analyse the association between changing ones' mind and a given characteristic; this is an exercise which is being attempted in the present study to identify factors associated with continuing midwifery practice.

Thus, in describing the design of the survey, it should be recognised that there is a combination of panel study, for the intra-stage comparisons, and trend study, for the inter-stage study.

4.2.2.2. The Sample

Due largely to the time constraint, the sample comprised all student midwives beginning training in Scotland on the earliest convenient date, December 1980. The Beginning group in Stage I was 303 students. As the researcher anticipated that later intakes would include a larger proportion of students avoiding the extended training (and whose views would be less typical of students taking the twelve month course) later groups taking the shorter course were avoided.

This is a purposive sample because the researcher used specialist knowledge to decide which students should be approached (Babbie, 1973:106). The major disadvantage of a non-random sample, such as this, is its unrepresentative nature, however, the deficiencies may be compensated by the size of the sample:

> "The larger the sample the less sampling variation, i.e. the less the likelihood that the sample will be a misleading one".
> (Abramson, 1974:31)

The sample for Stage II, chosen to replicate Stage I, initially comprised only student midwives beginning training in Scotland in

December 1982. Due to administrative changes in the interim, the size of the intake of in that month was greatly reduced (170 students). The large discrepancy between the size of Stage I and Stage II necessitated applying the questionnaire to the next (March 1983) intake, which was also smaller than Stage I (221 students) but, when combined with the earlier Stage II group, exceeded the number in Stage I (Table 5.1., Page 94)

Because of the likelihood of group characteristics differing from one intake to another, the samples selected for the Stage I and II intake started in December. Such differences may be present between the two intakes used in Stage II, as the smaller peripheral schools have no intake in December. Thus, the earlier intake (Stage IIa) comprises students either living in or attracted to large, urban, probably prestigious, teaching hospitals; whereas the later intake (Stage IIb) also includes students in the smaller, less well-known, more isolated schools. An assessment of certain characteristics is, therefore, necessary to determine whether the two Stage II intakes are part of the same population.

4.2.3. The Instrument

Postal questionnaires, pretested (Mander, 1980) on two groups of student midwives prior to the main study, were developed by this researcher specifically for this study. The development of the questionnaires involved discussion with senior midwives and midwife-researchers, drafting the questionnaires and pretesting them on appropriate student midwives. The students were observed for any signs of hesitancy and timed. Subsequent interviews probed any areas of difficulty, such as non-comprehension or offensive items. On the basis of this pretest the questionnaires were amended.

Each of the questionnaires (Appendices B & C, Pages 298 & 302) comprises five parts, the first (Section A) examines the reasons for undertaking midwifery training, and the views about midwifery and midwives. The second section (B) in the Beginners' questionnaire examines plans for the period immediately after qualifying. Sections C and D in the Beginners' questionnaire seek information about occupational and personal characteristics respectively. Section D also includes a request for the student registation number to assist comparison of the Completers' views. Section E is an area for comments.

The format of the Completers' questionnaire is similar, Section A being a replication with the addition of an item about attrition from training. Section B is also a replication of that section in the Beginners' questionnaire, adding the question (B9) concerning the changes necessary in midwifery to encourage practice. Section C in the Completers' questionnaire comprises a Likert-type scale to probe the student's views of midwifery, in an attempt to reveal positive or negative attitudes. Sections D and E replicate the final parts of the Beginners' questionnaire.

Only minor amendments were needed to the questionnaire which was produced as a result of the pretest, such as the change of the title from "State Certified Midwife" (SCM) to "Registered Midwife" (RM).

4.2.4. Data Collection

4.2.4.1. Distribution of Material

The "before and after" design sought the "uncontaminated" views of new students prior to exposure to midwifery. At the time of the design of the research project the practice of the CMB[S] was to post a package of documents to each student midwife in Scotland about four weeks before training commenced. These documents included certificates

being returned and details of the student's CMB[S] registration number. The officer of the statutory body agreed to distribute the Beginners' questionnaire with these documents, providing a satisfactory solution to the problem of "contamination"; a disadvantage of this arrangement may have been the risk of the questionnaire being perceived as issuing from the statutory body, thus applying pressure on the student to complete it.

Administrative changes resulted in the Stage II documents (and questionnaires) being distributed by the staff of the colleges of nursing and midwifery, which may have affected the response. The contact with midwifery, "contamination", may have increased, as the material is likely to have been distributed by midwife teachers and the researcher had no control over when, in relation to midwifery teaching or experience, this distribution occurred. Whether this difference between Stage I and Stage II is of any significance is hard to assess as the amount of contact is unknown; also the initial intention of avoiding "contamination" was uncontrollable for two reasons. First, most of the respondents had previously been exposed to midwives and midwifery, having completed an obstetric course. Second, the timing of the actual completion of the questionnaire was uncontrollable by the researcher. The second, less direct, method may have applied less and different pressure on the students, but it is likely that some pressure continued to be exerted.

4.2.4.2. Recruitment to the Study

Access to the respondents was facilitated by the statutory bodies, initially the CMB[S] and latterly the Scottish National Board for Nursing, Midwifery and Health Visiting (NB[S]). The statutory bodies' student registration number was used for identification, that

is, to permit comparison of the views of those respondents who gave their number on both questionnaires. As the student midwives were being approached as private individuals, not as employees, the employing authorities were not involved in the recruitment to the study and as the survey has no immediate implications for patient care, it was not necessary to obtain the permission of either employers or ethics committees. It was, however, deemed appropriate to inform both senior managers and college staff that students were being asked to be involved in this study (Appendices D - G, Pages 305-309).

The students were recruited to the study by a request in a letter which was enclosed with the questionnaire. This letter (Appendix H, Page 310) gave information about the purpose of the study, assured the student of anonymity and confidentiality, attempted to reduce the student's perception of the involvement of the statutory body, discounted any repercussions due to involvement or non-involvement, gave instructions about returning the questionnaire and mentioned the student's right not to participate. The covering letter aims to create a good impression with potential respondents by, for example, neat presentation and good quality paper (Treece and Treece, 1982:242). This is counterbalanced by the need to avoid a personal response because the respondent should be making a free, fully informed decision about whether to participate, rather than responding to an attractive presentation.

The possibility of including students who had failed the examination in the sample of Completers was considered during the design of the study (Mander, 1980:33). It was decided that the questionnaire should be applied to all students in the group completing training. The rationale is that, first, feelings about midwifery which develop

over twelve or eighteen months are unlikely to be seriously affected by examination failure and any adverse reaction is, in this writer's experience, directed at the examination system, rather than at midwifery. Second, the views of the less successful, students should provide a more complete picture of students' views of midwifery. Third, there would be administrative problems associated with <u>not</u> contacting these students, as special instructions to that effect would need to be given to the staff of the statutory body and the respondents may even be dissappointed at being excluded.

4.2.4.3. Follow Up

Following up tardy respondents involves sending reminders to stimulate responses. The problem encountered in the present study, of how to make contact having assured the individuals of anonymity, may be resolved by sending a further questionnaire to all respondents, thanking those who have replied and encouraging those who have not. This is probably an ideal solution.

In the present study the follow up of Stage I Completers was more difficult than anticipated, due to the large proportion of foreign students who returned home immediately. Despite this, all students whose registration numbers had not been received were sent a request for their cooperation (Appendix J, Page 314), a further copy of the questionnaire and a return envelope with either a stamp or an international reply coupon. The ethical difficulties were solved by taking only the addresses of those students not identifying themselves, directly from the records of the CMB[S], none being retained.

This exercise was costly both in terms of postage and time taken identifying students. In view of the disproportionately poor response it was not repeated for either of the Stage II groups; for these

groups the follow up comprised a reminder inserted into routine correspondence sent out by the statutory body (Appendix K, Page 315).

4.2.4.4. Dealing With Non-Response

In the present study non-response did not pose a major problem, the response rate ranging between 79% and 48%. But, on the grounds that the response rate fell gradually but consistently throughout the study, its significance warrants closer scrutiny. Non-response distorts the picture of the sample and reduces the possibility of generalising the findings to the target population. In his examination of this phenomenon, Simon (1969:118) emphasises the importance of knowing the reason for non-response, as this determines whether an error actually exists.

The methods which may be used to remedy this problem include, first, stimulating a better response by follow-up techniques, second, making a secondary investigation of whether the characteristics of the non-respondents differ from those of the respondents or, third, assuming that non-respondents are not different from respondents. The last solution is not acceptable despite being frequently used because "You have no <u>scientific</u> guarantee that the estimation is not wrong" (Simon, 1969:118). This is reinforced by the point made in the same discussion, that researchers can not assume that non-responders are randomly distributed.

4.3. Interrogation of the Research Method

Having described the method and the principles on which it is based, it is now necessary to scrutinise particular areas in which weaknesses may be identified.

4.3.1. Non-Response

Although non-response did not present major difficulties, the

fact that the researcher was unable to remedy the situation may be regarded as a weakness in the design of the study. Dealing with the problem by following up non-respondents, either to persuade them to complete their questionnaires or to examine their characteristics to assess whether they are part of a different population, were inappropriate because of the difficulty of gaining access to the sample. This was because at no time did the researcher possess details of the respondents' names, addresses or telephone numbers, at least two of which would have been necessary for these measures. Access to such information was limited and depended largely on the goodwill of the statutory body.

Simon's (1969:119) alternative suggestions for reducing the non-response rate are even less appropriate than those already mentioned. He recommends "persuading" the respondents by applying pressure in the form of using "someone important ... to ask for cooperation, on the stationery of a prestigious institution". His other suggestion involves offering "gifts or payment to the respondents". Both of these methods are ethically dubious, hardly being consistent with the concept of "freely given and informed consent" (RCN, 1977:2). Second, it is necessary to consider the effects of this type of pressure on the answers which the reluctant respondents eventually give, as Babbie (1969:119) himself states "you must be careful not to change the subjects' answers". Third, the latter suggestion, using gifts, would not be realistic due to the large numbers and budgetary restrictions.

4.3.2. Identification of the Respondents

In designing the research, considerable importance was attached to maintaining the anonymity of the respondents, to encourage them to be more forthcoming. Preserving anonymity may have exacerbated

problems caused by non-response, it also hindered comparison of some of the responses. This operated in two ways, first, a large proportion of respondents gave no identification number, in many this was because they did not have the number to hand and they apologised for the omission. In some the number was not given because the student correctly realised that their name would be traceable and they were unable to accept the researcher's assurance of confidentiality. The second type of error was associated with the concurrent changes in the organisation of nursing and midwifery in the UK, by which each nurse is given a Personal Identification Number (PIN, UKCC, 1984) for registration purposes. These numbers were distributed in April 1984, shortly before the Stage II Completers' data collection, and a large proportion of students mistakenly gave their PIN.

Non-identification limited the comparisons which could be made, as it reduced the number of respondents who gave their student registration number on both questionnaires. Despite this, the unidentifiable responses contribute to the group profile, rather than the description of individual changes in employment intentions.

4.3.3. Secondary Careers

The limitations of the study which have already been examined have been associated with the difficulty of identifying the students; this aspect may be related to another area of weakness. In designing the study it was anticipated that a number of student midwives would be undertaking the training with no intention of practising midwifery immediately, but intending to return at a later date, possibly after their own childbearing, making midwifery their secondary career (Appendix A, Page 294). Because it examines the immediate employment intentions and practice and does not take account of those who delay

using their qualification, the present study has no assessment built into it of whether such midwives do return. It may be that obtaining data on this group would provide a different and perhaps better picture of the "return on investment" involved in midwifery training.

4.3.4. The Instrument

Having identified some general factors which may constitute limitations to the value of the study, the instrument itself will now be examined critically.

4.3.4.1. Replication

It was intended that certain aspects of this study should check the findings of previous work (Section 4.1.4., Page 73). The extent to which this is possible is debateable, the reason being that only particular items are being repeated and under such circumstances it is impossible to make an ideal replication. Thus, though the item may be an exact copy of the original (such as items A6 and A7 in the Completers' questionnaire, Appendix C, Page 302), sampling has been on a different basis, and the items preceding it may have evoked another reaction or frame of mind, inevitably affecting the response.

4.3.4.2. Choice of the Instrument

A postal questionnaire was chosen for data collection because of certain constraints inherent in the study. First was the need to collect data during a brief, well-defined time, that is after confirmation of their acceptance for midwifery training and prior to their exposure to midwifery. The second constraint has been the geographical distribution of the students throughout Scotland, to obtain a sample which includes the various colleges of nursing and midwifery.

A disadvantage of the self-administered questionnaire is its inability to probe a topic in depth. Whereas hard data is easily

collected, soft data is "typically more difficult" (Babbie, 1973: 369). Thus, it may be suggested that the questionnaire in the present study is admirably suited to collecting data on employment intentions and changes in those intentions, but it is less well suited to probing the changes in attitude associated with the changing intentions. To reduce the likelihood of this criticism, a number of open questions were included, which aimed to provide an opportunity for respondents to state their views and also reduce the respondents' perceptions of forced choice. The volume of material obtained from these open items suggests that they were successful in achieving these aims.

4.3.4.3. Assumptions of Knowledge

During the design of the present study the assumption was made that, as all student nurses in Scotland had been required to undertake obstetric nurse training since 1972, the Beginning sample of student midwives would have some knowledge of midwifery on which to base their employment plans. This assumption was shown to be unfounded, despite the large proportion of students who had completed obstetric nurse training (Mander, 1983:46). A lack of knowldge as fundamental as this should have been revealed during the pretest. That this lack was not exposed suggests a fault in the pretest (Section 4.4., Page 89).

4.3.4.4. Potential Sources of Bias

Any work may be criticised on the grounds of sampling bias. The usual defence, that it was randomly selected, is inappropriate here as the sample was purposive (Fox, 1982:281; Knapp, 1978:210). Response bias and recall bias and techniques to alleviate resulting problems are discussed in Sections 4.2.2.1. and 4.3.1. (Pages 76 and 84).

Presenting the questionnaire in a neutral way aims to prevent the respondent making a personal, subjective response. The risk of a

personal response was increased by the researcher's contact with students in one college of nursing and midwifery, through teaching on midwifery research and other topics. It became necessary to organise a special series of lectures for the groups of students in the sample, to avoid their becoming too knowledgeable about the study. Recording bias, due to respondents' anxiety about the effect of the responses, should be minimised by assurances of confidentiality and anonymity in the covering letter.

A problem which may be exacerbated by the researcher's inability to identify the subjects is the bias due to groups of students discussing the project. No instructions were given as to whether the response should be a solitary or joint effort, as the researcher has no sanctions with which to ensure compliance. It is not impossible that the respondents consulted their colleagues about the purpose of items, thus influencing the response. As the researcher made no attempt to identify the students or their college of nursing and midwifery, it is impossible to ascertain whether such consultation occurred.

4.4. Difficulties Associated with the Pretest

Certain difficulties were encountered, which might have been prevented had more time been available for the pretest and pilot study of the instrument and project respectively.

4.4.1. Reliability

Tests of reliability may have been neglected during the pretest, so it is now necessary to consider the reliability of the instrument. Reliability is "the accuracy of the data in the sense of their stability or repeatability" (Fox, 1982:255/6). This stability is really determined by the characteristics of the measuring instrument;

the two possible sources of error are the instrument itself or the person using the instrument. In the present study the latter error is improbable, as only the researcher is involved in the data collection, and also the large proportion of closed questions make such error unlikely. This error may become significant if an attempt is made to replicate the study.

The other source of error lies in the instrument itself and this was not examined in the pretest. With hindsight, it may be suggested that reliability should have been assessed during the pretest, using a number of testers to exclude the possibility of human error and using such techniques as test-retest reliability and Kuder-Richardson reliability (Fox, 1982:256).

4.4.2. Validity

Validity ("the instrument actually does what it purports to do") is regarded by many researchers as the more important characteristic of a research instrument. This may be because validity is the more difficult to achieve (Fox, 1982:260; Treece & Treece, 1982:126)

During the pretest of the questionnaires (Mander, 1980:41) content validity was employed, involving this researcher and a number of others. The rather limited value of assessing content validity is increased if a jury is used to scrutinise the instrument, but ideally the predictive validity would be tested (Fox, 1982:266), as the purpose of the instrument in the present study is to identify those respondents who will practise as midwives. This suggestion is not feasible in this context, as predictive validity would require an eighteen month time span; this would permit an assessment of whether the characteristics identified at the beginning are genuinely associated with continuing midwifery practice. An alternative but

weaker assessment employs concurrent validity, in which two groups with established, differing characteristics test the instrument to assess its discrimination. With hindsight, such a test would have been both feasible and valuable during the pretest, this is applies particularly of the Likert-type attitude scale which comprises Section C of the Completers' questionnaire.

4.5. Summary

A critical examination has been made of the theoretical basis of the present study and its implementation. Non-identification has been shown to have caused certain problems. This examination serves both to alert the reader to any weaknesses and to suggest areas which may need amendment if replication is to be undertaken.

PART II - INTENTIONS AND EMPLOYMENT

INTRODUCTION

The second part of this thesis comprises an examination of the data provided by the present study. The analysis of the Beginners' data is first (Chapter 5) and it includes a profile of the sample, which is followed by an assessment of the generalisability of the findings. Data on career planning and mobility together with the students' expectations of midwifery complete this chapter.

Prior to the analysis of the Completers' data in Chapter 7, the meaning of midwifery practice is scrutinised, as this is the criterion by which the effects of training and its extension are assessed. The analysis of the Beginners' and the Completers data in Chapter 8 takes advantage of the concept of the experiment, discussed in Section 4.1.2.

CHAPTER 5

ANALYSIS OF THE DATA - THE BEGINNERS

This chapter summarises the data collected from the student midwives at the beginning of their training. Freeman's theory of career decision making has provided the framework for this chapter. An essential factor in making career decisions is the individual's own capability (Freeman, 1971:2). The "Profile" of the student midwives, provides a picture of the capabilities of the respondents in personal and professional terms. This profile also serves to supply data on the characteristics of student midwives, the lack of which impeded the literature review (Chapter 3). The generalisability of the data needs attention, and it is assessed by comparisons between the respondents in the present study and those in earlier studies. This section will ascertain whether these data and any conclusions may be generalised to students and midwives in other parts of the UK. New students' knowledge of midwifery must affect the quality of their career decisions so aspects of entry into midwifery and students' career plans are examined next. The next part returns to Freeman's approach in a discussion of the students' views and expectations of midwifery. This section serves as a baseline to assess change during training, which may be related to the employment decisions.

5.1. The Response

The response rate is of particular significance in the present study as it limits the generalisability of the conclusions (Section 4.2.4.4., Page 84). The number of questionnaires distributed to each group of student midwives beginning training is shown in Table 5.1., with the response rate. (Percentages throughout are rounded to one decimal point and are given in brackets).

It is apparent that the response to Stage I was unusually high for a postal questionnaire, according to Treece and Treece (1982:241), the subsequent questionnaires elicited more typical response rates; as these authors maintain:

> "if the questionnaire is simply an opinion poll there might be a 50% to 60% response. Any questionnaire sent through the mail that produces 75% to 85% response is doing extremely well."

Table 5.1. Response to the Beginners' Questionnaire Including Identification

	Stage I	Stage IIa	Stage IIb	Total
Questionnaires Distributed	303	172	225	700
Returned Completed	241	109	151	501
Response Rate	79.5%	63.4%	67.1%	71.6%
With CMB Numbers	215 (89.2%)	84 (77.1%)	123 (81.1%)	422 (84.2%)
No CMB Numbers	26	25	28	79

The numbers of students who identified themselves by giving their CMB[S] student registration number is also shown in Table 5.1. There is a perfect positive correlation, using Pearson's r, between the numbers of beginning students responding to the questionnaire and the proportion of students identifying themselves (Knapp, 1978:149). The number of respondents <u>not</u> identifying themselves is also quite consistent. No attempt has been made to probe students' reasons for not identifying themselves.

5.2. Profile of the Sample

This section describes the sample, which comprised all student

midwives beginning training in Scotland which was 303 students in Stage I. Comparison will be made with other work (Golden, 1979 and NFNMC, 1963) to assess the extent to which this sample is representative of student midwives in UK and generaliseable to other countries. The sample for Stage II of the study was chosen to replicate as closely as possible the Stage I sample. The Stage II sample initially comprised only student midwives beginning training in Scotland in the month equivalent to when the Stage I group began. This group comprised 172 students and will be referred to as Stage IIa. For reasons discussed elsewhere (Section 4.2.2.2, Page 78), it was decided to apply the questionnaire to the next intake of student midwives as well. This intake, referred to as Stage IIb, was also smaller than the Stage I group, being 225 students, but when combined the total numbers approximated to the Stage I group. (See Table 5.1., Page 94)

5.2.1. Personal Characteristics

Section D in the Beginners' questionnaire (Appendix B) sought information about the students' characteristics, including personal details.

5.2.1.1. Sex

Predictably, in view of the recent changes in sex discrimination legislation (HMSO, 1975) the sample included male student midwives. Table 5.2.1.1. compares Stages I and II, showing that the small number of male students was unevenly distributed throughout the study.

The reason for the rather erratic distribution of male students is that one college of nursing and midwifery in Scotland was selected for the "experiment" involving the training of male midwives which was in progress at the time of the present study (Speak & Aitken-Swan, 1982). This college selected certain intakes of student midwives to

include males; fortuitously, the intake used in Stage I was one of them.

Table 5.2.1.1. The Respondents' Sex

	Stage I	Stage II	Total
Female	231 (95.9%)	249 (95.8%)	480 (95.8%)
Male	6 (2.5%)	1 (0.4%)	7 (1.4%)
No Response	4 (1.7%)	10 (3.8%)	14 (2.8%)
Total	241 (100%)	260 (100%)	501 (100%)

5.2.1.2. Age

The questionnaire requested the respondents' age on the completion of training (Appendix B:D2, Page 301). The information was sought in this way for two reasons. First, as comparisons are to be made between employment decisions on completion of training, it is necessary to know the age of the people making those decisions. Second, if the conclusions of the present study are to be generalised to other parts of the UK, using other studies to draw comparisons, it is essential that the data should be comparable. Hence, this item requests age at the same point as Golden's study, that is, at the end of training. The categories were selected for the same reason. The data on the age of the sample are given in Table 5.2.1.2.

These data appear to suggest that the proportion of younger student midwives is decreasing. This perception is probably incorrect. It is important to bear in mind the way in which the question was phrased. As the training has been extended by six months, it is reasonable to assume that the Stage II students will be six months

older when they complete their course. This may account for the decrease in numbers of under 23 year olds and an approximately equivalent increase in the 23-24 year olds.

Table 5.2.1.2. Age of the Respondents (in Years)

	Stage I	Stage IIa	Stage IIb	Total
Under 23	58 (24.1%)	17 (15.6%)	26 (17.2%)	101 (20.2%)
23-24	99 (41.1%)	48 (44.0%)	76 (50.3%)	223 (44.5%)
Over 24	78 (32.4%)	38 (34.9%)	42 (27.8%)	158 (31.5%)
No Response	6 (2.5%)	6 (5.5%)	7 (4.6%)	19 (3.8%)
Total	241 (100%)	109 (100%)	151 (100%)	501 (100%)

It should be noted, however, that the increase in older student midwives (over 24 years old) which would be expected if this explanation is correct, has not been consistently maintained.

5.2.1.3. Nationality

The item dealing with nationality was the penultimate one on the questionnaire. This position was selected because this may be a sensitive topic (Oppenheim, 1966). The information on nationality was sought by an open question (Appendix B:D7, Page 301) with advice to the respondent to state the nationality on her passport in the event of any uncertainty. Despite this a large proportion of respondents gave their nationality as "Scottish" (Table 5.2.1.3.). This group should, for purposes of analysis, be combined with the "British" group. These responses suggest that the assumption about the sensitivity of this topic may have been justified.

Table 5.2.1.3. The Respondents' Nationality

	Stage I	Stage II	Total
Scottish	33 (13.2%)	53 (20.4%)	86 (17.2%)
British	136 (56.4%)	138 (53.1%)	274 (54.7%)
Commonwealth	45 (18.7%)	24 (9.2%)	69 (13.8%)
Eire	17 (7.0%)	32 (12.3%)	49 (9.8%)
Other/No Response	10 (4.1%)	13 (5.0%)	23 (4.6%)
Total	241 (100%)	260 (100%)	501 (100%)

Those respondents who gave their nationality as "Irish" also caused some difficulty, as it was not always clear which part of Ireland they came from. In the majority of cases other indicators, such as educational qualifications, were taken into account. But in those cases where there were no such clues the assumption was made that these respondents originated in the Republic of Ireland. This point may be significant in view of the employment prospects for British and other midwives.

Table 5.2.1.3. shows the fluctuating proportions of non-British students, particularly between Stage I and Stage II, but also in the numbers originating in Eire; the reasons for which are unclear.

5.2.2. Education

Item Dl of the Beginners' questionnaire (Appendix B, Page 298) sought information about the students' educational background. This has been classified according to the maximum educational achievement. Table 5.2.2. shows the educational background of the sample.

Table 5.2.2. The Respondents' Maximum Educational Achievement*

	Stage I	Stage II	Total
Highers/ "A" Levels	101 (41.9%)	158 (60.8%)	259 (51.7%)
"O" Grades/ Levels only	83 (34.4%)	40 (15.4%)	123 (24.6%)
NR/Other	57 (23.7%)	62 (23.8%)	119 (23.8%)
Total	241 (100%)	260 (100%)	501 (100%)

(The difference between those with Highers/"A" levels and others in the two samples is significant at .05, Chi square = 6.635 with 1DF)

* Throughout this work the decision has been made to use the "alpha level" of significance of .05. Higher levels of probability (eg. 0.1) are considered not significant, as they imply that there is a greater than 1 in 20 possibility of the findings being due to chance.

Difficulty was encountered in the classification of the non-British students (124 or 24.8% ofthe Beginners), as the educational qualifications could not be categorised. These data suggest that the educational standard among student midwives is becoming higher. The proportion of students beginning training with only "O" levels/grades or less decreased significantly during the period of the study, with a corresponding increase in the numbers with Highers or "A" levels.

5.2.3. Domestic Background

As the literature suggests that domestic circumstances influence the employment decision (Cleland, 1976), items were included in the questionnaire to explore the students' home responsibilities. Questions D5 and D6 asked about the presence or absence of children, their number and their age. Table 5.2.3.1. comprises a description of the number of student midwives beginning training caring for children.

Table 5.2.3.1. Student Midwives caring for Children and Child's Age Group

	Stage I	Stage II	Total
Under 5 only	3 (1.2%)	3 (1.2%)	6 (1.2%)
School age only	8 (3.3%)	8 (3.1%)	16 (3.2%)
Left school only	5 (2.1%)	1 (0.4%)	6 (1.2%)
School and left school	1 (0.4%)	2 (0.8%)	3 (0.6%)
None/no response	224 (93.0%)	246 (94.6%)	470 (93.8%)
Total	241 (100%)	260 (100%)	501 (100%)

These data show that the majority of student midwives have no children and, of those who have children, most take their training when their children are older and, presumably, require less attention, a small number take their training before their children begin school.

The students' marital status (Table 5.2.3.2.) was examined by item D4, which comprised a closed question.

Table 5.2.3.2. The Marital Status of the Student Midwives

	Stage I	Stage II	Total
Single	166 (68.9%)	196 (75.4%)	362 (72.3%)
Married	67 (27.8%)	48 (18.5%)	115 (23.0%)
Other/No Response	8 (3.3%)	16 (6.2%)	24 (4.8%)
Total	241 (100%)	260 (100%)	501 (100%)

The closed question did not suit some of the respondents, who indicated that their marital status was due to change during their training, that is, they were engaged to be married. This proposed change in status was not classified separately as the researcher has no information concerning either whether the marriages took place or the details of other students who did not plan (or did not give information about their plans) to be married. These data may reflect women's changing lifestyles, as the NFNMC study (1963) included only 72 (16.7%) married respondents.

5.2.4. Occupational Data

Information about the respondents' nursing background was sought in Section C of the Beginners' questionnaire (Appendix B, Page 298).

5.2.4.1. Nursing Qualification

The item probing the respondents' nursing qualification was a closed question (C1). Table 5.2.4.1. shows the prevalence of certain qualifications in each stage and that, with only a few exceptions, the students are Registered General Nurses, some of whom possess an additional certificate.

Table 5.2.4.1.Nursing Qualifications

	Stage I	Stage IIa	Stage IIa	Total
RGN only	228 (94.6%)	100 (91.7%)	142 (94.0%)	470 (93.8%)
RSCN +/- RGN	8 (3.3%)	4 (3.7%)	2 (1.3%)	14 (2.8%)
RMN +/- RGN	1 (0.4%)	4 (3.7%)	5 (4.0%)	10 (2.0%)
RGN & Other	4 (1.7%)	1 (0.9%)	2 (1.3%)	7 (1.4%)
Total	241 (100%)	109 (100%)	151 (100%)	501 (100%)

In this work the term "Registered General Nurse" (RGN) is being used to include those general nurses originally registered in other parts of the UK and those first registered in other countries, as well as those registered in Scotland (Appendix A, Page 294).

The "other" qualifications which some students held in addition to the RGN included the Registered Maternity Nurse; also included in this category were students holding more than two basic nursing qualifications, such as one person who was RGN, RSCN and RMN.

5.2.4.2. Obstetric Nurse (ON) Training

Whether the student midwife had taken an ON course during general training and the duration of any such course was probed in two items in Section C (C5 and C6) and the data for Stage I and Stage II are given in Table 5.2.4.2. It was anticipated that having completed an ON course would help the students to make well informed, durable decisions about their employment and careers in midwifery.

Table 5.2.4.2. Students with (and Duration of) ON Training

	Stage I	Stage II	Total
4-5 weeks	144 (59.7%)	183 (70.4%)	328 (65.5%)
6 weeks or more	40 (16.6%)	20 (7.7%)	60 (12.0%)
None	57 (23.7%)	56 (21.5%)	113 (22.5%)
Total	241 (100%)	260 (100%)	501 (100%)

Mander (1983) indicates that this assumption is not valid in the short term, as students with ON training, and particularly those with longer ON training, are more likely to discontinue midwifery training before it is completed. These data demonstrate that, while the number

of students with no ON experience is quite static, the number who have completed a shorter ON course has increased from Stage I to Stage II. This trend may reflect the statutory bodies' changing requirements.

5.2.4.3. Previous Nursing Experience

Two items were included (C7 and C8) which examined nursing experience prior to starting midwifery training. These items sought data which would reveal any association between such experience and staying in midwifery. The data show the pattern of nursing employment prior to training, but Table 5.2.4.3. gives the highest grade and compares the backgrounds of Stage I and Stage II respondents. In this table Australian sisters have been classified separately, because in that country the term "sister" equates with a registered nurse.

Table 5.2.4.3. The Highest Grade of Nursing Employment Previously Reached

	Stage I	Stage IIa	Stage IIb	Total
None	31 (12.9%)	17 (15.5%)	10 (6.6%)	58 (11.6%)
Under 1 year Staff Nurse	89 (36.9%)	52 (47.7%)	68 (45.0%)	209 (41.7%)
Over 1 year Staff nurse	89 (36.9%)	32 (29.4%)	62 (41.1%)	183 (36.5%)
Over 1 year Sister/CN	13 (5.4%)	5 (4.6%)	9 (6.0%)	27 (5.4%)
Australian Sister	8 (3.3%)	0 0	0 0	8 (1.6%)
Other	11 (4.6%)	3 (2.7%)	2 (1.3%)	16 (3.2%)
Total	241 (100%)	109 (100%)	151 (100%)	501 (100%)

These data clearly demonstrate the large proportion of students entering midwifery with considerable experience in nursing. The

"other" category includes a variety of posts, such as postgraduate and advanced nursing study, and employment as a "team leader" and as a "tutor" in New Zealand.

5.2.5. The Samples in Stage IIa and IIb

As there is a possibility (Section 4.2.2.2., Page 78) that the characteristics of the two intakes comprising Stage II are different, it is necessary to consider whether Stage IIa and Stage IIb are part of the same population. Personal and professional characteristics are being examined in making this assessment.

5.2.5.1. Nursing Qualifications

The two intakes were quite consistent in their nursing qualifications (See Table 5.2.4.1.); the majority in each group having only the RGN qualification (91.7% and 94% for Stage IIa and IIb respectively).

5.2.5.2. Previous Nursing Experience

On the whole Stage IIb had more nursing experience and that at a more senior grade than Stage IIa (Table 5.2.4.3.). In Stage IIb 6% of respondents had more than 12 months experience at Sister grade, as compared with 4.6% in Stage IIa. This observation is further supported by a smaller proportion, 6.6%, of Stage IIb having had no post registration nursing experience, compared with 15.5% of Stage IIa. This information may suggest that Stage IIb (which includes peripheral schools) were more inclined to stay at home and wait for a place in the small local school rather than move to one of the larger, urban schools.

5.2.5.3. Age

This suggestion, of the "stay-at-home" nature of the respondents in Stage IIb, is not supported by the age distribution (Table

5.2.1.2.), which shows that Stage IIa includes a slightly higher proportion of older students (34.9% being aged over 24 years at the end of training, compared with 28% in Stage IIb). Any age difference between these groups, who were the only ones giving comparable responses, does not reach the accepted level of significance (.05 using Chi Square, at 3DF).

5.2.5.4. Review - Stage IIa and IIb

The sex distribution, nationality and marital status of the two intakes are virtually identical. It may be concluded, therefore, that there are no considerable or consistent differences between the two intakes comprising stage II, which suggests that they are drawn from the same population.

5.2.6. The Samples in the Present Study and in Other Studies

If the conclusions of the present study are to be generalised to other parts of the UK it is necessary to ascertain whether there are common characteristics.

5.2.6.1. Nationality

One of the few topics which has been examined by all three recent research projects on new midwives is the nationality of the respondents. Both Golden (1979:1) and NFNMC (1963:18) sought this information, but Golden used different categories to code the data. There are probably valid reasons for these differences; for example in the present study a large proportion of the respondents (17.2%, see Table 5.2.1.3.) stated that they were "Scottish", such a category would be irrelevant to the other studies as they were conducted in England and Wales. Golden classified respondents from Eire with British respondents, concealing the number of Irish student midwives in her study. She also used "geographical" terms to categorise the

country of origin, such as "Asian", "West Indian" and "African" whereas NFNMC and the present study used terms denoting the relationship of the country of origin with the UK, such as "Commonwealth". The use of relative terms is more appropriate to a study focussing on the employment of respondents. Despite the differing classification the findings of the three studies are remarkably consistent in the nationality of their respondents, as shown in Table 5.2.6.1.

Table 5.2.6.1. Nationality in the Present and Other Studies

	Present Study	Golden	NFNMC
British	360 (71.9%)	548 (77.5%)	433 (78.1%)
Non-British	124 (24.7%)	159 (22.5%)	121 (21.8%)
No Response	17 (3.4%)	0 0	0 0
Total	501 (100%)	707 (100%)	554 (100%)

Not significant at .05 using Chi square = 3.66, at 2DF.

5.2.6.2. Age

Age is another topic which has been assessed by all three studies. The present study and Golden used the same point at which to assess age, that is on completion of midwifery training. NFNMC obtained their data approximately two years after the completion of training, then categorised the age groups according to the area of employment. The average age of the NFNMC sample was 27 years, from this it may be assumed that the average age on completion of training was 25 years. The present study appears to have sampled a younger group than Golden, whose work is being compared here with Stage I

(Table 5.2.6.2.). The present study included a larger proportion of respondents in the under 23 years category (24.1% compared with Golden's 8.6%) and a smaller proportion in the over 24 years category (32.4% compared with Golden's 37.5%). The advancing years of Golden's sample may be associated with the presence of "Direct Entrants" (Appendix A, Page 294) who are absent from the present study, and also with the "knock on" effect of the higher age requirement for general nurse training in England and Wales.

Table 5.2.6.2. Age in the Present and Another Study

	Present Study (Stage I)	Golden
Under 23 years	58 (24.1%)	61 (8.6%)
23-24 years	99 (41.1%)	381 (53.9%)
Over 24 years	78 (32.4%)	265 (37.5%)
No Response	6 (2.5%)	0 0
Total	241 (100%)	707 (100%)

5.2.6.3. Obstetric Nurse Training

Whether the respondents had completed an ON course was assessed by both Golden and this researcher (Table 5.2.6.3.). The difference between the findings in the two studies may be attributable to ON training having been made compulsory in England and Wales more recently than in Scotland.

A large proportion (36.1%) of Golden's sample had completed a longer ON course (twelve weeks), whereas in the present study only two respondents (0.4%) had completed an ON course of nine weeks or more.

As has been established elsewhere (Mander, 1983) student midwives with a longer ON training are less likely to complete their midwifery course it is unfortunate that Golden omits the attrition rate.

Table 5.2.6.3. ON Training in the Present and Another Study

	Present Study	Golden
ON Training	388 (77.4%)	358 (50.6%)
No ON Training	113 (22.5%)	343 (48.5%)
No Response	0 0	6 (0.8%)
Total	501 (100%)	707 (100%)

5.2.6.4. Previous Nursing Experience

The time spent in post-qualification nursing experience by the students in the two studies is quite similar (Table 5.2.6.4.) in spite of the slight difference in classification. The number of student midwives with brief (under one year) post qualification experience is slightly lower in the present study.

Table 5.2.6.4. Previous Nursing Experience in the Present and Another Study

	Present Study	Golden
No Nursing	58 (11.6%)	59 (8.3%)
Under 1 year in Nursing	209 (41.7%)	352 (49.8%)
Over 1 year in Nursing	234 (46.7%)	296 (41.9%)
No Response	0 0	6 (0.8%)
Total	501 (100%)	707 (100%)

5.2.6.5. Nursing Qualifications

The nursing qualifications of the two samples are also similar, as is shown in Table 5.2.6.5. The proportion of respondents with a registered general nurse qualification is slightly higher in the present study. This is not unpredictable as enrolled nurses and direct entrants (Appendix A, Page 294) are accepted for midwifery training only in England and Wales.

Table 5.2.6.5. Nursing Qualifications in Present and Another Study

	Present Study	Golden
RGN(+/- other)	497 (99.2%)	680 (96.2%)
Non RGN Nurse	4 (0.8%)	21 (3.0%)
Non Nurse	0 0	5 (0.7%)
Total	501 (100%)	707 (100%)

5.2.7. Review

This profile of the respondents demonstrates certain features which may have implications for their employment decisions. Developments with manpower implications have been identified, such as the growing numbers of students who are married and the number with dependent children.

It is apparent that in terms of nationality, nursing experience and nursing qualifications, the respondents in the present study are similar to those in previous studies. There are no consistent differences which would indicate that another population is being sampled. Variations in age and in ON training are more likely to be associated with the divergent systems of nurse education in the

respective countries, rather than any difference in population characteristics. For these reasons it is suggested that the findings of the present study, and any conclusions which are drawn, may be generalised to other parts of the UK.

5.3. Entry into Midwifery

The factors associated with the students' decision to take midwifery training were examined in items A1, A2, C3 and C4 of the Beginners' questionnaire (Appendix B, Page 298). These data were sought, first, to illuminate the decision making process in new students and, second, because it was anticipated that the factors which encouraged the student to begin training, may also encourage that person to continue in midwifery practice.

5.3.1. Reasons for Taking Midwifery Training

The students' primary and secondary reasons for beginning training were probed in item A2, which was a closed question incorporating some of the reasons suggested by NFNMC (1963:24). These data are given in Tables 5.3.1.1. and 5.3.1.2.

Summarising the responses to a closed item on the main reason for taking midwifery training, Table 5.3.1.1. shows that a large proportion of the respondents (223 or 44.5%) had decided to take midwifery training because they envisaged that it would help them to achieve career goals, either within or outside midwifery. An only slightly smaller number of students (216 or 41.3%) stated a more personal reason, relating to their own interest or to a desire to complete or round off their general nurse training, which may be a comment on that training.

Table 5.3.1.1. Main Reason for taking Midwifery Training

	Stage I	Stage II	Total
Midwifery Practice	28 (11.6%)	38 (14.6%)	66 (13.2%)
Promotion	27 (11.2%)	29 (11.2%)	56 (11.2%)
HV Training	20 (8.3%)	27 (10.4%)	47 (9.4%)
Work Abroad	25 (10.4%)	29 (11.2%)	54 (10.8%)
Complete Training	60 (24.9%)	53 (20.4%)	113 (22.6%)
Satisfy Interest	54 (22.4%)	49 (18.8%)	103 (20.6%)
Another reason /No single reason/DK	27 (11.2%)	35 (13.5%)	62 (12.4%)
Total	241 (48.1%)	260 (51.9%)	501 (100%)

These proportions are similar to those found by NFNMC, which were 48% and 46% respectively. A small number of respondents were unable to state a single reason and these responses have been combined, in Table 5.3.1.1., with those who gave reasons such as "liking babies", "preparing for own childbearing" and "for a change of job".

"Other Reasons" were mentioned more frequently when the respondents were asked to indicate their secondary reasons (Table 5.3.1.2.) for taking midwifery training, similarly, the possibility of using the midwifery certificate when working abroad was indicated more frequently. (More than one secondary reason was often given.)

Table 5.3.1.2. Secondary Reasons for Taking Midwifery Training

	Stage I	Stage II	Total
Midwifery Practice	4 (1.7%)	36 (13.8%)	40 (8.0%)
Promotion	24 (10.0%)	26 (10.0%)	50 (10.0%)
HV Training	21 (8.7%)	27 (10.4%)	48 (9.6%)
Work Abroad	44 (18.3%)	54 (20.8%)	98 (19.6%)
Complete Training	47 (19.5%)	59 (22.7%)	106 (21.2%)
Satisfy Interest	42 (17.4%)	68 (26.2%)	110 (22.0%)
Other Reasons	83 (34.4%)	92 (35.4%)	165 (32.9%)
Total	265	362	617

5.3.2. Group Effects

In the Beginners' Questionnaire (items C3 and C4) the researcher attempted to examine the extent to which employment decisions are made by the group, rather than by the individual, as the suggestion had been made that some students took midwifery training merely because their friends were doing so, in the absence of other opportunities.

Table 5.3.2. Size of Group of Students Staying Together for Training

	Total Study	
	Number	Percent
2 - 3	114	(22.7%)
4 or more	49	(9.8%)
Not in group	338	(67.4%)
Total	501	(100%)

Table 5.3.2. suggests that this phenomenon warrants closer study, as a considerable minority (32.5%) of students stated that they were part of an established group which had begun training "en masse".

5.3.3. Reasons for Choice of College of Nursing and Midwifery

Item Al in the beginners' questionnaire probed the students' reasons for their choice of midwifery training school. As has been mentioned already comparisons may be drawn between the decision to take midwifery training and the decision to continue in midwifery practice. It was anticipated that this item would reveal whether any of the factors influencing such decisions had a consistent effect, when compared with the completers' data.

Table 5.3.3. Reasons for Choice of College of Nursing & Midwifery

	Stage I	Stage II	Total
Locality	121 (50.2%)*	132 (50.8%)	253 (50.4%)
Friends coming	16 (6.6%)	12 (4.6%)	28 (5.6%)
Place sooner	49 (20.3%)	66 (25.4%)	115 (22.9%)
Recommended	66 (27.4%)	77 (29.6%)	143 (28.5%)
Avoid longer Training	19 (7.9%)	N/A	19 (3.8%)
Other reason /Don't know	4 (1.7%)	10 (3.9%)	14 (2.8%)
Total	275	197	572

*Some respondents gave more than one reason for choosing school.

It is generally accepted that, when applying for midwifery training, the candidate applies to a number of colleges and receives many offers, selecting the one which is most suitable. The purpose of

this item was to identify the deciding factor. Table 5.3.3. shows the differing importance of factors and indicates that the geographical situation is consistently the most important in making this decision.

In Stage II the item on avoiding the extended training was no longer appropriate. The "other reasons" included comments concerning the school being one which would accept males.

The large proportion (over fifty percent) of respondents indicating a place being available sooner or that the College was recommended to them was the main reason for their choice demonstrates the importance of personal contact in these decisions and, to a lesser extent, their opportunistic nature. The low priority given to "Friends coming" endorses the conclusion that group effects are not a powerful influence and that other factors account for the numbers of former colleagues who arrive at the same midwifery school at the same time.

5.3.4. Review

The data on entry into midwifery training indicate that only a small minority of students do so in order to make a career in midwifery. These data demonstrate the flexibility which new students incorporate into their decision to enter midwifery, perceiving it as facilitating the achievement of a number of goals outside midwifery. Geographical factors influence the choice of school more frequently than do colleagues.

5.4. Career Planning and Mobility

As this work involves an asessment of the extent to which student midwives' experience of midwifery is associated with changes in employment intentions, the direction and strength of these changes were examined. That employment decisions may be influenced by domestic factors encouraged scrutiny of occupational and geographical mobility.

5.4.1. Timing of Decision to Train as a Midwife

The data on the timing of this decision show both career planning and level of commitment to midwifery. Table 5.4.1.1. shows when the Stage I and Stage II respondents made the decision to take their midwifery training, in relation to when they actually began their training. This table suggests that for a large minority (41.7%) of the respondents, taking midwifery training is a relatively recent decision, meaning that it was made less than one year prior to starting training. The slight decrease in the numbers of students giving this response may be due to the lengthening waiting lists associated with reduced numbers of midwifery training places.

Table 5.4.1.1. Timing of the Decision to Train as a Midwife

	Stage I	Stage II	Total
Under 1 year ago	108 (44.8%)	101 (38.8%)	209 (41.7%)
1-3 years ago	107 (44.4%)	133 (51.1%)	240 (48.0%)
Over 3 years ago	26 (10.8%)	24 (9.2%)	51 (10.2%)
No response	0 0	1 (0.4%)	1 (0.2%)
Total	241 (100%)	260 (100%)	501 (100%)

For a minority of students (10.2%) the decision was made at least three years before commencing training. This suggests a high level of commitment to midwifery and may mean that these respondents entered nurse training with the sole intention of becoming midwives. Were this supposition to be correct, these respondents would have had little if any post registration nursing experience before training as midwives.

