PROFESSIONAL IDENTITY IN INTERPROFESSIONAL EDUCATION: MIDWIFERY NARRATIVES

ELVIRA BROWN

M.N., B.APP. SC. (ADVNURSING)., RM., RN.

THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

INSTITUTE OF HEALTH AND SPORT

VICTORIA UNIVERSITY

1 May 2019

Abstract

Interprofessional education (IPE) has been found to improve patient outcomes and increase health practitioner career satisfaction according to The World Health Organization (2010). Despite these identified benefits arising from over thirty years of IPE research in a global context, there is still surprisingly little evidence with regard to how midwives develop their professional identity within the context of IPE. This study examined the interprofessional aspects of professional identity development for students and qualified clinicians in midwifery, including midwifery clinical educators and midwifery academics.

This study utilised the theoretical framework of social constructionism. There were fifteen participants involved from three Australian universities, one hospital and one community setting. Using narrative inquiry as the methodology, stories were collected using in-depth interviews and a narrative approach. The individual stories were examined for revelations into the meanings drawn by each participant using a thematic analysis approach. Five themes emerged from the data. These were: shared misconceptions; shared understandings; shared misdirections; shared professional values; and shared misgivings. Then each story was examined for commonalities and differences of meaning drawn across all of the participants, congruent with Clandinin and Connelly's (2000) narrative inquiry space (NIS) analytical approach of relational, temporal and spatial. From this interpretive analysis, a further lens was developed to more adequately present the interpretation of the participants' narratives which could not be accommodated with the NIS. This resulted in the fourth element of 'fluidity' comprised of the influencers of 'empowerment', 'competence', 'value', and 'respect.' It is through the element of fluidity that the nascent nature of professional identity of the midwife in interprofessional education has been explored and presented.

Thus, a theoretical understanding of the intersection between IPE and professional identity development