Table 5.4.1.2. The Post Registration Nursing Experience of Those who made the Decision to Train as Midwives more than Three Years Earlier

Post Registration Experience	Number of Respondents	Percent
None	5	9.8%
Under 1 Year	17	33.3%
1 - 3 Years	18	35.3%
Over 3 Years	11	21.6%
Total	51	100%

Table 5.4.1.2. suggests that these respondents do not show this employment pattern. Comparison with Table 5.2.4.3. (Page 103) suggests that, unlike the full sample, many of the early deciders were employed for long periods at relatively senior levels between general and midwifery training. This suggests that other factors, such as domestic circumstances, or waiting lists in Stage II, may have delayed their entry into midwifery. These data do not, however, detract from the obvious commitment of this group of students.

The scant majority deciding to take midwifery training over one year before commencing (Table 5.4.1.1.) suggests that nurses generally do not plan their careers, but tend to be opportunistic, responding to circumstances as one job ends or ceases to be satisfying. This is supported by the data provided by the Completers (Table 7.3.1., Page 145), which indicates that student midwives wait until the final six months of their course before deciding their next employment. Whether this limited ability or reluctance to plan their employment is a characteristic of females, nurses or nurses' employment opportunities, requires further examination.

5.4.2. New Student Midwives' Employment Intentions

A closed item, based on that used by Golden, sought information about long and short term employment intentions with a view to showing any differences between Beginners' and Completers' intentions.

Figure 5.4.2. Student Midwives' Employment Intentions

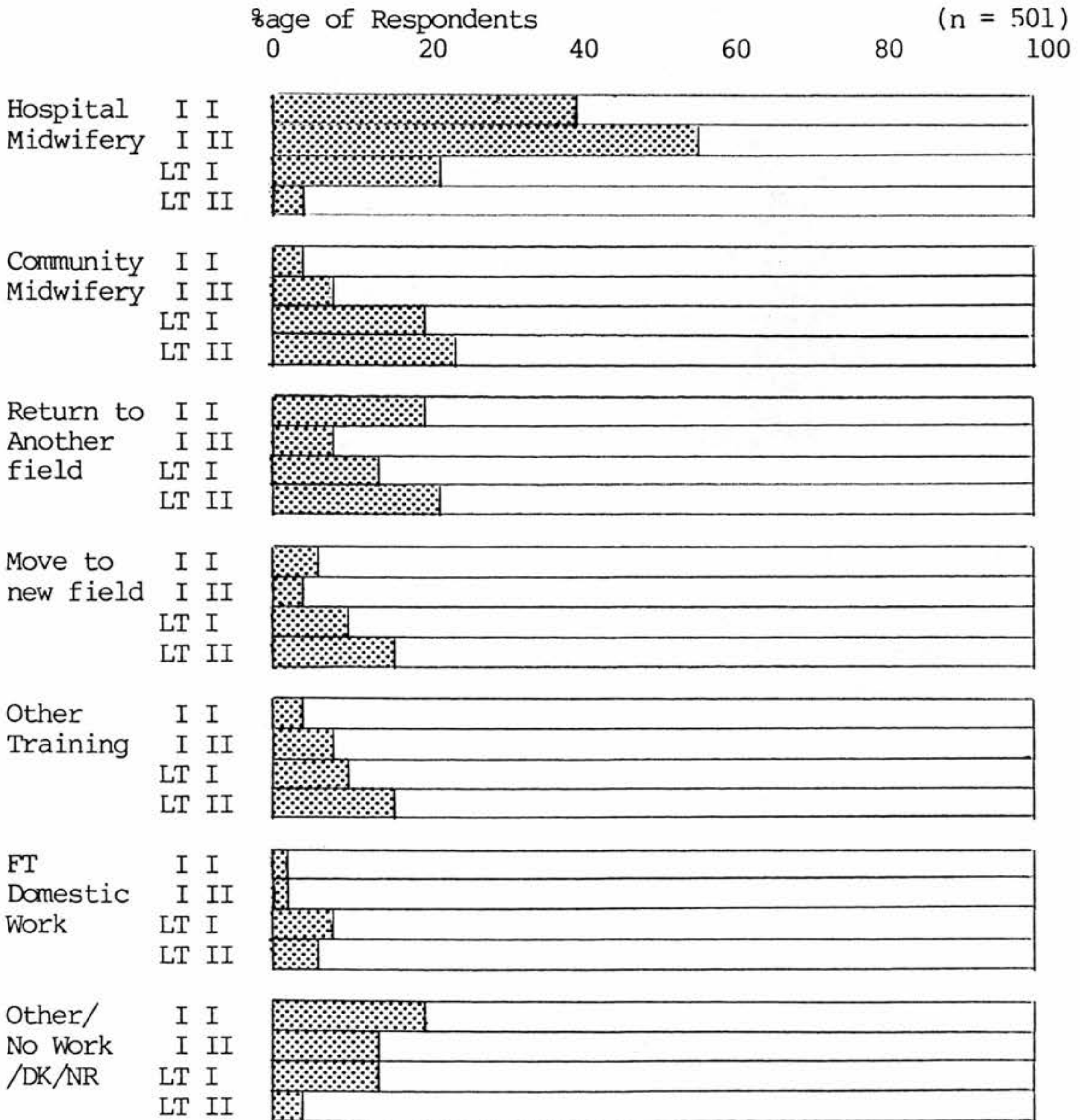


Figure 5.4.2. illustrates the proportion of students who plan to practise as midwives. A small majority (55.9%) plan to work as midwives on completion of their course, but this may not be a realistic assessment, as those who intend to find work immediately as community midwives may be prevented from doing so by the need to obtain midwifery experience first. Thus, the proportion of respondents planning to work immediately as midwives is reduced to a minority. A more optimistic interpretation of these data suggests that the number of new students intending to practise as midwives immediately is increasing steadily (46% in Stage I to 70.1% in Stage IIb); this may be a reflection of changing attitudes among new student midwives or may be due to deteriorating employment opportunities. It is also necessary to note the small proportion of student midwives with any long term intention of practising as midwives (28.9%).

The attraction of community work is clearly apparent from these data, including the intention of 19.6% of respondents to undertake health visitor training. This implies almost inevitably an intention to work as a health visitor. Small numbers gave this as their immediate employment intention, but a larger proportion (15.8%) stated that health visitor training is their long term plan.

Including those planning to undertake HV training, 150 respondents (29.9%) indicated their intention to undertake further training. This may be interpreted to mean that midwives perceive the need for further or continuing nursing education, but in view of the use in the questionnaire of the term "training" as opposed to courses or education, one may conclude that these respondents plan to obtain further nursing certificates, providing an illustration of the Lateral Movement Syndrome, the need for a nurse to collect a wide range of

experiences and qualifications, described by Hardy (1983).

A further point which may be drawn from Figure 5.4.2. is the proportions of respondents who are unable to indicate any career plans. This applies to immediate employment plans (18%) and long term plans (10%). These data demonstrate nurses' limited ability to plan their careers.

5.4.3. Country of Future Employment

Table 5.4.3.1. shows the respondents' plans for where they will live and/or work after completion of their midwifery training. These data become more meaningful when viewed in conjunction with the material on the respondents' country of origin. Table 5.4.3.2. shows the extent of the long term international mobility of the students.

Table 5.4.3.1. The Country in which the Student intends to live and/or work after Midwifery Training

	Stage I	Stage II	Total
Scotland	130 (53.9%)	140 (53.8%)	270 (53.9%)
England Wales or N.Ireland	16 (6.6%)	22 (8.5%)	38 (7.6%)
Eire	13 (5.4%)	12 (4.6%)	25 (5.0%)
Commonwealth	38 (15.8%)	23 (8.8%)	61 (12.2%)
Other Country	6 (2.5%)	15 (5.8%)	21 (4.2%)
Don't know /Other/No Response	38 (15.8%)	48 (18.5%)	86 (17.2%)
Total	241 (100%)	260 (100%)	501 (100%)

Table 5.4.3.2. Students' Intentions for Country of Residence

	Stage I	Stage II	Total
Returning to /Staying in Home Country	169 (70.1%)	175 (67.3%)	344 (68.7%)
Moving to/ Staying in Other Country	30 (12.4%)	26 (10.0%)	56 (11.2%)
Don't know/ No response	42 (17.4%)	59 (22.7%)	101 (20.2%)
Total	241 (100%)	260 (100%)	501 (100%)

The number of students demonstrating long term mobility in association with their midwifery training is somewhat greater than that shown by these students when they undertook their general nurse training. Their increasing mobility may be associated with any of a number of factors such as the limited opportunities for taking midwifery training in other countries, or Scotland's reputation for midwifery training.

5.4.4. Review

Student midwives' career planning is shown to operate on a short term basis. This may seem inappropriate in view of their high level of geographical mobility; alternatively, such mobility may require this.

5.5. Student Midwives' Views about Midwifery

The research design involves a comparison of the Beginners' views about midwifery with those of the same students on completion of their course. Any changes in the students views would be associated with, though not necessarily caused by, their midwifery training. These data provide the initial observation, with which Completers' data is to be compared, to assess the degree of socialisation in student midwives

and any association with the employment decision. The respondents' views were sought in the Beginners' Questionnaire by three items, two of which were originally devised and used by Golden (1979).

5.5.1. Value of the SCM/RM to a Non-Midwife

One of the items probing the respondents' views about midwifery took advantage of the commonly accepted phenomenon that many nurses who qualify as midwives never use their qualification by being employed as midwives. Items A3 and A4 in the Beginners' Questionnaire sought to ascertain, by a direct question, whether the respondent regarded the State Certified Midwife/Registered Midwife (SCM/RM, Appendix A) as being of any value to such a person and, if so, what the nature of that value might be. Table 5.5.1.1. shows the number of respondents who regard the midwifery qualification as valuable in such circumstances, and Table 5.5.1.2. details the value that respondents ascribe to possession of the midwifery qualification.

Table 5.5.1.1. The Value of the Midwifery Qualification to a Non-Midwife

	Stage I	Stage II	Total
SCM/RM of (stated) Value	171 (71.0%)	175 (67.3%)	346 (69.1%)
SCM/RM of (unstated) Value	23 (9.5%)	21 (8.1%)	44 (8.8%)
SCM/RM No value to non-midwife	43 (17.8%)	47 (18.1%)	90 (18.0%)
No/Other Response	4 (1.7%)	17 (6.5%)	21 (4.2%)
Total	241 (100%)	260 (100%)	501 (100%)

These data confirm that the entrants into midwifery training generally regard the SCM/RM qualification as an asset to a non-midwife. A small proportion are unable to define the nature of that value, but this does imply that the perception of the value is any less strong. The view that the midwifery qualification is essential to a general nurse is one which, in the experience of this researcher, is widely held among midwives and nurses.

The large proportion of the respondents who perceive the SCM/RM as a valuable qualification for a non-midwife may reflect a widely held perception or may be due to the uncertainty with which these new student midwives regard their future careers. Having committed themselves to taking midwifery training, these students have yet to decide whether their future lies in midwifery. Thus the belief that the qualification is definitely of value may resolve the dissonance resulting from the possibility that they may never use the qualification in the sense of being employed as midwives. If this suggestion is correct, then only those who are confident of either their commitment to midwifery or to their chosen career path are prepared to admit that the qualification may be of no value to a non-midwife.

The data in Table 5.5.1.2. indicate the ways in which the SCM/RM is perceived as being valuable to a non-midwife. The large proportion of respondents who considered that it satisfied an underlying interest or need for experience may be voicing a need which is stimulated but incompletely satisfied by the ON component of general nurse training.

Table 5.5.1.2. The Nature of the Value of the Midwifery Qualification (SCM/RM) to a Non-Midwife

(Percentages are the proportion of respondents in each Stage whostated the qualification was of value and stated the value).

	Stage I	Stage II	Total
Career	74 (43.3%)	56 (32.0%)	130 (37.5%)
Interest/ Experience	96 (56.1%)	108 (61.7%)	204 (58.9%)
Travel	10 (5.8%)	15 (8.6%)	25 (7.2%)
Complete Training	38 (22.2%)	56 (32.0%)	94 (27.2%)
?Liking/Change /Future Career*	7 (4.1%)	11 (6.3%)	18 (5.2%)
Total	225	246	471

*This item suggested that there was a query as to whether the respondent might like midwifery and she was taking the training to test it.

The respondents who stated that midwifery training makes nurse training complete may also be commenting on their general nurse training. This may not necessarily relate to the ON training, but may refer to their own unpreparedness to assume the role and responsibility of a qualified nurse, and their wish to use the 12 or 18 month midwifery course to complete their preparation.

The perception of a proportion of the student midwives, that the SCM/RM assists career advancement, will be discussed elsewhere (Section 6.3.1., Page 135) in relation to Hardy's Lateral Movement Syndrome. These data indicate that this syndrome still exists.

5.5.2. Opinions on the Length of Midwifery Training

Stage I respondents would have been well aware of the forthcoming extension of midwifery training, as the deliberations had been prog-

ressing for the previous three years. The item, first used by Golden, which probed their opinions on the length of training may merely have been asking them to articulate a view which they had acted on, consciously or otherwise, when applying for midwifery training; this was explicitly admitted by some respondents in item A1 (Table 5.3.3., Page 113). Despite this, as shown in Table 5.5.2., a small number of Stage I beginners considered the course to be too long. The purpose of this item was to assess the students' value of midwifery by encouraging them to judge the length of training and, indirectly, to indicate whether their time could be better spent.

Table 5.5.2. Opinions concerning Length of Training

	Stage I	Stage II	Total
Correct	177 (73.4%)	165 (63.5%)	342 (68.3%)
Too Long	15 (6.2%)	78 (30.0%)	93 (18.5%)
Too Short	29 (12.0%)	1 (0.4%)	30 (6.0%)
Unable to say /No Response	20 (8.2%)	16 (6.1%)	18 (3.6%)
Total	241 (100%)	260 (100%)	501 (100%)

It is hardly surprising that the proportion finding the course too long increased greatly in the group sampled immediately after the extension of training (Stage IIa), in which 35.8% stated this view. This finding is balanced to a certain extent by the relatively large proportion in Stage I who considered that the course was too short (12.0%). It is not impossible that these opinions were influenced by the imminent/recent extension of training.

5.5.3. Midwives' Characteristics

This closed item (A7 in the Beginners' Questionnaire) was included to assess the extent of the destereotyping process described by Lortie (1966) as part of the process of professional socialisation. The respondent was asked to indicate which of the characteristics applied to midwives. The nine characteristics stated ranged from the strongly positive and humane ("idealistic"), through the relatively neutral ("realistic"), to the authoritarian ("uncompromising").

Table 5.5.3. Respondents' Views on Midwives' Characteristics

	Stage I	Stage II	Total
Efficient	160 (66.4%)	171 (65.8%)	331 (66.1%)
Adaptable	150 (62.2%)	168 (64.6%)	316 (63.1%)
Realistic	132 (54.8%)	136 (52.3%)	268 (53.5%)
Cheerful	132 (54.8%)	127 (48.8%)	259 (51.7%)
Sincere	109 (45.2%)	97 (37.3%)	206 (41.1%)
Determined	45 (18.7%)	69 (26.5%)	114 (22.8%)
Idealistic	26 (10.8%)	24 (9.2%)	50 (10.0%)
Uncompromising	11 (4.6%)	7 (2.7%)	18 (3.6%)
Intolerant	6 (2.5%)	7 (2.7%)	11 (2.2%)
No Response/ Can't say/ Don't know any	14 (5.8%)	9 (3.5%)	23 (4.6%)
Total Responses	775	815	1590

This item is intended also to provide data on the students affinity for midwifery by demonstrating positive or negative views about the role models - midwives. Table 5.5.3. gives the data.

The characteristics which the researcher considers to be more favourable or positive, ("idealistic", "realistic", "cheerful" and "sincere") were said to apply by 423 respondents and were indicated as applying on 769 occasions. There was no limit to the number of characteristics which the respondents could indicate as applying.

The features which are regarded by the researcher as less appropriate for midwives ("determined", "uncompromising" and "intolerant"), were stated as applying to midwives by 133 respondents. As these characteristics were stated as applying on 143 occasions, some respondents considered that more than one of these adverse characteristics applies to midwives. Twenty three students did not give a valid reply to this item; of these eight were not prepared to generalise and a further two denied knowing any midwives.

As a combination of negative and positive responses was stated in a total of 556 responses and only 501 respondents completed the questionnaire, it is apparent that some respondents must have indicated that both extremes of characteristics apply. This suggests that a small number of respondents were exhibiting ambivalent views.

5.5.4. Review

New students' conviction of the value of midwifery training relates largely to its use outside midwifery. This conviction reflects on their basic nurse training, including the maternity component.

5.6. Expectations of Confidence in Certain Tasks

Item B3 in the Beginners Questionnaire, based on an item devised by Golden (1979), examined students' expectations of training, by

indicating tasks in which they expected to be confident on completion. Taken in isolation, these data (given in Table 5.6.) demonstrate the knowledge of the new students about the work of midwives and what is taught during midwifery training.

Table 5.6. The Expectations of New Student Midwives concerning Tasks in which they will be Confident on Completion of their Course

	Stage I	Stage II	Total
Home Confinement	156 (64.7%)	175 (67.3%)	331 (66.1%)
Hospital* Confinement	219 (90.9%)	242 (93.1%)	461 (92.0%)
Group* Teaching	174 (72.2%)	192 (73.8%)	366 (73.1%)
Individual* Teaching	191 (79.3%)	210 (80.8%)	401 (79.8%)
AN Visit*	170 (70.5%)	212 (81.5%)	382 (76.2%)
Scrub at CS	121 (50.2%)	144 (55.4%)	265 (52.9%)
AN/PN Ward*	169 (70.1%)	195 (75.0%)	364 (72.7%)
SCBU	62 (25.7%)	61 (23.5%)	123 (24.6%)
Promoting* Bonding	176 (73.0%)	131 (50.5%)	307 (61.3%)
Family* Planning	187 (77.6%)	208 (80.0%)	395 (78.8%)
Home Baby Care*	181 (75.1%)	212 (81.5%)	393 (78.4%)
Home PN Care*	183 (75.9%)	212 (81.5%)	395 (78.8%)
Don't Know/ No Response	1 (0.4%)	2 (0.8%)	3 (0.6%)
Total Responses	1990	2196	4186

(* Indicates tasks which are ordinarily part of a new midwife's work)

These data are interpreted as suggesting that, when compared with current practice, student midwives' expectations of midwifery and midwifery training are not based on fact. This imperfect knowledge of what midwifery involves is significant for two reasons. The first is that knowledge of what the occupation involves is a prerequisite for sound decision making (Loree & Leckie, 1977), together with self knowledge and route of entry into the occupation. These workers imply the impermanence of decisions made in the absence of this knowledge, which may apply to student midwives.

Second, that the new students' knowledge is so defective may be regarded as surprising in view of the large proportion (77.5%) of the sample having completed an ON course (Section 5.2.4.2., Page 102). Although knowledge of midwifery is not an aim of the ON course, the respondents' lack of knowledge of midwifery suggests that the general public may be even less well informed.

The large number of students expecting to be confident in care during a home confinement reflects an idealised perception of midwifery practice which is not consistent with the current trend towards hospital care. This idealised picture conflicts with the large proportion of students who expected to be confident in "Being a scrub nurse at a caesarean section" (CS) and in "Being in charge of a special care baby unit for a full shift" (SCBU). Both of these tasks are highly technical and, in the experience of this researcher, beyond the competence of some qualified midwives. Thus, the large numbers of students with such expectations have a false impression that midwifery training prepares them to work at a higher and more technical level than is actually the case.

5.7. Conclusions

This chapter has presented a profile of the student midwives, showing the minor difference between them and their equivalents in other parts of the UK. The students' limited knowledge of midwifery and the implications of this for career decision making has been discussed. As the purpose of this study is to compare the views of student midwives at the beginning and the end of their course, it was not anticipated that important data would be produced by the study of the Beginners' questionnaire in isolation, but rather to describe the background in order to to set the scene for the subsequent comparison. The following points may, however, be drawn from these data:

5.7.1. The educational qualifications of student midwives appear to be becoming higher; the differences between intakes are significant (Section 5.2.2.)

5.7.2. The proportion of experienced nurses who become student midwives is large and may have implications for their training. (Section 5.2.4.3.)

5.7.3. A small number of student midwives begin their training with heavy family responsibilities. (Section 5.2.3.1.)

5.7.4. Similarities with previous studies suggest that there are no major differences between student midwives in Scotland and those in other parts of Britain. (Section 5.2.6.)

5.7.5. Nurses deciding to train as midwives are influenced to a limited extent by the career intentions of their colleagues and this phenomenon requires further research. (Section 5.3.2.)

5.7.6. A small majority of new students indicate that they have any long term employment plans; this requires further study, with particular reference to the effects of general training on midwifery training. (Section 5.4.1.1.)

5.7.7. New student midwives have only limited knowledge of what is involved in midwifery and midwifery training. (Section 5.6.)

5.7.8. The numbers of new student midwives planning to work as midwives immediately appears to be increasing. (Section 5.4.2.)

5.7.9. Student midwives' reasons for taking midwifery training may reflect on their basic nurse training. (Section 5.3.1.)

CHAPTER 6

THE PRACTICE OF MIDWIFERY

This chapter examining the meaning of midwifery practice precedes the analysis of the Completers' data for two reasons. First, to assess whether new midwives do practise it is necessary to define what is meant by "practice" and how it may be measured. Second, those who do not practise as midwives may perceive other values in the SCM/RM and so the value of the midwifery qualification in these other settings is worth examining.

6.1. Defining Midwifery Practice

In a study such as this, which aims to examine both the employment intentions and actual employment practice of a group of workers at a certain stage in their careers, it is essential to decide which aspect of employment will be used as the dependent variable. In other words, if employment practice is to be measured or assessed, a definition of employment practice in midwifery is a prerequisite.

There are a number of interpretations of employment which might be appropriate, which will now be considered. From the employer or midwife manager's viewpoint, employment involves the hiring of staff to meet service needs, with the associated administrative work. The eventual separation ending the employment involves a similar bureaucratic component. To the midwife employee, the employment implies certain rights as well as certain obligations to the employer and others. For this researcher, though, these rights, obligations and administrative excesses are secondary compared with the nature of the work, the peripheral factors associated with it and their interaction to influence continuing midwifery employment. The term "practice" will be used to denote this work and these associated factors. This is

a word commonly used in midwifery to describe the role of a qualified midwife who is employed as such. This interpretation is rather limited, but even so it is supported by such definitions as exist.

The Central Midwives Board for Scotland (CMB [S], 1968) defines a practising midwife as one who Notifies Intention to Practise via the local supervising authority on an annual basis, notification not being possible for others. The UKCC has broadened the definition (1983) to:

> "A midwife who attends professionally upon a woman during pregnancy, labour, or the post natal period, or who holds a post for which a midwifery qualification is essential and notifies her intention to practise to the local supervising authority".

Thus, although the definition has been extended to include a summary of the work of a midwife, this is still not the crux of the definition; the crucial part continues to be the Notification.

The WHO definition of a midwife (CMB, 1983) emphasises the education of the midwife and its being essential to permit the practice of midwifery, but no attempt is made by WHO to define this practice; presumably because the work of midwives varies greatly between countries. This brief examination of the term "practice" serves to demonstrate that, though widely used in midwifery, the term has only one universal meaning and that bears little relation to the actual work of the midwife.

In the absence, therefore, of a more satisfactory measure of midwifery practice, the definition given by the CMB[S] (1968) and emphasising notification is being used in this study to permit an assessment of whether students completing midwifery training actually use that training and qualification. The main strength of this measure is its easy availability, with the cooperation of the statutory body.

Certain weaknesses are inherent in the use of this definition as a criterion; the first being its inability to indicate the duration of

practice, as notification refers only to practice "during" the year stated and not to the part or proportion of the twelve month period when practice will be undertaken. In the context of this research, using notification to represent the dependent variable may produce an unrealistically high estimate of the practice of midwifery; an under-estimation being impossible as all practising midwives are legally obliged to notify.

The second weakness of using notification as the criterion of practice is that it gives no indication of the proportion of the midwife's work which is midwifery. This point may be relevant to midwives who are not working on a full time basis, but it is particularly pertinent to the more isolated areas of Scotland, where triple duty (Appendix A, Page 294) posts are common. The job title gives no indication of the proportion of the work that is midwifery. It may be that among the ageing inhabitants of an underpopulated rural area, midwifery care is not the prime need!

A third weakness of using this definition of midwifery practice as the dependent variable, is its inability to demonstrate those respondents who will return to midwifery at a later date. This is a problem which is unavoidable in this type of research design, a greatly extended longitudinal study would be necessary to provide such data.

In view of the limitations of this measure of midwifery practice, other methods of collecting the data were contemplated. Approaches through the colleges of nursing and midwifery in which the students were based were a possibility. Although some colleges maintain contact with their former students, many would be unable to state either their address or the current employer. Involving the colleges might also

produce a further source of bias which would need to be considered in the data analysis.

The difficulties associated with contacting nurses by conventional routes are well documented (Hughes, 1958; Moores et al., 1982), largely because of their geographical mobility. Thus, the researcher in the present study found it necessary to use a definition of midwifery practice which, although more limited in its scope, was likely to produce a more complete response.

6.2. Midwifery as a Secondary Career

One explanation of the large numbers of midwives who do not practise on qualifying (Mander, 1980) is that they intend to return to midwifery later in life - to make midwifery their secondary career. Midwifery may fit Seear's (1971) definition (Appendix A, Page 294) in one of two ways. The first is that a woman, after taking her midwifery training early in her working life, leaves shortly afterwards to begin her childbearing and returns to midwifery probably on a part time basis, resuming full-time employment when the children are deemed old enough.

The second way in which Seear's definition may be appropriate to midwifery is in the case of the woman who, having completed her childbearing and associated responsibilities, undertakes her midwifery training because of her "first hand" experience of midwifery skills. This mature entrant is less likely to be present in Scotland due to the need for nurse registration prior to midwifery training. She does, however, feature in England and Wales as the "direct entrant".

A modification of the "in and out" pattern of female employment identified by Jope (Section 3.1., Page 34) has recently been recognised by senior midwives responsible for the recruitment and

employment. This alteration to the more traditional career pattern has developed as a result of the effect of current employment problems on males' employment. As the male "breadwinner" in the family unit has been made redundant or unable to find work, the female has been encouraged to abandon her traditional housewife/mother role to adopt that of breadwinner, leaving her male partner to adopt the home/family oriented duties. This deviation from the pattern described by Jope causes the woman to resume employment prematurely, which may be full time in preference to the part time arrangement described by Jope. These phenomena may have been responsible for the increase in part time working described by Gray and Smail (1982), but do not explain the disproportionately large increase in part time staff in midwifery, compared with mental deficiency and mental illness (index 100 in 1959 to 878, 598 and 331 respectively) which have many features in common.

6.3. The SCM/RM as an Aid to a Nursing Career

It would appear, therefore, that some students who undertake midwifery training contemplate the possibility of returning to midwifery after their own childbearing is over and that this return is being hastened by the present (1986) employment difficulties. Another established phenomenon also requires examination in relation to the employment of new midwives; this is the use of the midwifery qualification to advance a career in another field of nursing. This advancement may operate in one of two ways: first, to broaden experience to gain credibility and, second, to facilitate promotion.

6.3.1. Extending Experience

The perception among many nurses that a "broad" experience of nursing is necessary prior to the nurse specialising (Hardy, 1983) has resulted in midwifery being accepted as providing such experience. The

continuing existence of this perception may be demonstrated in the present study. In her study of the career patterns of leading nurses in England and Scotland, Hardy names this phenomenon the "Lateral Movement Syndrome". She suggests that such movement is necessary for the nurse to gain credibility both in her own esteem and in the eyes of her colleagues and potential employers. An alternative explanation for the perception of the need for "broad" experience may be that nurses perceive some deficiency in their basic nurse training, which may only be satisfied by taking a further training, such as midwifery.

6.3.2. Facilitating Promotion

The second way in which midwifery training is thought to aid a nurse's career lies in the belief that midwifery training is necessary for the nurse to gain promotion in any chosen area. This, it is commonly felt among nurses, was formerly a more explicit requirement, but there is little evidence to support the apocryphal account of a midwifery certificate being required for a sister's post on a male medical ward. The work of Hardy does support the existence of this belief. While suggesting that the "midwifery qualification is much abused", Hardy (1983:225) reports that 25 of her 35 respondents undertook midwifery training for reasons such as "needed for ward sister post". The present research may indicate whether this perception persists.

6.3.3. Transferability of Midwifery Skills

Hardy's work and this researcher's personal experience suggest that the midwifery certificate is perceived by nurses and by potential employers as evidence of "breadth of experience", indicating that the nurse has worked in a field of nursing which demonstrates many features which are different from nursing. Example of such features

may be the responsibilities of the midwife concerning drug administration and the different (healthy) clients. In view of these profound differences it is necessary to question whether the skills acquired in midwifery are transferable to other areas of nursing. If the answer is negative, the value of a midwifery qualification to a nurse is similarly questionable.

6.3.4. The Second Certificate

An alternative explanation for the perceived value of the midwifery qualification to nurses and their employers lies in its indication of the holder having completed a course of study beyond basic nurse education. This assumption is made by Williams (1979), who suggests the RSCN (Appendix A, Page 294) as an alternative second certificate. Were this assumption to be correct, similar numbers of nurses should be taking RMN and RNMH courses with equal proportions also leaving each of these areas. An SHHD survey (1974) indicates that nurses who undertake RMN and RNMD (as it then was) training, are more likely to remain in those areas. This suggests that nurses need midwifery training and experience, rather than just a second certificate.

6.3.5. Preparation for Practice Abroad

A further way in which midwifery training may assist a nursing career is found in the view that midwifery is necessary to prepare a nurse to work in a foreign country. The existence of this perception is clearly demonstrated by the Dan Mason Research Committee (NFNMC, 1963:24), in which 147 (12% of 1226) respondents stated that they had undertaken midwifery training to enable them to nurse overseas. This figure may not appear large, but should be compared with the number who trained in order to practise midwifery - only 24%.

It is necessary to consider whether midwifery training is really

essential for nursing in a foreign country, particularly in view of the stated policy of the SHHD (Mander, 1980), that the primary purpose of training midwives is to provide a midwifery service in Scotland. One may question the relevance of midwifery training to someone working as a nurse in a foreign country, with a different cultural background, different standards of health care, different obstetrical problems and disease conditions and a different value system (Nurden & Presern, 1986).

The working environment of the nurse is crucial. If the environment is sophisticated and developed the midwifery skills are likely to be appropriate. The relevance, however, of midwifery training is more questionable for the nurse working in a less developed, rural society, because of the differences already mentioned. Organisations who prefer to place midwives to work as nurses in remote areas argue that midwifery training is likely to provide a better standard of knowledge and skill than that available locally and that obstetric conditions and problems are likely to be similar despite cultural and societal differences (Tear, 1983).

It is suggested, therefore, that a nurse working in a foreign country is no more likely need a midwifery qualification to practise in an urban setting than a nurse in the UK although she may need obstetric experience for recognition as a nurse. If, however, the nurse is to work in a rural setting with a limited midwifery practice, the SCM/RM qualification is of little value in view of the huge differences in culture, health and environment.

6.4. Training as Preparation for Childbearing

The social value of midwifery experience is another reason suggested for taking training. "Social value" is used to indicate

areas which are useful in a non-occupational sense, such as in giving advice to friends and relatives, or as personal preparation for child-bearing. The belief that there is a high social value in midwifery training, is based largely on the researcher's personal experience of working with student midwives. On the basis of this experience a number of items were included in the present study to ascertain the prevalence of this view.

6.5. Conclusion

In this chapter midwifery practice as the dependent variable has been defined in terms of Notification of Intention to Practise. Despite certain recognised limitations in this definition, its great value lies in its consistency and availability. After defining the measure of practice, the value of midwifery training to those who do not practise as midwives has been questioned.

CHAPTER 7

ANALYSIS OF THE DATA - THE COMPLETERS

This chapter comprises a description of the data supplied on completion of the midwifery course of either twelve months (Stage I) or eighteen months (Stage II). To avoid duplication, those data from items replicated from the Beginners' Questionnaire are not included in this chapter, but contribute to the the comparisons made in Chapter 8. These data illuminate the role of reference groups and the time span involved in the decision making process. The respondents' reactions to the experience of midwifery training is discussed.

7.1. Response to the Completers' Questionnaire

The response rate of the Completers, consistently lower than the Beginners, fell steadily throughout the study as shown in Table 7.1.1. The proportion of students able and willing to identify themselves by providing their student registration number fell similarly.

Table 7.1.1. Response to the Completers' Questionnaire, Including Identification

	Stage I	Stage IIa	Stage IIb	Total
Questionnaires distributed	266	170	210	646
Returned completed	179	93	104	376
Response Rate	67.3%	54.7%	49.5%	58.2%
With CMB[S] Numbers	124	53	49	226
No CMB[S]/ Wrong Number	55	40	55	150

The reasons for the decline in response and identification are

not clear; the fact that a large proportion of respondents gave some identification, a registration number or a Personal Identification Number, suggests, however, that they were not resistant to or wary of identifying themselves, but rather that they did not understand the need for or have easy access to the required information. This interpretation is supported by those respondents who made comments such as:

"I cannot locate it. Apologies".

"Don't know. Trained at ________ Maternity Hospital".

7.2. Reference Group Effects

7.2.1. Changes in Group Size

Partly in an attempt to ascertain whether the concept of "infectious wastage" (Bendall, 1967) is relevant in this context and partly to ascertain whether the "group effects" sought in the Beginners' Questionnaire are operating on completion, the first items in the Completers' Questionnaire (A1 and 2, Appendix C) requested details of the number of students discontinuing from the group during the midwifery course. Infectious wastage is related to Notification in Section 7.6.5. (Page 161).

Table 7.2.1. Respondents' Perceptions of Reduction in Numbers in Group

Reduced	Stage I	Stage II	Total
Up to 3	87 (48.6%)	139 (70.6%)	226 (60.1%)
4 - 6/ Over 6	36 (20.1%)	15 (7.6%)	51 (13.6%)
Not Reduced	56 (31.3%)	43 (21.8%)	99 (26.3%)
Total	179 (100%)	197 (100%)	376 (100%)

The data (Table 7.2.1.) suggest that smaller numbers of students are discontinuing training, as the larger numbers in the "Reduced by 4-6/Over 6" groups in Stage I appear to have been transferred to the "Reduced by up to 3" group in Stage II. This observation is supported by the decreasing discrepancy between the numbers of questionnaires distributed to Beginners and Completers in each stage of the study, as shown in Table 8.1.1. (Page 165). It is necessary to question whether the low attrition rate in Stage IIa reflects a difference between students training in the small peripheral colleges excluded from Stage IIa, and those in larger, urban colleges of nursing and midwifery, which comprise Stage IIa or whether the differences are associated with the deteriorating economic climate.

7.2.2. Others in Group Practising as Midwives

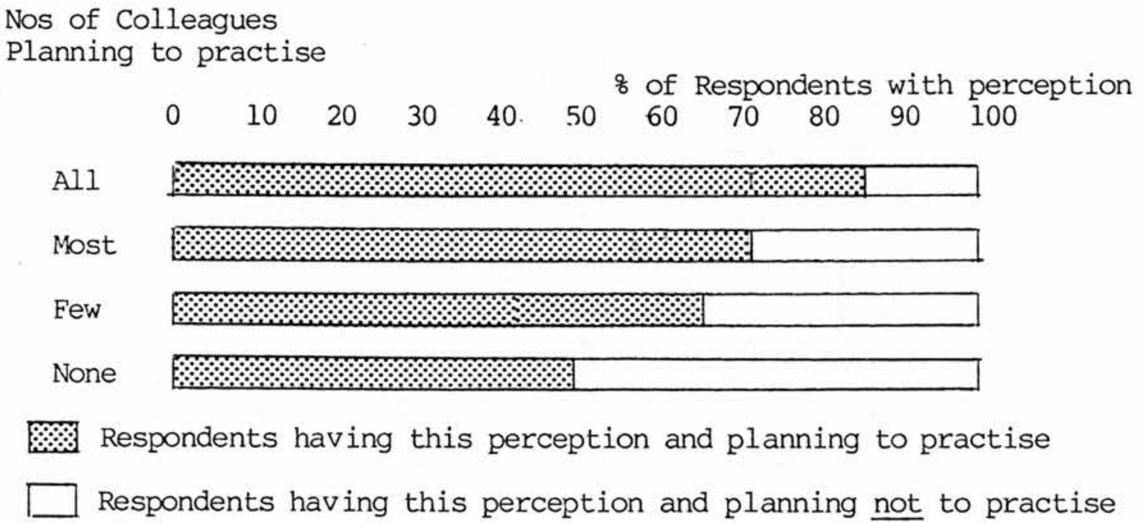
The association between the number of students in the group intending to practise as midwives and the intention of the respondent was probed in a closed item (B6). The purpose of obtaining these data (Table 7.2.2.) was to ascertain the extent to which students' employment plans are shared, or even influenced, by their colleagues.

Table 7.2.2. Respondents' Views of Colleagues Practising

	Stage I	Stage II	Total
All	6 (3.3%)	17 (8.6%)	23 (6.1%)
Most/half	89 (49.7%)	103 (52.3%)	192 (51.1%)
Few	83 (46.4%)	66 (33.5%)	149 (39.6%)
None/ No Response	1 (0.5%)	11 (5.5%)	12 (3.2%)
Total	179 (100%)	197 (100%)	376 (100%)

The data given in Figure 7.2.2. suggest that there is an association between respondents perceiving that their colleagues intend to work as midwives and their intention to do so. These data permit only reasoned speculation concerning the reasons for this association.

Fig. 7.2.2. Respondents' Views of Colleagues' Intentions and their Own



7.2.3. Family Advice

Items B7 and 8 in the Completers' Questionnaire sought to probe the effects of family advice on the employment decision. A number of workers, such as Redfern (1978), consider the family to be an important influence on the employment decision.

Table 7.2.3.1. Advice given by the Family on Future Employment

	Stage I	Stage II	Total
Give up Midwifery	20 (11.7%)	19 (9.6%)	39 (10.4%)
Continue in Midwifery	98 (54.7%)	122 (61.9%)	220 (58.5%)
Other	61 (34.1%)	56 (28.4%)	117 (31.1%)
Total	179 (100%)	197 (100%)	376 (100%)

Table 7.2.3.1. gives the data, which suggest that a large proportion of students are either given no advice by their families, or are advised only in very general terms, such as the person who wrote:

"They thought I should do what made me happy".

It is necessary to question whether this "advice" is any more than a confirmation, real or imaginary, of the student's own employment plans. Table 7.2.3.2. shows the extent to which the family advice coincides with the respondents stated employment intentions.

Table 7.2.3.2. Family Advice and Intention to Practise as Midwife

	Advice to Continue	Advice to Discontinue	Total
Intends to Practise	182 (82.7%)	10 (25.6%)	192 (74.1%)
Intends no Practice	38 (17.3%)	29 (74.4%)	67 (25.9%)
Total	220 (100%)	39 (100%)	259 (100%)

Significant at .005
Using Chi Squ = 59.9
With 1 DF

These data indicate that the students' employment intentions are significantly similar to the families' advice. The present data are unable to establish whether the students amended their employment plans to comply with their families' wishes or vice versa.

7.2.4. Review

The influence of the group and the family is demonstrated in these data. This influence appears to operate in favour of the new midwife continuing in midwifery.

7.3. Career Planning and Mobility

Information on the respondents' plans for future employment were sought because this area may be amenable to management intervention.

7.3.1. Timing of Employment Decision

The Completers' Questionnaire included one item (B3) probing the timing of the decision concerning forthcoming employment.

These data (Table 7.3.1.) show an apparent decrease in the size of the majority of student midwives making the employment decision less than six months prior to needing employment. A large majority of student midwives (78.5%) make their decision about future employment during their midwifery course. Only a small minority (19.4%) decide more than one year in advance of the completion of their course. For some of these the decision will be the one which was made prior to beginning training. It may be assumed, therefore, that for the majority of student midwives the employment decision will be influenced by their experience of midwifery.

Table 7.3.1. The Timing of the Decision about the next Employment

	Stage I	Stage II	Total
Under six months ago	102 (57.0%)	90 (45.7%)	192 (51.1%)
Six to twelve Months ago	46 (25.7%)	57 (28.9%)	103 (27.3%)
Over one Year ago	27 (15.1%)	46 (23.3%)	73 (19.4%)
No Response	4 (2.2%)	4 (2.0%)	8 (2.1%)
Total	179 (100%)	197 (100%)	376 (100%)

7.3.2. Factors Influencing Employment Decisions

The item seeking the influences on the employment decision was an open question which produced a wealth of relatively soft data, which are categorised in Table 7.3.2. The variables in this table indicate that the respondent mentioned the factor, but not whether it was used positively or negatively. An example of this is "Satisfaction" which was mentioned or implied by 7.7% of the respondents; eight respondents used the term in a relatively neutral way, without indicating whether the presence of this factor was a reason for staying in midwifery or whether its absence was a reason for leaving midwifery. All of these did, however, plan to work as midwives. Four respondents mentioned that the satisfaction which they obtained from midwifery had influenced their decision:

> "Job satisfaction while training".

All four of these respondents intended to work as hospital midwives on completion of the course. Seventeen respondents mentioned satisfaction as being either greater in another field or as lacking in midwifery:

> "Dissatisfied with the maternity hospital".
>
> "I did not enjoy midwifery, but found general nursing more satisfying".

Despite such negative comments eight of these seventeen respondents intended to work in midwifery on completion of the course. It may be concluded from these data that the respondents' dissatisfaction applies to certain local circumstances, which they are able to differentiate from midwifery practice in general. This table shows that a large proportion (28.2%) of new midwives consider it necessary to gain experience in the area in which they have just qualified. It may be anticipated that this need will decline in association with the extension of training, which is supported by these data.

Table 7.3.2. Factors Influencing the Employment Decision
(Percentages are proportions of respondents)

	Stage I	Stage II	Total
Experience/ Consolidate	55 (30.7%)	51 (25.9%)	106 (28.2%)
Enjoyment	50 (27.9%)	35 (17.8%)	85 (22.6%)
Domestic	29 (16.2%)	29 (14.7%)	58 (15.4%)
Job Available	9 (5.0%)	56 (28.4%)	65 (17.3%)
Promotion /Previous Commitment	12 (6.7%)	16 (8.1%)	28 (7.4%)
Satisfaction	17 (9.5%)	12 (6.1%)	29 (7.7%)
Money	10 (5.6%)	2 (1.0%)	12 (3.2%)
No/Other Response	33 (18.4%)	27 (13.7%)	60 (15.9%)
Total	215	228	443

As may be seen from Table 7.3.2., job availability gradually became more important as the research progressed, applying to increasing numbers with each stage of the study. The reverse is apparent in the declining numbers claiming that money was an influencing factor. In Stage I respondents made comments such as:

"Marital and financial circumstances".

"... in Saudi. Better money and working facilities. I like hot weather every day".

"Stay on in midwifery for 1-2 years to put my training into practice, but in the long term health visiting offers better hours and money".

Of the ten respondents who mentioned finance in Stage I, only one had no intention of ever working as a midwife. In Stage II there were fewer and briefer references to finance:

"Enjoy work. Financial reasons".

"Shift hours (unsocial). Finance. Family".

References to midwifery employment usually implied the difficulty of obtaining such work:

"Unable to obtain a job in midwifery to gather more experience. Therefore going back to general".

"Very few staff midwives posts available where I trained, and if I wait to see if post available may have ended up with no job and missed out in the new post (gynaecological staff nurse post)".

"The fact that we were not told whether or not we had posts until one week prior to completion of training".

"No jobs available in midwifery at the moment".

Rarely "job availability" meant the reverse:

"I need and want experience as a midwife. Job available".

7.3.3. Review

The factors influencing the employment decision, though usually exerted during midwifery training, are not easily amenable to action by midwifery managers. This applies particularly to perception of the deteriorating economic situation which has exerted an increasing influence on new midwives' employment decisions.

7.4. Views about Midwifery

The respondents' views about midwifery and midwifery employment were sought in items A3/4, A5 and A8, which were replications of items in the Beginners' Questionnaire and which are discussed in Chapter 8. Two items which were not replications, A6/7 and B9, are examined here. These items constituted a less or more direct assessment of the reasons for staying in or leaving midwifery and demonstrate the new midwives' beliefs concerning the control of retention.

7.4.1. Advice to Another Concerning Midwifery Training

Items A6 and A7 of the Completers' Questionnaire were based on

items used in the NFNMC survey (1963). These were open questions which requested the reasons why the respondent would respectively advise a suitable friend to and not to train in midwifery. The data are given in Tables 7.4.1.1. and 7.4.1.2., the categories being those used by NFNMC. These categories did not include one to cover the "emergency situations" mentioned by some respondents:

"This person may have to deliver a baby in casualty".

Table 7.4.1.1. Reasons for Advice to Train as Midwife
(Percentages are proportions of respondents)

	Stage I	Stage II	Total
Interest/ Satisfaction	87 (48.6%)	95 (48.2%)	182 (48.4%)
Complete Training /Emergency	28 (15.6%)	21 (10.7%)	49 (13.0%)
Promotion	24 (13.4%)	17 (8.6%)	41 (10.9%)
Experience	38 (21.2%)	43 (21.8%)	81 (21.5%)
Work Abroad	13 (7.3%)	3 (1.5%)	16 (4.3%)
Pleasant/ Happy	28 (15.6%)	33 (16.7%)	61 (16.2%)
Extra Qualification	9 (5.0%)	24 (12.2%)	33 (8.8%)
Other/No Reason	54 (30.1%)	69 (35.0%)	123 (32.7%)
Total	281	306	587

Thirty one respondents stated that they would not be prepared to advise a friend, making the question irrelevant. This response was not reported in the NFNMC study. A small number of these responses were not clear as to whether they were refusing to advise or refusing to advise against midwifery training:

"None really".

"I wouldn't advise a friend not to".

"In general I could not honestly advise someone to go into nursing. I would not however advise them against it if that was their chosen field".

"A suitable friend for midwifery would not get reasons".

"I would not advise anyone on their career".

Table 7.4.1.2. Reasons for Advice not to Train as Midwife
(Percentages are proportions of respondents)

	Stage I	Stage II	Total
Temperament	30 (16.8%)	44 (22.3%)	74 (19.7%)
Lower status	26 (14.5%)	16 (8.1%)	42 (11.2%)
No practice	16 (8.9%)	14 (7.1%)	30 (8.0%)
No nursing	12 (6.7%)	9 (4.6%)	21 (5.6%)
Study ++	29 (16.2%)	35 (17.7%)	64 (17.0%)
Monotonous	17 (9.5%)	14 (7.1)	31 (8.2%)
Other Reason	31 (17.3%)	33 (16.7%)	64 (17.0%)
No response	46 (25.7%)	42 (21.3%)	88 (23.4%)
Would not advise/against	2 (1.2%)	16 (8.1%)	18 (4.8%)
Total	209	223	432

A small number of respondents stated reasons associated with the personality of the friend, rather than those pertaining to the job, as the reason for advising:

A6 "If she is interested in the subject, then it is a nice aspect of nursing to work in. There is a lot of job satisfaction".

A7 "If (they) don't like babies, or teaching".

A6 "She/he must have a sincere interest in obstetrics - not adviseable for someone who is very geared to general work".

A7 "To do it for the sake of a second certificate".

A7 "If she is going to use it afterwards or if she is doing it because there is nothing else to do".

A7 "Unless she had always wanted to be a midwife or had nothing else to do for 18 months I would advise her against it as it would be a waste of time".

These quotations serve to support the observation by NFNMC:

"Comments were interesting and sometimes bitter".

The two latter quotations from respondents are among those who indicated that midwifery training may be taken as an alternative to being unemployed, a concept which became increasingly important as the study progressed.

The data appear to show a steady increase in the proportion of respondents who consider that obtaining a second qualification is a good reason for recommending midwifery training. Perhaps reciprocally, the value of the midwifery qualification as an aid to promotion appears to decline as the study progresses. The need to "complete" general nurse training or prepare for emergencies declines similarly.

These data show that the lower status of student midwives is perceived by a comparatively large proportion of respondents as a reason for not recommending midwifery training. For a large proportion (41.9%) of respondents taking midwifery training involved transferring from a charge nurse or senior staff nurse post; for a similar proportion the move was from a staff nurse post of less than one year's duration. The problems associated with this transition are described vividly by the respondents:

"Difficult to 'degress' to a student level after maybe years of a highly responsible position".

"Initially you tend to forget that you are RGN. You tend to lose confidence in your own ability".

"Its like going back to school again, you will be treated like an idiot. They aren't very friendly. If you enjoy general nursing then stay where you are".

A small minority of respondents used this item to mention the status of the midwife:

"Medical staff are eroding the midwife's duties - reducing her status to an obstetric nurse".

7.4.2. Changes to Encourage Midwifery Practice

An open item (B9) was included in the questionnaire to seek both the students' comments about problems in midwifery and solutions to perceived problems. Table 7.4.2. shows that a large proportion of respondents omitted this item, due to an inadvertent misdirection.

Table 7.4.2. Changes suggested to Encourage Practice in Midwifery
(Percentages are proportions of respondents)

	Stage I	Stage II	Total
Responsibility	20 (11.2%)	10 (5.0%)	30 (8.0%)
Salary	36 (20.1%)	16 (8.1%)	52 (13.8%)
Midwives' Role	23 (12.8%)	30 (15.2%)	53 (14.1%)
Staff/ Organisation	48 (26.8%)	44 (22.3%)	92 (24.5%)
Educational Factors/ Promotion	11 (6.1%)	3 (1.5%)	14 (7.1%)
Total Reponses	138	103	241
No Response	89 (49.7%)	115 (58.4%)	204 (54.3%)

These data suggest that salary, originally an important factor in retaining midwives, is becoming less important. The role of the midwife appears to be a matter of some concern to new midwives, but these

data indicate that organisational problems are consistently considered to be in need of attention.

A small number of respondents answered this item only in terms of student/new midwives, such as:

> "During the course there should be more emphasis placed on the responsibilities of a qualified midwife in charge of any particular unit. Throughout the course there seems to be marked division between qualified midwives and student midwives".

Most respondents interpreted this item in the broad terms intended:

> "To remain in specific areas for a longer length of time, so that they can gain confidence in that specific area before changing department".

Many respondents commented on the practice of rotating midwives through different areas and between day and night shifts. The comments varied considerably in their recommendations including longer, shorter, no rotation and various combinations.

The attitudes of other members of staff appear to cause some concern:

> "Financial reward for extra qualification. Better support from senior midwives".

> "Less rigid hierarchical structure in maternity hospitals. More independence and responsibility. More prestige in job".

As with the above comment, the role of the midwife was often mentioned, in relation to both other midwives and other occupational groups:

> "More jobs. More smaller birthing centres. Less obstetrician dependancy".

> "Greater employment of midwives. Improve understaffed areas. Friendlier trained midwives with more tolerant attitudes towards patients. More autonomy to midwife. Less interference".

Comments were also made about the organisation of the midwifery services:

"More home confinements. More relaxed atmosphere. Less status conscious attitude by staff".

7.4.3. Review

New midwives' views indicate awareness of organisational factors which, they believe, are amenable to action to encourage retention.

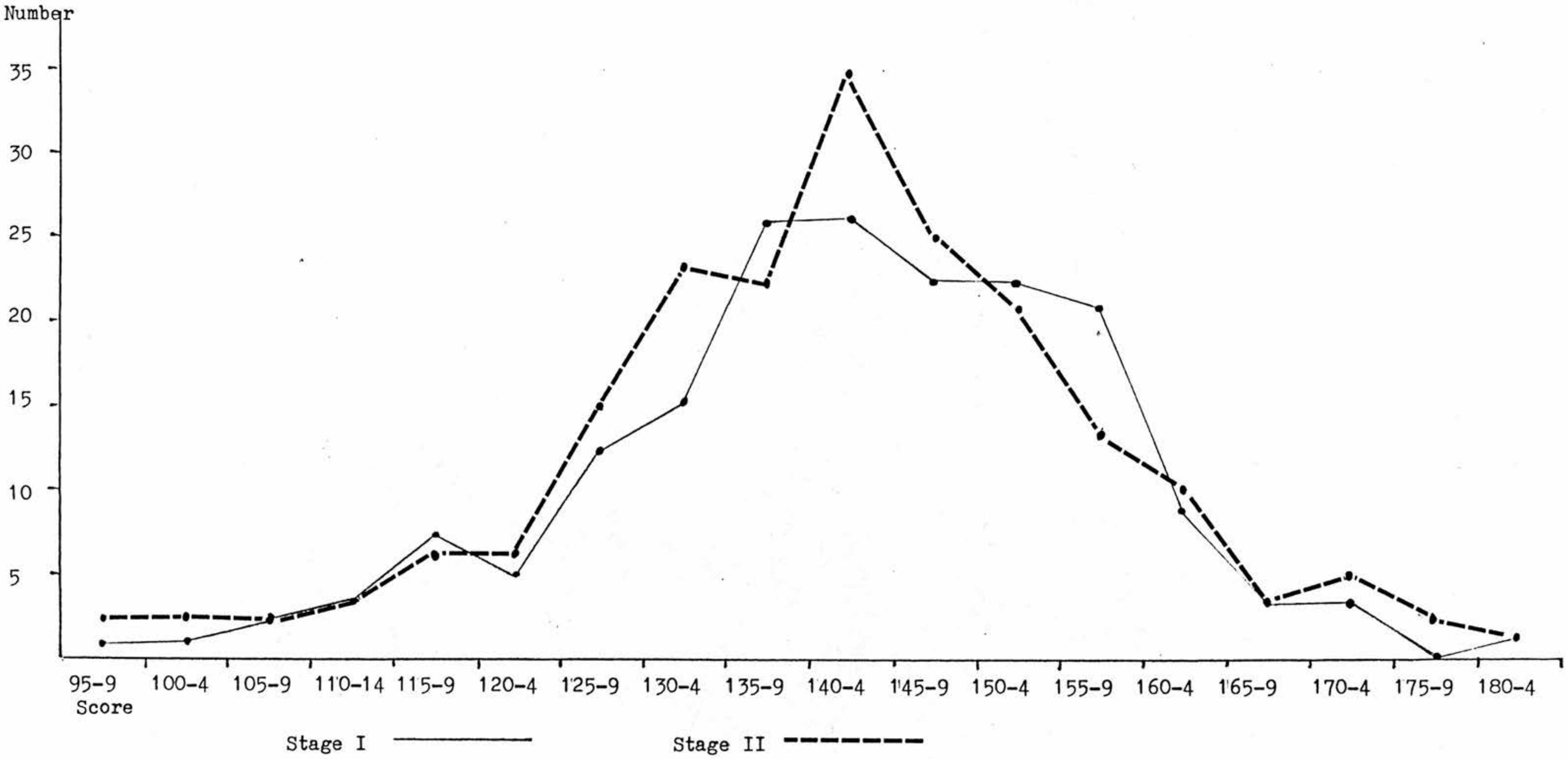
7.5. Attitudes to Midwifery

Section C of the Completers' Questionnaire was used to probe the respondents' attitudes to midwifery to examine any association between attitude and employment intention or practice. A Likert-type scale was devised for this (Appendix C, Page 302), which contained equal numbers of positive and negative statements about midwifery. The scores produced in response to this item were analysed in a number of ways to examine their value. Table 7.5. shows a three-way split by degree of "favourability" of response and Stage. Although the three-way split demonstrates an increase over time in the number with lower scores (unfavourable to midwifery) and a decrease in the number scoring higher, no significant difference in attitudes to midwifery is attributable to the extension. Figure 7.5. (Page 155) illustrates the changes in the distribution of the scores in each Stage.

Table 7.5. The Scores in the Attitude Survey

	Stage I	Stage IIa	Stage IIb	Total
Low Score (83-136)	55 (30.7%)	32 (34.4%)	38 (36.5%)	125 (33.2%)
Medium Score (137-148)	60 (33.5%)	30 (32.2%)	35 (33.6%)	125 (33.2%)
High Score (149-184)	64 (35.7%)	31 (33.3%)	31 (29.8%)	126 (33.5%)
Total	179 (100%)	93 (100%)	104 (100%)	376 (100%)
Mean Score	142.78	141.59	142.38	142.37

Figure 7.5. The Scores in the Attitude Survey by Stage



As the purpose of Section C was to examine any association between the respondents' attitudes to midwifery and their intention to practise as midwives, the scores are of limited value when viewed in isolation. After examining notifications generally, the Section C scores will be compared first with the respondents' intentions to practise as midwives, then with the numbers of respondents who actually practised, as demonstrated by those who Notified their Intention to Practise.

7.6. Notifications of Intention to Practise

Notification of Intention to Practise was selected as the final outcome measure to ascertain any changes in employment decisions in relation to changes in midwifery training. The reason for the selection of this variable is that it is an absolute measure of the number of qualified midwives requiring the midwifery qualification for their work. The data in this section relate largely to the respondents who identified themselves, resulting in the totals being reduced (Table 7.1.1., Page 140).

7.6.1. The Number of Midwives Notifying

Table 7.6.1.1. appears to show a marginally declining number of newly qualified midwives in the study population who notified their intention to practise on completion of their course.

Table 7.6.1.1. The Number of New Midwives who Notified
(Expressed as the Percentage of Beginners)

	Stage I	Stage IIa	Stage IIb	Total
Notified	134 (44.2%)	54 (31.4%)	91 (40.4%)	279 (39.8%)

These data suggest that the reservations expressed (Section 2.1.1., Page 5) regarding the more optimistic but less reliable RCM

data are justified, as RCM appear to have assessed employment intentions rather than employment practice. On the basis of these data it is necessary to conclude that the problem of non-retention of new midwives persists in Scotland.

Table 7.6.1.2. shows the proportion of new midwives who responded to the Completers' Questionnaire and identified themselves and who Notified their Intention to Practise.

Table 7.6.1.2. Respondents to the Completers' Questionnaire who Identified and Notified

	Stage I	Stage IIa	Stage IIb	Total
Notified	64 (51.6%)	19 (38.0%)	23 (46.9%)	106 (47.7%)

These data suggest that midwives who identified themselves on the Completers' Questionnaire are slightly over-represented among those who Notified their intention to practise. Despite the marginal decline in the numbers notifying (only possible if employed), these data fail to support the common view that midwifery employment is not available.

7.6.2. Attitude Scores and Immediate Employment Intentions

Table 7.6.2. summarises the data from the whole study on the respondents' immediate employment intentions in relation to their scores in the attitude survey. Higher scores are being regarded as showing an attitude which is more "favourable to midwifery". The scores were split into three approximately equal groups; the different levels in the three-way split showed significant difference in terms of employment plans. The respondents having high scores (149 - 184), thought to reflect the most favourable attitude to midwifery, were significantly more likely to intend to practise midwifery immediately when compared with those who earned low scores (83 - 136).

Table 7.6.2. Attitude Scores and Immediate Employment Intentions

	Low Score 83-136	Medium Score 137-148	High Score 149-184	Total
Plans to Practise	79 (63.2%)	90 (72.0%)	96 (76.2%)	265 (70.5%)
No Plans to Practise	46 (36.8%)	35 (28.0%)	30 (23.8%)	111 (29.5%)
Total	125 (100%)	125 (100%)	126 (100%)	376 (100%)

The difference between Low scorers and Others is Significant at .05 Using Chi Squ = 4.7698 With 1DF

These data demonstrate that those scoring lower on the attitude survey are significantly less likely to have plans to practise, suggesting that the attitude survey is measuring affinity towards midwifery.

7.6.3. Notification and Stated Employment Intention

It was anticipated that there would be some discrepancy between the employment intentions stated on the Completers' Questionnaire and the actual employment of the midwives. Table 7.6.3. demonstrates the association between the intention to work as a midwife on qualifying and the actual employment, that is, the Notification.

Table 7.6.3. Statement of Employment Intention and Notification of Respondents intending to Live/Work in Scotland

	Intend Practice	Intend No Practice	Intend to Work Elsewhere	Total
Notified	94 (49.2%)	4 (6.0%)	8 (6.8%)	106 (28.2%)
Did not Notify	97 (50.8%)	63 (94.0%)	110 (93.2%)	270 (71.8%)
Total	191 (100%)	67 (100%)	118 (100%)	376 (100%)

Significant at .005 Using Chi Squ = 85.36 with 2DF

This table shows that significantly more of the respondents intending to practise did so than may have been expected. However, of the identifiers who stated that they intended to practise, 37.6% did not notify. Less expected was the, admittedly small, number of respondents who stated that they had no intention of practising midwifery or of working in Scotland and who subsequently notified that they were working as midwives in Scotland. In response to item B2, which probed the factors influencing the employment decision (Section 7.3.2., Page 146), these respondents made the following comments:

"There are no posts vacant in our maternity unit".

"I can't get a midwifery post in my local hospital and I am unable to travel far".

"No jobs available in midwifery at the moment".

Although these comments suggest that the respondents are compelled by the employment situation to move out of midwifery, it is necessary to bear in mind that these people were stating that they had no plans to work as midwives and that this has been reversed, within less than six months. It may be suggested that as long as midwives are required to change their employment plans at such short notice, it is hardly surprising that they show only a limited ability to plan their careers (Sections 5.4.1., Page 115 and 7.3.1., Page 145).

7.6.4. Attitude Scores and Notification

The data in Table 7.6.4.1. compare the attitude scores with the Notification of Intention to Practise of those respondents who identified themselves in the Completers' Questionnaire. This table summarises the data for the three stages of the study and suggests that Notifiers are over-represented among the higher scorers; but the data, as well as the mean scores of the six groups (which are not given here but are summarised in Section 8.3.4.), show that the diff-

erences in the expected direction shown in the table, between the higher and the lower scorers, are not significant.

Table 7.6.4.1. Respondents' Attitude Scores and Notification

	Low Score 83-136	Medium Score 137-148	High Score 149-184	Total
Notified	29 (43.9%)	35 (46.1%)	45 (53.6%)	109 (48.2%)
Did Not Notify	37 (56.1%)	41 (53.9%)	39 (46.4%)	117 (51.8%)
Total	66 (100%)	76 (100%)	84 (100%)	226 (100%)

Table 7.6.4.2. shows the Stage I data, which discriminate between lower scorers and others (the medium and high columns are united for testing significance), the higher scorers being significantly more likely to notify. It may be that this discrepancy is associated with the greater choice available to the Stage I; that is, because they made their employment decisions before the economic recession affected midwifery, their employment and attitudes correlate more closely.

Table 7.6.4.2. Stage I Attitude Scores and Notification

	Low Score 83-136	Medium Score 137-148	High Score 149-184	Total
Notified	12 (35.2%)	22 (53.7%)	30 (61.2%)	64 (51.6%)
Did Not Notify	22 (64.8%)	19 (46.3%)	19 (38.8%)	60 (48.4%)
Total	34 (100%)	41 (100%)	49 (100%)	124 (100%)

Chi Squ = 4.97 Significant at .05 Using 1DF

The Stage I situation may be contrasted with the Stage II groups whose employment choices were limited by the availability of jobs, regardless of their own inclinations and attitudes.

7.6.5. Attrition during the Course and Notification

An attempt was made to determine whether the concept of "infectious wastage" (Bendall, 1967) pertained to new midwives; this is the phenomenon in which circumstances within a group of students cause increasing numbers of them to discontinue.

Table 7.6.5. Student Midwife Attrition and Notification

	Attrition 4 and over	Attrition 3 or less	Total
Notified	17 (48.6%)	89 (46.6%)	106 (46.9%)
Did not Notify	18 (51.4%)	102 (53.4%)	120 (53.1%)
Total	35 (100%)	191 (100%)	226 (100%)

This assessment was made by comparing the notifications of those respondents who reported high attrition (four or more) during their midwifery course with the rates among others. The expectation was that if this concept does apply in midwifery, the notification rate would be low among the high attrition respondents. The data shown in Table 7.6.5. do not appear to support the presence of this phenomenon.

7.6.6. Review

The attitude survey appears to discriminate between those who do and do not intend to practise, but the relationship between intention and practice has been complicated by the respondents' perceptions of the deteriorating employment environment.

7.7 Conclusions

Analysis of the Completers' data has illustrated the role of reference groups and the time factor in employment planning. Other influences on the employment decision have been identified, some of

which, the respondents believe, are amenable to management action. Certain conclusions may be drawn from these data, even before comparisons are made with the Beginners' data, which was the primary aim and which are to be found in Chapter 8.

7.7.1. Comments made by the respondents suggest that they experienced difficulty in identifying themselves, rather than being reluctant to do so. (Section 7.1.1.)

7.7.2. Students intending to practise as midwives are more likely to perceive that many of their colleagues have similar intentions. (Section 7.2.2.)

7.7.3. Family advice reported by students tends to coincide with their employment plans. (Section 7.2.3.)

7.7.4. A large majority of students make their plans for their forthcomimg employment within 12 months prior to completing their midwifery course. (Section 7.3.1.)

7.7.5. Many new midwives perceive a need to gain more experience in midwifery, although this perception may be becoming less prevalent. (Section 7.3.2.)

7.7.6. As the study progressed job availability was more frequently mentioned as a factor influencing the employment decision. (Section 7.3.2.)

7.7.7. The view that a second qualification is of value to a nurse is still held, also that midwifery is a suitable course to provide that qualification. (Section 7.4.1.)

7.7.8. The lower status of a student midwife, compared with other grades, is seen by some respondents as a reason for not recommending midwifery training. (Section 7.4.1.)

7.7.9. Changes in the organisation of midwifery is seen as one way of encouraging more midwives to practise. (Section 7.4.2.)

7.7.10. The problem of the non-retention of new midwives persists in Scotland. (Section 7.6.1.)

7.7.11. The attitude survey measures the degree of affinity towards midwifery. (Section 7.6.2.)

7.7.12. Midwives appear to be vulnerable to changes in their circumstances which may necessitate sudden reversals in their employment plans. (Section 7.6.3.)

CHAPTER 8

THE ANALYSIS OF THE DATA - THE BEGINNERS AND THE COMPLETERS

The components of this research project, as has been established in Section 4.1.2. (Page 70), may be regarded as natural experiments; the reason being that the manipulation of the independent variables is by an agent other than the researcher (Simon, 1969). Continuing the concept of the experiment in this chapter, the data will be analysed on the basis of two concurrent natural experiments.

The first experiment investigates the employment decisions associated with midwifery training by scrutinising Beginners' and Completers' employment intentions and practice. This scrutiny is undertaken in two stages, providing detail of different aspects while avoiding duplication. The Double Identifiers' data are scrutinised first, these are the respondents who, having identified themselves in both questionnaires, are known to be the same respondents. These data, first, provide a picture of the changing views concerning midwifery and, second, describe changes in employment plans. The latter part of this chapter draws on the Notifying Beginners' data to relate personal and occupational factors to the actual employment.

The second experiment involves the changes in employment decisions associated with the extension of midwifery training; this experiment aims to evaluate aspects of the extension of training.

Initially, though, it is necessary to describe the response and those whose views will be reported in this chapter.

8.1. The Response

Details of the response are given in Table 8.1.1., which summarises the Beginners' and Completers' Questionnaires in all stages of the study. The overall response rate for the study was 65.2%.

In reading these data it is necessary to recall that both questionnaires were applied to the same group of students at the beginning and on completion of their course.

Table 8.1.1. Summary of the Response to the Questionnaires

Stage	I	IIa	IIb	Total
BEGINNERS' Questionnaires distributed	303	172	225	700
Questionnaires Returned	241	109	151	501
Response Rate	79.5%	63.4%	67.1%	71.6%
COMPLETERS' Questionnaires distributed	266	170	210	646
Questionnaires Returned	179	93	104	376
Response Rate	67.3%	54.7%	49.5%	58.2%

The difference between the number of questionnaires distributed to the Beginners and Completers is due to attrition from the course. 54 Students left the course, making the dropout rate for the sample 7.7% (Table 8.1.1.). It may be estimated that this is the proportion who failed to respond to the Completers' Questionnaire due to having dropped out; the reason for the further decrease (71) in response is not apparent.

Section D of each questionnaire requested the respondent to give their CMB[S] student registration number. Some were unable to comply with this request and gave other identifications. Table 8.1.2. shows the number of students who identified themselves at each stage of the study and also those who identified themselves in both questionnaires - the "Double Identifiers".

Table 8.1.2. Respondents Identifying Themselves

	Stage I	Stage IIa	Stage IIb	Total
Beginners With CMB[S] Numbers	215 (89.2%)	84 (69.3%)	123 (81.5%)	422 (84.2%)
Completers With CMB[S] Numbers	124 (69.3%)	53 (57.0%)	49 (47.1%)	226 (60.1%)
Respondents Identifying In both Questionnaires	102	30	35	167

8.2. Midwifery Training Experiment - Midwifery Data

Scrutiny of the Double Identifier Beginners and Completers provides background data on their plans and views regarding midwifery.

8.2.1. Employment Plans and Mobility

Distinguishing a person's plans for employment and place of residence may be difficult, as the two may be interdependent; for this reason these topics will be examined together in this section. Data on immediate employment plans (B1 in both Beginners' and Completers' Questionnaires, Appendices B & C) are given in Table 8.2.1.1.

The data demonstrate a trend in favour of midwifery, with a realistic preference for employment in hospital. When the "Hospital Midwifery" group are compared with others the change is shown to be significant. The degree of this change declines in the later stages, but this is largely explained by the increasing proportions of new students intending to work as midwives. This increasing commitment to midwifery, as demonstrated by the intention to work as a midwife, may be attributable to the increased commitment required to undertake an eighteen month, as opposed to a twelve month, course. The trend in favour of hospital midwifery employment may be only partially

explained in the equally consistent trend away from community work.

One explanation of the change in favour of midwifery practice is that it is due to declining employment opportunities in other areas of nursing. Were this to be the case Stage I respondents, who showed less perception of unemployment, would show a less marked change towards midwifery. The data, which are not given here, demonstrate an equally significant change in favour of midwifery among Stage I repondents.

Table 8.2.1.1. The Immediate Employment Intentions of the Double Identifier Beginners and the Completers

	Beginners	Completers
Hospital Midwifery	87 (52.1%)	114 (68.3%)
Community Midwifery	11 (6.6%)	0 (0)
Return to another field	25 (15.0%)	26 (15.6%)
Move to new field	11 (6.6%)	5 (3.0%)
H.V. Training	6 (3.6%)	1 (0.5%)
Other Post/ Training	4 (2.4%)	1 (0.5%)
FT Domestic Work	1 (0.5%)	5 (3.0%)
Non Nursing/ DK/NR	22 (13.2%)	15 (9.0%)
Total	167 (100%)	167 (100%)

Change in "Hospital Midwifery" compared with others is Significant at .001 Using the McNemar Test Chi Squ = 43.02 With 1 DF

The changing opinions of the respondents away from undertaking health visitor training, though representing few respondents, are both

consistent and significant. This trend is supported by the data, part of which is shown in Table 8.2.1.2., on the respondents' long term employment plans and also by the data on "The main reason for taking midwifery training" (Table 5.3.1.1., Page 111) which show that 9.4% of Beginners train as midwives to become health visitors.

Table 8.2.1.2. Double Identifiers' Intentions regarding Health Visitor Training at Some Time

	Beginners	Completers	Total
Intend HV Training	39 (23.3%)	21 (12.6%)	60 (18.0%)
No Intention HV Training	128 (76.7%)	146 (87.4%)	274 (82.0%)
Total	167 (100%)	167 (100%)	334 (100%)

Significant at .025
Using McNemar Test Chi Squ = 6.58
With 1 DF

The data on the respondents' plans concerning where to live and work (Table 8.2.1.3.) were sought in a closed item in each questionnaire. These data suggest that midwifery training in Scotland is achieving its two main aims of providing midwives for the Scottish health care system and for developing countries (Mander, 1980:3).

The data show that, among the Beginners, a large proportion (17.4%) are uncertain of where their next job will be; this supports the suggestion made already (Section 5.4.1., Page 115) of the short term nature of nurses' employment planning. The numbers in this Beginning "Don't know" group appear to have contributed to the significant increase in the "Scotland" category by the end of the course. These data do not reveal whether these respondents are Scottish nurses who are contemplating moving away but stay, or whether

they are nurses from other countries who are contemplating staying in Scotland and do so. This question is answered by the data (Table 8.2.1.4.), which show a large proportion of the uncertain respondents to be Scottish, suggesting that the latter reason is appropriate.

Table 8.2.1.3 The Country in which to Live and Work

	Beginners	Completers
Scotland	96 (57.5%)	122 (73.0%)
England, Wales & NI	13 (7.8%)	14 (8.4%)
Eire	11 (6.6%)	5 (3.0%)
Commonwealth	16 (9.6%)	16 (9.6%)
Other Country	2 (1.2%)	3 (1.8%)
Don't Know	29 (17.4%)	7 (4.2%)
Total	167 (100%)	167 (100%)

Change in "Scotland" when compared with others is Significant at .001 Using the McNemar Test Chi Squ = 19.1842 With 1 DF

Table 8.2.1.4. The Nationality of Double Identifiers who were uncertain where to Live and Work in Future

Nationality	n	%
Scottish	9	(10.7%)
British (Probably Scottish)	23	(27.4%)
British (Probably not Scottish)	17	(20.2%)
Non-British	35	(41.7%)
Total	84	(100%)

8.2.2. Views about Midwifery

The data on the respondents' views on midwifery were collected to relate any change to change in individual employment plans, but group trends are sought in this scrutiny of the Double Identifiers' data.

8.2.2.1. Value of the SCM/RM to a Non-midwife

These data (Table 8.2.2.1.), particularly the items "Career", "Travel" and "Complete Training", suggest consistency both in the numbers of student midwives valuing the midwifery qualification and their reasons for valuing it.

The consistently high and increasing proportion of respondents (Table 8.2.2.1.) who indicated rather vague, general value ("Interest/ Experience") support the contention (Section 5.5.1., Page 121) that this belief may be a way of coping with the uncertainty of nurse/midwifery employment. These data may reflect the increasing uncertainty of the midwifery labour market.

Table 8.2.2.1. Value of SCM/RM to a Non-Midwife

(Percentages are proportions of Double Identifiers. Many respondents indicated more than one reason.)

	Beginners	Completers	Total
Career	50 (29.9%)	49 (29.3%)	99 (29.6%)
Interest/ Experience	72 (43.1%)	87 (52.1%)	159 (47.6%)
Travel	9 (5.4%)	12 (7.2%)	21 (6.3%)
Complete Training	37 (22.1%)	38 (22.7%)	75 (22.5%)
?Liking/ ?Future Career /Change	9 (5.4%)	13 (7.8%)	22 (6.6%)
Total	204	199	403

8.2.2.2. Opinions on the Length of Midwifery Training

This item was included to ascertain whether the respondents considered the time taken for midwifery training to be well spent.

Table 8.2.2.2. Double Identifiers' Opinions on the Length of Training

	Stage I		Stage II		Total	
	Beginners(102)	Completers(102)	Beginners(65)	Completers(65)	Beginners(167)	Completers(167)
Correct	79.4	64.7%	72.3	76.9%	76.6	69.5%
Too long	2.9%	2.0%	24.6%	23.1%	11.4%	10.2%
Too short	11.8%	30.4%	0	0	7.2%	18.6%
Can't say /NR	5.9%	2.9%	3.1%	0	4.8%	1.8%
Total	100%	100%	100%	100%	100%	100%

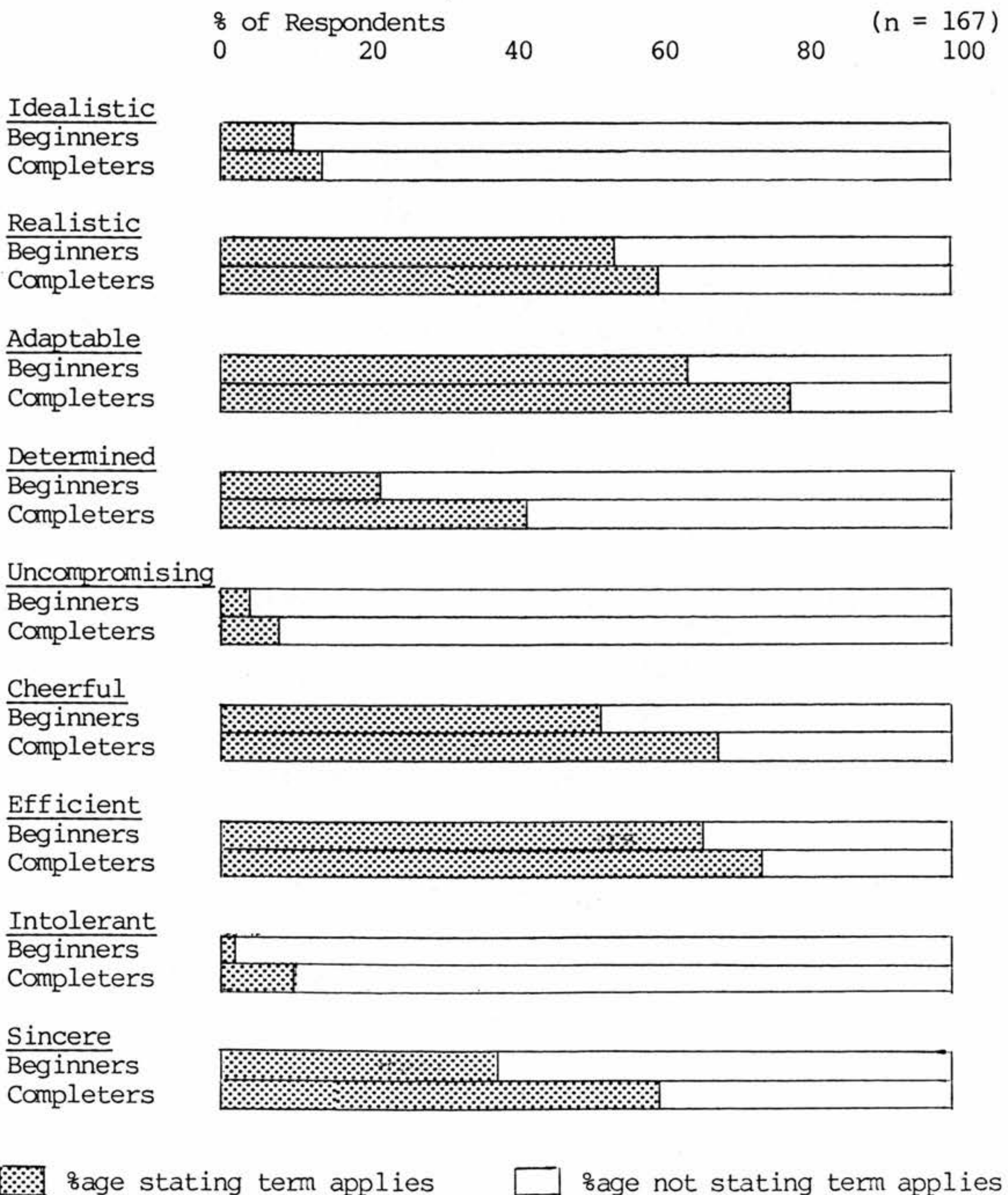
The data (Table 8.2.2.2.) suggest that the respondents are generally satisfied with the duration of the midwifery course, and on this basis it may be assumed that they consider their time to have been well spent. The increase in the "Too short" category during Stage I may reflect more than an increasing awareness of their own limitations as these new midwives prepare for greater responsibilities as staff nurses/midwives. This increase may reflect the general view at the time of the unsatisfactorily short duration of the midwifery course. This surmise is supported by the total disappearance of the "Too short" group in Stage II. The consistent proportion considering the course "Too Long" in Stage II represent a dissatisfied minority which equates with the Stage I dissatisfied groups.

8.2.2.3. Midwives' Characteristics

This item (A7/A8 in the Beginners'/Completers' questionnaire respectively), examined where the respondents envisaged midwives on a

humane (positive)/authoritarian (negative) continuum. The data are summarised in Figure 8.2.2.3. and demonstrate some polarisation in the views of new midwives. This suggests that an increasing proportion of students perceive midwives positively, indicating effective socialisation into midwifery. A smaller proportion react differently, as shown by the increasing proportion perceiving authoritarian characteristics.

Figure 8.2.2.3. Opinions of Midwives' Characteristics



When compared with those who did not state that these words apply, the Completers showed significant increases both in the numbers of those who considered midwives to have the humane characteristic "Sincere" and in the numbers who considered midwives to show the more authoritarian characteristic "Determined"; the increase in the former was particularly significant. The numbers stating the relatively neutral characteristic "Cheerful" showed a less marked but still significant increase; but the more authoritarian characteristics "Uncompromising", "Determined" and "Intolerant" also showed increases, despite the smaller numbers, the latter two being significant. It is possible that these changes may be due to Completers having a clearer image of a "Midwife". Table 8.2.2.3. summarises the numerical data.

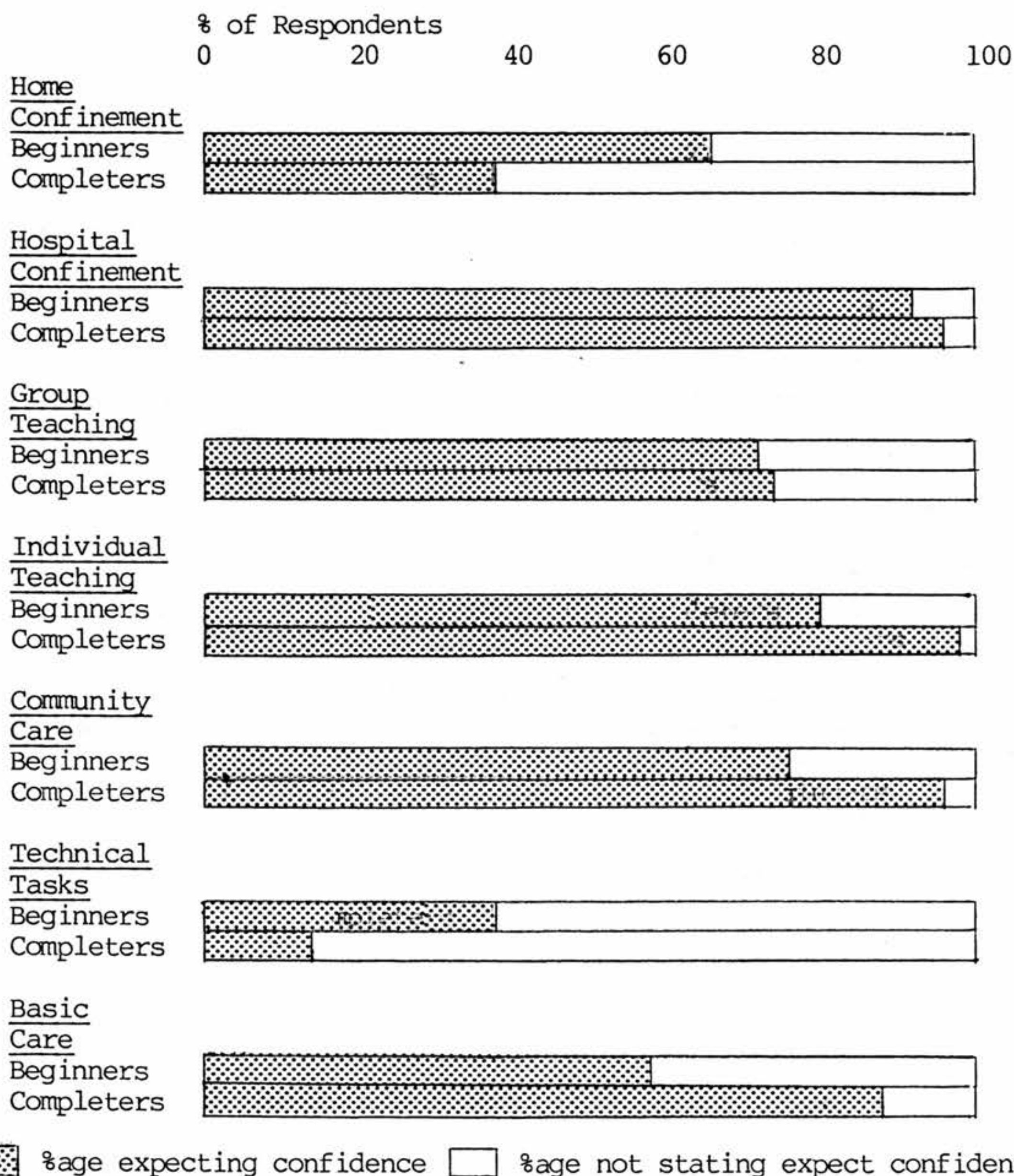
Table 8.2.2.3. Summary: Opinions of Midwives' Characteristics
(Percentages are proportions of Double Identifiers)

	Beginners	Completers	Total	Significance
Determined	39 (23.3%)	70 (41.9%)	109 (32.6%)	Using McNemar Chi Squ = 7.5714 With 1 DF Significant at .01
Cheerful	99 (59.3%)	128 (76.6%)	227 (68.0%)	Using McNemar Chi Squ =11.391 With 1 DF Significant at .001
Intolerant	5 (3.0%)	15 (9.0%)	20 (6.0%)	Using McNemar Chi Squ =7.5787 With 1 DF Significant at .01
Sincere	59 (35.3%)	103 (61.7%)	162 (48.5%)	Using McNemar Chi Squ = 43.9545 With 1 DF Significant at .001

8.2.2.4. Expectations of confidence

An item (B3 & B5 in the Beginners' and the Completers' questionnaire respectively) sought to ascertain the extent to which student midwives' expectations are satisfied during midwifery training. It is assumed that if expectations are not satisfied and the student fails to reach her desired level of confidence by the end of the course, she is less likely to practise midwifery.

Figure 8.2.2.4. Expectations of confidence in Certain Tasks
(Percentages are proportions of Double Identifiers n = 167)



The data indicate that, as has been discussed already (Section 5.6., Page 126), the expectations of new students are not realistic, when compared with the stated role of the midwife (RCM, 1981). This does not detract from the fact that these expectations are not being satisfied; the deficit is most apparent in "technical" tasks ("Being scrub nurse at a caesarean section" and "Being in charge of a SCBU for a full shift") and less obvious in "A normal delivery, assisted by an

unqualified person in the patient's own home". The non-fulfillment of their expectations may be associated with incomplete socialisation.

New students' unrealistic expectations and their limited knowledge of midwifery is supported by the discrepancy between the number of Beginners expecting confidence and the number of Completers being confident in certain tasks which are crucial to midwifery. Examples of these tasks, summarised in Table 8.2.2.4. as "Basic Care", include "Assisting the development of parent/baby relationships", "Providing basic family planning information" and "Being in charge of an ante/ post natal ward for a full shift".

The Completers' level of confidence in "Group Teaching" may be a source of concern, as this is frequently undertaken by midwives in antenatal education and in the post natal ward. It may be that this deficit is less serious than the data indicate, as such formal teaching may be an area in which even experienced teachers encounter some anxiety, which may prevent them from claiming to be confident. Thus, a low level of confidence among new midwives is not surprising.

8.2.3. Review

The data on the Double Identifier Beginners and Completers in the midwifery training experiment demonstrate the generally increasing numbers showing positive perceptions of midwifery. Exceptions to this trend are identified in the polarisation in the opinions of midwives' characteristics and the non-realisation of certain expectations.

8.3. Midwifery Training Experiment - Employment Data

Detailed analysis of individuals' changing views on employment is facilitated by continuing the analysis of the data provided by those who identified in both the Beginners' and the Completers' questionnaires - the Double Identifiers (See Table 8.1.2., Page 166).

8.3.1. Personal Characteristics

The data, which are not given here, indicate that in terms of sex distribution, age, nationality and marital status, the Double Identifiers are not significantly different from the full sample.

8.3.2. Employment Intentions

The changes in the Double Identifiers' midwifery employment intentions associated with midwifery training are shown in Table 8.3.2.1. The McNemar test, used to show the significance of changes in individuals' views, suggests they are largely favourable to midwifery (Siegel, 1956).

Table 8.3.2.1. Double Identifiers' Immediate Employment Intentions

	Completers: Intend Practice	Don't Know	Intend No Practice	Total
Beginners				
Intend Practice	71 (42.5%)	5 (3.0%)	22 (13.2%)	98 (58.7%)
Don't Know	14 (8.3%)	1 (0.6%)	5 (3.0%)	20 (12.0%)
Intend No Practice	30 (17.9%)	2 (1.2%)	17 (10.2%)	49 (29.3%)
Total	115 (69.6%)	8 (4.8%)	44 (26.4%)	167 (100%)

These data (summarised for the application of the McNemar test in Table 8.3.2.2.) show that of the 98 Beginners intending midwifery practice, 22 had changed their minds to intend not to practice by the end of the course. Only 17 of the 49 Beginners intending no practice continued with that intention. A large majority of the uncertain Beginners came to intend to practise. It is apparent that a small majority of students do not alter their employment plans in associa-

tion with midwifery training and, of those who do alter their plans, more change in favour of midwifery practice than decide against it.

Table 8.3.2.2. Summary of Changes in Employment Intentions of Double Identifiers

	Completers: Not Intending Practice (Including Don't know)	Intending Practice	Total
Beginners			
Intending Practice	27	71	98
Not Intending Practice (Including Don't know)	25	44	69
Total	52	115	167

Significant at .05 Using McNemar Test Chi Squ = 4.56 With 1 DF

8.3.3. Employment Intentions and Notifications

The discrepancy between employment intentions and employment is demonstrated in Table 8.3.3. which shows the proportions of the Double Identifiers who Notified their Intention to Practice. If these data are read in conjunction with Table 8.3.2.1., they show that a larger proportion (85.7% of 14) of those who begin as uncertain change in favour of midwifery practice, than those who consistently intend to practise (77.5% of 71).

The discrepancy between Completers' intentions and employment practice raises the question of what developments, during this brief period, may cause longstanding employment plans to be abandoned? That these are actually reversals and not mere cross-border movements is supported by the data on the intentions and employment of Completers intending to live/work in Scotland (Section 7.6.3., Page 158).

Table 8.3.3. The Employment Practice of Double Identifiers
(expressed as a percentage of immediate employment plans giving row totals [with actual numbers in brackets]: n = 167)

	Completers			
	Intend Practice	Don't Know	Intend No Practice	Total
Beginners				
Intend Practice	91.7% [55]	0 0	8.3% [5]	100% [60]
Don't Know	85.7% [12]	0 0	14.3% [2]	100% [14]
Intend No Practice	89.5% [17]	5.3% [1]	5.3% [1]	100% [19]
Total	90.3% [84]	1.1% [1]	8.6% [8]	100% [93]

8.3.4. Employment Intentions, Notifications and Attitude Scores

Attitude scores (Section C of the Completers' Questionnaire) are compared with employment intentions/practice in Table 8.3.4.

Table 8.3.4. Changes in Employment Intentions, Employment Practice and Attitude Scores of Double Identifiers

			Mean Score		Scores					
					Low 83-136		Medium 137-148		High 148-184	
	Number	Notified	Notifiers (N)	Non Notifiers (NN)	N	NN	N	NN	N	NN
Changed Views Towards Midwifery	46	30	142.7	136.0	9	6	8	7	12	4
Changed Views Away from Midwifery	32	6	147.0	140.4	0	7	4	10	2	9
No Change	89	56	148.0	140.7	9	14	21	10	26	9
Total	167	92	145.9	139.0	18	27	33	27	40	22

Using the Mann-Whitney U test z = 16.57, the difference between group means of Notifiers' and Non-notifiers' scores is significant at .05.

The data show that Notifers have significantly higher mean scores in the attitude scale than Non-notifiers, suggesting more favourable attitudes to midwifery. The scale appears to discriminate between high and low scorers' employment practice, reflecting the changing views regarding midwifery. This is apparent in the larger proportion with high scores, who changed their intentions in favour of midwifery and notified and in the reversed proportion whose views changed in the opposite direction and did not notify.

8.3.5. Changing Employment Intentions

As it may be possible to identify factors associated with continuing midwifery practice, the data are being scrutinised to detect factors associated with changing views in favour of midwifery.

8.3.5.1. Post Registration Nursing Experience

Table 8.3.5.1. shows the nursing experience of the Double Identifiers who did and did not change their employment intentions.

Table 8.3.5.1. Double Identifiers' Nursing Experience and Changes in Employment Intentions

	No Experience	Some Experience	Total
Favourable Change	9 (40.9%)	37 (25.5%)	46 (27.5%)
Unfavourable /No Change	13 (59.1)	108 (74.5%)	121 (72.5%)
Total	22 (100%)	145 (100%)	167 (100%)

These data suggest that students with no nursing experience are particularly likely to change their minds in favour of midwifery, but this observation is not significant. The commonly held view is that for reasons of personal/professional development nursing experience is

valuable prior to taking further training; these data indicate that this view may not be to the advantage of midwifery manpower.

8.3.5.2. Educational Background

The highest educational attainment of the Double Identifiers (Table 8.3.5.2.) shows that students with higher educational qualifications (SCE Highers or GCE "A" Levels) are more likely to alter their employment plans in favour of midwifery.

Table 8.3.5.2. Double Identifiers' Highest Educational Attainment and Changes in Employment Intentions

	Highers/ "A" levels	Other Education	Total
Favourable Change	26 (30.9%)	20 (24.1%)	46 (27.5%)
Unfavourable /No Change	58 (69.1%)	63 (75.9%)	121 (72.5%)
Total	84 (100%)	83 (100%)	167 (100%)

8.3.5.3. Dependent Children

Although the numbers of Double Identifiers with children is too small to permit generalisation (Table 8.3.5.3.), those who have children in their care appear to be less likely to change their employment plans. This item deserves further research attention.

Table 8.3.5.3. Double Identifiers' Dependent Children and Changes in Employment Intentions

	With Children	No Children	Total
Unchanging Beginners	10 (66.7%)	75 (49.3%)	85 (50.9%)
Others	5 (33.3%)	77 (50.7%)	82 (49.1%)
Total	15 (100%)	152 (100%)	167 (100%)

8.3.5.4. Nationality

Table 8.3.5.4. shows the nationality of the Double Identifiers and how this relates to change in their employment plans.

Table 8.3.5.4. Double Identifiers' Nationality and Changes in Employment Intentions

	British	Others	Total
Favourable Change	37 (52.1%)	9 (9.4%)	46 (27.5%)
Unfavourable /No Change	34 (47.9%)	87 (90.6%)	121 (72.5%)
Total	71 (100%)	96 (100%)	167 (100%)

These data indicate, not surprisingly, that British respondents are more likely than others to change their employment plans in favour of midwifery. It may be that increased commitment to a certain career plan is required to bring a student from another country to train as a midwife, and that this commitment is reflected in these data.

8.3.6. Review

The personal data provided by the Double Identifiers permits detailed scrutiny of the changing views of individual respondents. The aim of this exercise, the identification of factors associated with continuing midwifery practice, has been achieved. Nursing experience and educational background may provide indicators of changing intentions, but the other factors are of, as yet, uncertain value. Both of these variables require further study, prior to being recognised as predictors of midwifery practice. So far, the identification of predictive factors has been only in terms of respondents' employment intentions; as has been shown already (Section 8.3.3., Page 178) there is a discrepancy between respondents' employment intentions and their

employment practice, as measured by "Notification of Intention to Practise". It is necessary, therefore, to scrutinise the employment practice of those who identified themselves as Beginners and eventually Notified their Intention to Practise - the Notifying Beginners.

8.4. Midwifery Training Experiment - The Notifying Beginners

To identify factors associated with continuing midwifery practice, the personal/professional backgrounds of Notifying Beginners are examined. Table 8.4. gives the number in this group. The total (188), a small proportion of the number of Beginners (26.9%), may reduce the value of this examination; it is necessary to recall that only 39.9% of the Beginners notified on completion. Thus, 67.4% of the notifiers are included in this sample, suggesting that it may be large enough to permit conclusions to be drawn. Comparisons are made with the remainder of the Double Identifiers, who provided data as Beginners and as Completers and who are known not to have notified (n = 73).

Table 8.4. Notifiers Identifying as Beginners

	Stage I	Stage IIa	Stage IIb	Total
Total Beginners	303	172	225	700
Notified (%age of Beginners)	134 (44.2%)	54 (31.4%)	91 (40.4%)	279 (39.9%)
Identified and Notified (%age of Notifiers)	105 (78.3%)	29 (53.7%)	54 (59.3%)	188 (67.4%)

8.4.1. Educational Background

Table 8.4.1. shows the data on the educational background, suggesting that those student midwives with higher educational attainment (SCE Highers and GCE "A" levels) are significantly more likely to practise midwifery on qualifying.

Table 8.4.1. Educational Attainment of the Notifying Beginners

	Highers/ "A" levels	Other Education	Total
Notifiers	103 (78.0%)	85 (65.9%)	188 (72.0%)
Non Notifiers	29 (22.0%)	44 (34.1%)	73 (28.0%)
Total	132 (100%)	129 (100%)	261 (100%)

Significant at .05
Using Chi square = 4.7634
With 1 DF

8.4.2. Post Registration Nursing Experience

The nursing experience of the Notifying Beginners is shown in Table 8.4.2. These data suggest that respondents with "Less Experience" (defined as none or less than twelve months employed as a staff nurse) are more likely to practice as midwives.

Table 8.4.2. The Nursing Experience of the Notifying Beginners

	Less Experience (12 mth or less)	More Experience (Over 12 mth)	Total
Notifiers	119 (76.3%)	69 (65.7%)	188 (72.0%)
Non Notifiers	37 (23.7%)	36 (34.3%)	73 (28.0%)
Total	156 (100%)	105 (100%)	261 (100%)

8.4.3. Age on Completion of Training

The data on the age of the Notifying Beginners are given in Table 8.4.3.1. It is necessary to recall that the Completers in Stage II were six months older than those in Stage I and, for this reason

direct comparison is not made.

Table 8.4.3.1. Age on Completion of Training of the Stage II Notifying Beginners

	Under 23	Over 23	Total
Notifiers	17 (89.5%)	58 (68.2%)	75 (72.1%)
Non Notifiers	2 (10.5%)	27 (31.8%)	29 (27.9%)
Total	19 (100%)	85 (100%)	104 (100%)

In order to avoid duplication the Stage I data are not shown here, but separate analysis of both sets of data suggests that younger midwives are over-represented among those who Notified Intention to Practise and that older midwives (aged over 23 years on completion of training) are reciprocally under-represented. These findings fail to reach the accepted level of significance.

The possibility of age and nursing experience (Section 8.4.2. Page 183) being not separate effects, but an artefact of the correlation between the two variables, merits examination. Table 8.4.3.2. shows the relationship between age and experience. The use of the gamma coefficient of correlation suggests that there is a weakly positive association between age and nursing experience (Anderson & Sclove, 1978; Knapp, 1978). Further examination using the partial correlation shows that the correlation between experience and notification, after controlling for age is .115. This random correlation indicates that any relationship between between experience and notification is dependent on age.

Table 8.4.3.2. The Identifying Beginners' Age and Nursing Experience (Excluding Non Responders)

Age	Experience: SN Under 12 Mth	SN Over 12 Mth	Sister Grade	Total
Under 23	74 (85.1%)	13 (14.9%)	0 (0)	87 (100%)
23 - 24	114 (59.4%)	71 (37.0%)	7 (3.6%)	192 (100%)
Over 24	51 (36.2%)	83 (58.9%)	7 (5.0%)	141 (100%)
Total	239 (56.9%)	167 (39.8%)	14 (3.33%)	420 (100%)

The value of gamma (coefficient of correlation) is .41.

8.4.4. Marital Status

The marital status of the Notifying Beginners is shown in Table 8.4.4. Married people appear to be over-represented among the notifiers, but the differences are not significant.

Table 8.4.4. Marital Status of the Notifying Beginners

	Single/ Other	Married	Total
Notifiers	135 (70.7%)	53 (75.7%)	188 (72.0%)
Non Notifiers	56 (29.3%)	17 (24.3%)	73 (28.0%)
Total	191 (100%)	70 (100%)	261 (100%)

8.4.5. Review

The Notifying Beginners' data suggest that educational background, nursing experience and age (the latter two are not independent) are associated with continuing midwifery practice. Being

younger, and therefore having less nursing experience, and higher educational attainment have been associated with a greater likelihood of changing employment plans in favour of midwifery practice and the data which have been given in this section suggest that these midwives go on to implement their changed employment intentions.

8.5. Extension of Training Experiment - Stage I and II Comparisons

One of the research questions (Section 2.5.4., Page 33) constituted an attempt to evaluate any association between the extension of midwifery training and changes in the employment decisions of new midwives. With a view to making this evaluation the relevant data from all the Completers in Stage I and Stage II, not just the Double Identifiers, are scrutinised. The use of the data from the whole sample is appropriate on account of the similar backgrounds, all dropouts being excluded, the important difference being the duration of training which has been completed.

8.5.1. The Completers' Employment Intentions

The immediate employment intentions of the newly qualified midwives, produced by a closed item replicated in both questionnaires, are shown in Table 8.5.1.

These data show a reduction in the proportion of respondents planning to work as midwives. By comparing each possible outcome with the intentions of the remainder of the sample and applying the Chi Square test, this reduction is shown to be not significant. By using the same technique the numbers of respondents planning to leave nursing after completing midwifery training, comprising those taking up non-nursing work and those who will be unemployed, also shows an increase which is not significant.

Table 8.5.1. Completers' Immediate Employment Intentions

	Stage I	Stage II	Total
Hospital Midwifery	128 (71.5%)	128 (65.0%)	256 (68.1%)
Community Midwifery	2 (1.1%)	4 (2.0%)	6 (1.6%)
Return to another field	23 (12.9%)	26 (13.2%)	49 (13.0%)
Move to new field	6 (3.3%)	7 (3.5%)	13 (3.5%)
Other Post/ Training	3 (1.7%)	8 (4.5%)	11 (2.4%)
FT Domestic Work	5 (2.8%)	4 (2.0%)	9 (2.4%)
Non Nursing/ DK/NR	12 (6.7%)	16 (8.1%)	28 (7.4%)
Unemployment	0 0	4 (2.0%)	4 (1.1%)
Total	179 (100%)	197 (100%)	376 (100%)

8.5.2. Notification of Intention to Practise

Table 8.5.2. shows the significant decrease in the proportion of new midwives notifying intention to practise. The value of this observation may be reduced by the changing employment environment.

Table 8.5.2. Number of Completers who Identified and Notified

	Stage I	Stage II	Total
Completers Notified (%age of Beginners)	134 (44.2%)	145 (36.5%)	279 (39.8%)

Decrease in proportion notifying is Significant at .05 Using Chi Square = 4.25 With 1 DF

	Stage I	Stage II	Total
Completers Identified and Notified (%age of Notifiers)	64 (47.8%)	42 (29.0%)	106 (38.0%)

The data on the number of Completers who notifed in each stage of the research are difficult to interpret in terms of the widely held perception that the number of jobs available for new midwives is declining. The extent to which the decrease in the proportion notifying is due to the extended course is difficult to assess in view of the perceived deterioration in the employment environment. It may be suggested that, although the proportion of new midwives finding work shows a decline, there is a relative shortage of midwives' posts due to increasing numbers of new midwives seeking midwifery work, associated with the shortage of posts in other areas of nursing. This explanation is not supported by the data (Table 8.5.1.), which show that numbers of Completers intending midwifery employment are also quite constant, any differences being of no statistical significance. It is necessary to emphasise that this sample represents new midwives throughout Scotland and may disguise local employment difficulties, which may be sufficiently poor in any given locality to justify this perception.

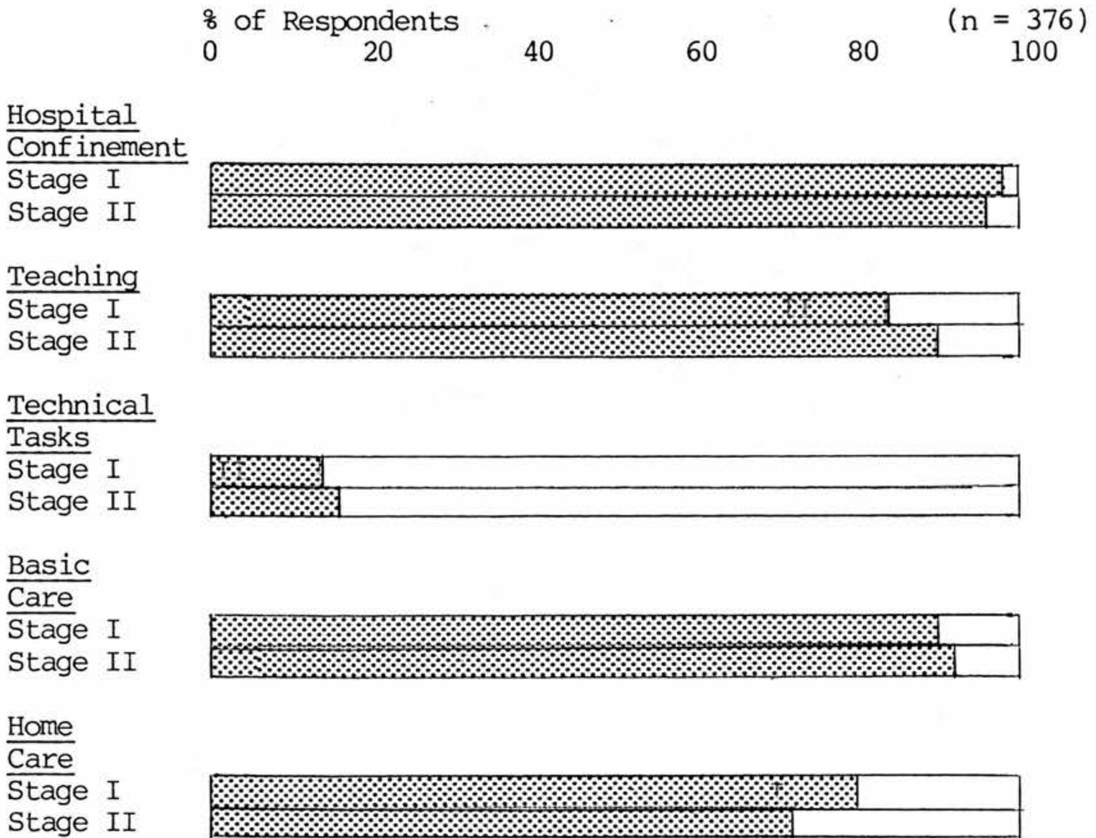
8.5.3. Confidence in Certain Tasks

The data on repondents' confidence are given in Figure 8.5.3. New midwives show decreasing confidence in domiciliary midwifery, these data are combined under the title "Home Care". The possibility of this being a chance result in a list of twelve items can not be ignored. This decrease is most obvious in the "Home Confinement", but confidence is also lacking in basic domiciliary care. Whether this reduction in confidence is associated with the decreased proportion of community experience in the extended course merits further attention. This decline in confidence should be a source of concern to midwife managers as the duration of hospitalisation of maternity patients

decreases and the importance of community midwifery care increases.

The increase in the number of respondents claiming confidence in teaching is equally worthy of comment. This increase is most marked in the "group teaching" category. The reasons for this increase are not apparent from the present data.

Figure 8.5.3. Confidence of the Completers in Certain Tasks



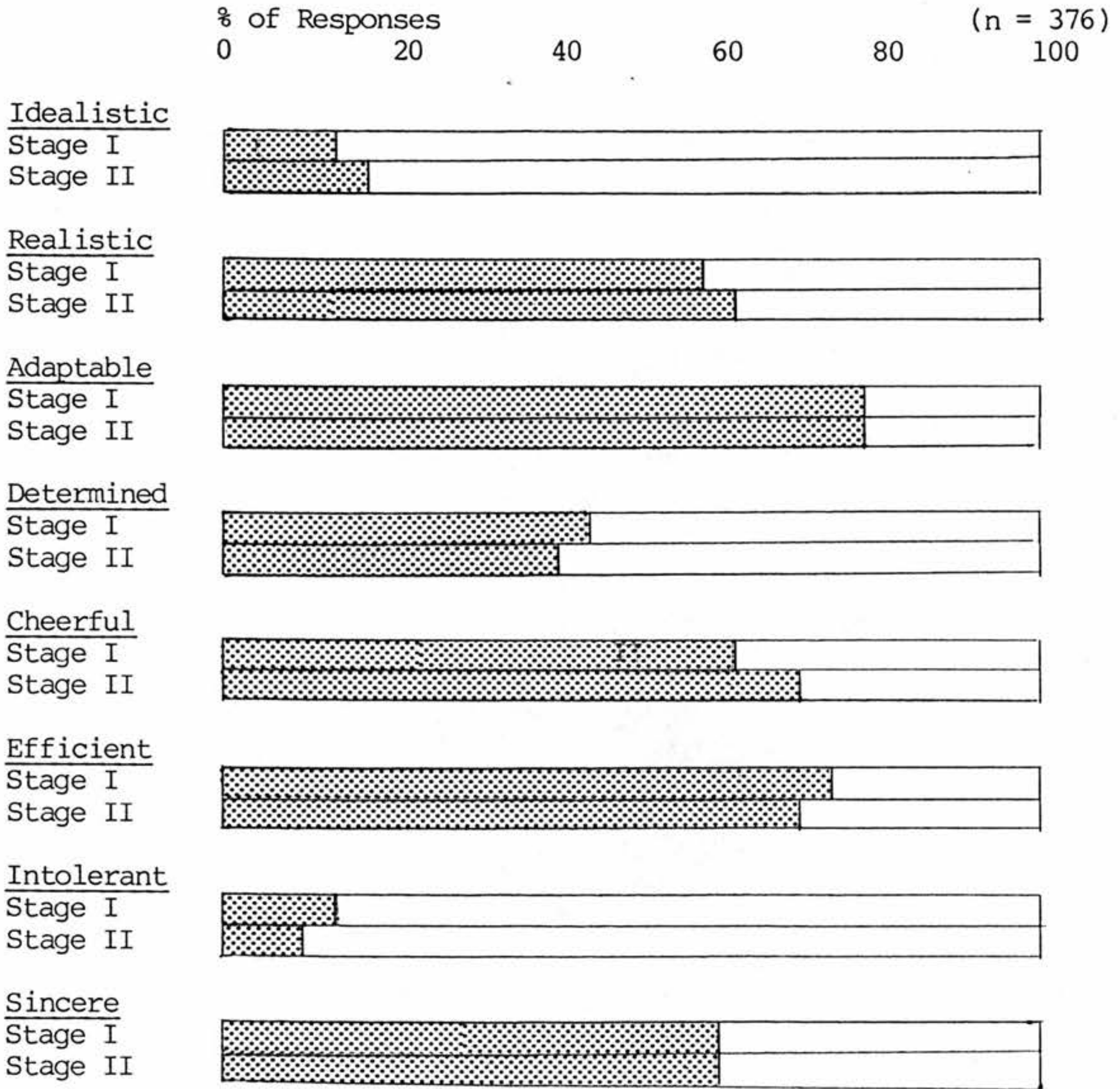
%age expecting confidence %age not stating expect confidence

8.5.4. Midwives' Characteristics

Figure 8.5.4. illustrates the data which show the views held by the Completers regarding midwives' personal and occupational characteristics. The perceptions of humane characteristics appear to increase in association with the extended training and there is a similar decrease in the numbers attributing authoritarian characteristics,

these differences fail to reach the level of significance, but suggest that students taking the eighteen month course become more favourably disposed towards midwifery, although this is not necesarily reflected in their employment practice.

Figure 8.5.4. Completers' Views of Midwives' Characteristics



8.5.5. Opinions on the Length of Midwifery Training

The data on the respondents' views on the length of midwifery training are given in Table 8.5.5. It was anticipated that this item

might reveal any dissatisfaction among student midwives at spending twelve months or eighteen months training for a qualification which they may not actually use.

These data indicate that, regardless of the duration of training, a large majority of student midwives consider the time to be appropriate. This suggests that these respondents consider their time to have been well spent.

Table 8.5.5. Completers' Opinions on the Length of Training

	Stage I	Stage II	Total
Correct	125 (69.8%)	147 (74.6%)	272 (72.3%)
Too long	3 (1.7%)	47 (23.9%)	50 (13.3%)
Too short	48 (26.8%)	2 (1.0%)	50 (13.3%)
Can't say /NR	3 (1.7%)	1 (0.5%)	4 (1.1%)
Total	179 (100%)	197 (100%)	376 (100%)

Significant at .005
Using Chi Square = 81.947
With 2 DF

In each stage approximately one quarter of the respondents are dissatisfied with the length of the training. The movement of respondents between dissatisfied groups in each stage is significant. These respondents occupy the "Too short" category prior to the extension of training and the "Too long" category afterwards. This group may represent students who are aware of forthcoming and recent changes and who consider that such changes inevitably reflect on the course which they are taking. An alternative explanation may be that

although students consider that the midwifery course should have been lengthened, eighteen months is too long for such a course.

8.5.6. Review

The evaluation of the extension of training in terms of its effects on employment decisions has been confounded by the changing employment situation, or at least the respondents' strong perception of that situation. Because of this, it is only possible to surmise that the extension of training has not affected new midwives' employment practice, despite their views of midwives and midwifery being more favourable.

8.6. Conclusions

The data on the Double Identifiers suggest that socialisation of new midwives into midwifery may be incomplete. In the midwifery training experiment, these data permit the identification of certain factors which may be associated with changing intentions regarding midwifery practice. These factors are related to actual practice by scrutiny of the Notifying Beginners' data. In the extension of training experiment the evaluation has been limited by respondents' perceptions of the employment environment.

On the basis of the comparison between the data provided by the Beginners and the Completers it is possible to draw certain conclusions:

8.6.1. The immediate employment intentions of the respondents show that there is a net increase in the number of students intending to work as midwives in association with completing midwifery training (Section 8.2.1.).

8.6.2. Undertaking health visitor training becomes significantly less attractive in association with midwifery training (Section 8.2.1.).

8.6.3. The intention to live and work in Scotland is significantly commoner among new midwives than among new students, but there may be uncertainty about the locality of future employment (Section 8.2.1.).

8.6.4. The views on the characteristics of midwives change in association with midwifery training, some of which are significant. The direction of this change is largely favourable, but it shows some degree of polarisation. (Section 8.2.2.3.).

8.6.5. Beginning student midwives' views of midwifery are not accurate when compared with literature provided by the Royal College of Midwives (Section 8.2.2.4.).

8.6.6. A small majority of students do not change their employment intentions; of those who do change their intentions a significantly larger proportion change in favour of midwifery (Section 8.3.2.).

8.6.7. There is a discrepancy between stated employment intentions and employment practice (Section 8.3.3.).

8.6.8. Those respondents who notify their intention to practise midwifery have significantly higher scores in the attitude survey (Section 8.3.4.).

8.6.9. Younger student midwives, who usually have less post registration nursing experience, are more likely to (1) change their employment intentions during their course in favour of midwifery and (2) to practise midwifery on qualifying (Sections 8.3.5.1., 8.4.2., and 8.4.3.).

8.6.10. Students with higher educational qualifications (GCE "A" levels/SCE Higher grades) are more likely to change their employment

intentions in favour of midwifery (Section 8.3.5.2.) and are significantly more likely practise as midwives (Section 8.4.1.).

8.6.11. During the period of data collection there has been an increase in the number of new midwives notifying their intention to practise, but there has been a significant decrease in the proportions notifying (Section 8.5.2.).

8.6.12. Midwives who have completed the eighteen month midwifery course seem less confident in undertaking certain basic tasks which are involved in domiciliary midwifery practice, although there may be an element of chance in this finding. Similarly, they appear to have greater confidence in their ability to teach patients (Section 8.5.3.).

8.6.13. That a large majority of new midwives are satisfied with the duration of their midwifery course is interpreted to indicate that they consider that their time has been well-spent (Section 8.5.5.).

PART III - THE MIDWIFERY EMPLOYMENT DECISION MODEL

INTRODUCTION

The third part of this thesis comprises work on the development of the Midwifery Employment Decision Model (MEDM). This model is a progression from the research detailed in Parts I and II and it both illustrates this material and anticipates its testing and application. The nature of Part III, being a development from the previous Parts, requires that new literature be introduced at certain points to support the argument being presented.

This part incorporates, in Chapter 9, an exploration of the appropriateness of the use of a theoretical model prior to a brief account of the MEDM. Chapter 10 reviews the psychological theory on which the MEDM is based. The components of the MEDM are derived from the data provided in the present study. These data are interpreted and the resulting components of the model are scrutinised in chapters eleven, twelve and thirteen. These chapters are organised to examine the MEDM components which, based on Freeman's model, are decreasingly individually oriented. Thus, personal characteristics are considered first, followed by the attributes of the occupation and, finally, extrinsic factors relating largely to the labour market.

CHAPTER 9

THE RELEVANCE OF A MIDWIFERY EMPLOYMENT DECISION MODEL

9.1. The Model

This research has shown that a range of factors influence the employment decision made by a new midwife. These influences are exerted at various times in relation to the completion of the midwifery course. The effects of these factors are increased or moderated by other phenomena, resulting in complex interactions. A theoretical model, the Midwifery Employment Decision Model (MEDM), is being developed to illuminate the interplay among these factors.

9.2. Functions of Models

The use of a theoretical model in a context such as that of the present study is well established, despite criticisms of their limited applicability (NDCG, 1973:11).

The essential simplicity of theoretical models is clearly spelt out:

> "A symbolic depiction in logical terms of an idealised, relatively simple situation showing the structure of the original system".
> (Hazzard, 1971:39).

Thus, a model is a simplified representation of theory, the use of which is appropriate here because of the wide range of inter-related phenomena identified as affecting the employment decision. Research-based knowledge such as this may be represented in one of two ways, first, as a model demonstrating the structure of the system, or, second, as theory, demonstrating its function. Theory development using models exemplifies the interdependence of research, theory and practice. Descriptive levels of theory precede more complex areas; as shown by the MEDM, which incorporates a largely descriptive approach allowing for certain predictive components, yet to be tested (Hardy,

1974; Riehl & Roy, 1974; Dickoff et al., 1968).

The main advantage of models is their ability to aid understanding of more complex concepts. That understanding is advanced by their heuristic nature which encourages further study (Aggleton & Chalmers, 1984; DiRenzo, 1967:248). Both of these features make a model relevant in the present context.

9.3. Classification of Models

The classification of models is fraught with semantic inconsistencies; certain authors explain their meaning of terms used, whereas other authors may regard such terms as interchangeable. These inconsistencies further impede the application of models to practice.

Models may be classified according to whether they are physical or abstract; examples of each could be live role models at one extreme and models of nursing theory at the other. Physical models may be living or replicas, the latter being subdivided into "Analog" and "Iconic" models, depending on their resemblence to that which they represent. Symbolic models, of which the MEDM is an example, may be figurative or diagrammatic (Aggleton and Chalmers, 1984; Bevis, 1982; Hardy, 1974)

The form of models is considered by Stevens (1979) in her examination of theory construction and development, in which she regrets the use of the prescriptive form in nursing theory. She recommends that nursing should concentrate more on describing what "is", with a view to deciding future directions by assessing where change is most needed. As Stevens regards models as a crucial component of theory construction, these criticisms may be considered to apply here. The relevance of Stevens' commendation of the descriptive form is apparent in the present study; the material presented in

the MEDM is largely descriptive, but includes components which, subject to further research, may have predictive value and be implemented in selection.

9.4. Criticisms of Models

Theoretical models are the subject of criticism which may not be entirely justified, as it relates more to the misuse, non-use or non-application of the model. Anderson and Moore (1967) discuss a weakness in the use of models, when they suggest that models are of great value, but only providing that their limitations are recognised and accepted. These authors believe that the value of models lies in their heuristic nature, rather than their ability to provide explanations. As any model is limited to providing an imitation or representation of a phenomenon, to equate similarity of appearance with similarity of process is misguided.

The model may be elevated to the level of theory, resulting in quite unjustified claims; DiRenzo (1967) reduces the possibility of this by emphasising that models are merely tools to facilitate the development of theory, rather than an end in themselves.

Roper (1983) provocatively suggests some criticisms which may be levelled at nursing models. Their <u>theoretical</u> nature makes them less acceptable to those who perceive the unbridgeable gap between theory and practice. Assuming the role of "devil's advocate", she maintains that theoretical models are developed and employed by "armchair academics", questioning any practical application for such models. They are merely used to jog the memory in the recall of complex concepts, without achieving much more. She demolishes these arguments by stating their crucial role in theory building, particularly in the reduction of the education/practice gap in nursing. Roper's criticisms

of models encapsulate those frequently made. Their main problem is their limited applicability or application to practice, which may be associated with the terminology used. There are certain well known and well utilised exceptions to this criticism. These pitfalls are being avoided in the MEDM to facilitate implementation.

9.5. A Model in Nurse Manpower Planning

The preceding discussion demonstrates the value of a theoretical model in explaining complex situations and interactions and the possibility of extending its use forward in time to assist problem solving. For these reasons this device, in the form of the MEDM, is to be used to describe the factors, identified during the present study, influencing the employment decisions of new midwives. The use of a model in this way is not entirely novel. Although no literature has been identified on the use of models to describe midwifery employment decisions, the Institute for Operational Research (IOR, 1976) used a model to explain the retention of nurses completing basic training in Scotland. IOR perceive that the value of this model is twofold:

(1) as an aid to policy formation in the colleges of nursing and midwifery, to assist decisions concerning the criteria for entry.

(2) to predict the number of new entrants to nursing on a yearly basis, in the hope of facilitating manpower planning for nurses.

IOR do not explicitly state that their model is to be used to aid the selection of learners, but it is not impossible that the combination of (1) and (2) could result in such a use of the model.

Thus, it would appear that the use of a descriptive model with potentially predictive components, although not used previously in midwifery manpower planning would be appropriate to assist the examination of the employment decisions of new midwives.

9.6. The Midwifery Employment Decision Model

Before scrutinising the components of the model, it is necessary to examine the nature, aims and features of the MEDM.

9.6.1. Nature of the MEDM

The MEDM comprises a symbolic representation of the factors which contribute to new midwives' employment decisions and the inter-relationship between these factors. This representation is in the form of two diagrams (Figures 9.6.1.1. and 9.6.1.2.), in which the latter is an enlarged version of one segment of the former. In that this model bears almost no resemblance to any living or real object, it is an abstract model. The arrow-shaped segments in both diagrams suggest the progressive, dynamic nature of the model. They indicate forward movement at a minimal rate, with occasional deliberate, possibly externally induced, changes of direction.

The MEDM, which may be regarded as comprising applied, as opposed to pure theory (Dickoff _et al_., 1968), is generally descriptive and illustrates the features identified in the present study as being associated with new midwives' employment decisions. Some components of the model may have predictive value, which has yet to be established. This model represents, in Hazzards' (1971) terms, an open system, as it recognises environmental effects in the descriptive components.

9.6.2. Aims

Although the MEDM illuminates new midwives' employment decisions, its primary purpose is to facilitate manpower planning by providing a tool which may be used by midwifery managers to control the retention of new midwives in midwifery. To achieve this aim further testing of the model is required, so, to this extent, the model must be regarded as heuristic rather than definitive.

FIGURE 9.6.1.1. THE MEDM: VOCATIONAL DEVELOPMENT

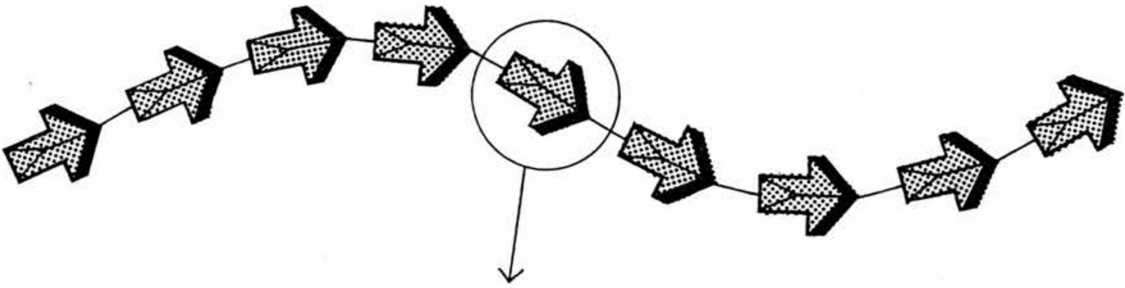


FIGURE 9.6.1.2. THE MEDM: OCCUPATIONAL CHOICE

BEGINNING FACTORS

COMPLETING FACTORS

YOUTH

LESS NURSING EXPERIENCE

EEC

Labour Market

Salary

MORE EDUCATION

DEPENDENT CHILDREN

RECRUITMENT

EXPECTATIONS

MARITAL STATUS

Reference Groups

Contingencies

Conflicts

Midwife's Role

OCCUPATIONAL FACTORS

KEY

Employment Decision (To work as Midwife)......... ⊙

Post Decisional Events.............................

Career Choice......................................

Potentially Predictive Elements..................PREDICTIVE

Descriptive Elements............................Descriptive

Factors Operating in Favour of/Stabilising...... /Against Decision (To work as Midwife)

9.6.3. Features of the MEDM

The MEDM, as mentioned already, is a dynamic model incorporating two time scales. In the longer time scale the segments represent the series of occupational choices, with the employment decision depicted as the central point, which a person makes during their life-long work career (Fig. 9.6.1.1.). This series of discrete segments in a logical order with deviations and turns represents vocational development. Each of the segments in Fig. 9.6.1.1. represents the process of occupational choice, which is relatively short term compared with career choice and vocational development; both of these continue throughout a person's life, but the latter encompasses psychological and emotional maturation.

The shorter time scale (Fig. 9.6.1.2.) represents the occupational choice associated with midwifery, an episode which involves the processes leading up to and directly following the employment decision. This decision is a momentary event which is the culmination of the decision making process and which immediately precedes employment as, up until that moment, any employment intentions may be revoked, as has been shown by the present study. The data are given in Table 7.6.3. (Page 158), which shows that 101 (39.1%) of the identifying Completers failed to implement the employment intention stated less than 6 months previously when they qualified.

Career choice continues to develop as a background activity throughout the process of occupational choice and it contributes to vocational development. This is illustrated in the present study by the changes in the respondents' long term (career) plans over the short time span of twelve or eighteen months (Table 10.2.3.).

The components contributing to the employment decision operate by

influencing the person to decide either in favour of working as a midwife or in the reverse direction. These influences are represented in Fig. 9.6.1.2. by arrows pointing either towards or away from the centre point which represents the employment decision to work as a midwife.

9.7. Summary

A theoretical model has been shown, despite recognised criticisms, to be the appropriate method of demonstrating the employment decisions of new midwives. A model is particularly appropriate to illustrate the findings of the present study, as it, because of its heuristic characteristics, may be further developed by utilising the criticism of other workers. Having described the nature, aims and features of the model, its psychological framework and components will be scrutinised in detail in chapters ten, eleven, twelve and thirteen.

CHAPTER 10

EMPLOYMENT DECISIONS

The development of the Midwifery Employment Decision Model (MEDM), incorporates variables identified as relevant during the present study. The theory on which the Model is founded, however, is recognised psychological theory. Before examining the nature of the psychological theory, it is necessary to consider its relevance to the MEDM.

10.1. Relevance of Existing Theory

Prior to the scrutiny of the psychological framework of the MEDM certain factors, which may influence its relevance, merit examination.

10.1.1. The Model

One of the functions of theoretical models is to assist the development of theory. The MEDM comprises an attempt to develop knowledge of midwives' employment decisions. However, an essential prerequisite is an understanding of relevant existing theory.

The dynamic nature of employment decision models is emphasised in an "economic theory of occupational choice" (Freeman, 1971); learning is a crucial component of the dynamic process permitting such choices to be made.

A dynamic model is appropriate in this context because decision making is a continuing process, defying description in a static form. Although the implementation of the decision occurs at one moment, that is when the new midwife takes up her first post certification appointment or other occupation, the psychological processes leading to that moment may have begun many years earlier. This view is supported by Edwards (1961:473) who considers the value of static decision theory, regretting its "limited future" and claiming that,

due to the nature of the components, "the really applicable decision theories will be dynamic". The dynamic nature of the midwifery employment decision is clearly demonstrated in the data (Table 8.3.2.2.), which shows that 46.7% of Double Identifiers change their immediate employment plans during midwifery training.

10.1.2. Assumption of Decision Making

In developing this model it has been necessary to assume that the new midwife does make an employment decision. This is regarded by some as a luxury denied to workers in less developed societies (Lancashire, 1971:194; Vroom, 1964:49). Unemployment causes this to apply in late twentieth century Scotland but, as discussed elsewhere, midwifery unemployment is probably not a widespread or prevalent phenomenon.

The arguments against the existence of employment decisions are made on two levels. The first uses a personal orientation, exemplified by Roberts (1977), to suggest that individuals do not actually choose jobs, but are forced by a variety of circumstances, notably parental occupation, to accept those which are available. He quotes Maizels (1970), whose work indicates that, even in those halcyon days of full employment, only one third of school leavers found the jobs which they desired. Roberts extends his argument by regarding occupational socialisation as a mere reduction of the mismatch between aspirations and reality, using strategies such as "disengagement" and "secondary gratifications". This argument, however, is effectively countered by Herriot, Ecob and Hutchison (1980:235) as a "false dichotomy", due to the complex interrelationship of variables influencing the decision, as reflected in the MEDM. The work of Vroom (1964) may be cited to demonstrate a further weakness in Roberts' case, in his lucid account of the differences between "occupational preferences, choices and

attainments". Roberts and Maizels appear to have been comparing the first with the last and ignoring the intermediate category and any intervening variables.

The second argument against the existence of employment decisions is at the societal level. Etzioni (1968) propounds a view of a society which rigidly controls and limits the actions of its members. He maintains that a person's employment results from a combination of unconscious choices and compulsion to follow an involuntary course. Etzioni regards unconscious decisions as non-decisions, producing an image of the worker as a hapless being lacking volition and control; this is reminiscent of Roberts, who considers socio-economic class as the determining and limiting factor, controlling an individual's occupational and social mobility.

Ginzberg (1951:26) and his colleagues, before discussing their ill-fated theory of occupational choice, consider that the choice may be less open than usually thought. These authors suggest that Accident Theory may provide the explanation for employment decisions, but discard this as inappropriate, claiming little relevance to the individual's decisions and using large scale examples (increasing industrialisation and World War II) to support their view. They then go on to examine Impulse Theory as another possible explanation. This is also discarded on the grounds that even though unconscious factors contribute to employment decisions, many forces operate at a conscious level, are known to the individual and are subject to his control. Ginzberg reports that interviewees in their study were surprised at the detail of decision making that was easily recalled. In spite of the weak examples, Ginsberg's work supports the contention that these decisions are essentially rational, rather than purely impulsive.

Thus, the existence of employment decisions has been questioned, but, it is reasonable to assume that new midwives make these decisions.

10.1.3. Occupational Mobility

Having established that employment decisions are a feature of job changes, it is necessary to draw on sociological material to demonstrate the frequency of employment changes and the prevalence of the associated decisions. The "lifework pattern", described by Miller and Form (1964:539), is pertinent in this context as it explains the stages in a person's employment life. The appropriate period in the context of the MEDM is the trial work period, which is the middle phase, following the preparatory and initial periods during which the person has learned of work values and their inherent contradictions. Miller and Form estimate that the trial work period lasts about ten to fifteen years and includes various patterns of employment mobility, such as vertical, horizontal and residential. The new midwives in the present study must, by definition be experiencing the trial work period, as this is the stage when work has become established, but has not yet reached the stable period of "job persistence" involving "steadiness or resignation". Workers change jobs most frequently while in their early years in the labour force, settling down with advancing age. The proportion of highly mobile workers in the 21-30 age group is equal to the proportion of virtually immobile workers in the 61 plus category. These data show the need for frequent employment decisions in the age group in which the majority of new midwives are found.

It may be suggested that this analysis of occupational mobility is not appropriate to a largely female work force in the latter part of the twentieth century. This is not the case as evidence is

accumulating to show that women are now adopting many of the features of male employment including, in all probability, their occupational mobility patterns (Jope, 1980).

Whereas this trial work period is generally interpreted as a normal, healthy feature of a person's career, it is perceived by others as destructive. The differentialists would be included among the latter, as their main aim in careers guidance was to fit the person with certain characteristics and abilities into a work environment needing those features - "square pegs into square holes" or "matching" (Lancashire, 1971).

This negative view of the trial work period is examined in depth by Jordaan (1963). Exploratory behaviour is considered in the context of psychological theory, then related to vocational exploratory behaviour and the development of self concept. Jordaan concludes that the value or otherwise of this exercise, which is later referred to as "floundering", depends on a range of dimensions reflecting intention, deliberation, effectiveness and vocational relevance. Whereas exploratory behaviour represents the positive end of Jordaan's continuum, consistent with the views of Miller and Form (1964), floundering is the negative, destructive aspect.

Thus, considerable mobility and frequent employment decisions characterise a certain stage in an individual's working life; it is during this stage that midwifery training is undertaken and the decision of whether to continue is made.

10.1.4. Decision Theory

Decision theory, of which expectancy theory is a cognitive version, originated in the work of Pascal in the seventeenth century. Pascal regarded decision making as the "maximisation of expectation".

Decision theory is examined by Janis and Mann (1977:3) in terms of "Man, the reluctant decision maker". This reluctance is attributed to a fear of making the wrong decision resulting in loss of self esteem. The decision making process begins with information gathering and contingency planning. Then follow decision making strategies to achieve maximum utilisation of the information and other material available. "Information inundation" is one of the pitfalls awaiting the unwary decision maker by leading to the possible neglect of vital variables; another is suboptimisation due to the incorrect assessment of intangibles.

Expectancy theory is based on:

> "the strength of a tendency to act in a certain way depends on the strength of an expectancy that the act will be followed by a given consequence (or outcome) and on the value or attractiveness of that consequence (or outcome) to the actor". (Lawler 1973:45)

Janis and Mann question its relevance on the grounds that human beings are incapable of a sufficient degree of objectivity. This criticism is little more than a counsel of perfection in a less than perfect science. They proceed to explore the work of Simon (1959) and his preference for sacrificing, rather than optimising, and his minimally satisfying "satisficing".

An essential component of decision theory and one that is incorporated into the MEDM is the consequences of the decision. These, in the form of anticipatory regret, may actually precede the implementation of the decision, thus forcing the individual to evaluate or at least reconsider the decision. Factors predisposing to anticipatory regret are the adoption of a second best choice, immediate unfavourable consequences or the subsequent availability of new information.

Festinger (1964) probes the psychological consequences of decision making, positively correlating the degree of predecisional conflict with the degree of post decisional commitment. Festinger continues by discussing post decisional conflict and dissonance and the strategies used to cope with such conflicts.

One such strategy involves the associated information gathering (Jecker, 1964); the wide-ranging, all-encompassing collection of information prior to the decision may be compared with the more discriminating post decisional collection. This serves a quite different purpose, which is to confirm the flawlessness of the decision which has just been made. The individual only entertains information congruent with the accepted alternative and, conversely, material unfavourable to the rejected choice. The purpose of this strategy is the conversion of dissonance to consonance.

This view of post decisional information gathering conflicts with the views of writers such as Rosen (1961) cited by Jecker, but it is supported and explained by Walster and Festinger (1964). In recounting the changes in relative salience immediately after the decision, they describe the increasing significance of the favourable aspects of the rejected alternative and, reciprocally, the greater salience of the negative aspects of the accepted alternative. These twin processes have the effect of increasing post decisional dissonance, reduction of which is acheived by Jecker's strategies. The relevance of these post decisional processes to the MEDM is difficult to assess. This is partly because, although referring to the <u>immediate</u> post decisional period, there is no indication of the time scale involved; thus such dissonance may affect the new student midwife for an unknown period of time, perhaps influencing her employment decision on completion of

training. The other difficulty in applying this theory to the MEDM is associated with the "black box" nature of the present study, which is unable to either support or refute the existence or duration of this dissonance. It is reasonable to assume that these conflicts do exist in student midwives, but information is lacking on whether they influence employment decisions. It may be assumed that the attrition rate of student midwives is related to such conflict, as attrition shows a marked decline later in the course (Mander, 1983).

Various aspects of decision theory have been suggested as applicable to employment decisions; one of these is expectancy-valence theory which is incorporated into the MEDM,

10.1.5. Sources

The theoretical background of the MEDM is derived largely from the work of occupational psychologists specialising in vocational guidance counselling. It is necessary to question the relevance of material from this source to illuminate a manpower problem. Vocational guidance in the USA has developed more rapidly than in the UK, because of the need for the would-be employee to maximise his own potential (Jones 1973:73). Any person in whom this need is combined with any occupational uncertainty is regarded by the counsellor as a potential client. Competition with other counsellors constitutes a stimulus for each counsellor to improve his service using the most recent research-based techniques. The limited significance ordinarily attached to "market forces" in the UK may explain why this phenomenon is not apparent here.

Vroom (1964:49) also provides an explanation for the abundance of vocational guidance research. Like Roberts (1977), but to a lesser extent, he considers that the choice of employees by organisations is

of similar significance to occupational choice. Vroom regards organisational choice as less amenable to research, resulting in the concentration of research material on the individual's occupational choice. No evidence has been located to suggest that the thrust of occupational research has been redirected in response to the current employment environment, as might be expected if these explanations are correct.

Lancashire (1971), apparently seriously, suggests that psychologists' interest in occupational choice reflects their personal difficulty situated astride the arts/science divide. Being attracted in both directions, they perceive themselves as in the ideal position to counsel others!

Thus, occupational psychology, though undertaken with a different application in mind, would appear to be relevant in this context.

10.2. Employment Decisions and Career Choice

Prior to their inclusion in the MEDM the theory of career choice and its terminology merit scrutiny.

10.2.1. Terminology

Throughout this work the topic under examination has been the employment of new midwives, in the hope of illuminating the decision processes associated with this employment. The term employment has been used in preference to the others available. Earlier in this chapter other terms have been used, such as vocation and career, because these are the terms used by the relevant author. The Glossary (Appendix A, Page 294) provides working definitions of the various terms, but it is necessary to consider the reasons for the varying terminology and its implications for the MEDM.

The reasons for the variation in terminology relate to the

distinction, made by Vroom (1964) and mentioned in Section 10.1.5. (Page 211), between organisational choice of employees and individuals' choice of employer. These seemingly diametrically opposed orientations result in the same area, occupations, being approached by sociologists and psychologists respectively. Kantas (1986) attempted the unenviable task of examining "how the transition to work is effected" by drawing on both sociological and psychological theory. He identifies the confusion arising from the fragmented nature of the different disciplines and attributes this to "each one employing its own concepts, instruments, terminology and fundamental principles".

Super and Bohn (1971:113) regret the confusion and explore the differences between "occupations" and "careers". This exploration is relevant in this context as they, like the MEDM, adopt a multidisciplinary approach drawing on economic, sociological and psychological concepts. After discussing their characteristics, the variability of occupations is compared with the relative stability of careers. This line of thought leads inevitably to consider the commitment associated with each, because in more prestigious fields the terms are virtually synonymous, examples given focus on the classical professions. The basic difference is temporal, an occupation being "what one does" as opposed to a career which is "the course pursued over a period of time".

The differing terminology used in this field serves to emphasise the subtle differences in career patterns.

10.2.2. The Temporal Features of the Model

The present study focusses on the decision which is implemented when the new midwife takes up her first appointment or occupation. This implementation is essentially a point in her life, having no

duration, it is preceded by being "in training" and followed by being "in post". Despite the momentary nature of the implementation, the decision making process may have begun years earlier and ended at the moment of implementation, leaving only the post decisional processes for completion. For 48% of respondents in the present study the relevant decision making process began two to four years earlier, and for a further 10.2% at least four years earlier.

In theoretical terms the decision comprises twin processes which have been proceeding simultaneously: the long term career development and the relatively immediate occupational decision (Super and Bohn, 1971). Although the occupational decision process is almost complete when the employment commences, the career development will continue throughout life (Miller and Form, 1964:539). These twin processes will now be examined in greater detail.

10.2.3. Career Choice

Theory of career choice in the early twentieth century concentrated on individuals' differing abilities and capacities and the possibility of "matching" the person to the job (Lancashire, 1971:198). Differentialists, such as Parsons, Roe and more recently Holland, regard the success of guidance as dependent on self-evaluation and knowledge of the jobs available.

The work of Charlotte Buehler (1937) proposed that the growth of personality is in developmental stages, each stage requiring to be completed successfully before the next stage may be approached. It was not until 1951 that Ginzberg and his multi-disciplinary team applied this approach to occupational choice. These writers refuted the "once and for all" view held by the differentialists, regarding choice as a dynamic, developmental process, evolving through a logical

sequence of decisions which accumulate over a period of years. In detailing stages of occupational choice, they introduced the concept of the standard of decision making improving with increasing maturity.

In their book's fourth printing, Ginzberg et al. (1966:viii) state that the demise of their theory was due to its neglect of the relationship between occupational choice and the deeper layers of personality. This neglect permitted other workers to rectify this omission and achieve recognition. Its demise was due equally to the weakness of the third component of the theory, which refers to the irreversibility of occupational choice. The basis of this component was the dependence of choice on "chronological age and development". They argued that variables influencing development are not replicable, so backtracking is impossible. These writers admitted that some degree of shift, presumably lateral, is possible, but because later decisions are limited by earlier ones there is no scope for "U turns".

There are certain weak links which impede the acceptance of this component of the theory. The bond between chronological age and development is more flexible than Ginzberg suggests. The limitation of later decisions by earlier ones is not necessarily the negative unyielding, influence which these writers assume. Altogether this component of the theory presented an excessively rigid interpretation of the situation. Chown (1958:181) found the age at which school pupils make their occupational choices varies considerably, according to the pupil's sex and type of education; girls and non-grammar school pupils being likely to decide earlier. The frequent reversals of pupils' views, limited and innaccurate knowledge and the influence of external factors, such as parents, prevented Chown from identifying Ginzberg's stages.

The work of Super and his colleagues followed that of Ginzberg _et al_, extending and modifying it along developmental lines. The essence of Super's theory is "vocational development", which is defined (Super, 1957a:vii) as "the process of growth and learning which underlies the sequence of vocational behaviour". Vocational development incorporates the growth of self-concept and requires the successful completion of certain developmental tasks before progressing to the next stage.

Super (1957b:80) defines three developmental stages. Adolescence is the first stage during which the young person explores social and occupational aspects of the adult world; this permits him to develop his own self-concept, which inevitably demonstrates certain conflicts. The identification of role models and use of role playing facilitate some solutions, resulting in certain aspirations regarding the forthcoming career pattern.

The second stage is the stage of transition from school to work. As well as coping with cultural changes, the young person identifies and resolves discrepancies between his aspirations and his achievement. This process is "reality testing" of the fantasies contributing to the adolescent phase. During the transition phase an identifiable phenomenon is the "trial process", which Super (1957b:112) credits to Miller and Form (1951). Alternatively known as "floundering", this process helps the young person to find a place in the world of work which fits their self-concept, and to adjust to both work requirements and working life generally.

Transition ends when the third stage "establishment" begins, at approximately twenty five years of age. After the individual's self concept has been modified during the transition phase, it is reflected

in an appropriate occupation during the stable period in the newly identified niche in the world of work.

A vital concept which is crucial to Super's theory is "vocational adjustment", which developes, increases and is reflected, as the definition states, in the individual's job satisfaction:

> "The degree of efficiency relative to his peer group, with which a person has utilised his capacities in coping with and completing the vocational developmental tasks of his life stage, as indicated by his satifaction with his vocation".
> (Super & Others, 1957:131)

This theory of vocational development is a life-long sequence, relating closely to Miller and Form's "lifework pattern" (1964:539). Because of this it has been criticised as being too general to have any practical application (Carkhuff, 1967).

The developmentalists' theory envisages the process of career choice as a long term, on going, sequence of decisions in a logical progression. The continuing nature of career choice is demonstrated in the present study by the radical changes in respondents' long term employment intentions during midwifery training (Table 10.2.3.).

Table 10.2.3. Changes in Double Identifiers' Long Term Employment Intentions

	Number		Percentage	
Consistent	75		44.9%	
Intend Midwifery		16		9.6%
Intend No Midwifery		28		16.8%
DK/NR		31		18.6%
Not Consistent	92		55.1%	
Total	167		100%	

Super is probably most significant in providing a theoretical framework; as he emphasises identification and alignment of self-

concept with occupation. Although Tiedeman (1963) demonstrated the stages of decision making he failed to clarify the psychological processes involved in making the decision. For this reason it is necessary to look beyond the developmentalists for the theory of employment decision making.

10.2.4. Employment Decisions - Theory

"Drive theory" originated in the early twentieth century in the work of Woodworth (1947) and was founded on the two basic elements of habit strength and drive. Against this backdrop of accepted behaviour-reward theory, Vroom (1964) applied the behaviour-based expectancy-valence theory of motivation to organisational behaviour, developing the work of Lewin (1935) who had differentiated behaviour based on learning from history-free behaviour to arrive at expectancy theory, the basis of which is summarised by Porter and Lawler (1968:9) as:

> "People have behaviour response "expectations" or "anticipations" about future events".

Vroom explained his theory in terms of the situation as perceived at the time of making the decision:

> "The choices made by a person in a given situation are explained in terms of his motives and cognitions at the time he makes the choice. The processes by which these motives or cognitions were acquired is not specified, nor is it regarded as crucial to a consideration of their present role in behaviour". (Vroom, 1964)

To apply expectancy-valence theory to employment decision making, it was necessary for Vroom initially to differentiate three components culminating in employment. The first component is occupational preferences, which are the valence or attractiveness of the various alternatives, and are determined both by motivational and cognitive variables. Preferences are modified by subjective probability and expected costs of attainment to produce the second component, occupational choices. These reflect closely the individual's value

system. Occupational attainments (actual work) may be different again, being modified by the individual's ability, in addition to external factors.

Vroom's expectancy-valence theory incorporated three main features (Kerr, 1982a:92) these are:

(i) expectancy is the belief concerning the likelihood that a particular act will be followed by a particular outcome (Porter and Lawler, 1968:9).

(ii) valence, according to Lewin (1935), is the "affective orientation towards particular outcomes", which, Vroom emphasises, is based on anticipated satisfaction. Valence may be increased or decreased according to the instrumentality of a certain outcome. This is the extent to which the person sees that outcome leading to the attainment of other outcomes.

(iii) force is the compulsion for a person to make a certain choice and it is a product of valence and the probability of attainment (Mitchell and Beach, 1976:235).

In the first of his two models, Vroom incorporated valence and instrumentality to develop a predictor of job satisfaction, occupational preference or the valence of good performance. This "Model 1" predicts that the person's employment decision is based on how they perceive the job helping them to achieve certain outcomes which are more or less desirable (Mitchell and Beach, 1976:235).

Vroom's "Model 2" predicts job effort by calculating the force on a person to perform a particular action, which is irrelevant in this context.

Edwards (1961) applied expectancy-valence theory to a wide range of decision-making situations. His work resulted in two models, one

descriptive and the other normative. The crucial difference between the two being the dependence of the former on subjective expected utility (SEU), compared with the more objective inputs into the latter. These models constitute dynamic decision processes because of the instability of the environment and the need for learning.

The SEU model would involve the potential employee considering the subjective probability of each of a range of jobs providing certain outcomes and the value attached to gaining or not gaining those outcomes (Mitchell and Beach, 1976:237). The descriptive model suggests that the person chooses the job with the maximum SEU.

A major weakness of expectancy-valence theory derives from the feature which was originally its strength, that is its history-free nature (Porter and Lawler, 1968:13). This is evident in the relatively minor significance attached to previous learning experiences. It may be argued that in the current, rapidly changing employment situation this is not a weakness serious enough to prevent this theory being applied in the MEDM.

Expectancy-valence theory is criticised for limiting occupational choice to a "one off" decision; this should be overcome in the MEDM by regarding career choice and employment decisions as twin processes.

The contribution of expectancy-valence theory to the MEDM is its explanation of the reason for the Beginners deciding to take midwifery training. The relevent data (from Item A2, Appendix B) are discussed in Section 5.3.1., demonstrating the perceived instrumentality of midwifery training. These new students anticipate that the midwifery qualification (the primary outcome) will lead to the attainment of other, secondary, outcomes. A majority of respondents (55%) stated that their main reason for taking midwifery training related to an

outcome outside midwifery. These secondary outcomes include "Promotion", "HV training", "Working Abroad", personal "Childbearing", completing "Nurse Training" and maintaining Group Relationships.

Mitchell and Beach (1976:238) suggest that the assumption of subjective probabilities being congruent with probability theory may not be justified. The mathematical precision of Vroom's and Edwards' models is probably inadequate for anything other than a descriptive model. For this reason this argument should not prevent the utilisation of expectancy-valence theory in the MEDM. After further criticism of the "cavalier" characteristics of expectancy-valence theory, Mitchell and Beach conclude that its applications provide sufficient evidence to support its use to produce valid predictions of occupational choice, relevant examples of which now follow.

10.2.5. Employment Decisions - Applications

Herriot, Ecob and Hutchison (1980) tested models of expectancy-valence decision theory to predict occupation intentions of final year engineering students, using a longitudinal approach comprising a series of eight questionnaires. They found that the predictive models increased markedly in their predictive power nearer to the time of the implementation of the decision. These writers found that certain "outside events" were positively correlated with changing attitude towards employment; these included interviews with employers, rejection of an application and rejection after an interview. Herriot, Ecob and Hutchison argue that these changes in attitudes are responsible for changes in employment intentions, although the data fail to support this. They further suggest (p233) that the data supports the use of their modification of the expectancy-valence model to predict specific employment choice in a group with considerable

pre-existing occupational commitment. The work of Herriot et al demonstrates marked similarities with the present study in terms of its longitudinal nature and the association with a vocational learning experience. These similarities would appear to support the use expectancy-valence theory in the MEDM.

Herriot et al. indicate the importance of the nature of the relationship between attitudes and intentions; whether they achieve this is debateable. The data in the present study establish a firm link between attitudes to an occupation and employment intentions and then advance the argument by relating these to employment practice.

The attitude scale, the instrument used to demonstrate these links, is not incorporated into the MEDM because its use would not be appropriate for the selection of new students. The predictive power of this instrument is, however, apparent in the significant differences between low and high scorers' intentions to practise as midwives (Section 7.6.2., Page 158). The potential value of this instrument in predicting employment practice is shown in Section 7.6.4.2. (Page 160); this demonstrates that the ratios of notifiers (practising midwives) to non-notifiers are reversed to a significant extent when the low scorers are compared with the high scorers.

Kerr (1982b) used expectancy-valence theory to study the differential take up of supplementary pensions by elderly people. He envisaged the relationships between the components of the decision process in terms of the Vroom (1964) "Model 1". The outcomes, which were largely negatively perceived, were dependent on the initial act of applying for a supplementary pension. The immediate ("first order") outcomes were modified and made even less attractive by their instrumentality in achieving "second order" outcomes, including "more

money" and "people would think I was poor". Kerr demonstrates the logical sequence of decisions made by these elderly people and reveals points at which intervention could be made to reduce non-claiming.

Although Duff and Cotgrove (1982) did not use expectancy-valence theory, their work related to that of the developmentalists, in that they studied the relationship between social values and choice of occupation. This work is significant in the present context because it demonstrates that there is a close relationship between preference and occupation. Another significant observation made by Duff and Cotgrove is the great shifts in values during long courses, a feature also noted in the present study in the context of the characteristics of midwives. The data show (Table 8.2.2.3., Page 172) that new midwives perceive certain characteristics as being more prevalent in midwives after their completion of the midwifery course. An example is their increasing perception of midwives as "sincere".

10.3. Summary

The employment decision is made in the context of a less than stable period in the work life of the new midwife. During this period such decisions are a salient and frequently recurring feature. The decision process, illustrated in the MEDM, continues from before the beginning of training to after implementation of the decision. This process comprises two themes, the first is the more long term, contributing to career development and requiring a continuing series of career choices. The second theme is the more immediate, relatively short term occupational choice which reflects the expectation that a certain decision will achieve certain goals or outcomes, but which is modified to incorporate attitudes and external events.

CHAPTER 11

THE INTRINSIC COMPONENTS OF THE MODEL

This, the first of the chapters examining the components of the model, focusses on the personal factors, or those most attributable to the individual, and assesses their contribution to the Midwifery Employment Decision Model (MEDM). These factors have been identified in the present study as contributing to the employment decision.

11.1. Personal Variables

Consciously or otherwise, there are certain personal variables which influence the new midwife's employment decision. The importance of these variables has been demonstrated in the present study as well as in others' work. Their predictive value has yet to be assessed by testing the MEDM. The relevance of each variable is now examined.

11.1.1. Age

Younger people are assumed to be less stable in their employment, due to their undergoing their "trial work period". In a nursing context, this is supported by Abel's manpower study (1976), which revealed that the loss from nursing fell from almost 50% in the under 25 age group to 5% in the 45 to 55 year olds. This assumption may be misleading as other studies suggest that this inverse relationship between labour mobility and age is not "entirely consistent" (Redfern, 1978:240).

The decision of new midwives not to practise is regarded as wastage (Section 2.3.2., Page 21) and may be compared with the more publicised nursing wastage. The present study does not, however, support the general picture of younger personnel being less stable in their occupational choices. As shown in Table 8.4.3.1. (Page 178), younger midwives (under 23 years) are more likely to implement their

intentions to practise midwifery than are older midwives. This finding may be associated with older nurses having practised as such prior to midwifery training, and their desire to return to the field in which they have become socialised. Thus, age is a component of the MEDM, but this advantage of younger midwives is not consistent with current selection practice and, due to demographic changes such as the forthcoming decline in the number of school leavers, would become more and more difficult to utilise.

11.1.2. Education

There is a widespread perception of greater occupational stability among more educated and intellectually able employees, which may relate to the tendency to remain in an area of great personal investment. The present study, however, clearly suggests that student midwives with more advanced educational qualifications (SCE Highers or GCE "A" Levels) are more likely to change their minds in favour of midwifery and are significantly more likely to implement that decision by practising (Tables 8.3.5.2. and 8.4.1., Pages 180 and 183); this justifies the inclusion of education in the MEDM.

The implementation of this component would be unlikely to cause any difficulty in the present economic climate, but due to anticipated reductions in the number of school leavers and increased competition with other service industries for well-qualified recruits this component becomes less feasible.

11.1.3. Post Registration Nursing Experience

The findings of the present study suggest (Section 8.4.2., Page 183) that new midwives with longer nursing experience are more likely to leave midwifery, although experience does not operate independently of age. The converse also holds, in that those with no previous

experience are more likely to intend to remain (Table 8.3.5.1., Page 180). Thus, any present employment difficulties may be self-limiting, because student midwives are currently compelled to await a training vacancy, meanwhile "marking time" as staff nurses. This inevitably increases their socialisation in that area, with which midwifery must compete and may be compared unfavourably at the time of the midwifery employment decision, perhaps providing vacancies for other midwives. However, according to senior midwives (Section 13.1.3.1., Page 255), fear of unemployment may prevent this from occurring. The data indicate that nursing experience and age should be included in the MEDM.

11.1.4. Marital Status

The effect of a person's marital status on their employment decisions is usually attributed to a combination of their gender and their family responsibilities, causing them to cease employment for longer or shorter periods. The childrearing variable is examined separately (Section 11.1.5., Page 227), but the relationship between marital status and the midwifery employment decision is shown in Table 11.1.4.

Table 11.1.4. The Marital Status of Notifiers Identifying as Beginners

	Married	Single/ Other	Total
Notifiers	50 (43.5%)	138 (35.8%)	188 (37.5%)
Non-Notifiers	65 (56.5%)	248 (64.2%)	313 (62.5%)
Total	115 (100%)	386 (100%)	501 (100%)

Despite married midwives being over-represented among the

notifiers, the difference does not reach the level of significance, but, subject to further research, marital status is a component of the MEDM.

Ward (1981:74) attributes her finding of greater occupational stability among older women entering medicine to their tendency to remain single. This association between age, marital status and employment decision can not be supported by the present study, as larger proportions of older (over 24 years) midwives are married and less inclined to practise.

11.1.5. Dependent Children

The significance of the family in career planning is stressed by Miller (1984:18), although she regrets that all too often it is viewed as an individual activity. Her "Family-Career Connection Model" illustrates the interdependence of career decisions within the family and she concludes that such decisions "have major impact on the family and influence the career decisions of other family members".

The traditional assumption regarding children and women's employment decisions is encapsulated in the words of Ward (1981:76):

> "The participation rates of the married respondents are not unnaturally affected by the number of children per respondent".

Unfortunately her data fail to support this assumption, showing large variations in the work participation, quite unrelated to the presence, number or age of children. The inaccuracy of this traditional view is endorsed by Moores et al. (1983:229), whose sample of 2325 qualified female nurses included women with children comprising 60% of full time and 92% of part time workers.

In the present study a tiny proportion of the respondents were caring for children (6.2%). The employment practice of this small group suggested stability in their employment preference, regardless

of how favourable to midwifery it was (Table 8.3.5.3., Page 181). As this small sample does not permit generalisation further research is needed. If these employment preferences are found to be more stable, it may be due to the need for mothers to plan any employment carefully and, because of the implications for others, to implement their plans. There is, however, no allowance for the domestic events on which traditional assumptions about working mothers are founded.

11.1.6. Review

Personal factors which may have some predictive value in the MEDM include education, age/nursing experience and marital status. These features may apply to "Direct Entrants" (Appendix A, Page 294) found in other parts of the UK. As this study was undertaken in Scotland where there are no direct entrants, any assessment of their contribution is impossible.

11.2. Reference Groups

Individuals draw on their contacts with others to develop their own values and aspirations; as this process inevitably affects the employment decision, so reference groups, who provide these contacts, must contribute to the MEDM. Two types of reference groups are recognised and a third is proposed (Hadley & Levy, 1970:55); "normative" groups are those which set standards to which a person <u>ought</u> to adhere, whereas "comparison" groups provide a measure against which a person is able to evaluate their own performance. The third, proposed, reference group is that to which a person aspires, but, as differences between it and the normative group are negligible, this reference group will be ignored.

In the context of the MEDM the family and the occupational work group are the important reference groups. Their importance varies

according to the individual's stage of vocational development (Super, 1957b:86), so these groups will be considered in chronological order.

11.2.1. The Family

The role of a reference group shows considerable flexibility both in terms of its degree of significance and also in relation to its normative/comparative function. The family is initially a normative reference group, setting and enforcing standards. Later, and probably relating more to siblings than parents, the family serves as a comparative reference group. This changing function demonstrates the family's long term and immediate influence on employment decisions (Hadley & Levy, 1970:55).

The role of the family in vocational development is largely that of facilitator, in that it provides positive (and perhaps negative) role models, and also learning experiences to assist the development of self concept (Super, 1957b:242). This long term beneficial function of the family is illustrated in the work of Ward (1981:74) in which the occupational activity of the parents, particularly the mother, is closely reflected in that of the daughter.

Roberts (1977) interprets Super's ideas less constructively, viewing the employee as a passive, acquiescent being, vulnerable to the vagaries of the employment market and envisaging the family as limiting the opportunities of the individual by confining horizons and social mobility.

As other normative reference groups assume greater significance, the parental family provides more tangible resources which are of immediate or short term value. These are the contacts and other openings which an established mentor may provide for a protegee. The relevance of such contacts is difficult to envisage in the context of

public sector nursing/midwifery; so the significance of the family as a normative reference group declines with increasing maturity. This conclusion is supported by the present study in which data on family consultation was sought, hoping that "family" would be interpreted in the broad sense intended. A large proportion of respondents denied consulting their families concerning their employment decision. Some resented the suggestion that they might have consulted the family, possibly because this was interpreted as imputing immaturity. Eighteen respondents (15.4% of those who denied consulting their family, Items B7 & B8, Appendix C, Page 302) elicited this strong negative reaction:

"No opinion offered".

"It is entirely my own decision".

"Their attitude has nothing to do with it".

Despite these reservations 68.8% (259) of respondents stated that they had been advised by their family. The direction of family advice is largely favourable towards midwifery, as 58.5% of Completers reported being advised to continue in midwifery by their families. For these reasons this variable becomes a component of the MEDM.

11.2.2. The Occupational Peer Group

The influence of the occupational group may be identified at three loci in the MEDM. Because of this pervasive and potentially significant influence the nature and function of this group merits attention.

Reference groups multiply and diversify as the individual matures and separates geographically and ideologically from the family. The declining direct influence of the family corresponds with an increasing indirect influence, through the mediating effect of the wider sphere of groups, to some of which the family has introduced the

young person. The occupational group is but one of them, but which, in the present context because of the nature of the work and conditions, may be difficult to distinguish from the social group.

The physical and social attributes of the occupational work group require its members to conform to its norms and values. In the present context the group influences the employment decision by using group pressure and shared values to increase conformity (Hackman, 1976:1515).

Such group activity is constructive, rather than dysfunctional as demonstrated by Stoner (1961); his "risky shift" phenomenon showed the increasing riskiness of group decisions, compared with those taken by group members prior to discussion. There are three suggested reasons for this phenomenon: first, diffusion of responsibility among group members: second, risk takers' desire for group respect and, third, group leaders' greater inclination to risk (Maccrimmon and Taylor, 1976). This phenomenon is relevant in the present context due to the perceived riskiness of the of the labour market. "Risky shift" may encourage groups of nurses or student midwives to reach decisions which appear too daunting for the lone decision maker .

The first locus at which group influences may be identified is the decision to undertake training. Table 5.3.2. (Page 112) shows a substantial minority of student midwives (32.5%) beginning training as part of a group, usually comprising less than four.

The other locus of group influence in the MEDM is the decision on completion of training. The extent of this influence is difficult to assess due to the other, possibly over-riding influences, such as (fear of) unemployment and perceived job non-availability. This degree of detail is not provided in the present data. The data do, however,

support the existence of shared values. Figure 7.2.2. (Page 143) shows that a respondent who intends to practise as a midwife is more likely to perceive and state that more of her fellow students are similarly inclined; the reverse also applies. The data are unable to determine whether the reality or the perception of the group's intentions is the more important. As midwifery employment is currently perceived as risky, and because group decisions tend towards risk, the influence of the group is probably in favour of midwifery employment.

11.2.3. Review

Both the literature and the present study indicate the importance of reference groups in making employment decisions. The family and, subject to further study, the occupational group have been identified as contributing to the MEDM, both favouring continuing in midwifery.

11.3. Contingencies

It is necessary to consider the rationale for the inclusion of contingencies in an employment decision model, as it may be argued that such events, because of their unpredictability, should be excluded from a model with any aspirations to predictive value. Ginzberg et al. (1951:19), while refuting accident theory as a basis for occupational decisions, are unable to deny that chance events have some contribution; the extent of this contribution being determined by the ability of the individual to recognise and respond to them. Super (1957b:276) similarly disregards chance because of its limited application in vocational guidance, a possible explanation for the dearth of literature on this topic.

On the basis of these authors' statements, it may be suggested that contingencies should be included in the MEDM for four reasons. The first is the contribution of chance events and the second the

variation in the ability of the individual to respond to them (Ginzberg, 1951:19). The other reasons relate to Super's attribution of irrelevance due to unpredictability, but their non-predictive nature does not reduce their descriptive value and, more powerfully, the allowances or contingency arrangements that are made by the decision maker in view of the possibility of these events.

11.3.1. Strategies

Mechanisms for coping with contingencies involve both flexible or contingency planning and decision making in an uncertain environment.

11.3.1.1. Contingency Planning

"An unplanned exposure to a powerful influence" is Ginzberg's definition of unpredictable events (1951:19), an extreme form of contingency. The definition's value is that it does not limit the events, neither by their benefit or harm, nor by the immediacy or duration of the effect, nor by the situation (work or other) of the event. A weakness of this definition is its implicit assumption that the event has actually occurred. This is significant in the present context as the possibility of such events causes the employment decisions of even young women to be flexible, to avoid the need for later modifications of aspirations and plans (Silverstone and Ward, 1980:208). Incorporating a contingency or "flexibility" factor into employment decisions is a characteristic of female employment patterns because, at the time of writing, there is a greater likelihood of unpredictable events impinging on the woman's occupation than that of any male partner. This is associated with assumptions of women's responsibilities concerning not only childbearing, but also child-rearing and caring for elderly dependents. This approach suggests that the occupations chosen by women are those in which there is a maximum

of flexibility to respond to a wide range of unpredictable factors in job and family (Silverstone, 1980:29).

This need for "flexibility" relates not only to the woman's choice of occupation, but to her selection of a lifestyle incorporating an occupation with minimal role conflict. This lifestyle is determined largely by the needs and demands of others, such as spouse and children.

It may be further suggested that the work of occupational theorists originated in a period when women's participation in the labour market was the exception rather than the rule, resulting in theory which neglected women's careers. This may account for the absence of contingencies from occupational theory, as men tend to be insulated from them. Young and Willmott (1973:278) predict the demise of this arrangement due to the sharing of family roles.

The existence of contingency planning in the present study is supported by the data from Item A2 (Appendix B, Page 298), which shows that 48 (9.6%) respondents considered that one of their reasons for taking midwifery training was that it would help prepare them for their own childbearing. In response to Item Bl, 7.4% of respondents stated that their long term employment intention was full time domestic work, a relatively easy alternative in a largely female occupational group.

The need to include chance events in the MEDM is supported by a study of doctors' career decisions, which demonstrates that chance is an important factor, as it was responsible for influencing the decisions of 23% of the respondents, particularly women (Hutt, 1979). This work suggests that chance is equal to financial remuneration as a determining factor, the latter being more prevalent among males.

11.3.1.2. Uncertainty Reduction

Certain strategies are recommended for decision making in an uncertain environment. In the present context uncertainty is due to the lack of information about future events which may impinge on the midwife's employment. As shown in Section 11.3.2. (Page 236) these events are quite unpredictable as to their timing and, perhaps to a lesser extent, the likelihood of their occurrence.

The prevalence of unquantifiable intangibles or "soft spots" in the most "hard edged" of businesses is discussed by Knight (1971), who admits the difficulty of making decisions in such circumstances. An opposite and uncharacteristically unsympathetic view is taken by Super (1957b:278) in his advocacy of information gathering for uncertainty reduction: "Given sufficient knowledge there is no such thing as chance". Raiffa (1968) also recommends information as the solution to uncertainty, but adopts the Bayesian viewpoint of moderating the information by utility and subjective probability. These subjective judgements are expanded (Scott, 1967:23) to include "judgement, opinion, belief and subjective estimates of values"; questioning the possibility of making rational judgements in a state of uncertainty, he concludes that more information will provide a solution.

To Scott uncertainty encompasses all shades of knowledge of probability distribution from near certainty to no knowledge; a more manageable definition of uncertainty (Miller & Starr, 1967:115) "lack of knowledge of the probabilities of outcomes" is the basis for two strategies not resorting to information gathering, which is not feasible in the present context. The choice of strategy depends on the attitude (the degree of optimism) of the decision maker. Scott's first strategy, the "maximin" approach, reflects pessimism by recommending

the choice with the largest minimum payoff, assuming that whatever is worst will happen. This conservative approach results in a better than expected return if events are anything less than totally malign.

The second strategy which might be appropriate for an uncertain new midwife is Scott's more optimistic "maximax" approach. This involves the identification of the choices with the largest payoffs, the one selected depends on the decision maker's feelings - the coefficient of optimism. The nature of the payoffs in the present context may be social, financial or occupational benefits, or job features.

11.3.2. The Nature of Contingencies

The assumption may appear to have been made that these events are inevitably to the individual's disadvantage. The examples provided by the present study indicate that this does not invariably apply. The main factors influencing the employment decision were sought (Item B2, Appendix C, Page 302). Some answers suggested important events, but failed to enlarge:

"My private life".

"Marital and financial circumstances".

Other respondents were more forthcoming about their experiences, which are predictable in their occurrence and probably their timing:

"The fact that I was 20 weeks pregnant when I finished the course".

"Getting married to an obstetrician and working in ----".

A small number of respondents reported happily unpredictable events:

"I met and married my husband after starting the course, had intended to stay in midwifery before this".

Others' employment decisions were influenced by unfortunate events:

"My husband was involved in a serious accident and is unable to look after himself".

These events are obviously critical for those involved and

although the examples are of a personal nature, similarly significant work-related events may be imagined; such as caring for a frightened, unsupported woman and helping her to achieve a satisfying birth experience, or alternatively, sharing with a couple their experience of the difficult birth of a handicapped baby. Such events would fulfil Caplan's criteria for inducing a crisis:

> "A crisis is provoked when a person faces an obstacle to important life goals that is, for a time, insurmountable through utilisation of customary methods of problem-solving". (Caplan, 1961:18)

This definition suggests that crises are stimulated by hostile events. Rapoport (1962), however, states that crises which originate as bad experiences develop in a more constructive way through their potential for growth (1962:212). She gives as an example a person's reaction to bereavement, which may initially be one of depression, but allows the person to work to integrate the event into their experience of life. This example reinforces the feature mentioned in Caplan's definition, that existing strategies are inadequate for solving the current problem, providing an opportunity for growth.

Although Caplan's definition demonstrates the seriousness of a crisis Farberow (1973) presents a less extreme picture by interpreting a crisis as an acceleration of the change which is a constant feature of human existence. This modified view is valuable in that it provides for a range of situations which are regarded as crises by those involved, but which would present no threat to others: "What is a crisis for one ... may not be a crisis for another" (Glasser and Glasser, 1970:6). The rationale for this variation is attributable to three factors: the perception of the event, the situational support available for the person experiencing it and the coping mechanisms or resources of that person. Thus, the degree of the response to the

hazardous event is determined by the person rather than by the event itself (Fogel, 1981:213).

The crisis response involves a temporary escalation in tension, followed by a period of disequilibrium, during which the person attempts a number of strategies to solve the problem. These may achieve a solution or a redefinition of the problem, or, in the event of failure, lead to avoidance of the problem (Rapoport, 1962) during which time functioning becomes less and less efficient (Glasser & Glasser, 1970:6). The purpose of these strategies is to return the person to their own steady state or "homeostasis" (Aguilera & Messick, 1982:5). This return may not always produce the satisfactory outcome (growth) mentioned already, as the adaptive mechanism may provide a short term solution to the problem, but it may not be in the "best interests of that person and his fellows" (Caplan, 1961:18).

These events may be regarded as maturational or situational, the former being normal processes of growth, whereas the latter tend to be external events. The two are not exclusive so certain events, such as pregnancy and childbirth, may have elements of both (Fogel, 1981:213).

The concept of crisis contributes to the employment decision as it includes events such as marriage and childbearing (Fogel 1981:213) which the new midwife is likely to consider, as well as others which come less easily to mind, when making the employment decision.

11.3.3. Review

In order to make allowance for contingencies, which may assume the proportions of crises, the new midwife is likely to use the contingency approach, incorporating a more optimistic or more pessimistic strategy depending on her attitude. These events are, therefore, an essential element of the MEDM. Being either intrapersonal or environ-

mental, contingencies provide a suitable point for moving on to examine the other components of the MEDM which are increasingly distant from the individual, these are the occupational and the extrinsic factors.

11.4. Summary

On the basis of the data provided by the present study certain variables have been identified as increasing the likelihood of the new midwife deciding to practise midwifery. More advanced education, younger age and less post registration nursing experience (the latter two not being independent) operate in favour of a decision to continue in midwifery. Encouragement by the family and the occupational group have a similar effect. New midwives' allowance for contingencies also features in their decision. The predictive value of these variables requires testing in future research together with clarification of the effect of marital status.

CHAPTER 12

OCCUPATIONAL ROLE COMPONENTS OF THE MODEL

After the examination of the personal components of the decision model in the previous chapter, this one focusses on the components which are less individually-based and which pertain to the midwifery occupation. These components comprise the changes associated with midwives' changing role and the changing occupational status. This material is drawn largely from the soft data provided by the respondents and suggests the effect of these changes on employment decisions and, thus, the Midwifery Employment Decision Model (MEDM).

Certain developments in the role of the midwife are criticised by the respondents. The possibility of reversing these developments by changes in midwifery training is considered. Respondents' views of midwifery show whether it is regarded as a discrete occupational group, which is important because this definition determines the gravity of the loss from midwifery.

The changing occupational status of midwifery may impede socialisation and, therefore, retention in midwifery. The socialisation process is considered, including whether socialisation is to midwife or student status; this is followed by midwifery's changing status, demonstrated by the respondents' perceptions of the power base of midwifery. Certain conflicts are shown to exist among midwives which, if not adequately resolved, may decrease the likelihood of new midwives practising.

In this chapter the data referred to are provided largely by the responses to two open items in the Completers' questionnaire (B2 and B9, Appendix C, Page 302, the number of the item is indicated alongside each comment). Soft data may be provided by "asides", the

relevance of which are difficult to assess as there is no evidence of priority. That these were open items lends increased significance to the comments as it must be assumed that the topics were prioritised by the respondents, and only the most urgent were mentioned.

12.1. Midwives' Current Role

The data on the number of respondents volunteering that changes in the midwife's role would encourage practice, are presented in Table 7.4.2. (Page 152). These indicate that 53 (14.1%) of the Completers considered that changes in the role would encourage midwives to practise after qualifying. Problems in the midwife's role are attributed to factors which prevent the midwife from practising <u>midwifery</u> skills. One factor which is regarded as limiting the midwife's practice and autonomy is the hospitalisation of a large majority of women for childbirth. This is claimed to have affected respondents' employment decisions:

> (B2) "Dissatisfaction working in hospital environment".
>
> (B2) "Would like to work outwith hospitals. (B9) More natural births and home confinements".
>
> (B9) "Hospital policy varies - in my hospital it remains rigid and there is high turnover of staff. More home deliveries or domino schemes".

These responses reflect a view widely held among midwives, that midwifery skills have traditionally been practised in the community, therefore these skills may only be fully utilised in that setting:

> (B9) "More community midwives, a swing to home deliveries".

This desire for an idealised form of community midwifery is associated with the small numbers of midwives still in practice who are able to recall the reality of community midwifery when maternity beds were in short supply. Thus, new midwives are aware of the difficulties encountered in hospital practice and believe that because

the aggravating factors are absent from community midwifery, then community practice provides the solution to the problem. The difficulties associated with hospital midwifery tend to focus on relationships with medical personnel:

> (B9) "Return midwife to her role as practitioner rather than obstetric nurse or drs assistant".

> (B9) "Less interference from Drs who insist upon making childbirth pathological and threatening the midwives' role".

> (A7) "Too many females. Interference from medical staff. (E) I feel that the main reasons for low morale among midwives are (1) Mechanisation of birth. Induction rate rising. Epidurals rising. Forceps rising. LSCS rising."

The "strain and conflict" (Walker, 1976) between midwives and medical personnel is perceived most strongly in the context of care in labour, where both occupational groups converge on the patient and where both midwives and doctors perceive that they have ultimate responsibility for decision making:

> (B9) "Midwives should be consulted more in the labour ward as regards management of patients. They should be allowed to manage completely those patients who are having a normal labour".

> (B9) "Particularly care in labour ward, where we could see patients, assess them and care for them without medical interference, except when necessary".

The need for a team approach to the provision of maternity care is widely accepted in Scotland. It would appear, however, that some new midwives still yearn for the autonomy which midwives had when they were independent practitioners:

> (B9) "More scope and autonomy within the job. Midwife more as independent professional".

> (B9) "More recognition for midwives as practitioners in their own right".

> (A7) "In a hospital the midwife being a practitioner is a myth".

It is apparent that new midwives recognise the midwife's declining role and the conflicts between the role for which they have

been prepared and the one which they may practise. The association between this recognition and employment intentions/decisions is not clear from the data shown in Table 12.1, provided by those who responded to item B9 on the factors which would encourage practice.

Table 12.1. Completers Stating that Changes in Midwife's Role would encourage Practice and Notification

	Stated Role	Role not Mentioned	Total
Responded to B9 and Notified	14 (26.4%)	32 (32.0%)	46 (30.1%)
Responded to B9 & No Notification	39 (73.6%)	68 (68.0%)	270 (69.9%)
Total	53 (100%)	100 (100%)	153 (100%)

12.2. Relevance of Midwifery Training

Certain changes are being introduced into midwifery practice which may contribute to the reversal of the decline in the midwife's role. Although at the time of the data collection the midwifery process was far from being established, a small number of respondents anticipated that this scientific approach to planning care would contribute to the retention of midwives, presumably by increasing their satisfaction with their work:

(B9) "Individual patient care. Nursing care plans".

The extending role of the midwife may also be regarded as a method of slowing the decline in the midwife's role. Though this has limited applicability to student midwives, the new midwives perceived the midwife's extending role as encouraging practice:

(B9) "Extended duties ie giving Syntocinon".

(B9) "Total patient care eg suturing episiotomy".

(B9) "Allow them to do more eg suture episiotomies, perform artifical rupture of membranes and make decisions regarding their patients".

The developments sought by some respondents appear to be being achieved by a few:

(B9) "The midwife is exercising more judgement and managing her patient more independently of medical supervision".

This discrepancy indicates the variation in practice between midwives in different parts of Scotland.

It is necessary to question whether the desire of midwives to regain their autonomy is consistent with the extending role which most appear to find desirable and which involves midwives undertaking more technical tasks. The answer to this problem lies in the crucial link between these apparently contradictory aspirations; this is the concept of continuity of care, which is the ultimate goal and the logical connection.

As has been suggested already (Section 2.3.1.3., Page 19), the extending role of the midwife may be interpreted as a form of over-training, making midwifery training less relevant. Reciprocally there are certain areas of midwifery for which students consider themselves to be <u>inadequately</u> prepared. Of the tasks in which new midwives could realistically expect to be confident, Table 8.2.2.4. (Page 174) shows that Completers were not confident in Group Teaching (25.3%), organising an Antenatal/Postnatal Ward (7.5%) and Supervising Baby Care at Home (4.3%). All of these tasks are essential to the traditional role of the midwife and lack of confidence in them must limit the midwife's abilility to envisage herself practising as such. That any student is able to complete training without being confident in them reflects adversely on that training.

12.3. Midwives as an Occupational Group

The occupational status of midwifery with regard to nursing is of importance for two reasons. The first, relating to manpower, is that if these are separate occupational groups movement from midwifery into nursing constitutes wastage, which is a serious and expensive problem. If, however, they constitute one occupation this movement may be regarded as career development, a healthier and more beneficial process. The second reason for the significance of this question relates to the socialisation of nurses and midwives. One occupation would require socialisation on one occasion only, however, a person entering a different occupation requires to be socialised anew. As one of the reasons suggested for the non-retention of new midwives is their incomplete socialisation, this differentiation merits attention.

The data from items A3 and A4 in the Completers' questionnaire (Appendix C, Page 302) provide the relevant data (Table 8.2.2.1., Page 170), which shows that a scant minority (47.8%) of respondents stated that the midwifery qualification is of value to a non-midwife for reasons of Career advancement or Completion of Basic Training. Both of these reasons indicate that midwifery knowledge may be utilised in other areas of nursing and suggest a united occupational group, an interpretation supported by comments:

> (A4) "It is of value in cases of emergency or if you are working in some area not in close contact with medical aid eg Outback".

> (A4) "The nurse could be working in gynaecology or could be of use in general female surgery".

> (A4) "Gives insight into the healthy aspect of nursing, therefore an extension of the role of the general field".

In response to item B2 important differences between nursing and midwifery were revealed, suggesting that the respondents regard them as two discrete occupational groups:

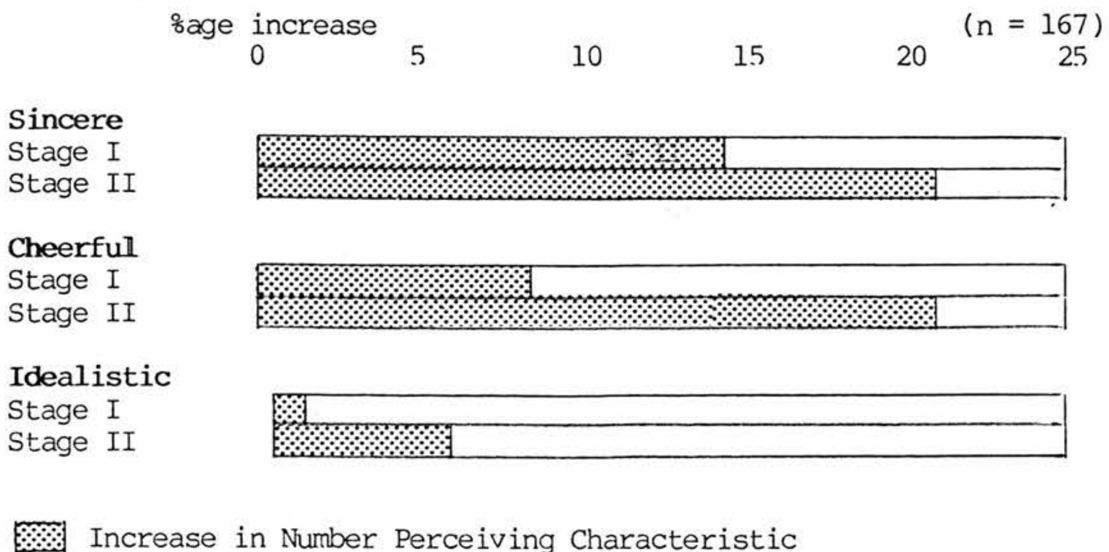
(B2) "Have found the pace of work slightly slow and miss high intensity of nursing care, more dependent patients".

It is apparent that new midwives perceive midwifery as a component of nursing, despite certain differences, as the skills learned in the former are transferable to the latter. This may explain the ease of movement into and out of midwifery for training, and the sudden reversals in employment intentions. This perception contributes to the MEDM by facilitating changes in occupational choice.

12.4. Midwifery Socialisation and Employment Intentions

Incomplete socialisation into midwifery as a cause of non-retention may be corrected by the extension of training (Williams, 1979). The item probing socialisation (A7 and A8 in the Beginners' and the Completers' Questionnaires respectively) demonstrated polarisation in the views of midwives' characteristics. More detailed examination reveals that the majority of respondents adopted midwives' values, more envisaging them as humane after training. Figure 12.4. shows the increase in the number of Completing Double Identifiers attributing certain humane characteristics to midwives, compared with Beginners.

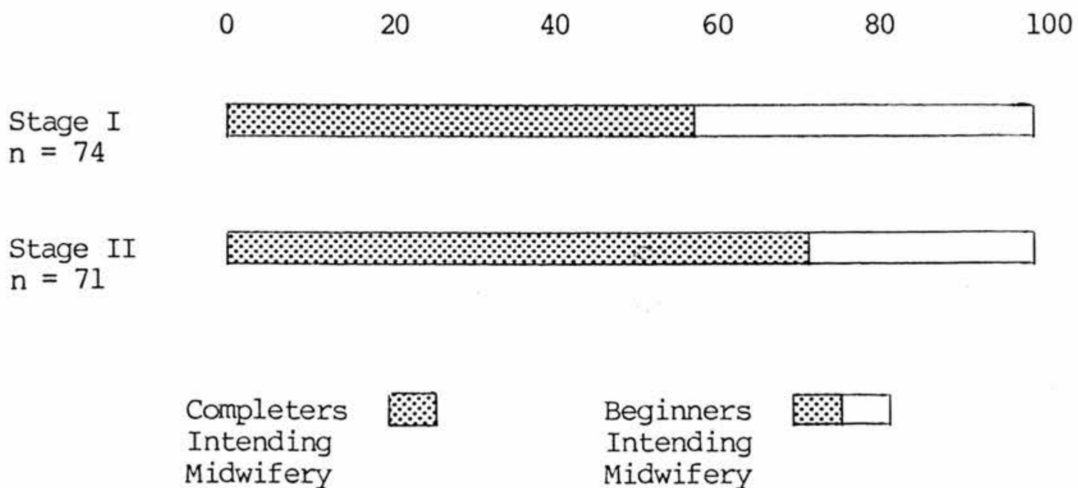
Figure 12.4.1. Difference in Number Perceiving Midwives' Characteristics



Consistently more Stage II respondents perceive midwives as humane. These data suggest that Williams' assertion may be correct with regard to socialisation.

The changing employment intentions in association with the extension of training are demonstrated by the responses to item B1 in the Beginners' and Completers' Questionnaire. The data (Table 8.5.1., Page 187) suggest that the employment intentions are stable in spite of the extension of training. This stability may be spurious, as the Stage II respondents believed strongly that the state of the labour market prevented jobs being available for many of them. For this reason an examination of the long term plans may present a less biassed picture of the plans for employment and one which may be related to the socialisation data. The long term employment intentions indicate that larger proportions of those completing the longer course plan to work as midwives in the long term (Figure 12.4.2.).

Figure 12.4.2. Long Term Employment Intentions of Midwifery Practice - Completers Intending as Proportion of Beginners Intending



These data suggest that, although no changes in immediate employment plans are identifiable and although generally fewer completers plan to

work as midwives on a long term basis, in association with the longer training long term plans are less unfavourable to midwifery.

Although the hard data fail to demonstrate the socialisation of student midwives, a phenomenon identified in the soft data warrants attention. The respondents' comments indicate their belief in the separation between qualified and student midwives. This arouses the suspicion that their preparation is to work as student midwives and their socialisation has been into that role, preventing them from envisaging themselves as qualified midwives:

> (B9) "If the attitude to student midwives improved it would help greatly. You are not included in decisions re patients' treatment, not allowed to have any initiative. There is very little support. Tasks such as BP & P are allocated, should there be a elevation you are asked to repeat the procedure, which is common practice as a RGN. These minor points annoy and frustrate you as you feel your general experience and staffing is wasted as they don't trust you to do basic procedures. One ward sister even had ANs checking up on student midwives' urinalysis. Little wonder student midwives leave or give up their training. The latter was only one of the many incidents that leave you feeling disgusted, angry and humiliated".

> (B9) "Changes in training ie given more responsibility gradually throughout training, as many feel a grudge towards their seniors who fail to recognise their capabilities".

Another respondent commented similarly, but more constructively, suggesting improving socialisation:

> (B9) "During the course there should be some emphasis placed on the responsibilities of a qualified midwife in charge of any particular unit. Throughout the course there seems to be marked division between qualified midwives and student midwives".

These comments indicate the difficulty of moving into a group (qualified midwives) in view of the great degree of separation.

12.5. Professional Status of Midwifery

The professional status is undergoing certain developments which may affect the socialisation of student midwives and their retention in midwifery.

12.5.1. Changing Professional Status

Changes in the professional status of midwifery are apparent to students completing midwifery training, as are certain measures to correct these changes. Although the questionnaire did not seek responses relating directly to the occupational status, the responses to the open items indicate that this topic is of importance to new midwives.

The ultimate feature of professional status is control over one's work, both on a general and on a more personal scale. The responses quoted in Section 12.1. (Page 241) demonstrate the perception of midwives' declining control over their own work. This decline appears to be associated with the extending control exercised by obstetricians and other medical personnel alongside whom midwives work:

> (A7)"Midwifery is a fading profession in Britain, being taken over by the obstetricians".

12.5.2. Hierarchy

Almost one quarter (24.5%) of Completers stated that improvements in staffing and organisational factors would encourage more midwives to practise (Table 7.4.2., Page 152). A frequently mentioned aspect of the organisation is the senior nursing structure. The development of a hierarchical structure is one method of achieving professionalisation (Illsley, 1980). That this hierarchy is thought to exist in midwifery is evident from respondents' comments:

> (B9) "More social events for senior and junior staff. There is not enough communication between them".

> (B9) "Midwifery in my opinion is dominated heavily by inexperienced senior staff".

> (E) "There are too many chiefs and not enough indians in midwifery".

12.5.3. Problems Associated with the Hierarchy

A hierarchy is intrinsically neutral and probably inevitable in organisations such as those providing health care. The respondents associate certain problems with the existence of this structure. One such problem is the lack of support from those at higher levels in the midwifery organisation, identified as being particularly significant to the subjects of the present study - new midwives:

(B9) "Better support from senior midwives".

(B9) "More support for newly qualified midwives".

The problem of an unsupportive senior nursing structure is aggravated by another problem which is commonly perceived to exist, this is a shortage of staff:

(B9) "More staff so that they are not overworked".

(B9) "1. More staff in hospital. 2. Better backup by seniors. 3. More money".

(B9) "I believe that shortage of staff in a lot of hospitals discourages midwives to continue as they are given a lot of responsibility immediately after they qualify. I think they need a lot of support and guidance during this initial period".

12.5.4. Review

New midwives perceive that the professional status of midwifery is in doubt. The hierarchy which has developed, perhaps in response to this doubt, is considered unhelpful, particularly to new midwives.

12.6. Conflicts Associated with the Midwife's Role

The lack of support for junior grades may present them with certain conflicts, but others have also been identified as existing in new midwives. These were recognised in items which probed expectations and their fulfillment in association with midwifery training.

The non-fulfillment of of Beginners' expectations is demonstrated in Figure 8.2.2.4. (Page 174), which shows that for three of the

twelve items listed (Home Confinement, Scrub at CS, SCBU), the number of Completers claiming confidence was considerably lower than the number of Beginners anticipating confidence. Regardless of how realistic the Beginners' expectations are, midwifery training and midwifery itself are failing to satisfy the expectations of new entrants.

A conflict identified in nursing (Bendall & Pembrey, 1972), which may exist in midwifery is the difficulty which some entrants encounter in adjusting their ideals to conform with reality. This conflict has been suggested as giving rise to dissonance which, if unresolved, results in the departure of the new entrant. There are limited data on this phenomenon, but one respondent observed:

> (E) "I enjoyed very much my midwifery training, but at times was disillusioned by the way medical staff and sadly some midwives treated mothers as if they had no intelligence of any description. I guess it is a leftover from an old school of thought".

A further conflict has been demonstrated (Menzies, 1961) which may have implications for new midwives' employment decisions and their retention in midwifery. This is the association between the lack of a support system and nurses' enthusiasm to undertake post-registration courses, which avoids their having to accept responsibility for which they feel ill-prepared. This rationale suggests that there is a low level of responsibility in post-registration courses, which is endorsed by the Completers' comments on midwifery training. The initial assumption may be incorrect, however, as student midwives find difficulty adjusting to their limited responsibility. The responses quoted in Section 12.4. Page 246) support this assertion and others commented:

> (B9) "Improvement in attitudes to student midwives by seniors, bearing in mind they are trained nurses and not primary school children".

(B9) "To give them more credit for sense as student midwives and more responsibility".

12.7. Conclusion

New midwives' strong perception of the changing and declining role of the midwife is clear. They are critical of certain developments and also relationships with senior midwives and medical staff. The midwifery process and the extending role of the midwife are regarded enthusiastically and may correct the declining role. New midwives' perception of midwifery as an area of nursing enables them to move freely between the two, an ease which may be necessitated by the perceived difficulty of joining the occupational group into which they are incompletely socialised. Other occupational conflicts which inhibit the retention of new midwives focus on the limited support they envisage new midwives obtain from their seniors and the limited responsibility they are given as students.

It is difficult to establish the effect of the midwife's changing occupational role on employment decisions. The data show that 23.7% of Stage I Completers (before unemployment became a major preoccupation) stated that occupational role factors were the main influences on their employment decisions. So, for this reason, occupational role merits inclusion in the MEDM.

CHAPTER 13

THE EXTRINSIC COMPONENTS OF THE MODEL

Certain components of the Midwifery Employment Decision Model (MEDM) are to only a very limited extent dependent on the individual. Those most remote from the new midwife, and to which she makes least contribution, are examined in this chapter. The aim is to assess their relationship to the decision and to the other components of the model.

13.1. The State of the Labour Market

In designing an employment decision model in Scotland in the late 1980s, the state of the labour market is a variable which can not be ignored. In a more general context this would require only an examination of unemployment, but as this study focusses on new midwives, the variation in the numbers being employed is inextricably involved. The responses in the present study indicate that unemployment is perceived as the fundamental problem, so it is here that the examination of the labour market must begin, regarding changes in staffing as an aggravating factor.

13.1.1. Unemployment and the Unemployed

The usual classification of unemployment according to duration, recurrence and onset (Sinfield, 1981) is of limited value in this context. The crux of the problem is the prospect of unemployment, and the effect of this prospect on employment decisions. The type of unemployment which a new midwife might encounter is consistent with the "growth gap" variety (Hughes and Perlman, 1984:31), in which output fails to grow in line with capacity. Growth gap unemployment is due to an incompatability between the size of the labour force and the work or jobs available. In the present context the imbalance is

associated with problems on both sides of the equation, due to a stable, regularly augmented work force and limitation of its size for financial reasons. The limited responsiveness of student midwife recruitment to any decline in job availability is due to the vital contibution of students to midwifery service manpower and the inevitable long term implications of employing other, more permanent grades.

13.1.2. The Existence of Midwifery Unemployment

Despite the prevalence of the perception of nurse/midwifery unemployment, hard data supporting this perception are difficult to locate. Anecdotal reports (Mitchell, 1983) abound in the nursing press. These comprise reports from newly qualified personnel of their experiences in trying to find employment, including reports of entire groups in which none were successful. This is supported by the findings of Stage II of the present study and personal observation of student midwives nearing completion with no job prospects.

That this is a localised phenomenon is supported, first, by the observation that certain smaller midwifery units encounter serious difficulty recruiting midwifery staff (SHHD, 1984a).

Second, the localised nature of health service unemployment is supported by the uneven application of current staffing restrictions (ISD, 1985), which is perceived as aggravating unemployment problems (Mitchell, 1983). In the early stages of the staffing restrictions (year beginning September 1983) the mean change in staffing levels in Scotland was a 2.6% increase. The maximum change in qualified nurse/ midwifery staff was an increase of 10.4% in Shetland, which was balanced by decreases in other areas. These data are consistent with the anecdotal reports mentioned already.

13.1.3. The Significance of Unemployment

In the present study the existence of unemployment is of significance for a number of reasons.

13.1.3.1. Specific Significance in the Model

The widespread perception of midwifery unemployment, and the anecdotal and other supporting evidence, may influence the MEDM at two points, the first of which is observed at recruitment. Verbal reports from senior midwives recruiting students indicate that potential students are reluctant to leave existing jobs to begin midwifery training when the likelihood of finding subsequent employment appears remote. Such a move is envisged as jeopardising rather than enhancing job opportunities. The data demonstrate the reduction in student midwife numbers (Table 13.1.3.1.), but fail to indicate whether the reduction is due to this phenomenon or to staffing restrictions.

Table 13.1.3.1. Numbers of Student Midwives Indexed on Approved Midwifery Courses 1982-1985 (NB[S], 1985a)

Year	Number of Students	Percentage of 1982/3 Numbers
1982/3	813	100%
1983/4	754	92.7%
1984/5	693	85.2%

The second point in the MEDM when this perception of the existence of unemployment may exert an influence is on completion, when the student midwife may consider that it is "very important to find something quickly" (Berthoud, 1979:29). Thus, their preferred or chosen employment is likely to differ from their occupational attain-

ment, as it has been expedient to accept the first job available, in case the job of choice fails to materialise.

13.1.3.2. Personal Significance

Employment is significant in personal and social terms as it provides not only an income, but also a "social arena to meet basic human needs" (Clarke, 1982:40). The social and economic exclusion of unemployment is due to the image of maturity, usually attributed to those earning their living, being denied to those who for some reason do not work. The absence of a framework defining leisure and work and the declining perception of self worth in the unemployed person are further causes of distress (Burgoyne, 1985). The increasing strain within a relationship in association with unemployment is attributed to changes in the traditional or assumed roles, which may be less relevant in the context of a largely female occupational group.

That a period of unemployment may affect future employment prospects is considered by Sinfield (1981:129) in the context of the decline of manual skills. This is a cause for concern in new midwives, as a midwife who has had no opportunity to practise or demonstrate practical skills will be seriously disadvantaged when competing for a job. It is necessary to question also whether a potential employer's opinion of a midwife would be affected by a record of unemployment.

Thus, the student midwife, aware of these implications and perceiving midwifery unemployment as prevalent, is likely to be influenced in making the employment decision.

13.1.3.3. Unemployment in the Health Care System

The problem of nursing unemployment was examined in a well-publicised research project which predated the current economic recession and which may have influenced attitudes to unemployed nurses and midwives (Martin and Capelin, 1978). "Slow to place" nurses were found to be unemployable due to their availability at inappropriate hours, their family commitments and their being unable/unwilling to travel to a job. Some may argue that it is these unemployable nurses and their midwife counterparts who give rise to the current perception of unemployment. This is an unlikely explanation as these are most probably those women who have withdrawn from the labour market due to the recession (Hutt, 1986), leaving the employable seeking work.

In the general population increasing unemployment is associated with continuing deceleration of growth in the economy (Department of Employment [DOE], 1986a:S2). This is likely to have had some effect in midwifery, probably in association with the need for midwives to become breadwinners and the subsequent declining employment mobility (Bosanquet and Gerard, 1985). Reductions in staffing levels ("the cuts") have been an additional and arguably more significant factor.

In England the first round of staffing reductions resulted in twice the desired number of job losses, 11,400 were shed rather than the intended 4,800 (Howie, 1984). To correct this "overshoot" it would be necessary to create 6,800 new posts; the feasibility of this policy must be questioned (RCM, 1985b) as the 1985 pay increase to nurses and midwives is to be partly funded by health boards from existing resources, diminishing the funds available for new posts.

Dunn (1982), writing about nursing unemployment, sums up the meaning of unemployment in this context, suggesting that the numbers

are less significant than the perception of unemployment:

"... for a profession used to excellent career prospects and job security this changing scene is unnerving".

13.1.4. Measurement of Midwifery Unemployment

As mentioned already there is a widespread perception of a problem of midwifery unemployment. Considerable difficulty is encountered in assessing the justification for this perception, which may be due to the fact that midwives in Scotland must first be registered nurses. Dual qualification facilitates their movement into nursing if unable to find a post in midwifery. In view of the dearth of data and to ascertain the extent to which the perception of unemployment is justified, the data provided by the present study, government surveys and an RCM survey will be reviewed.

13.1.4.1. The Present Study

This study illustrates both the increasing perception of unemployment and the anxiety it engenders. Immediate employment intentions were sought in a closed item (B1, Appendix C, Page 302). Unemployment did not feature in Stage I, but by Stage II respondents were stating this to be their next "occupation" (Table 13.1.4.1.1.).

Table 13.1.4.1.1. Completers' Immediate Employment Intentions - "Unemployment" and "Don't Know"

	Stage I	Stage II	Total
Unemployment	0 0	4 (2.1%)	4 (1.1%)
Employment/ Other Occupation	172 (96.1%)	193 (97.9%)	365 (97.1%)
Don't Know	7 (3.9%)	0 0	7 (1.9%)
Total	179 (100%)	197 (100%)	376 (100%)

The anxiety of completing student midwives regarding their future occupation is reflected in two items. One is the item on immediate employment intentions in which respondents stating "Don't Know" disappeared as the study progressed. This suggests that student midwives are becoming sufficiently concerned to make more definite arrangements for their future occupation.

The second indicator of anxiety concerning unemployment is the open item probing factors affecting the completers' employment decision (B2). Table 13.1.4.1.2. shows that "job availability" was mentioned more frequently as the study progressed, reflecting its increasing significance.

Table 13.1.4.1.2. Factors Affecting the Employment Decision - Proportion of Responses Stating "Job Availability"

	Stage I	Stage IIa	Stage IIb	Total
Job Availability	9 (4.2%)	31 (26.5%)	25 (22.5%)	65 (14.7%)
Other Response	206 (95.8%)	86 (73.5%)	86 (77.5%)	378 (85.3%)
Total	215 (100%)	117 (100%)	111 (100%)	443 (100%)

The respondents' perception of the gravity of the employment situation and their action is shown in their comments (to Item B2):

"No posts in midwifery".

"Inability to get a job in midwifery in Edinburgh".

"Job prospects - unemployment in home region - going to work in London".

13.1.4.2. Departmental Data

Having indicated the local variations in nurse staffing restrictions (Section 13.1.2., Page 254), similar variations in general

unemployment levels are also found to exist. The general unemployment rate (DOE, 1986b:S26) varies from 27.6% in Forres to 6.9% in Shetland; it is noteworthy that the latter was affected leniently by nurse staffing restrictions, suggesting that a wide range of workers benefit in areas of economic growth.

That the general recession continues to give rise to concern is supported by DOE data (1986b:S2 and S4), which enables them to predict a further deceleration of growth from 3.5% in 1985, to 1.8% in 1986, and reaching 1.4% in 1987.

Table 13.1.4.2. Index of Unemployed Women in Scotland (excluding school leavers) 1984-86

Index March 1984 = 100.0

1984	March	100.0
	June	99.7
	October	101.9
	December	103.4
1985	March	103.5
	June	104.9
	October	105.2
	December	105.6
1986	March	105.8

(Based on DOE, 1985:S26 & 1986b:S24)

Table 13.1.4.2. uses March 1984 as an index figure to demonstrate the continuing increase in female unemployment in Scotland. This may, however be an underestimate of the situation as it has been suggested that some women have withdrawn from the labour market due to the

recession (Hutt, 1986). Although these figures clearly demonstrate the trend in unemployment, is not feasible to assume that they accurately reflect the proportions of midwifery unemployment, as employees in the service sector tend to be less vulnerable (Sorrentino, 1981).

13.1.4.3. Royal College of Midwives Data

An alternative picture of the state of the labour market is shown in the difficulties encountered in the provision of a maternity service. This is clearly enumerated by the data provided by a survey of the heads of midwifery in England and Wales (RCM, 1985a:7), which shows that 849 vacancies exist for qualified midwives, in addition to the 301 midwives absent on maternity leave and not being replaced. The respondents to this survey estimated that an increase of 23.25% in the number of qualified midwives currently employed is needed to provide an adequate service. Unfortunately these figures give no indication of the extent to which the shortfall is due to staffing restrictions or to the difficulty of attracting personnel to work in certain areas.

13.1.4.4. Estimate

In the absence of empirical data an attempt will be made to calculate the level of midwifery unemployment. A "prudent" estimate, based on data provided by the government departments and statutory bodies (See Appendix L, Page 316), suggests that between 150 and 200 midwives are unemployed in Scotland at the time of writing. On the basis of this figure, an estimate that approximately four per cent of midwives in Scotland seeking employment are unable to find work. This figure may not appear to justify the general impression of widespread midwifery unemployment, but as new midwives, "finalists" in Hicks' (1982) terms, are particularly vulnerable to this problem their perception may be appropriate.

13.1.5. Review

These data suggest that, although there is little hard data to support its existence, unemployment is perceived as a problem by a wide range of midwives. This perception is due partly to the general economic recession and more directly to the staffing restrictions within the national health service. Therefore the state of the labour market must be a component of the MEDM, its effect on the employment decision being quite variable.

13.2. The European Community

The wider employment opportunities available to midwives since the implementation of the Midwives' Directives should have broadened the long term if not the immediate employment horizons for new midwives. It is necessary to question whether membership of the European Community (EEC) merits a place as a component of the MEDM.

13.2.1. The Midwives' Directives

Due largely to the huge variations in midwifery practice among the member states, the Midwives' Directives were eventually signed in January 1980 and came into effect, after a period for adjustment, in January 1983 . This was four years and six years respectively after the implementation of the nurses' and doctors' directives (Bent, 1982 & 1983; Quinn, 1980b).

The Directives aim to translate into reality the terms of the Treaty of Rome in order to achieve the elimination of barriers between peoples, by encouraging freedom of movement of goods, people, services and capital (Collins, 1983). In this context the Directives provide for "mutual recognition" of workers, allowing the member states to prepare their "professionals" in the appropriate way, but conforming to a basic minimum to permit recognition of qualifications.

The implications of these aims were expected to cause problems in midwifery even before the signing of the Midwives' Directives, as it was anticipated that fewer students would be attracted to and recruited for the longer course, resulting in a declining number of midwives. A clash of interests ensued as upholding the "European ideal" and the need to lengthen midwifery training conflicted with the anticipated disastrous manpower consequences (Quinn, 1980b).

13.2.2. Changes Associated with Membership

Initial fears of "large scale migrations" of workers proved unjustified and the limited data available suggest that migration is balanced, but with a slight tendency for nurses to prefer to leave the UK (Personnel Division, 1982; UKCC, 1986a). Anxiety was also present among midwives that some nurses may take advantage of the mutual recognition of qualifications. An example would be the nurse who is a citizen of a member state not offering a reduction in the duration of midwifery training to nurses, who would move to another country where such a reduction is offered. Evidence to support the existence of this movement is not available.

The influence of EEC membership on employment decisions in the present study is shown in Table 13.2.2., which gives the number of new midwives planning to work in countries other than the UK. This table also compares Stage I (preceding implementation of the directives) with Stage II (following implementation).

Table 13.2.2. Completers Planning to Live/Work Outside UK

	Stage I	Stage II	Total
EEC Countries	3 (1.7%)	6 (3.0%)	9 (2.4%)
Other (Non UK) Countries	9 (5.0%)	3 (1.7%)	12 (3.2%)
Other Response	167 (93.3%)	188 (95.4%)	355 (94.4%)
Total	179 (100%)	197 (100%)	376 (100%)

These data show that only a small proportion of new midwives plan to work abroad, and suggest a slight decline in the numbers so planning. This suggestion, however, must be modified by the existence of two factors. First is the decreasing number of Commonwealth nurses undertaking midwifery training in Scotland (Table 5.2.1.3., Page 98), so that fewer plan to return home on completion. The second factor is the number of student midwives from the Republic of Ireland whose return home is delayed (See Below). It may be suggested that, in the light of these factors, the mobility of new midwives is actually increasing.

A problem which developed due to the Midwives Directives and which affected some of the respondents in the present study is associated with the choice given to member states regarding the length of the midwifery course (3000 hours/eighteen months or 3600 hours/two years). The UK choice of the eighteen month course added to the recognised attraction of Scottish midwifery training for Irish nurses faced with the two year course in Ireland (Bent, 1982:385). The need for an additional one year period of "professional practice" for EEC recognition of qualifications was not always anticipated by students. This resulted in some consternation among Irish nurses who, until they had

completed their additional year, were unable to return to work as midwives in their own country. This consternation is illustrated by the comments of respondents in response to Item B2.

"Being from Ireland I had to work a year before returning".

"In Ireland in order to register you have to staff for a year as a midwife in the UK, that is the reason".

Although the problems of Irish midwives are particularly well recognised in Scotland, the Midwives' Directives do affect others, as a new (Dutch) midwife stated in response to item B2:

"EEC Directives and own future plans".

Other respondents also took the Midwives' Directives into account when making their employment decision. In response to item B2 they stated:

"I am staying to work in this midwifery unit as I must practise midwifery for one year to be recognised as a midwife in EEC countries".

"To obtain EEC midwifery standards".

A further inhibiting factor, which Quinn (1980a) regards as "specific to midwifery" is the definition of the sphere of practice. This has been shown to vary considerably between midwives and between locations within the UK (Bradley, 1981), but the variation becomes even greater if European states are included. This variation includes the midwife's employment, social status, and education, as well as the nature of practice (Jeffs, 1980; Newson, 1981; Bent, 1982) .

13.2.3. Review

New midwives' need to complete twelve months professional practice prior to recognition of qualifications has reduced the impact of UK membership on new midwives' employment decisions, but despite this, new midwives' intention to migrate has increased. Certain groups, such as Irish midwives, have been particularly affected by EEC

membership, but this was probably a temporary phenomenon associated with Ireland becoming an EEC member state. As well as the Irish respondents, others asserted that UK membership of the EEC had influenced their employment decision. As it remains to be seen whether the impact of EEC membership on new midwives' employment decisions will increase or decrease, EEC membership must, on the basis of the present data be a component of the MEDM, but this will need to be reassessed as UK membership becomes more firmly established. EEC membership is quite variable in its effect in the MEDM, as it appears to increase the mobility of some new midwives, while causing others to practise.

13.3. Finance

Finance is a component of the MEDM largely because of the respondents' perception of its importance; a perception which is reflected in the midwifery and, to a lesser extent, other occupational literature. As the issues associated with the pay structures and financial costs of training are specific to midwifery, it is necessary to question the extrinsic nature of this component. The respondents and other sources indicate that a large element of the difficulty relates to comparisons made between midwifery and other groups, such as health visitors and general nurses, indicating the areas explored during the preparation for the employment decision. The contribution of training costs to the MEDM may not be immediately apparent. Though the costs of training may not consciously influence the individual's decision, whether there is a training place available determines the need for a midwifery employment decision, and the availability of training places is dependent on their being financed and, thus, their costs.

The problems associated with finance and their effect on the MEDM

are examined first, followed by a solution which has been suggested.

13.3.1. Training Costs

The costs of midwifery training and the limited return to the health service on this spending initiated the present study, to assess whether this imbalance is amenable to action. The extension of midwifery training increased the salary costs of student midwives by 50%. As no extra finance was provided from central funds to cover the costs of the extension, the number of student midwives recruited was reduced. This reduction is reflected in the differing numbers of students in Stage I and Stage IIb, which are the two comparable stages of the present study (Table 13.3.1.).

Table 13.3.1. Numbers of Students Beginning Midwifery Training

	Stage I	Stage IIb
Number	303	225
%age of Stage I	100%	74.3%

This reduction, in combination with the widely perceived nursing unemployment due to the economic recession, exacerbated the demand for training places.

It may be suggested that the costs of midwifery training may be disregarded in view of students reimbursing those costs in service manpower. This is a false argument as, even after a student midwife's salary has been reduced to take account of the service input, the cost of midwifery training is still 63.0% greater than the salary. This estimate (Snowdon, 1985) is probably an underestimate as any allowance for overheads, such as recruitment costs, is omitted. Snowdon accepts that 6.6 thousand pounds should be added to make allowance for the

costs of general nurse training if the total costs of producing a new midwife are sought.

This material serves to support Moores' contention, quoted in Chapter 4, that "a trainee ... is no longer a cheap commodity".

13.3.2. Financial Remuneration

Despite 52 (13.8%) of Completers having volunteered that changes in salary would encourage more midwives to practise (Table 7.4.2., Page 152), the limited effect of salary on employment decisions may be argued for two reasons. The first is that student midwives' salary is equal to that of similarly experienced staff nurses who remain in general nursing. The second argument is the uncertain value of cash as a motivator to work or, presumably, as an incentive to continue in work.

The first argument is answered by taking a long term view of the midwife's career. Although the student midwife salary equals that of a staff nurse, the earlier promotion of the nurse to sister grade benefits her, while the midwife is "marking time" in salary terms by gaining experience prior to promotion to midwifery sister (RCM, 1986). A similar comparison may be made between the midwife and a nurse who becomes a health visitor. The latter undertakes a shorter period of training and immediately receives a salary 17.1% higher than the staff midwife's maximum salary. Thus the midwife is effectively disadvantaged. The new midwives' awareness of these grading/pay anomalies is revealed in response to Item B9 (Appendix B, Page 298 to which quotations in this section refer, unless preceded by a number):

"Faster promotion/Increase in salary".

(A7) In some ways interferes with established careers and so one may lose opportunities for promotion".

(E) "Poor promotion and no financial benefits for being midwife".

The importance of this awareness is shown by the 5.6% of Stage I Completers who stated that money had affected their employment decision (Table 7.3.2., Page 147). Salary was mentioned less often as job availability became more of a preoccupation to new midwives.

One source of discontent in the Stage I respondents, which was subsequently remedied, was the absence of any increment in pay during midwifery training:

(A7) "Lost increment during midwifery training".

13.3.3. A Solution to Problems of Finance

The restoration of the midwifery differential is widely viewed as the solution to a range of problems in midwifery. The implementation of this solution would be quick, but its effect is less certain. The differential is sometimes, incorrectly, referred to as the "midwifery lead". A "lead", which is paid to certain grades of nurses working in the psychiatric and geriatric fields, is introduced specifically to attract staff into unpopular disciplines which, according to RCM (1984), makes it inappropriate in midwifery. The rationale for the midwifery differential was that it was paid in recognition of the particular responsibility taken by midwives.

The midwifery differential was paid to all grades of staff working in midwifery, until it was withdrawn following the Halsbury Committee Report (DHSS, 1974) in an attempt to rationalise pay structures. At the time of its withdrawal the differential added thirty pounds per annum to midwives' salaries. Since 1974 midwives' pressure groups have sought to restore a differential to their salary structure in recognition of midwives' special responsibilities. Respondents in the present study advocated the restoration of the midwifery differential for a range of reasons. The responses to item

B9 which follow show that the comparison between midwives' and others' salary is regarded as being to midwives' disadvantage:

> "Salary differential from general nurses. Better promotion prospects".

> "More substantial pay than in general nursing".

As mentioned already, 13.0% of Completers envisaged salary as the solution to problems of retention, an opinion shared by the RCM:

> "... the acute problems of recruitment and retention of midwives within the National Health Service will only be improved by establishing a separate and realistic salary scale for midwives which adequately reflects the value of their work and their responsibilities" (RCM,1986).

The value of salary as an incentive to work is not clear. Studies in this area focus on the effect of cash bonuses in increasing output, rather than the decision of whether to work or not (Opsahl & Dunnette, 1970). Respondents, however, were in no doubt as to the effect of salary on continuing to practise:

> "A pay incentive, by increase in wage of staff nurse to a midwifery status wage".

> "Financial encouragement after completing what is a difficult course".

> "Additional incentive on qualifying. One example increased pay for additional qualification".

Extra pay, acting as an incentive to practise, is regarded as a tangible recognition of work completed:

> "Pay incentives, bonus for extra certificate".

> "Earn more money for doing another course".

> "A raise in salary commensurate with having achieved the extra qualification".

The widely accepted concept of extra pay in recognition of higher qualifications develops, in some respondents, to reflect the desire for acknowledgment of midwives' work:

"Increased financial rewards for 2nd certificate and for responsibility undertaken".

"UK midwives are not given an extra allowance for their midwifery qualification. I feel that in this way, they may feel that their special effort in learning midwifery after 3 years SRN training is not a recognised effort in terms of incentives. Besides general hospital offers much variety of nursing care: one should look into giving incentives to midwives who had devoted themselves in their area of nursing".

The failure of midwives' pay to reflect the value which they attach to midwives' work is identified by a few respondents:

"? Salary increase for increased responsibility".

"Differing pay scale - recognising special talents and skills learnt".

"A realistic salary for responsibility".

The comparison of midwives' pay with that of general nurses results in a finding of no difference. In view of this and the observation that midwives' responsibility passes unrecognised in financial terms, it may be suggested that midwives' pay does reflect society's evaluation of their work. The implication is that midwives' work is perceived as not being qualitatively different from that of general nurses.

13.3.4. Review

Finance affects the MEDM at the time of recruitment, by controlling the number of training places available, and at the time of the employment decision. Dissatisfaction with their remuneration among midwives is due to the lack of a differential between themselves and other, less qualified, nurses, which may reflect the role of the midwife. The reinstatement of the midwifery differential is widely thought to provide a solution to a range of problems in midwifery.

13.4. Summary

Certain extrinsic variables have been shown by the present study

to influence the employment decisions of new midwives. Perceptions of midwifery unemployment are aggravated by staffing restrictions, which may be compounded by limited flexibility in the numbers of midwives being trained. The effect of unemployment in the MEDM is quite unpredictable, due to wide local variations. Similarly variable is the effect of UK membership of the EEC on the employment decisions of UK and Irish student midwives, which is to encourage mobility and stability respectively. Lack of adequate financial remuneration is widely regarded as not encouraging midwives to stay in midwifery, so it is concluded that this component operates against the decision to practise.

PART IV - CONCLUSION

INTRODUCTION

In this thesis the existence of the problem of non-retention of new midwives has been established. The changing midwifery environment and its possible effects on the problem have been discussed. The research which has been described has produced data which have been analysed and interpreted, drawing on theory derived from occupational psychology, to develop an essentially descriptive and potentially predictive model.

In this, the final part, the crucial and possibly most neglected phase of the research process is examined. This is the implications of the work for those who will apply it - the practitioners. This phase is the most important and most difficult, especially in practice disciplines such as nursing or midwifery, as it involves bridging gulfs often regarded as unapproachable, even less bridgeable. These are the great divides, first, between the researcher and the practitioner and, second, between education and service. Hence the need for careful, if not painstaking, assessment of the practical implications of the completed work, to permit the findings of the study to be utilised by those working in these specialised areas of midwifery.

CHAPTER 14

SUMMARY AND RECOMMENDATIONS

The design of the present study took advantage of a change, the extension of training, to examine a longstanding problem, the non-retention of new midwives. At this time the researcher was responding to inevitable change in the midwifery environment. In summarising the work and making recommendations, the initial reactive strategy becomes more proactive, and the researcher suggests changes to midwifery based on the findings of the present study.

As the research process may appear to have been completed, the significance of this final part may require explanation. The rationale relates to material discussed in Section 9.1. (Page 196), which shows that the development of theory in areas such as nursing or midwifery is a continuing, dynamic phenomenon in which theory, research and practice are interdependent. Thus, there is a need for scrutiny of the implications of this study for managers and practitioners, for educationists and for researchers in nursing and midwifery. For this reason the final Part is integral to the work. It begins with the Conclusions, which are stated in the form of answers to the research questions, devised at the beginning of the study. These are followed by the implications and recommendations, which are based on areas illuminated during the present study and which are essential to the development of midwifery theory and can in no way be regarded as a mere postscript.

14.1. Conclusions

The research questions were formulated following scrutiny of the problem of non-retention of new midwives (Section 2.5., Page 32). The

study answered these to a certain extent, but was constrained by environmental factors from providing answers to certain parts. The research questions are enumerated here, together with the major conclusions.

14.1.1. Who undertakes midwifery training in Scotland and why?

A profile of student midwives has been drawn up, incorporating personal, domestic and occupational characteristics (Section 5.2., Page 94). The new students' considerable occupational experience and increasing educational qualifications are particularly noteworthy. In only a small minority of students do the reasons for undertaking midwifery training pertain to midwifery practice. This clearly indicates that nurses use midwifery as a "stepping stone", the relevance of which has been questioned (Section 6.3.3., Page 136). For a large proportion of new students the reasons appear to reflect on their basic nurse training, including both the obstetric and other components (Section 5.3.1., Page 110).

14.1.2. What are the new student midwives' employment intentions?

A small majority of new students intend to work immediately as midwives (Section 5.4.2., Page 117). A considerably smaller proportion plan to work as midwives on a long term basis. The data consistently show the markedly limited ability of these respondents to plan their careers. This is in terms of both the occupation and the place to live and work. This lack of planning is associated with a certain vulnerability to sudden changes in their circumstances requiring abrupt revision of their employment plans.

14.1.2a. Are these intentions different from the intentions expressed on completion of midwifery training?

A small majority of student midwives do not change their

employment plans (Section 8.3.2., Page 176). The Completers are consistently more inclined to intend to work as midwives immediately, an intention expressed by a large majority. The significant change in intentions in favour of hospital midwifery practice is at the expense of community midwifery (Section 8.2.1., Page 166). That a large majority of new midwives make their next employment decision while training may have implications for their midwifery course.

14.1.2b. If there are any differences between Beginners' and Completers' intentions, or between intentions and employment, are there any personal or other characteristics which may be associated with these differences?

Certain characteristics have been identified which may be predictive of continuing practice. New midwives with no post registration nursing experience are particularly likely to change their employment intentions in favour of midwifery. Student midwives with higher educational qualifications are also likely to change towards midwifery. The attitudes of student midwives as measured by the attitude survey are predictive of employment intentions and practice.

14.1.2c. How do employment intentions develop in association with the extended midwifery training?

The immediate employment intentions of midwives who have completed the eighteen month course suggest that fewer wish to practise, but the difference is not significant. This conclusion, and the evaluation of the extended training, may be less valid in view of the respondents' perception of the deteriorating employment environment. The Completers' long-term employment plans show that more of those who completed the extended course intend to work as midwives, which may be a more accurate assessment (Section 12.4., Page 246).

14.1.3. How do the expressed intentions relate to the employment of new midwives?

There is a shortfall between the number of Completers who intend to practise as midwives and the number who subsequently Notify. The number of Completers who intend to practise and do so approximately equals the number who intend to practise and do not. Of the Completers who intend not to practise, a small proportion do so (Section 8.3.3., Page 178). Younger midwives and those with higher educational qualifications are more likely to practise (Section 8.4., Page 183/4).

14.1.4. Are there any changes in employment practice in association with the extension of midwifery training?

The proportion of new midwives practising declined during the study, but the general perception of the deteriorating employment situation prevents this decline from being attributed to the extension of training.

14.1.5. What are the phenomena which influence a new midwife's employment decision?

The employment decision is influenced by a range of variables which are attributable to the individual to a greater or lesser degree. Those most closely related to the individual, the intrinsic variables, include personal characteristics, reference groups and contingencies. Changes in midwives' occupational role and certain aspects of the organisation of midwifery are widely perceived as making midwifery less attractive to new entrants (Section 7.4.2., Page 152). Certain extrinsic phenomena, such as the employment climate, UK membership of the EEC and finance, influence the new midwife's employment decision. The effects of these influences are illustrated in the Midwifery Employment Decision Model (Figures 9.6.1.1. & 2. Page 201).

14.1.6. What are student midwives' views of midwifery training and midwifery?

The prevalence of changing views in favour of midwifery suggests that new midwives view midwifery and, one assumes, their course positively. This assumption is based on the majority of new midwives stating that the time taken for midwifery training is appropriate. Small numbers are dissatisfied with the length of the course, being equally divided between those who consider it too long or too short. These criticisms are interpreted to indicate discontent with how their time has been spent (Section 8.2.2.2., Page 171). The attitude scale suggests that a large majority of new midwives are favourable towards midwifery. Views on midwives characteristics indicate a polarisation among new midwives, the majority of whom perceive midwives positively.

14.1.6a. Does midwifery training meet their expectations?

The unrealistic nature of new students' expectations, means that some of these expectations can not be met. These unrealistic expectations may anticipate midwives practising at either a more simplistic or a more technical level (Section 5.6., Page 126). Such expectations reflect the lack of knowledge about midwifery among new students. These expectations, though, do remain unsatisfied.

With regard to student midwives' more realistic expectations, midwifery does appear to satisfy them. The exception to this is teaching groups, which is frequently undertaken by students and midwives, and in which one quarter of Completers were not confident (Section 8.2.2.4., Page 174).

14.1.6b. How do they perceive the value of the midwifery qualification?

Student midwives consider that the midwifery qualification will

assist them as nurses either, retrospectively, by compensating for any deficits in their first level course or, prospectively, by advancing their future careers.

14.1.7. Review

Despite considerable nursing experience and family responsibilities, student midwives lack the knowledge of midwifery on which to base sound career decisions. This deficit is associated with frequent, sudden reversals of plans. Midwifery training is widely regarded as a means to an end other than midwifery practice. General satisfaction with the midwifery course is indicated by an increased intention to practise midwifery immediately.

14.2. Implications and Recommendations for Management and Practice

The problem - the non-retention of new midwives - which led to this study is largely a problem for midwife managers. With this group of midwives in mind, changes are being suggested to ameliorate problems identified during the study.

The Midwifery Employment Decision Model (MEDM) has been designed as a tool to enable midwife managers to control the retention of new midwives. Its main aim is to prevent dire shortages of midwives, such as the one which preceded the present study. The first stage of the application of the model is its testing, which is to be undertaken in two stages, using initially a narrower and later a broader approach.

14.2.1. The Midwifery Employment Decision Model

As with any theoretical model, prior to its acceptance and utilisation the MEDM should be tested by attempting to disconfirm its applicability. If the MEDM is found to withstand these attempts, then support for and acceptance of its predictive and theoretical position will strengthen. This testing may demonstrate the relevance of the

MEDM or it may demonstrate some weakness, for which a new component may be substituted or new theory developed.

The null hypothesis in the initial testing would be that, in terms of their immediate employment practice, there is no difference between student midwives selected in the conventional way and those selected using the MEDM. The testing of the MEDM could involve a quasi-experimental design, using a split sample technique. This would involve half of an intake of student midwives being selected in the traditional way to form the control group, and the other half being selected by the researcher using the MEDM. The advantage of this technique is that it would result in the same extraneous variables exerting their effects equally on both groups, controlling these variables. This is crucial in such a study as certain factors vary widely; an example is the perception of job availability, which varies with local staffing levels (Section 13.1.2., Page 254).

The test would be undertaken in a college of nursing and midwifery with a large intake of student midwives. This would permit discriminant analysis to demonstrate the "best set", that is the most statistically significant, among the potentially predictive components of the MEDM. The potentially discriminating variables identified during the present study would be analysed to maximise discrimination by forming one or more linear combinations or discriminant functions. This technique carries the advantage of indicating the degree of relationship (positivity/negativity) between the items, permitting a weighting or scoring system to be developed. Weighting coefficients are used, which "serve to identify the variables which contribute most to differentiation along the respective dimension (function)" (Klecka, 1975:436; Kerr, 1982:179; O'Muircheartaigh & Payne, 1977).

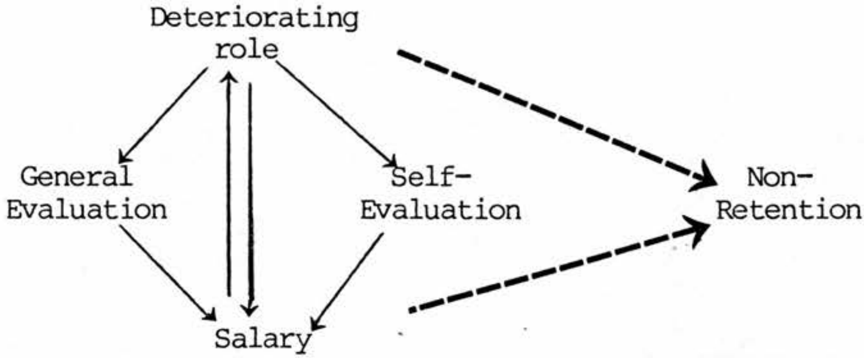
14.2.2. A Comprehensive Approach

The present study resulted from an exacerbation of the perception of a shortage of midwives, which has been more or less prevalent since the advent of midwifery training. Although this study has not addressed the problem of shortage, it has demonstrated the number of nurses who take midwifery training and don't practise. This phenomenon constitutes non-retention, which exacerbates any shortage and has serious implications for managers and practitioners in terms of both finance and the provision of maternity care.

Although the present study focusses on selection as an approach to the problem of non-retention, it is necessary to accept that other aspects of midwifery are amenable to action to improve retention. These aspects have been identified by respondents (Section 7.4.2., Page 152). In a later stage of testing the MEDM these aspects may be investigated utilising other developments in midwifery. This comprehensive approach is inappropriate in the initial testing of the MEDM, because combining a number of innovations or independent variables would impede the identification of their individual effects.

Factors identified in this study as aggravating non-retention are the deteriorating role of the midwife and the undifferentiated salary structure (Sections 12.1., Page 241 and 13.3.2., Page 268). These two factors are not unrelated, as remuneration reflects the value ascribed to midwives' work (Section 13.3.3., Page 269). This conclusion is endorsed by the Completers' discontent with the midwife's role and salary, combined with the Beginners' (largely incorrect) perceptions of midwives' work (Section 5.6., Page 126), probably reflecting a general view. Figure 14.2.2. summarises the interaction of these phenomena.

Figure 14.2.2. Phenomena Identified as Contributing to Non-Retention



Factors suggested by the present study as being interdependent. - - - - -

Reasons for interdependence, suggested by literature. ————

The interdependence of salary and role is due to the linkage of midwives' salary grade to that of staff nurses, an arrangement likely to continue until midwives' work can be shown to be qualitatively different. By the same token, midwives will not reassert themselves to regain their role until they are confident that their increased responsibility will be recognised in both status and salary; thus, the arrows in Figure 14.2.2. link midwives' self-evaluation and salary. The interdependence of these factors indicates that a piecemeal remedy is not a long term solution. Although the implementation of the MEDM may alleviate non-retention, a comprehensive answer to these problems is required.

The approach being proposed would address the three elements identified as intractable using a theoretical framework developed by Vogt and her multidisciplinary team to retain professional nurses (1983). These workers sought to improve nursing retention by revision of the occupational role, appropriate remuneration and a holistic

approach to care. The proposed approach, while meeting midwives aspirations and the need for efficiency, takes account of the increasing desire among consumers for some degree of control over their care. The three elements are here scrutinised in chronological order, followed by discussion of their implications.

14.2.2.1. Selection

The selection of learners would utilise the MEDM, which concentrates on younger, better educated and less experienced entrants. It is assumed that this would result in a large majority being retained to practise midwifery, requiring a smaller number to be recruited in order to maintain midwifery manpower. The student contribution to service manpower would, in consequence, be proportionately reduced.

14.2.2.2. Occupational Role

Developments in the midwife's occupational role, sought by many and introduced by a few (Flint, 1985), constitutes the second element of this comprehensive approach. This role would involve midwives working in small groups, taking responsibility for all aspects of care for women other than those exhibiting high risk features (See Appendix A, Page 294) from initial contact to eventual discharge. The midwife would comply with all statutory obligations, such as those requiring medical consultation (UKCC, 1983).

14.2.2.3. Salary

As the midwife assumes greater responsibility there would be a commensurate salary increase, which would be financed by the reduction in midwifery training costs and the decrease in other qualified staff.

14.2.2.4. Implications of the Comprehensive Approach

Although certain practical implications of this approach may appear to reduce its feasibility, they are not insuperable.

14.2.2.4.1. Provision of Care

It is widely accepted that much "midwifery work" could be undertaken by less qualified personnel, but this may not be consistent with the general desire for better continuity and more "holistic" care. These concepts are not necessarily incompatible. The care of the childbearing family already comprises a large element of self/mutual care (Janus, 1986), which would be further enlarged, and other aspects of care would be provided by a small team of midwives and other nursing personnel.

Identification of the non-midwifery component of midwives' work has been neglected in recent research because of the need to establish the midwife's role in relation to, for example, medical personnel (Robinson Golden & Bradley, 1983:329). Definition of the non-midwifery component would permit the midwife to practise uniquely midwifery skills, increasing job satisfaction and efficiency, and other tasks to be delegated to personnel who are less qualified and less costly of health service resources.

14.2.2.4.2. Teaching and Delegation

The midwife's role as a teacher and communicator would be further expanded, which would have implications for the midwifery curriculum. Supervision of self-care and others' care would increase, as would the scope of midwifery practice.

14.2.2.4.3. Routine Ante Natal Care

The system of ante natal care introduced by Hall _et al_. (1985) involves the precise definition of the aims of each ante natal visit and a reduction in the number of visits planned for each woman. Hall originally proposed that midwives' input into this form of care should be substantially greater than in the traditional arrangement. So, on

the basis of Hall's findings, her scheme is quite compatable with the proposed approach.

14.2.2.4.4. Medical Training and Manpower

The implementation of this approach to maternity care would have profound implications for obstetric and other medical manpower. The role of medical personnel would be to treat sick women and babies, making exposure to normal childbearing less relevant. The implications, particularly financial considerations for general practitioners, would need close scrutiny, unlike the brief attention given by Hall et al. Difficulties may be anticipated because, as Hall found, depriving medical practitioners of contact with normal, healthy women is not appreciated.

14.2.2.4.5. Continuity of Care

A crucial aspect of midwifery which is not consistent with conventional practice is consumer oriented continuity of care. Flint (1985) demonstrates that continuity is feasible in the provision of midwifery care, assuming midwives are sufficiently flexible.

14.2.2.4.6. Evaluation

The initial implementation of this approach would be an evaluative project, using cost-benefit analysis as the evaluative instrument, partly because of the financial and manpower implications and partly because it enumerates and evaluates all aspects of the prospective change, regardless of to whom the costs and benefits accrue. This technique would permit a degree of precision in measuring the effects of this approach which is denied by other evaluative methods.

14.2.3. Review

In addition to the main problem of the non-retention of new midwives, the present study has identified certain other problem areas

in midwifery which may be amenable to management intervention. A comprehensive approach has been suggested to remedy three inter-dependent factors.

14.3. Implications and Recommendations for Education

As well as problems relating to midwifery practice and management, the present study has drawn attention to certain aspects of education. Some of the difficulties encountered relate to midwifery training, but others involve the first level nursing course which inevitably in Scotland precedes midwifery. Thus, it is necessary to give attention to education in both of these areas.

14.3.1. Midwifery Training

A source of dissatisfaction, which was clearly illustrated in the soft data, is the lack of recognition of students' previous nursing experience. The great variation in this experience may make its recognition more difficult, but in view of the discontent aroused this exercise may be worthwhile. The association between dissatisfaction with their non-recognition and the disinclination of more experienced nurses to remain in midwifery is an area which warrants further research.

14.3.2. First Level Nurse Training

The need of large numbers of nurses to take midwifery training "to complete their nurse training" reflects adversely on their first level course (Section 5.3.1., Page 110). That it is left over from an earlier era of nursing fails to explain the prevalence of this perception. Aspects of this problem are currently under consideration among nurses and midwives (UKCC, 1986b). While avoiding prejudging the present discussions, it may be suggested that first level courses should attach more emphasis to the ability of the nurse to function as

such immediately, rather than requiring further preparation - the second certificate.

The obstetric nursing component of the first level nursing course, was modified shortly after the data collection (NBS, 1985). Whether these modifications have alleviated any of the associated problems revealed in the present study merits continuing observation.

The unrealistic expectations of large numbers of nurses entering midwifery training suggest the need for not only amendment to the obstetric component of the first level course but also better career advice for nurses. The provision of effective careers guidance would assist sound, durable employment decisions, preventing the sudden reversals demonstrated in the present study and, it may be assumed, the associated personal trauma.

14.4. Implications and Recommendations for Research

Research needs revealed in the present study focus on the testing of the MEDM, which has been discussed in the context of the implications and recommendations for Management and Practice (Section 14.2., Page 279). Other areas requiring research have also been identified. As the design of the present study did not include the examination of long term employment or career, scrutiny of their subsequent employment is now necessary to demonstrate how respondents' plans changed over time. Questioning those who changed their minds away from midwifery has also been impracticable. These "backsliders" merit attention to furnish data for an alternative approach to the retention of midwives.

Three other, more peripheral, areas have also been identified as needing investigation. The first is the lack of empirical data on midwifery unemployment, which has prevented an assessment of the

validity of this prevalent perception. Second, the changes in midwifery employment patterns associated with the establishment of male midwives warrant long term observation to ascertain whether the developments anticipated in Section 2.3.3.3. (Page 25) are justified. The third problem, which was identified during the present study is the dearth of literature on midwives and midwifery employment. The factors associated with this deficiency merit attention.

14.4.1. Follow-Up

The present study focusses on the employment decision on completion of training. The rationale for this focus is that newly qualified midwives who never practise fail to reimburse their training costs to the NHS in the form of midwifery service. Midwives who practise for a longer or shorter period reimburse those costs to a greater or lesser extent. As practising midwives are considered in the present study to be relative successes, they were categorised as "not requiring action" and given little further attention. Beyond the fact that they did practise, nothing is known of the pattern of their practice; this applies particularly to the duration of practice. To ascertain the duration of practice, which is equated with reimbursement, a follow up study would be an appropriate sequel to the present study. The follow-up may take two forms:

14.4.1.1. The Volunteers

The Completers' covering letter (Appendix I, Page 312) included a request for later contact for detailed observation of career development. A small number of respondents (41) signified consent by providing a name and address. Long term follow up of this group will provide data on whether their careers develop as planned. The data will also reveal the extent to which their careers conform with the

male pattern described by Miller and Form (1964) or the more current and female pattern identified by Jope (1980). This small group may also provide data on midwifery as a secondary career; an aspect which was inevitably neglected during the present study. Such a study may demonstrate the "return on investment" involved in midwifery training. One may question the rationale of such a study, as the value of the recruitment of these midwives, though great in itself, must be reduced by the costs involved in preparing them to return to midwifery practice after so long a gap. The answer to this question lies in the anticipated demographic changes which will make school leavers a precious commodity, causing the "returners" to become increasingly valuable in manpower terms.

14.4.1.2. Notification

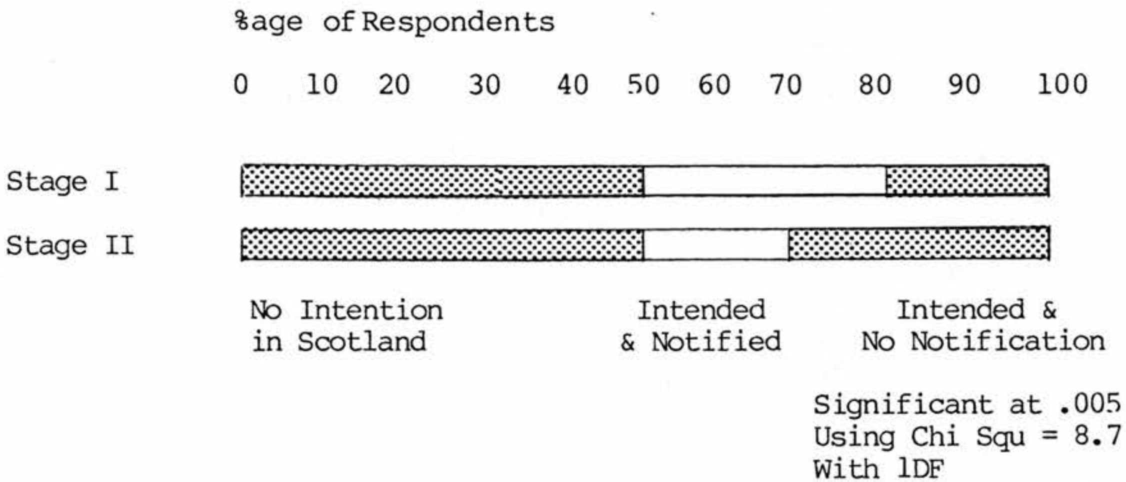
Unlike other studies in the area of midwifery employment (eg Robinson, 1986), the present study observed employment practice as well as employment intentions. This was facilitated by the scrutiny of midwives' Notifications of Intention to Practise. To identify the continuing nature of the practice of those who completed a longer or shorter midwifery course and the employment practice of a cohort of midwives, permission may be obtained to repeat the scrutiny of midwives' notifications.

14.4.2. The "Backsliders"

The discrepancy between employment intentions and employment practice is well-recognised and was clearly manifested in the present study. Figure 14.4.2. shows the extent of the discrepancy. The proportion of respondents intending to work outside midwifery and/or outside Scotland is stable throughout the study at fifty percent. A disconcerting development between Stage I and II is the reversal of the

proportions implementing their intention to practise midwifery in Scotland. Of those completing the twelve month course 69.0% (53) implemented their intention to practise in Scotland, but following the eighteen month course only 37.7% (37) did so.

Figure 14.4.2. Completers' Intentions and Practice Concerning Working as Midwives in Scotland



The reasons for this significant increase in backsliding may relate to factors within or outside midwifery. It is clear, though, that this phenomenon warrants closer examination, as it may be amenable to management intervention.

14.4.3. Other Areas Requiring Research

During the present study changes in certain peripheral areas have been identified as needing investigation. Two of these three areas were found to be quite deficient in empirical data, these are midwifery unemployment and literature on midwives. The third is a comparatively recent development which deserves careful monitoring. It is the effect of male midwives on midwifery careers and employment.

14.4.3.1. Measurement of Midwifery Unemployment

A major problem in assessing the significance of midwifery unemployment is associated with the fact that a large majority of

midwives are also registered nurses. Midwives unable to find work as such, may move into other nursing fields. A further and not unrelated problem is the definition of unemployment, which is known to have a variety of interpretations and which will be compounded by the dual qualification and the preponderance of young women with families. It may be suggested that the relationship between these factors and unemployment needs examination, as the flexibility which they provide and require respectively impedes assessment of the problem.

Due to the lack of differentiation by employment data collecting agencies, official statistics fail to provide data on midwives, so it may be necessary to fall back on self-reporting of unemployment, in spite of the weaknesses already mentioned. Methods of identifying midwives who regard themselves as unemployed may take advantage of informal networks and the dual qualification. At the risk of antagonising nurse managers wary of "poaching", contact with qualified midwives working outside midwifery may be made. These contacts would reveal whether this is their preferred work and whether they know any other non-practising midwives. The methods used by Moores _et al._ (1982), during a nurse recruitment campaign may be useful. These included snowballing, which would constitute the second line approach and which might be utilised in the event of the reversal of the current employment difficulties.

14.4.3.2. Midwifery Literature

Throughout the present study it has been necessary to draw on literature relating to groups other than midwives to illuminate the employment decision process, as mentioned in the introductions to Chapters 4 and 5. The dearth of literature on midwives and midwifery employment reflects a more general picture of the occupational group

and which is attributable to two factors. The first is the nature of academic literature which, because of the different system of higher education, tends to be largely dependent on the contribution from USA. This, associated with the virtual absence of midwives in USA, results in almost no American midwifery literature. The second factor is related to the first, in that the newly revived discipline of midwifery in USA is still primarily concerned with clinical practice, not yet being sufficiently large or established to move into management or manpower. UK midwifery literature is in a similar position for a different reason. Having traditionally utilised other disciplines' literature (Section 3.3.4.2. Page 51) and only recently begun to develop its own, it is beginning by developing a sound clinical knowledge base.

The extent to which this situation is changing in both countries warrants closer attention.

14.4.3.3. Males in Midwifery

The introduction of male midwives was closely monitored (Speak & Aitken-Swan, 1982) but, perhaps to compensate for earlier resistance, their subsequent progress has been largely ignored. In view of the dire effects of the presence of male nurses on careers in other areas (Section 2.3.3.3., Page 25), the employment patterns of male midwives should be monitored. This material would reveal whether the pattern observed in those other areas is being replicated in midwifery. On the basis of such a study the occupational group would be in a position to decide whether any developments are to the advantage of midwifery.

14.4.4. Review

Research suggested to follow the present study has focussed first on following up the long term employment plans of the sample. Those

who change their minds <u>away</u> from midwifery employment deserve close attention. The other areas identified as being in need of research include midwifery unemployment, which has some aspects which may be utilised to recruit midwives should the present employment situation be reversed, and the paucity of relevant midwifery literature, which requires examination in association with the changing midwifery environment in UK and USA. Lastly, changes in midwifery employment patterns asociated with the newly arrived male midwives require attention to assess the extent to which patterns observed in other areas of nursing are developing in midwifery.

14.5. Summary

This thesis has incorporated the process of change in a variety of ways. The initial design took advantage of a change in the organisation of midwifery training. The data have demonstrated changes in employment decisions in association with midwifery training, and the reasons for their impermanence, in spite of generally and increasingly favourable views about midwifery. In the final chapter recommendations for change have been made which should ameliorate factors identified as aggravating the problem of non-retention.

APPENDIX A

GLOSSARY

CAREER: "The sequence of occupations, jobs and positions held throughout a person's working life. The structured sequence of events in the life of a person as he progresses in a job or as he changes from one job to another in the occupational structure".

(Super et al., 1957a:131)

CMB[S]: Central Midwives Board for Scotland, which was the statutory body established by the Midwives Act (Scotland, 1915), until its functions were taken over by the National Board for Nursing, Midwifery and Health Visiting for Scotland in 1982. The CMB[S] was authorised to frame rules regulating the training and practice of midwives, to conduct examinations and to maintain a roll of people who had been awarded its certificate.

(Myles, 1975:646)

DIRECT ENTRANT: A person without any nursing qualifications who may be accepted for midwifery training in approved institutions in England and Wales. In 1981 the duration of this course was extended from two years to three years.

(Robinson, Golden & Bradley, 1983:1)

DNE: Director of Nurse Education

DNO: Divisional Nursing Officer, later Director of Nursing Services.

DOMINO SCHEME: "Patients are cared for antenatally by the community midwife, delivered in hospital by the community midwife and then discharged withing 24 hours for post natal care in the community". The name is an acronym (DOMiciliary IN and Out).

(Robinson, Golden & Bradley, 1983:1)

DOUBLE DUTIES: A post incorporating both general nursing and midwifery duties, held by a nurse who is doubly qualified.

FIRST LEVEL STUDENT: A learner undergoing initial preparation for

registration as RGN, RSCN, RMN or RMNH. (UKCC, 1986:78)

JBCNS: The Joint Board of Clinical Nursing Studies (CCNS in Scotland) was set up in 1970 (1969) to develop and coordinate post basic education in clinical specialities for nurses and midwives (until its functions were taken over by the National Board for Nursing, Midwifery and Health Visiting for Scotland in 1982).

(Lancaster, 1979)

LOW RISK: A pregnant woman who does not manifest certain risk factors associated with childbearing complications. Such a woman would be over five feet tall, have had no previous uterine surgery, have no history of intra uterine growth retardation, stillbirths or neonatal deaths. She would have had not more than two terminations or miscarriages and would not have any gross medical conditions. (Flint, 1984:16)

NB[S]: National Board for Nursing Midwifery and Health Visiting for Scotland. This is one of the statutory bodies set up in 1982 by the Nurses Midwives and Health Visitors Act (1979) to take over the functions of the CMB[S] and other statutory bodies. It is an autonomous body which is primarily responsible for training.

(UKCC, 1982)

NOTIFICATION OF INTENTION TO PRACTISE: "Whenever a midwife intends to practise she shall inform every local supervising authority in whose area she intends to practise, and shall give a like notice in the month of January in every year thereafter in which she continues to practise on the form prescribed in Schedule II".

(UKCC, 1983:17)

OCCUPATION: "A category in the social structuring of work. Work activity as seen from the sociological or economic point of view .... A group of similar jobs in several establishments; a job being a group of similar positions in one establishment, and a

position a group of tasks performed by one person".

(Super *et al.*, 1957a:131)

PROFESSION: "The practitioners by virtue of a long and specialised intellectual training, have acquired a technique which enables them to render a specialised service to the community. This service they perform for a fixed remuneration whether by way of a fee or salary. They develop a sense of responsibility for the technique which they manifest in their concern for the competence and honour of the practitioners as a whole - a concern which is sometimes shared with the state. They build up associations on which they erect ... machinery for imposing tests of competence and enforcing the observance of certain standards of conduct".

(Carr-Saunders & Wilson, 1933:284)

RCM: Royal College of Midwives - "The aim of the Royal College of Midwives is to further the education and efficiency of midwives, in order to provide the best possible service for mothers and babies. It is a negotiating body, representing the midwives' interests and has been the chief instrument in promoting progress in the practice of midwifery by midwives and the means of improving their conditions of service, salary and status".

(Myles, 1975:646)

RGN: Registered General Nurse, formerly State Registered Nurse in England and Wales.

RMN: Registered Mental Nurse

RNMD: Registered Nurse for Mental Defectives, now Registered Nurse for Mental Mandicap

RSCN: Registered Sick Childrens' Nurse

SECONDARY CAREER: "A career which a woman takes up or resumes after interruption of employment". (Seear, 1971)

SCBU: Special Care Baby Unit

SCM/RM: State Certified Midwife, now Registered Midwife

SYNTOCINON: An oxytocic drug administered to childbearing women to induce or accelerate labour.

TRIPLE DUTIES: A post incorporating general nursing, midwifery and health visiting duties, held by a nurse who is triply qualified.

VOCATION: "The person-centred aspects of work; the psychological conception of work as the behaviour of individual persons".

(Super <u>et</u> <u>al</u>., 1957a:131)

TURNOVER: "Movements into and out of the manpower system - both losses and additions". (Redfern, 1978)

UKCC: "The UKCC was established in November 1980 under the Nurses Midwives and Health Visitors Act (1979b). The principal functions of the UKCC are to establish and improve standards of training and professional conduct for nurses midwives and health visitors". (UKCC, 1982)

WASTAGE: "Loss from the manpower system". (Redfern, 1978)

APPENDIX B - BEGINNERS' QUESTIONNAIRE

QUESTIONNAIRE

Tick (✓) the box next to the answer or answers which you consider to be correct, please unless requested to do otherwise.

Section A

I would like you to tell me a little about your ideas about midwifery. I.D. Code (1-5)

Card no 1(6)

1. Why did you choose to train at this school of midwifery? Please tick your one main reason. (7)
   - You wanted to train in this locality ☐
   - Your friends were coming to this school ☐
   - This school offered you a place sooner than others ☐
   - This school has been recommended to you ☐
   - To avoid having to undertake the lengthened training ☐
   - Don't know ☐
   - Other reason, please specify.

2. Nurses undertake midwifery training for many different reasons. Please tell me your main reason for doing midwifery training by putting a number one (1) in the appropriate box. If any other reasons apply, please indicate them by putting a zero (0) in the appropriate box(es). (8-20)
   - To practise midwifery long term (over one year) ☐
   - To practise midwifery for a short while (under one year) ☐
   - To gain promotion in a field of nursing, other than midwifery ☐
   - To prepare for Health Visitor training ☐
   - To work abroad ☐
   - To prepare for your own childbearing ☐
   - To make your nurse training complete ☐
   - To satisfy your interest in midwifery ☐
   - To make a change from your previous work ☐
   - Because you like babies ☐
   - Because your friends are doing midwifery ☐
   - Another reason ☐
   - Don't know. ☐

3. Some people who have taken a midwifery course and qualified as midwives do not actually work as midwives. Do you think that the S.C.M. (State Certified Midwife) qualification is of any value to such a person? (21)
   Yes ☐ No ☐ (If "No", go on to question 5).

4. If "yes" to question 3, please state the ways in which the S.C.M. qualification is of value to a person who is qualified as a midwife but not employed as a midwife (22-28)

5. What do you think about the length of the midwifery course? (29)
   It is too long ☐ It is the correct length ☐ It is too short ☐

6. When did you make the decision to undertake midwifery training? (30)
   - Less than one year ago ☐
   - Between one and three years ago ☐
   - More than three years ago ☐

7. Please tick any of the following words which apply to midwives (31-39)
   idealistic ☐ realistic ☐ adaptable ☐ determined ☐ uncompromising ☐
   cheerful ☐ efficient ☐ intolerant ☐ sincere ☐

Section B

As the majority of student midwives do complete their course successfully, I would like you to tell me about what you expect when your course is successfully completed.

1. Some people have very definite plans about what they intend to do when their midwifery course is over; others have only a general idea. I would like to know what your intentions are, regardless of how vague they are at the moment. Please indicate your immediate plans by putting an "I" in the appropriate box; and indicate your long term plans by putting an "X" in the appropriate box(es). (40-50)
   - Practise as a midwife in a hospital or a small unit ☐
   - Practise as a midwife in the community ☐
   - Return to a post in another field of nursing which is already arranged ☐
   - Return to another field of nursing ☐
   - Move to another branch of nursing which will be new to you ☐
   - Undertake health visitor training ☐
   - Undertake a training other than H.V. or further midwifery training ☐
   - Fulfil domestic commitments, full time ☐
   - Undertake work outside nursing or midwifery ☐
   - Don't know ☐
   - Other work, please specify

2. In which country do you intend to live and/or work after the successful completion of your training? (51)
   - Scotland ☐ England, Wales or Northern Ireland ☐
   - Don't know ☐ Another Country, please specify

3. Most people have some ideas about what they will be able to do when the course is over. I would like you to tell me about your ideas. When you have completed your midwifery training do you expect to feel confident in performing any, some or all of the following tasks? Please put a tick into the box next to the task(s) in which you expect to feel confident. (52-63)
   - A normal delivery, assisted by an unqualified person, in the patient's own home ☐
   - A normal delivery, assisted by an unqualified person, in a hospital or a small unit. ☐
   - Teaching groups of parents in preparation for childbearing ☐
   - Teaching individual mothers ☐
   - Making an ante natal visit to a patient's home ☐
   - Being scrub nurse at a caesarean section ☐
   - Being in charge of an ante/post natal ward for a full shift ☐
   - Being in charge of a special care baby unit for a full shift ☐
   - Promoting the development of the mother/baby relationship ☐
   - Providing basic family planning information ☐
   - Supervising the mother caring for her baby in her own home ☐
   - Caring for the post natal mother after transfer home. ☐

Section C

I would like you to tell me about your nursing background.

1. What is your basic nursing qualification? (66-69)
   - Registered General Nurse (or S.R.N.) ☐
   - Registered Sick Childrens Nurse ☐
   - Registered Mental Nurse ☐
   - Registered Mental Defective Nurse. ☐

2. Please write the name of the town and the country where you trained to obtain your basic nursing qualification. (70)
   Town Country

3. Consider the students who undertook basic nurse training at the same school and at the same time as you did. Have any of them come to this school of midwifery and are in the same class as you? (71)
   Yes ☐ No ☐ (If "No", go on to question 5).

4. If "Yes" to question 3, please indicate how many students, including yourself have come together from your training school. (72)
   Number

5. Did you take an obstetric nursing course during your basic nurse training? (73)
   Yes ☐ No ☐ (If "No", go on to question 7).

6. If "Yes" to question 5, please indicate the duration of the obstetric nursing course which you took. (74)
   4-5 weeks ☐ 6-8 weeks ☐ 9-12 weeks ☐ Other, please specify

7. Have you had any nursing experience since completing your basic nurse training? (75)
   Yes ☐ No ☐ (If "No", please go on the next section).

8. If "Yes" to question 7, please indicate the post or grade in which you were employed, and also the approximate length of time you were in each post. (76-78)
   Post Staff Nurse ☐ Duration
   Sister ☐
   Other, please specify

Section D

Please give me, in confidence, a little information about yourself.

ID Code (1-5)

Card No. 2 (6)

1. How many passes do you have in these examinations? Please write the number of passes in the appropriate box. (7-11)
   - C.S.E.
   - G.C.E. "O" level or S.C.E. "O" Grade
   - Higher
   - G.C.E. "A" level
   - Other, please specify

2. How old will you be when your course is completed? (12)
   - Less than 23 years
   - 23-24 years
   - 25 years or more

3. Are you female or male ? (13)

4. What is your marital status? (14)
   Married   Single   Other.

5. Do you have any children in your care at the moment? (15)
   Yes   No   (If "No", go on to question 7).

6. If "Yes" to question 5, have any of your children (16)
   - Not yet started school
   - Started, but not left school
   - Left school

7. What nationality are you? If you are uncertain, please write the name of the country stated on your passport. (17)
   Nationality

8. To enable me to see how your feelings progress, I would like you to tell me your number on the C.M.B. Register of Students (see the green document enclosed).

Section E

If you have any comments relating to any of the subjects mentioned in this questionnaire, please make your comments here.

APPENDIX C - COMPLETERS' QUESTIONNAIRE

QUESTIONNAIRE

Please tick (✓) the box next to the answer or answers which you consider to be correct, unless requested to do otherwise.

	ID Code (1-5)
SECTION A	
I would like you to tell me a little about your ideas about midwifery.	Card No 1(6)
1. But first of all, how many student midwives are there in your class, including yourself? Please write the number in the box. ☐	(7-8)
2. How many student midwives were there in your class when you began your midwifery training? Please write the number in the box. ☐	(9-10)
3. Some people who have taken a midwifery course and qualified as midwives do not actually work as midwives. Do you think that the R.M. (Registered Midwife) qualification is of any value to such a person? Yes ☐ No ☐ (If "No", go on to question 5).	(11)
4. If "Yes" to question 3, please state the ways in which the R.M. qualification is of value to someone who is qualified as a midwife, but who is not employed as a midwife.	(12-18)
5. What do you think about the length of the midwifery course? It is too long ☐ It is the correct length ☐ It is too short ☐	(19)
6. What are the main reasons that would make you advise a suitable friend to train in midwifery?	(20-34)
7. What are the main reasons that would make you advise a suitable friend not to train in midwifery?	(35-50)
8. Please tick any of the following words which apply to midwives. ☐ idealistic ☐ realistic ☐ adaptable ☐ determined ☐ uncompromising ☐ cheerful ☐ efficient ☐ intolerant ☐ sincere	(51-59)

SECTION B

I would like you to tell me about what you are going to do, now that your midwifery course is completed. (60-70)

1. What work are you going to do? Please indicate your immediate plans by putting an"I" in the appropriate box; and indicate your long term plans by putting an "X" in the appropriate box(es).
   - [ ] Practise as a midwife in a hospital or a small unit
   - [ ] Practise as a midwife in the community
   - [ ] Return to a post in another field of nursing which was arranged before you began your midwifery training
   - [ ] Return to another field of nursing
   - [ ] Move to another branch of nursing which will be new to you
   - [ ] Undertake Health Visitor Training
   - [ ] Undertake a training other than H.V. or further midwifery training
   - [ ] Fulfil domestic commitments, full time
   - [ ] Undertake work outside nursing or midwifery
   - [ ] Don't know
   - [ ] No work / Other work, please specify

2. What are the main factors which influenced you in making the decision about what you are going to do next? (71-79)

ID Code (1-5

Card No 2 (6)

3. When did you make the decision about what you are going to do next? (7)
   [ ] Less than 6 months ago [ ] 6 to 12 months ago [ ] More than 12 months ago

4. In which country do you intend to live and/or work now? (8)
   [ ] Scotland [ ] England, Wales or Northern Ireland
   [ ] Don't know [ ] Another country, please specify

5. This is a list of some examples of the work which a midwife might be expected to carry out. Now that you have completed your training do you feel confident in performing any, some, or all of these midwifery duties? Please put a tick in the box next to those in which you do feel confident. (9-20)
   - [ ] A normal delivery, assisted by an unqualified person, in the patient's home
   - [ ] A normal delivery, assisted by an unqualified person, in a maternity unit
   - [ ] Teaching groups of parents in preparation for childbirth
   - [ ] Teaching individual mothers
   - [ ] Making an ante natal visit to a patient's home
   - [ ] Being scrub nurse at a caesarean section
   - [ ] Being in charge of an ante/post natal ward for a full shift
   - [ ] Being in charge of a special care baby unit for a full shift
   - [ ] Assisting the development of parent/baby relationships
   - [ ] Providing basic family planning information
   - [ ] Supervising the mother caring for her baby in her own home
   - [ ] Caring for the post natal mother after transfer home

6. How many of the other student midwives in your group are going to practise as midwives? (21)
   [ ] All of them [ ] Most of them [ ] A few of them [ ] None of them

7. Have you discussed your next job with your immediate family? (22)
   [ ] Yes [ ] No (If "No", go on to Section C).

8. If "Yes" to question 6, what was their attitude? (23)
   [ ] You should give up midwifery [ ] You should continue in midwifery

9. Are there any changes which might encourage midwives to continue to practise midwifery after they qualify? If so, what are they? (24-32)

SECTION C

In this section there are 42 statements. None is necessarily true; none is necessarily false. They contain no hidden meanings, there are no catches in them. But you will agree or disagree with them to some extent, perhaps strongly, unless you are uncertain what the statement means, or unless you cannot be sure which way the balance lies. Will you please show alongside each item what your opinion is, by putting a ring around the appropriate letter.

SA means strongly agree — A means agree or tend to agree

U means uncertain or undecided — D means disagree or tend to disagree

SD means strongly disagree

Example: Midwives are always cheerful SA (A) U D SD

			(33-35)
1.	Senior midwives have an unnecessarily authoritarian attitude	SA A U D SD	(36)
2.	The anxious mother gets little help from midwives	SA A U D SD	(37)
3.	Midwives and other disciplines discuss patients' problems in a responsible way	SA A U D SD	(38)
4.	Midwives don't always practise the high standards which they advocate	SA A U D SD	(39)
5.	Midwifery does not provide many social contacts	SA A U D SD	(40)
6.	Midwives make their patients feel important	SA A U D SD	(41)
7.	Midwives do not know who their most senior bosses are, or even what they look like	SA A U D SD	(42)
8.	In midwifery what is taught and what is practised are very similar	SA A U D SD	(43)
9.	Senior midwives disapprove of staff going off sick with minor infections, which might infect patients	SA A U D SD	(44)
10.	The shortage of midwives causes lower standards of care	SA A U D SD	(45)
11.	Midwives are sociable towards each other	SA A U D SD	(46)
12.	A maternity hospital is a pleasant place in which to work	SA A U D SD	(47)
13.	More hospital deliveries means that midwives can practise their skills confidently	SA A U D SD	(48)
14.	Midwives are generally held in high esteem	SA A U D SD	(49)
15.	Morale among midwives is low	SA A U D SD	(50)
16.	Anyone should be proud to be known as a midwife	SA A U D SD	(51)
17.	The decreasing number of home confinements means that midwives are less satisfied with their work	SA A U D SD	(52)
18.	A midwife is generally recognised as a well qualified and well experienced person	SA A U D SD	(53)
19.	Midwives should specialise by working only in one particular ward	SA A U D SD	(54)
20.	Despite being overworked midwives enjoy their work	SA A U D SD	(55)
21.	Anxiety and low morale, among staff, are great problems in a materity unit	SA A U D SD	(56)
22.	Some inexperienced midwives are given too much responsibility with too little support	SA A U D SD	(57)
23.	The work of a midwife is assessed fairly by her seniors	SA A U D SD	(58)

24.	Maternity units are so depersonalised and mechanised that they are like sausage factories	SA A U D SD	(59)
25.	Midwives deserve to be respected more	SA A U D SD	(60)
26.	In midwifery the off duty and weekends off are allocated fairly	SA A U D SD	(61)
27.	When new midwives are given responsibility they are well supported by their seniors	SA A U D SD	(62)
28.	Many people these days think that anybody can do the work of a midwife	SA A U D SD	(63)
29.	Midwifery patients need nursing care which is different from that needed by other patients	SA A U D SD	(64)
30.	Midwives are good at putting a mother at her ease	SA A U D SD	(65)
31.	The work of a midwife is unpleasant, as she may be involved in tragedies, such as stillbirths	SA A U D SD	(66)
32.	Everyone in a maternity unit accepts that a midwife with even a minor infection should go off sick	SA A U D SD	(67)
33.	It is a good idea for midwives to gain experience in all wards	SA A U D SD	(68)
34.	Midwives who have high ideals do not stay in midwifery	SA A U D SD	(69)
35.	Despite their difficulties the morale of midwives is high	SA A U D SD	(70)
36.	New midwives are given poor off duty and few weekends off	SA A U D SD	(71)
37.	In maternity units there is little discussion between different grades and disciplines	SA A U D SD	(72)
38.	Midwifery is less satisfying than nursing because the patients are healthy	SA A U D SD	(73)
39.	Senior midwives derive great satisfaction from their work	SA A U D SD	(74)
40.	In current midwifery practice there is too much interference	SA A U D SD	(75)
41.	People are friendly and helpful when a midwife starts on a new ward	SA A U D SD	(76)
42.	The midwife finds satisfaction helping people with problems, such as when the baby has died	SA A U D SD	(77)

SECTION D

I would like to be able to observe how students' ideas develop during midwifery training. To allow this to be done I would like you to tell me your C.M.B. student registration number. I will make no attempt to identify you and the information which you have given in this questionnaire will remain confidential.

SECTION E

If you have any comments relating to any of the subjects mentioned in this questionnaire, please make them here or add an extra sheet.

APPENDIX D - INFORMATION LETTER TO CANOs

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
ADAM FERGUSON BUILDING, 40 GEORGE SQUARE, EDINBURGH EH8 9LL.
Head of Department: **Professor Annie T. Altschul** Telex 727442 (Unived G).
Tel. 031 667-1011 Ext. 6466

October 1982

Dear Madam,

Research - The Employment Decisions of Newly Qualified Midwives

You may recall that I wrote to you in October 1980 to inform you of Stage I of my research project involving student midwives. I was very pleased with both the interest shown by senior midwives and the cooperation of the student midwives. Stage II of this work is now about to begin and I will be sending questionnaires to the group of students who begin training in December 1982.

The research, you may recall, involves studying the employment intentions of student midwives on two occasions; just before they begin their training and again just as they complete their course. The findings of these two sets of observations will be compared in an effort to detect any change and to try to obtain some indication of the reason for any change which may be demonstrated. These two studies will be made using postal questionnaires. The first is to be distributed, with the student midwife registration documents, to all the students who have places in the midwifery schools beginning in Scotland in December 1982. All these student midwives will be invited to participate. The second questionnaire is to be distributed with the final examination results on the completion of training.

If you have any comments which you would like to make, if you would like me to tell you more about the study, or if you need more information in case the students question you, please do not hesitate to contact me.

Yours sincerely,

Rosemary Mander (Miss).

Department of Nursing Studies
University of Edinburgh,
Adam Ferguson Building,
40, George Square,
Edinburgh.
October 1980

ar Madam,

Research - The Employment Decisions of Newly Qualified Midwives

When working as a midwifery tutor I became interested in the employment the students after they qualified; I realised that many of the learners failed to actise as midwives and I sought an opportunity to examine the problem. The opportunity ne in the form of the dissertation which I have just completed for the MSc Nursing ninistration course at the University of Edinburgh. The research is to be completed ile I am on the staff of the Nursing Studies Department at the University.

The research involves studying the employment intentions of student dwives on two occasions; just before they begin their training and again just as ey complete their course. The findings of these two sets of observations will be npared, in an effort to detect any change and to try to obtain some indication of e reason for any change which may be demonstrated. These two studies will be made ing postal questionnaires; the first is to be distributed, with the student midwife gistration documents, to the students who have places in the midwifery schools ginning in December 1980. All the student midwives in that intake in Scotland will invited to participate. The second questionnaire is to be distributed with the final amination results on the completion of training.

It is planned that these two questionnaires should be applied again, students in training in 1982-84, to ascertain whether the extension of midwifery aining has any effect on the employment decisions.

If you have any comments which you would like to make, or if you would ke me to tell you more about the study, or if you need more information to help you answer the students questions, please do not hesitate to contact me at the above dress.

Yours sincerely,

Rosemary Mander (Miss).
Lecturer.

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
ADAM FERGUSON BUILDING, 40 GEORGE SQUARE, EDINBURGH EH8 9LL.
Head of Department: **Professor Annie T. Altschul** Telex 727442 (Unived G).
Tel. 031 667-1011 Ext. 6466

February 1983

Dear Madam,

Research - The Employment Decisions of Newly Qualified Midwives

As you probably recall, I distributed, with your help, a questionnaire to the December 1982 intake of student midwives in Scotland. The response of the students to this questionnaire was quite good, but I learned after the distribution that the December intake had been considerably reduced compared with the numbers in the group with which I intend to make comparisons. For this reason and because a number of midwife tutors informed me that the smaller schools were unrepresented as they did not have a December intake, it is necessary for me to repeat the distribution of questionnaires. As a result all the student midwives who begin training in Scotland in February/March 1983 will receive a questionnaire included with the documents returned to them by the Central Midwives Board for Scotland at the beginning of their training. A further and final questionnaire will be sent to each of these students, with the final examination results on completion of training.

If you have any comments which you would like to make, if you would like me to tell you more about the study, or if you need more information in case the students question you, please do not hesitate to contact me.

Yours sincerely,

Rosemary Mander (Miss).

APPENDIX F - INFORMATION LETTER TO DNEs

Department of Nursing Studies
40 George Square,
Edinburgh EH8 9LL
May 1984

Dear Madam,

Research - The Employment Decisions of Newly Qualified Midwives

You may recall that I have written to you previously to inform you of earlier stages of my research project involving student midwives. I was ver; pleased both with the interest shown by senior midwives and with the cooper- ation of the student midwives. The final part of this work is now about to be completed when I send out questionnaires to the groups of student midwive who began training in December 1982 and in March 1983.

The research, you probably remember, involves studying the employment intentions of student midwives on two occasions: just before they begin thei training and again just as they complete their course. The findings of these two sets of observations will be compared in an effort to detect any change. These studies are being made using postal questionnaires. The final one is to be distributed with the final examination results, to all the students in the groups mentioned above.

If you have any comments which you would like to make, if you would like me to tell you more about the study, or if you need any more informatio in case the learners question you, please do not hesitate to contact me.

Yours sincerely,

Rosemary Mander (Miss),
Lecturer.

APPENDIX G - INFORMATION SENT TO DNOs

Rosemary Mander,
Lecturer, Department of Nursing Studies,
University of Edinburgh

Research - The Employment Decisions of Newly Qualified Midwives

The Problem:

The problem of the retention of newly qualified midwives in midwifery has been recognised since the early part of the twentieth century. Although many reasons and solutions have been suggested the problem persists, and is, perhaps, becoming more significant in association with certain current changes. It may be that the extension of midwifery training is likely to increase the costs of training a midwife, and this makes the need for better selection of student midwives more urgent.

The Research:

It is intended to examine the employment intentions of student midwives, both before the start of their training and on completion of training, in order to reveal any change which may have taken place with regard to those intentions during training. An attempt will also be made to relate any change in the employment intentions to the students' attitudes to midwifery. It may be possible to identify factors which predict 'stayers' in midwifery by relating personal factors to employment intentions and actual employment, thus assisting the selection of student midwives who will be retained in midwifery on completion of training.

As it has been suggested that the extension of midwifery training should aid the retention of newly qualified midwives, the examination of employment intentions will be replicated when the extension of training is established, to assess whether this prediction is correct.

The Method:

The examination of the employment intentions of the student midwives will be made by means of a self-administered questionnaire, which is to be distibuted with the help of the Central Midwives Board for Scotland, with papers which all student midwives receive. Questionnaires will be sent, at the beginning and end of training to all the student midwives who begin their midwifery training in Scotland in December 1980, a group of approximately three hundred. A second pair of questionnaires will be sent to all student midwives who begin their (18 month) midwifery training in Scotland in December 1982.

Pretest		July - September 1980
Stage 1	Commencement questionnaire	November 1980
	Completion questionnaire	November 1981
Stage 2	Commencement questionnaire	November 1982
	Completion questionnaire	May 1984

Finance:

Funds for the Pretest were provided by the Florence Nightingale Memorial Committee. The Main Study (Stage 1 and Stage 2) is supported by the Scottish Home and Health Department.

APPENDIX H - COVERING LETTERS TO BEGINNERS

Department of Nursing Studies,
University of Edinburgh,
Adam Ferguson Building,
40, George Square,
Edinburgh, EH8 9LL.
October 1980.

· Student Midwife,

Research - The Employment Decisions of Newly Qualified Midwives

I am undertaking a study into the employment of new midwives and would very much
·eciate your help. I am writing this letter to explain what I hope to do and how you
assist me.

I worked for some years as a midwife and then became a midwifery tutor. I now teach
Edinburgh University, which enables me to do this research. The topic is one which
st interested me when I was working as a tutor: What do student midwives do after they
.ify, and why?

The research which I am doing to examine this topic involves asking a group of student
vives about their ideas before they learn a lot about midwifery, and then asking
n about their ideas again, just as they complete their training. The purpose is to
how their ideas develop. This process may be repeated in a couple of years from now,
see if the ideas of student midwives change with time; this study will involve students
will be in training at that time.

I would like to reassure you that if you answer my questions, the information which
give will not be disclosed to anyone; it will, eventually, be produced in the form
statistics to which your information will contribute, but will not allow you to be
tified. As I have no record of your name I cannot reveal that to anyone. The Central
vives Board for Scotland have been very helpful in distributing this material for me,
that is the limit of their connection with this research, your participation in this
dy will have no effect on your training or on its outcome.

If you are willing to help me, I would like you to complete the enclosed questionnaire
takes about 20 minutes) and return it to me in the envelope provided within a month.
ope very much that you will be prepared to answer the questions, as the more students
participate the more valuable the results will be. If, however, you feel you are unable
help me, I respect your feelings and accept your decision. If this is the case, I would
grateful if you could return the blank questionnaire to me within a month.

I am grateful to you for spending some of your time reading this letter. If you would
to know any more about the study, please contact me at the above address.

Yours sincerely,

Rosemary Mander.

Rosemary Mander (Miss)
Lecturer.

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
ADAM FERGUSON BUILDING, 40 GEORGE SQUARE, EDINBURGH EH8 9LL.
Head of Department: **Professor Annie T. Altschul** Telex 727442 (Unived G).
Tel. 031 667-1011 Ext. 6466

February 1982

Dear Student Midwife,

Research - The Employment Decisions of Newly Qualified Midwives

I am undertaking a study into the employment of new midwives and would very much appreciate your help. I am writing this letter to explain what I hope to do and how you can assist me.

I worked for some years as a midwife and then became a midwifery tutor. I now teach at the University of Edinburgh, which enables me to do this research. The topic is one which first interested me when I was a tutor: What do student midwives do after they qualify, and why?

The research which I am doing to examine this topic involves asking a group of student midwives about their ideas before they learn a lot about midwifery, and then asking them about their ideas again just as they complete their training. The purpose is to see how their ideas develop. I have already completed this process with a group of students who finished their training some time ago; I would now like to find out whether there are any differences associated with the longer training.

I would like to reassure you that if you answer my questions, the information which you give will not be disclosed to anyone; it will, eventually, be produced in the form of statistics, to which your information will contribute but wll not allow you to be identified. As I have no record of your name, and will not make any attempt to find it, I cannot reveal that to anyone. The Central Midwives Board for Scotland and its staff have been very helpful in distributing this material for me, but they have no further involvement; your participation in this research will have no effect on your midwifery training or its outcome.

If you are willing to help me, I would like you to complete all four sections of the enclosed questionnaire (it takes about 20 minutes) and return it to me in the envelope provided within a month. I hope very much that you will be prepared to answer the questions, as the more students who participate the more valuable the results will be. If, however, you feel that you are unable to help, I respect your feelings and accept your decision. I am grateful to you for spending some of your time reading this letter. If you would like more information about the study, please contact me at the above address.

Yours sincerely,

Rosemary Mander (Miss).

APPENDIX I - COVERING LETTERS TO COMPLETERS

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
ADAM FERGUSON BUILDING, 40 GEORGE SQUARE, EDINBURGH EH8 9LL.
Head of Department: **Professor Annie T. Altschul** **Telex 727442 (Unived G).**
Tel. 031 667-1011 Ext. 6466

November 1981

Dear Student Midwife,

Research - The Employment Decisions of Newly Qualifed Midwives

I was very pleased with the response which I received when I asked you and your colleagues to complete my questionnaire when you were beginning your midwifery training.

Now that you have completed your training I would like you to help me once again by completing this second questionnaire. The questionnaire, which is enclosed, should take about 20 to 25 minutes to complete, and I would be grateful if you could return it to me within a month, using the stamped, addressed envelope. I hope that you will be prepared to answer the questions, as the more students who participate, the more valuable the results will be. This applies equally to those who were unable to complete the first questionnaire; if you did not return it to me or did not fill it in, I would still like you to complete this one. If you are one of the students who have been unsuccessful in the examination, I would also like you to complete the questionnaire; I consider that the views of people who have failed will be particularly valuable, in that they will provide a more complete picture of the views of student midwives.

If you feel that you are unable to help me, I respect your feelings and accept you decision. If this is the case, I would be grateful if you could return the blank questionnaire to me within a month.

This is the final questionnaire that you will receive as part of the present

-2-

/careers of people who trained as midwives may be undertaken. If you would be prepared to be involved in such a survey, I would be grateful if you could give me your name and a permanent address to which material could be sent; this information should not be written on the questionnaire, but on a separate paper.

The aim of this questionnaire is to examine the views of student midwives when they complete their training; I hope to obtain information about your future employment and your ideas about midwifery generally. I should make it clear that when the term "midwife" is used in the questionnaire, it refers to a qualified midwife.

I would like to repeat the assurances which I gave in my previous letter to you: that you will not be identified, that your opinions will not be revealed alone, and that your involvement (or non-involvement) in this study will in no way affect your work.

I am grateful to you for spending some of your time reading this letter and for your help in completing this research.

Yours sincerely,

Rosemary Mander (Miss),
Lecturer.

Department of Nursing Studies,
40 George Square,
Edinburgh EH8 9LL.
May 1984

Dear Student Midwife,

Research - The Employment Decisions of Newly Qualified Midwives

I was very pleased with the response when I asked you and your colleagues to complete my questionnaire when you were beginning your midwifery training.

Now that you have completed your training, I would like you to help me once again by completing this second questionnaire. The questionnaire, which is enclosed, should take about 20 to 25 minutes to complete, and I would be grateful if you could return it to me within a month, using the stamped, addressed envelope. I hope that you will be prepared to answer the questions, as the more students who participate, the more valuable the results will be. This applies equally to those who were unable to complete the first questionnaire; if you did not return it to me, or did not fill it in, I would still like you to complete this one. If you are one of the students who have been unsuccessful in the examination, I would also like you to complete the questionnaire, as I consider that the views of people who have failed the examination will be particularly valuable, in that they will provide a more complete picture of the views of student midwives.

If you feel that you are unable to help me, I respect your feelings and accept your decision. If this is the case, I would be grateful if you could return the blank questionnaire to me within a month.

This is the final questionnaire that you will recieve as part of the present study. It is possible that, at some time in the future, a survey of the careers of people who trained as midwives may be undertaken. If you would be prepared to be involved in such a survey, I would be grateful if you could give me your name and a permanent address to which material could be sent. This information should not be written on the questionnaire, but on a separate piece of paper.

The aim of this questionnaire is to examine the views of student/

/student midwives when they complete their training; I hope to obtain information about your future employment and your ideas about midwifery generally. I should make it clear that when the term 'midwife' is used in the questionnaire, it refers to a qualified midwife.

I would like to repeat the assurance which I gave in my previous letter to you, that you will not be identified, that your opinions will not be revealed alone and that your involvemnt (or non-involvement) in this study will in no way affect your work.

I am grateful to you for spending some of your time reading this letter and for your help in completing this research.

Yours sincerely,

Rosemary Mander (Miss),
Lecturer.

APPENDIX J - STAGE I FOLLOW UP LETTER

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
ADAM FERGUSON BUILDING, 40 GEORGE SQUARE, EDINBURGH EH8 9LL.
Head of Department: Professor Annie T. Altschul Telex 727442 (Univcd G).
Tel. 031 667-1011 Ext. 6466

February 1982

Dear Madam (or Sir),

Research - The Employment Decisions of Newly Qualified Midwives

Having made contact with you through the generous help of the Central Midwives Board for Scotland on previous occasions, I am writing to you with their assistance now. Of the questionnaires which were sent out recently, a number were not returned, probably because the recipients were too busy. As a result I am writing this letter to request that, if you have not yet returned the recent questionnaire to me, you might complete the one which is enclosed and send it to me in the stamped, addressed envelope which is also enclosed.

The reason for this request is that it is necessary for a certain number of replies to be received if any conclusions are to be drawn about what people do after completing their midwifery training. It is also likely that, if a good response is received, useful information about employment patterns will become available to the midwifery profession.

As some people who replied mentioned that they were unable to recall their C.M.B. student registration number, your number has been inserted (in pencil). Knowing this number may be of value to me in my attempt to ascertain whether employment intentions change during midwifery training. If you would prefer me not to use this number you should erase it, although I would like to reassure you that no attempt will be made to ascribe the views expressed in the questionnaire to any individual.

If you would be prepared to be included in a future study which may be planned as a follow-up to this work, I would be grateful if you could give me your name and a permanent address separately.

If you have already returned your questionnaire to me, I am grateful for your help and am sorry to have made this request unnecessarily. Thank you for spending time reading this letter, for considering the reply and, perhaps, for sending the completed questionnaire to me.

Yours sincerely,

Rosemary Mander (Miss),
Lecturer.

APPENDIX K - STAGE II FOLLOW UP NOTE

UNIVERSITY OF EDINBURGH
Department of Nursing Studies
Adam Ferguson Building
40 George Square
Edinburgh EH8 9LL

telex 727442
tel. 031 - 667 1011 Ext. 6466

Research - Midwives' Employment

Many thanks for completing the questionnaire, the response was better than I could have hoped for. The findings will be published in the nursing press.

If you have not yet returned your questionnaire - please do.

APPENDIX L - MIDWIFERY UNEMPLOYMENT

In estimating the size of the problem of midwifery unemployment in Scotland, the following assumptions have been made:

1. That nurse/midwife unemployment is equally distributed
   (a) between nurses and midwives
   (b) among the countries in the UK
2. "Qualified staff in Maternity" equates with the number of midwives
3. midwives reported as unemployed are employable and seeking work.

This figure must be regarded with considerable caution as the assumptions upon which it is based may not be valid. It is likely to have been lowered by women's withdrawal from the labour market and by non-reporting by some unemployed women due to their being married to employed men. As this figure has been derived from country-wide data, it does not indicate the wide variations in the local rates of unemployment.

Nursing and Midwifery Staff (Whole Time Equivalents)

England 1983 All Nursing/Midwifery (DHSS, 1985:40)	393086	
- Learners/Unqualified	81752	
	------	311334
Wales 1983 All Nursing/Midwifery Staff (Welsh Office, 1984:25)	23275	
- Learners/Unqualified	10520	
	-----	12755
Northern Ireland 1983 Registered Nurses	6268	
Midwives	859	
Enrolled Nurses	2869	
Nursery Nurses	14	
(Department of Health and Social Services, 1983:8.4)	----	10010
Scotland 1983 All Nursing Staff (ISD, 1985:8)		32232.1
Total Qualified Nursing and Midwifery Staff		366331

Ratio Scotland/UK $= \frac{32232}{366331} = \frac{1}{11.36}$

Unemployed Nurses/Midwives in UK (Labour Force Survey, 1984) 22000

Unemployed Nurses/Midwives in Scotland $= \frac{22000}{11.36} = 1937$

Qualified Nurse/Midwifery Staff in Scotland	32232.1	
Qualified Staff in Maternity in Scotland (ISD, 1985)	2616.7	
Qualified Nurses		29615.4

Ratio Midwives/Nurses in Scotland $= \frac{29615.4}{2616.7} = 1 : 11.3$

Unemployed Midwives $= \frac{1937}{11.3} = 171$

Estimate of the proportion of Midwives who are unemployed

Midwives Notified January 1985 (NBS, 1985:39)	4028
Estimated unemployed Midwives	171
Estimated Scottish Midwife Labour Force	4199

Estimate 4% Midwives in Scotland are unemployed.

REFERENCES

ABEL P.M. et al (1976) Nursing Manpower 1. A Sound Statistical Base for Policy Making. Nursing Times January 1/8 Vol 72 No 1 Occasional Papers pp 1-4

ABRAMSON J.H.(1974) Survey Methods in Community Medicine Edinburgh Churchill Livingstone

AGGLETON P. & CHALMERS H. (1984) Models and Theories: Defining the Terms Nursing Times Vol 80 No 36 September 5 pp 24-28

AGUILERA D.C. & MESSICK J.M. (1982) Crisis Intervention Theory and Methodology St Louis Mosby

ALLEN D. (1985) Reorganisation at District Level Nursing Mirror May 1 Vol 160 No 18 pp 22-23

ALTMAN S.H. (1970) The Structure of Nursing Education and its Impact on Supply in KLARMAN H.E. Empirical Studies in Health Economics pp 335-52 Baltimore John Hopkins

ANDERSON A.R. & MOORE O.K. (1967) Models and Explanations in the Behavioural Sciences Ch IV in DIRENZO G.J. (Ed) Concepts, Theory and Explanation in the Behavioural Sciences New York Random House

ANDERSON B.F. (1969) The Psychology Experiment Belmont California Wadsworth

ANDERSON T.W. & SCLOVE S.L. (1978) An Introduction to the Statistical Analysis of Data Boston Houghton Mifflin

ASHWORTH P. (1981) The Midwifery/Nursing Process at Home and Abroad Research and the Midwife Conference Proceedings

ASKHAM J. & BARBOUR R.S. (1986) The Role of the Midwife in Scotland with particular Reference to the Extent of her Responsibility within the Maternity Care Team Department of Obstetrics and Gynaecology University of Aberdeen

BABBIE E.R. (1973) Survey Research Methods California Wadsworth

BALY M.E. (1976) Nursing and Social Change London Heinemann

BARBER J. (1981) The New Structure of the NHS Nursing Focus November Vol 3 No 3 pp 526-30.

BECKER H.S. & CARPER J. (1956) The Elements of Identification with an Occupation American Sociological Review 21 pp 341-8

BENDALL E.R.D. (1967) Calculating Wastage Rates Nursing Times September 29 Vol 63 pp 1300-1

BENDALL E.R.D. & PEMBREY S. (1972) The Nurse Graduate in the UK - Career Motivation International Nursing Review Vol 19 No 1 pp 53-92

BENDALL E.R.D. (1973) The Relationship between Recall and Application of Learning in Trainee Nurses Unpublished PhD Thesis University of London

BENNETT C. & LUMSDAINE A.A. (1975) Social Programme Evaluation: Definitions and Issues in BENNETT C. & LUMSDAINE A.A. Evaluation and Experiment New York Academic Press

BENT E.A. (1982) The Midwives' Directives Journal of Advanced Nursing Vol 7 No 4 July pp 384-6

BENT E.A. (1983) EEC Midwives' Directives Midwives Chronicle March Vol 96 No 1142 pp 77-8

BERTHOUD R. (1979) Unemployed Professionals and Executives Policy Studies Institute London

BEVIS E.O. (1982) Curriculum Building in Nursing: A Process St. Louis Mosby

BLENKINSOP D. (1982) "Women Should Aim for the Top Jobs" says RNO: News Report on RCN Conference Nursing Times November 24 Vol 78 No 47 pp 1965

BLUNT M. (1981) Planning the Paramedics: The Case of Occupational Therapy in LONG A. & MERCER G. Manpower Planning in the NHS Farnborough Gower

BOSANQUET N. & GERARD K. (1985) Nursing Manpower: Recent Trends and Policy Options University of York Centre for Health Economics

BRADLEY S. (1981) A Preliminary Report on the Research Project on the Role and Responsibilities of the Midwife Part 2 Midwives Chronicle Vol 94 No 1119 February pp 11

BUCHER R. & STRAUSS A. (1961) Professions in Process The American Journal of Sociology No 66 pp 325

BUEHLER C. (1937) From Birth to Maturity Translation E. & W. MENAKER London Kegan Paul

BURGOYNE J. (1985) Unemployment and Married Life Unemployment Unit Bulletin Issue 18 November pp 7-10

BURRETT J. (1983) Episiorrhaphy - A Challenge to be Accepted? Midwives Chronicle Vol 96 No 1146 July pp 324

BURSLEM R.W. (1979) Shortage of Midwives (Letter) British Medical Journal No 6202 December 1st pp 1442-3

CAMPBELL D.T. & STANLEY J.C. (1968) Experimental and Quasi Experimental Designs for Research Chicago Rand McNally

CAPLAN G. (1961) An Approach to Community Mental Health London Tavistock

CARKHUFF R.R. (1967) Do We Have a Theory of Occupational Choice? The Personnel and Guidance Journal Vol 46 pp 335-45 Cited in LANCASHIRE R. (1971) Occupational Choice Theory and Occupational Guidance Practice in WARR P.B. Psychology at Work Penguin Harmondsworth

CARPENTER M. (1977) The New Managerialism and Professionalism in Nursing in (Eds) STACEY M., REID M., HEATH M & DINGWALL R. Health and the Division of Labour London Croom Helm

CARR-SAUNDERS A.M. & WILSON P.A. (1933) The Professions Oxford Clarendon Press

CMB (1979) Report of the Work of the Central Midwives Board for Year Ended March 1979 London

CMBs (1983) The Role of the Midwife Norwich Hymns Ancient and Modern

CMB [S] (1968) Rules Edinburgh HMSO

CMB [S] (1976) Student Nurses - Obstetric Secondment Revised Curriculum

CMB [S] (1977) Guidelines for Extension of Training

CHORLTON P. (1985) Low Pay "Drives Midwives out of the Profession" Guardian May 27 p 3

CHOWN S.M. (1958) The Formation of Occupational Choice among Grammar School Pupils Occupational Psychology 32 pp 171-82

CLARKE R. (1982) Work in Crisis - The Dilemma of a Nation Edinburgh Saint Andrew Press

CLELAND V., SMITH J. & McHUGH N. (1973) Inducements for Nursing Employment Nursing Research Vol 22 No 5 pp 414-422 September/October

CLELAND V., BASS A.R., McHUGH N. & MONTANO J. (1976) Social and Psychologic Influences on Employment of Married Nurses Nursing Research Vol 25 No 2 pp 90-97 March/April

COLLINS S. (1983) The European Community International Nursing Review 30:6 pp 178

COOPERS AND LYBRAND ASSOCIATES (1986) General Management in the Scottish Health Service: Application to Units Edinburgh SHHD

COTTER A. (1982) Gone The Health Services No 23 pp 18-19 14th May

COUTTS L.C. (1981) More than an Optional Extra in Health Teaching: a Nursing Activity Edinburgh SHEG Occasional Paper

CRONK M. (1979) Getting Back into Practice Nursing Mirror October 25 Vol 149 No 17 pp 38-39

CROOG S.H., CAUDILL W. & BLUMEN J.L. (1968) Value Orientations, Religious Identity and Career Decisions of Nursing Students in Japan Nursing Research Vol 17 No 2 pp 161-166 March/April

CUNNINGHAM C.V. (1979) Staff Nurses and their Reasons for Leaving Unpublished M. Phil Thesis University of Edinburgh

DAN MASON NURSING RESEARCH COMMITTEE (1956) The Work of Recently Qualified Nurses in MACGUIRE J. Threshold to Nursing pp 222 London Bell

DAVIES C. & FRANCIS A. (1976) Perceptions of Structures in NHS Hospitals in Editor: STACEY M. The Sociology of the National Health Service Sociological Review Monograph No 22 University of Keele

DAVIS F. & OLESON V.L. (1964) Baccalaureate Students Images of Nursing Nursing Research Winter Vol 13 No 1 pp 8-15

DAVIS F. O & OLESON V.L. (1963) Initiation into a Women's Profession: Identity Problems in the Status Transition of Co-ed to Student Nurse Reprinted in VOLLMER H.M. & MILLS D.L. (1966) Professionalisation From Sociometry 26 No 1 March 1963 pp 89-101

DAVIS F. (1975) Professional Socialisation as a Subjective Experience... Chapter 6 in (Eds) COX C. & MEAD A. A Sociology of Medical Practice London Collier Macmillan

DOE (1985) Labour Market Data Employment Gazette March Vol 93 No 3 Supplement

DOE (1986a) Commentary - Trends in Labour Statistics Employment Gazette March/April Vol 94 No 3 p S2

DOE (1986b) Labour Market Data Employment Gazette March/April Vol 94 No 3 Supplement

DHSS (1974) Report of the Committee of Enquiry into the Pay and Related Conditions of Service of Nurses and Midwives Chairman Halsbury London HMSO

DHSS/NHS SUB GROUP (1975) Leavers (Standard Measures and Classifications) Manpower Planning & Personnel Information No 1 DHSS

DHSS (1978) Royal Commission on the National Health Service The Management of Financial Resources in the NHS Research Paper No 2 London HMSO

DHSS (1979) The Royal Commission on the National Health Service Cmnd 7615 London HMSO

DHSS (1985) Health and Personal Social Services Statistics for England 1985 Edition London HMSO

DEPARTMENT OF HEALTH AND SOCIAL SERVICES (1983) Trends in Health and Personal Social Services Statistics

DICKIE M.K. (1979) Extension of Midwifery Training Unpublished Middle Management Project Queen Margaret College Edinburgh

DICKOFF J., JAMES P. & WIEDENBACH E. (1968) Theory in a Practice Discipline: Part I Practice Oriented Theory Nursing Research September/October 17:5 pp 415-35

DIMMOCK S. (1985a) Griffiths and Management: Managing the Business Nursing Times February 13 Vol 81 No 7 pp 48-49

DIMMOCK S. (1985b) Griffiths and Management: What Role For Nurses? Nursing Times Feb 20 Vol 81 No 8 pp 30-31

DIRENZO G.J. (1967) Toward Explanation in the Behavioural Sciences Ch IX in DIRENZO G.J. (Ed) Concepts, Theory and Explanation in the Behavioural Sciences New York Random House

DONNISON J. (1977) Midwives and Medical Men London Heinemann

DUFF A. & COTGROVE S. (1982) Social Values and the Choice of Careers in Industry Journal of Occupational Psychology 55 pp 97-107

DUNN A. (1982) A Worrying Trend Nursing Times Nov 24 Vol 78 No 47 p 1963

EDITORIAL (1983) Nurse-Midwifery Programs Accredited by Division of Accreditation ACNM Journal of Nurse-Midwifery Vol 28 No 4 July/August pp 9-12

EDWARDS W. (1961) Behavioral Decision Theory Annual Review of Psychology 12 pp 473-498

ENGLEMAN S.R. (1977) Crude Brush in the Art of Manpower Scenarios Health and Social Services Journal Vol 87 No 45 pp 926-9

ENGLEMAN S.R. (1980) Health Economics, Health Economists and the NHS Community Medicine No 2 pp 126-134

ETZIONI A. (1968) The Active Society New York The Free Press

ETZIONI A. (1969) The Semi Professions and their Organisation New York Columbia University The Free Press

EEC (1980) Council Directives 80/154/EEC, 80/155/EEC & 80/156/EEC Official Journal of the European Communities L33 Vol 23 pp 1-14 Office for Official Publications of the EEC

FARBEROW N.L. (1973) The Crisis is Chronic American Psychologist May 28:5 pp 388-94

FESTINGER L. (1957) A Theory of Cognitive Dissonance London Tavistock

FESTINGER L. (1964) Conflict Decision and Dissonance London Tavistock

FLINT C. (1985) The Team From Tooting Nursing Times Vol 81 No 5 January 30 pp16-18

FOGEL C.I. (1981) The Unwanted Pregnancy in FOGEL C.I. & WOODS N.F. (1981) Health Care of Women: A Nursing Perspective St Louis Mosby

FOX D. (1982) Fundamentals of Research in Nursing 4th Edition Connecticut Appleton Century Crofts

FREEMAN R.B. (1971) The Market for College Trained Manpower Harvard University Press

FREIDSON E. (1968) The Impurity of Professional Authority in BECKER H.S., GREER B., REISSMAN D.M & WEISS R.S. Institutions and the Person Chicago Aldine

FREIDSON E. (1977) The Futures of Professionalisation in (Eds) STACEY M., REID M., HEATH M & DINGWALL R. Health and the Division of Labour London Croom Helm

FRY L.J. & MILLER J. (1977) Observations of an Emerging Profession Journal of Sociology and Social Welfare May pp 822-39

GINZBERG E., GINSBURG S., AXELRAD S. & HERMA J. (1951) Occupational Choice: An Approach to a General Theory Columbia University Press

GINZBERG E., GINSBURG S., AXELRAD S. & HERMA J. (1966) Occupational Choice: An Approach to a General Theory (Fourth Printing) Columbia University Press

GLASER W.A. (1963) American and Foreign Hospitals in FREIDSON E. (Ed) The Hospital in Modern Society New York Glencoe Free Press

GLASSER P.H. & GLASSER L.N. (1970) Families in Crisis New York Harper and Row

GOLDBERG E.M. & CONNELLY N. (1981) Evaluative Research in Social Care Policy Studies Institute London Heinemann

GOLDBERG E.M. & CONNELLY N. (1982) The Effectiveness of Social Care for the Elderly London Heinemann

GOLDEN J. (1979) The Views of Newly Qualified Midwives Chelsea College N.E.R.U. Occasional Papers No 1

GOODE W. (1966) Professions and Non-Professions in VOLLMER H. and MILLS D. Professionalisation New Jersey Prentice-Hall

GOTHARD W.P. (1985) Vocational Guidance Theory and Practice London Croom Helm

GRAY A. & SMAIL R. (1982) A Review of Trends in the Scottish Hospital Nursing Labour Force 1959-79 HERU Aberdeen Nursing Paper No 1

GREENHAUS J.H. & SIMON W.E. (1976) Self Esteem, Career Salience and the Choice of an Ideal Occupation Journal of Vocational Behaviour February Vol 8 No 1 pp 51-58

GREENWOOD E. (1966) The Elements of Professionalisation in VOLLMER H. and MILLS D. Professionalisation New Jersey Prentice-Hall

GRIFFITHS (1983) NHS Management Inquiry - Letter to the Secretary of State for Social Services

HACKMAN J.R. (1976) Group Influences on Individuals in DUNNETTE M.D. Handbook of Industrial and Organisational Psychology Chicago Rand McNally

HADLEY R.G. & LEVY W.V. (1970) Vocational Development and Reference Groups in ROTH R.M., HERSHENSON D.B. & HILLIARD D.T. The Psychology of Vocational Development Boston Allyn & Bacon Inc.

HALL M., MACINTYRE S. & PORTER M. (1985) Ante Natal Care Assessed - A Case Study Aberdeen University Press

HARDY L.K. (1983) An Exploration of the Career Histories of Leading Female Nurses in England and Scotland Unpublished PhD Thesis University of Edinburgh

HARDY M.E. (1974) Theories: Components, Development, Evaluation Nursing Research March - April Vol 23 No 2 pp 100-7

HAUG M.R. (1973) Deprofessionalisation: an Alternative Hypothesis for the Future in (Ed) P. HALMOS Sociological Review Monograph No 20 University of Keele

HAZZARD M.E. (1971) An Overview of Systems Theory Nursing Clinics of North America Vol 6 No 3 Sept pp 385-93

HENDERSON V. (1968) Basic Principles of Nursing Care ICN Basle Karger

HERRIOT P., ECOB R. & HUTCHISON M. (1980) Decision Theory and Occupational Choice: Some Longitudinal Data Journal of Occupational Psychology September 53 pp 223-236

HEYMAN R., SHAW M.P. & HARDING J. (1983) A Personal Construct Theory Approach to the Socialisation of Nursing Trainees in Two British General Hospitals Journal of Advanced Nursing Vol 8 No 1 pp 59-67

HICKS C. (1982) Nurses on the Dole Nursing Times November 24 Vol 78 No 47 pp 1974-7

HMSO (1936) Midwives Bill Bill 135 Bills Public (2) 1935-6 Vol II

HMSO (1949) Report of the Working Party on Midwives Ministry of Health, Department of Health for Scotland & Ministry of Labour and National Service

HMSO (1972) Report of the Committee on Nursing Cmnd 5115

HMSO (1975) Sex Discrimination Act Chapter 65 London HMSO

HMSO (1979a) Patients First: Consultative Paper on the Structure and Management of the National Health Service in England and Wales DHSS & Welsh Office

HMSO (1979b) Nurses Midwives and Health Visitors Bill 1978-9 Bill 53 47/5

HOLLAND J.L. (1973) Making Vocational Choices - A Theory of Careers New Jersey Prentice-Hall

HOWIE C. (1984) Jobs - The Amazing Disappearing Act Nursing Times September 12 Vol 80 No 37 pp 16-17

HUGHES E.C., HUGHES H.M. & DEUTSCHER I. (1958) Twenty Thousand Nurses Tell their Story Philadelphia Lippincott

HUGHES J.J. & PERLMAN R. (1984) The Economics of Unemployment: A Comparative Analysis of Britain and the United States Brighton Wheatsheaf

HUNT J.M. (1974) The Teaching and Practice of Surgical Dressings in Three London Hospitals London RCN

HUNTER D. (1985) Scottish Griffiths: Old Scotch into New Bottles Health and Social Service Journal Vol XCV No 4962 August 22 pp 1034-5

HUNTINGTON M.J. (1957) The Development of Professional Self-Image in (Eds) MERTON R.K., READER G.G. & KENDALL P.L. The Student Physician Harvard University Press

HUTT R., PARSONS D. & PEARSON R. (1979) The determinants of Doctors' Career Decisions Institute of Manpower Studies for DHSS & SHHD

HUTT R. (1986) The Context of Change Senior Nurse Vol 4 No 4 April pp 22-3

ILLSLEY R. (1980) Professional or Public Health? London Nuffield

INSTITUTE FOR OPERATIONAL RESEARCH (1976) A Manpower Model of Nurses Completing Basic Training in Scotland London Tavistock

ISD (1985) Information Services Division - Scottish Health Service Manpower September 1984 Edinburgh Common Services Agency

JANIS I.L. & MANN L. (1977) Decision Making: A Psychological Analysis of Conflict, Choice and Commitment New York The Free Press

JANUS (1986) Jottings Midwife Health Visitor and Community Nurse July Vol 22 No 7 p 217

JECKER J.D. (1964) Seeking Information Before and After Decisions in FESTINGER L. (1964) Conflict Decision and Dissonance London Tavistock

JEFFS J. (1980) A New Look at Childbirth in the Netherlands Midwives Chronicle Vol 93 No 1115 December pp 431-3

JOHNSON W. (1981) Regional Close Up - S.E. Thames Nursing Focus August Vol 2 No 12 pp 432

JONES C.L. (1973) An Experimental and Longitudinal Study of Changes in Undergraduates Occupational Attitudes over their first Sixteen Months at University Unpublished PhD Thesis University of Edinburgh

JOPE A.M. (1980) Career Patterns of Graduate Nurses: Analysis of Selected Personal, Professional and Employment Variables University of Manitoba

JORDAAN J.P. (1963) Exploratory Behaviour: The Formation of Self and Occupational Concepts in SUPER D.E., STARISHEVSKY R., MATLIN N. & JORDAAN J.P. (1963) Career Development: Self Concept Theory New York College Entrance Examination Board

KANTAS A. (1986) Occupational Choice and Values Unpublished PhD Thesis University of Edinburgh

KATZ F.E. (1969) Nurses in ETZIONI A. The Semi Professions and their Organisation New York Columbia University The Free Press

KERR S.A. (1982a) Differential Take up of Supplementary Pensions: An Approach from Cognitive Psychology Unpublished PhD Thesis University of Edinburgh

KERR S.A. (1982b) Final Report: Differential Take up of Supplementary Pensions Department of Psychology University of Edinburgh

KINGS FUND WORKING PARTY (1985) The Professional Role of Nurses in the New Management Structures in England London Kings Fund

KLECKA W.R. (1975) Discriminant Analysis Chapter 23 in NIE N., HULL C.H., JENKINS J.G., STEINBRENNER K. & BENT D.H. (1975) SPSS Statistical Package for the Social Sciences 2nd Edn New York McGraw Hill

KNAPP R.G. (1978) Basic Statistics for Nurses New York Wiley

KNIGHT K. (1971) Decisions are Hard to Make Because of All Those Human Factors in INNOVATION (1971) Decision Making in a Changing World Princeton Auerbach

KRAMER M. (1967) A Comparative Study of Characteristics of Attitudes and Opinions of Neophyte British and American Nurses International Journal of Nursing Studies Vol 4 pp 281-294

LABOUR FORCE SURVEY (1984) Eurostat: Employment and Unemployment Luxembourg Statistical Office of the European Communities and Personal Communication

LANCASHIRE R. (1971) Occupational Choice Theory and Occupational Guidance Practice in WARR P.B. Psychology at Work Penguin Harmondsworth

LANCASTER A. (1979) Nursing and Midwifery Sourcebook London G. Allen & Unwin

LANCET (1948) Editorial: What is Nursing? Lancet Jan 10 No 1 pp 69-70

LANGFORD J. (1984) Training the Nursing Auxiliary Senior Nurse Vol 1 No 31 October 31 pp 7-11

LAWLER E.E. (1973) Motivation in Work Organisations California Brooks/Cole

LEADER (1983) The Pressure Pays Off Nursing Mirror Vol 157 No 10 September 7 pp 5

LEWIN K. (1935) Dynamic Theory of Personality New York McGraw Hill

LEWIS P. (1984) Men in Midwifery: The Inside Story Nursing Mirror March 21 Vol 158 No 12 pp 17-18

LEWIS P. (1985) Care of the Small Baby on the Post Natal Ward Midwives Chronicle December Vol 98 No 1175 pp 313-5

LONG A. & MERCER G. (1978) Nurses Down the Drain Nursing Mirror Vol 147 No 7 23rd November pp 16-19

LOREE D.L. & LECKIE I. (1977) Occupation and Career Perceptions of Nursing Students in New Brunswick Canadian Nurse Vol 73 No 12 pp 30-33

MACCRIMMON K.R. & TAYLOR R.N. (1976) Decision Making and Problem Solving in DUNNETTE M.D. Handbook of Industrial and Organisational Psychology Chicago Rand McNally

McGILLOWAY F.A. (1981) Nursing Science - An Unfolding in Sequence in SMITH J.P. Nursing Science in Practice London Butterworths

MACGUIRE J.M. (1961) From Student to Nurse Oxford Oxford ANTC

MACLEAN G.O. (1980) Where Have all the Midwives Gone? Midwives Chronicle Vol 93 No 1108 May pp 158-9

MANDER R. (1980) The Development and Pretest of Questionnaires to be used for a Study of the Employment Decisions of Newly Qualified Midwives Unpublished MSc. Dissertation University of Edinburgh

MANDER R. (1983) Stop and Consider: Student Midwife Wastage in Training Research and the Midwife Conference Proceedings

MANDER R. (1986) Refresher Courses: Unfulfilled Potential? Midwives Chronicle Vol 99 No 1176 January/February pp 4-5

MARTIN D. & CAPELIN H. (1978) Nursing Research Project: A Report on the Characteristics of Unemployed Nurses and Unfilled Nursing Vacancies Employment Services Division of Manpower Services Commission

MARTIN F.M. & BODDY F.A. (1962) Career Preferences of Medical Students Sociological Review Monograph No 5 pp 21-33

MELIA K.M. (1981) Student Nurses' Accounts of their Work and Training Unpublished PhD Thesis University of Edinburgh

MELIA K.M. (1982) "Tell it as it is" Qualitative Methodology and Nursing Research: Understanding the Student Nurse's World Journal of Advanced Nursing Vol 7 pp 327-335

MELIA K.M. (1984) Student Nurses' Construction of Occupational Socialisation Journal of Sociology of Health and Illness November

MENZIES I.E.P. (1961) The Functioning of Social Systems as a Defence against Anxiety in J. MACGUIRE (1969) Threshold to Nursing London Bell

MERCER J. (1981) Health Care and Remedial Professionalisation Health Services Manpower Review Vol 7 No 1 pp 11-13

MERTON R.K., READER G.G. & KENDALL P.L. (1957) The Student Physician Harvard University Press

METCALFE C. (1981) Patient Allocation in a Maternity Ward - The Results of a Research Study in Research and the Midwife, Conference Proceedings pp 25-37

MILLER D.C. & FORM W.H. (1964) Industrial Sociology 2nd Edn New York Harper & Row

MILLER D.W. & STARR M.K. (1967) The Structure of Human Decisions New Jersey Prentice-Hall

MILLER J. (1984) The Family-Career Connection Columbus Ohio State University

MINISTRY OF HEALTH (1929) Report of the Departmental Committee on the Training and Employment of Midwives HMSO

MINISTRY OF HEALTH & SHHD (1966) Report of the Committee on Senior Nursing Staff Structure Chairman Salmon London HMSO

MITCHELL J. (1983) The Hidden Job Losses Nursing Times Vol 79 No 41 October 12 p 14

MITCHELL T.R. & BEACH L.R. (1976) A Review of Occupational Preference and Choice Research using Expectancy Theory and Decision Theory Journal of Occupational Psychology 49 pp 231-248

MOORES B. (1979) The Cost Effectiveness of Nurse Education Nursing Times Vol 75 No 25 June 21st pp 65-68

MOORES B. (1980) Towards Rational Midwifery Service Planning Journal of Advanced Nursing Vol 5 pp 301-11

MOORES B., SINGH B. & TUN A. (1982) Attitudes of 2325 Active and Inactive Nurses to Aspects of their Work Journal of Advanced Nursing Vol 7 pp 483-9

MOORES B., SINGH B. & TUN A. (1983) An Analysis of Factors which Impinge on a Nurse's Decision to Enter, Stay in, Leave or Re-enter the Nursing Profession Journal of Advanced Nursing Vol 8:3 pp 227-235

MOSER K.A., JONES D.R., FOX A.J. & GOLDBLATT P.O. (1986) Unemployment and Mortality: Further Evidence from the OPCS Longitudinal Study 1971-1981 Lancet February 15 1: 8477

MYLES M.F. (1975) Textbook for Midwives 8th Edition Edinburgh Churchill Livingstone

NB[S] (1985a) Annual Report 1984-5 Edinburgh

NB[S] (1985b) Maternity Care: Module Component Descriptor Edinburgh

NFNMC (1963) Some Aspects of the Work of the Midwife Dan Mason Research Committee of National Florence Nightingale Memorial Committee

NEWSON K. (1981) Direct Entry Method of Training Midwives in Three Countries: I The Netherlands Midwives Chronicle Vol 94 No 1118 February pp 39-43

NURDEN R. & PRESERN C. (1986) Voluntary Service Overseas Midwifery Vol 2 No 1 March pp 11-14

NDGC (1973) Nursing Development Conference Group: Concept Formalisation in Nursing Boston Little Brown

NUTTALL P. (1983) Male Takeover or Female Giveaway? Nursing Times January 12 Vol 79 No 2 pp 10-11

O'MUIRCHEARTAIGH C.A. & PAYNE C. (1977) Exploring Data Structures Vol I Chichester Wiley

OPPENHEIM A.N. (1966) Questionnaire Design and Attitude Measurement London Heinemann

OPSAHL R.L. & DUNNETTE M.D. (1970) Motivation and Performance: Some Specific Job Characteristics in VROOM V.H. & DECI E.L. Management and Motivation Harmondsworth Penguin

PEARL A. & REISSMAN F. (1965) New Careers for the Poor New York The Free Press Cited by HAUG M. (1973) Deprofessionalisation: an Alternative Hypothesis for the Future in Ed. P. HALMOS Sociological Review Monograph No 20 University of Keele

PEARSON J.F. (1982) Is Technology Misused in Modern Obstetrics? Maternal and Child Health Vol 7 No 5 May pp 160-165

PERSONNEL DIVISION (1982) Health Professionals in the European Community Health Trends DHSS No 3 Vol 14 pp 49-52

POLIT D.F. & HUNGLER B.P. (1985) Essentials of Nursing Research: Methods and Applications Philadelphia Lippincott

POLLOCK L. & WEST E. (1984) On being a Woman and a Psychiatric Nurse Senior Nurse Vol 1 No 17 July 25 pp 10-13

PORTER L.W. & LAWLER E.E. (1968) Managerial Attitudes and Performance Illinois R.D. Irwin

POWELL D.L. (1972) Occupational Choice and Role Conceptions of Nursing Students Social and Economic Studies Vol 21 No 3 pp 284-312

PRICE J.L. & MUELLER C.W. (1981) Professional Turnover: The Case of Nurses New York SP Medical & Scientific

QUINN S. (1980a) Nursing in the European Community London Croom Helm

QUINN S. (1980b) The Health Professions in Europe: 2. Nurses and Midwives Nursing Focus August Vol 1 Issue 12 pp 466-7

RAIFFA H. (1968) Decision Analysis - Introductory Lectures on Choices under Uncertainty Reading Mass. Addison-Wesley

RAPOPORT L. (1962) The State of Crisis: Some Theoretical Considerations Social Services Review 36: 211-7

REDFERN S.J. (1978) Absence and Wastage of Trained Nurses: a Selective Review of the Literature Journal of Advanced Nursing Vol 3 pp 231-49

REVANS R.W. (1964) Standards for Morale: Cause and Effect in Hospitals Cambridge University Press for Nuffield Provincial Hospitals Trust

RIEHL J. & ROY C. (1974) Conceptual Models for Nursing Practice New York Appleton Century Crofts

RILEY M.W. (1963) <u>Sociological Research I: A Case Approach</u> New York Harcourt, Brace and World

ROBERTS K. (1977) The Social Conditions, Consequences and Limitations of Careers Guidance <u>British Journal of Guidance and Counselling</u> Vol 5 No 1 January pp 1-9

ROBINSON S. (1980) Are There Enough Midwives? <u>Nursing Times</u> April 24th Vol 76 No 17

ROBINSON S., GOLDEN J. & BRADLEY S. (1983) <u>A Study of the Role and Responsibilities of the Midwife</u> London Chelsea College/DHSS

ROBINSON S. (1986) The 18 Month Training: What Difference has it made? <u>Midwives Chronicle</u> Vol 99 No 1177 February pp 22-29

ROCH S. (1983) Is the Midwife Accountable? <u>Nursing Times</u> Vol 70 No 39 September 28 pp 38-39

ROGERS J. (1982) <u>Report of the Follow up Study Volume 1: The Career Patterns of Nurses who have completed a JBCNS Certificate</u> London DHSS

ROGERS R. (1985) College Sounds Warning Over Griffiths <u>Senior Nurse</u> Vol 3 No 4 October pp 6

ROPER N., LOGAN W.W. & TIERNEY A.J. (1980) <u>The Elements of Nursing</u> Edinburgh Churchill Livingstone

ROPER N. (1983) A Model for Nursing <u>Nursing Mirror</u> Vol 157 No 22 November 30 pp 21-23

RCM (1979) Evidence to the Comparability Commission <u>Midwives Chronicle</u> October Vol 92 No 1101 pp 348

RCM (1980) <u>Evidence to the Select Committee on Neonatal and Perinatal Mortality</u> Nursing Times January 24 pp 139

RCM (1981) <u>Scottish Board - The Role of the Practising Midwife</u> Edinburgh

RCM (1984) RCM Evidence to the Pay Review Body for Nursing and Midwifery Staff and Professions Allied to Medicine <u>Midwives Chronicle</u> April Vol 97 No 1155 Supplement pp 1-8

RCM (1985a) Evidence to the Pay Review Body for Nursing and Midwifery Staff and the Professions Allied to Medicine <u>Midwives Chronicle</u> February Vol 98 No 1165 Supplement

RCM (1985b) Personal Communication (Labour Relations Officer)

RCM (1986) RCM Evidence to the Pay Review Body for Nursing Staff and Midwives and Professions Allied to Medicine 1986 <u>Midwives Chronicle</u> March Vol 99 No 1178 Supplement pp i - ix

RCN (1977) Ethics Related to Research in Nursing London Royal College of Nursing of the UK

RCN (1984) Association of Nursing Management: Nursing within the New Management Arrangements London RCN

SCOTT W.G. (1967) Decision Concepts in CASTLES F.G., MURRAY D.J. & POTTER D.C. (1967) Decisions, Organisations and Society Harmondsworth Open University Press

SCOTT-WRIGHT M., GILMORE M. & TIERNEY A. (1977) The Nurse Graduate in Nursing: Preliminary Findings of a Follow up Study of Former Students of the University of Edinburgh Degree/Nursing Programme Health Bulletin November pp 317-324

SHHD (1974) Nursing Manpower Planning Report No 3 Nurse Staffing (Hospital) Survey Book of Tables Edinburgh

SHHD (1976) The Way Ahead HMSO

SHHD (1984a) Nurse Staffing Establishment Survey - Limited Circulation

SHHD (1984b) Management of the National Health Service in Scotland NHS Circular No 634/84 June 6

SHHD (1986) General Management at Unit Level and the Development of Senior Management Structures Edinburgh SHHD

SEEAR B.N. (1971) Re-entry of Women into the Labour Market after Interruption in Employment Paris OECD

SEYBOLT J.W., PAVETT C. & WALKER D.D. (1978) Turnover among Nurses: it can be Managed Journal of Nursing Administration September Vol 8 No 9 pp 4-9

SEYBOLT J.W. & WALKER D.D. (1980) Attitude Survey proves to be a Powerful Tool for Reversing Turnover Journal of Health and Social Services May 1st pp 77-80

SHEGOG R. (1966) The Future of the Maternity Services: A Suitable Case for Study in McLACHLAN G. (Ed) Progress and Problems in Medical Care Nuffield Provincial Hospitals Trust

SHOWLER B. & SINFIELD A. (1981) Unemployment and the Unemployed in 1980 in SHOWLER B. & SINFIELD A. The Workless State Oxford Martin Robertson

SIEGEL S. (1956) Non Parametric Statistics New York McGraw Hill

SILVERSTONE R. (1980) Accountancy in SILVERSTONE R. & WARD A. (1980) Careers of Professional Women London Croom Helm

SILVERSTONE R. & WARD A. (1980) Summing Up in SILVERSTONE R. & WARD A. (1980) Careers of Professional Women London Croom Helm

SIMON H.A. (1959) Theories of Decision Making in Economics and Behavioural Science American Economic Review Vol 49 No 3 January pp 253-83 in CASTLES F.G., MURRAY D.J. & POTTER D.C. (1971) Decisions, Organisations and Society Harmondsworth Open University Press/Penguin

SIMON J.L. (1969) Basic Research Methods in Social Science New York Random House

SIMPSON I.H. (1979) From Student to Nurse: a Longitudinal Study of Socialisation Cambridge University Press

SINFIELD A. (1976) Unemployment and the Social Structure Chapter 12 in ROYAL ECONOMIC SOCIETY The Concept and Measurement of Involuntary Unemployment London G. Allen & Unwin

SINFIELD A. (1981) Unemployment in an Unequal Society Chapter 5 in SHOWLER B. & SINFIELD A. The Workless State Oxford Martin Robertson

SINGER E.J. & RAMSDEN J. (1972) Human Resources - Obtaining Results from People at Work London McGraw-Hill

SINGH A. & MACGUIRE J. (1971) Occupational Values and Stereotypes in a Group of Trained Nurses Nursing Times Occasional Paper October 21 Vol 67 pp 165

SLEEP J. (1983) The West Berkshire Episiotomy Trial in Research and the Midwife Conference Proceedings pp 81-95

SMITH J.P. (1981) Nursing Science in Nursing Practice London Butterworths

SNOWDON M. (1985) The Cost of Midwifery Training per Student Personal Communication

SORRENTINO C. (1981) Unemployment in International Perspective in SHOWLER B. & SINFIELD A. The Workless State Oxford Martin Robertson

SPEAK M. & AITKEN-SWAN J. (1982) Male Midwives: A Report of Two Studies London DHSS

STERN R.S., JENNINGS M., DELBANCO T.L., DORSEY J.L., STOECKLE J.D. & LAWRENCE R.S. (1977) Graduate Education in Primary Care - An Economic Analysis New England Journal of Medicine Vol 297 No 12 pp 638-43

STEVENS B.J. (1979) Nursing Theory - Analysis Application Evaluation Boston Little Brown & Co

STONER J.A.F.A. (1961) Comparison of Individual and Group Decisions Including Risk Unpublished Master's Thesis School of Industrial Management MIT Cited in BROWN R. (1965) Social Psychology New York The Free Press

STRAUSS G. (1964) Apprenticeship - An Evaluation of Need in ROSS A.M. Employment Policy and the Labour Market University of California Press

SUPER D.E. & OTHERS (1957a) Vocational Development: A Framework for Research New York Teachers' College Press

SUPER D.E. (1957b) The Psychology of Careers: An Introduction to Vocational Development New York Harper & Row

SUPER D.E., STARISHEVSKY R., MATLIN N. & JORDAAN J.P. (1963) Career Development: Self Concept Theory New York College Entrance Examination Board

SUPER D.E. & BOHN M.J. (1971) Occupational Psychology London Tavistock

TEAR (1983) Tear Fund (Personal Communication)

TIEDEMAN D.V. & O'HARA R.P. (1963) Career Development Choice and Adjustment New York College Entrance Examination Board

TITTLE C.K. (1981) Careers and The Family Beverly Hills Sage Publications

TREECE E.W. & TREECE J.W. (1982) Elements of Research in Nursing St Louis Mosby

UKCC (1981) The UKCC: The First Twelve Months

UKCC (1982) UKCC Review January

UKCC (1983) Handbook of Midwives Rules London UKCC

UKCC (1984) Personal Identification Number

UKCC (1986a) The Movement of Nurses and Midwives to and from EEC Countries Personal Communication

UKCC (1986b) Project 2000: A New Preparation for Practice London UKCC

VOGT J.F., COX J.L., VELTHOUSE B.A. & THAMES B.H. (1983) Retaining Professional Nurses St Louis Mosby

VROOM V.H. (1964) Work and Motivation New York J. Wiley

WALKER J.F. (1972) The Changing Role of the Midwife International Journal of Nursing Studies Vol 9 pp 85-94

WALKER J.F. (1976) Midwife or Obstetric Nurse? Some Perceptions of Midwives and Obstetricians of the Role of the Midwife Journal of Advanced Nursing Vol 1 pp 129-138

WALSTER E. & FESTINGER L. (1964) The Post Decision Process in FESTINGER L. (1964) Conflict Decision and Dissonance London Tavistock

WARD A. (1981) Careers of Medical Women Medical Care Research Unit University of Sheffield

WARD M.E. & ADAMS M.E. (1979) A Masters Degree in Midwifery Midwives Chronicle Vol 92 No 1093 February pp 37-8

WEEPLE E.J. (1984) The General Management Function in the NHS in Scotland: Proposals for Discussion Letter to Secretary of State

WELSH OFFICE (1984) Health and Personal Social Services Statistics for Wales No 11 1984 HMSO

WHITFIELD S. (1983) The Midwifery Process in Practice Midwives Chronicle Vol 96 No 1145 pp 186-9

WILLCOCKS A.J. & McLACHLAN G. (1968) Problems and Progress in Medical Care Nuffield Provincial Hospitals Trust Series 3 Oxford University Press

WILLIAMS A. & ANDERSON R. (1975) Efficiency in the Social Services Oxford Blackwell

WILLIAMS S.M.K. (1979) Student Nurses' Attitudes towards Midwifery Nursing Times Vol 75 No 10 April 5th Occasional Papers pp 41

WOODWORTH R.S. (1947) Psychology 12th Edn London Methuen

YOUNG D. (1986) Is there Life after Griffiths? Nursing Times February 12 Vol 82 No 7 pp 33-34

YOUNG M. & WILLMOTT P. (1973) The Symmetrical Family London Routledge & Kegan Paul

BIBLIOGRAPHY

AULD M.G. (1976) How Many Nurses? London RCN

BOYD K.M. (1979) The Ethics of Resource Allocation in Health Care Edinburgh University Press

COYLE A. (1984) Redundant Women London The Women's Press

DAVIS F., GEER B., REISMAN D. & WEISS R.S. (1968) Institutions and the Person Chicago Aldine Publishing

DAVIS F. & OLESON V. (1965) The Career Outlook of Professionally Educated Women Psychiatry Vol 28:4 pp 334-335

DRUMMOND M. & MOONEY G. (1981) Economic Appraisal in Health Care Hospital and Health Services Review Vol 77 No 9 October pp 277-82

FISHBEIN M. & AJZEN I. (1975) Belief, Attitude, Intention and Behaviour Reading, Mass. Addison Wesley

BUXTON M.J. & KLEIN R.E. (1978) Allocating Health Resources: A Commentary on the Report of the Resource Allocation working Party London HMSO

HOCKEY L. (1978) The Future Nurse Journal of Advanced Nursing No 3 pp 571-82

JAHODA G. (1952) Job Attitudes and Job Choice Among Secondary Modern School Leavers Occupational Psychology July XVI No 3 pp 125-40

MACGUIRE G. (1969) Threshold to Nursing London Bell and Sons

MOSER C.A. & KALTON G. (1979) Survey Methods in Social Investigation 2nd Edition London ELBS & Heinemann

MURRAY M. (1983) Role Conflict and Intention to Leave Nursing Journal of Advanced Nursing Vol 8 No 1 January pp 29-32

SHHD (1981) Continuing Education for ther Nursing Profession in Scotland (The Auld Report) Edinburgh HMSO

SIMPSON R. (1974) The Disappearing Male Mental Nurse Unpublished MSc Thesis University of Edinburgh

TIERNEY A.J. (1983) Married Women in Nursing Nursing Times September 7 Vol 79 No 24 pp 30-33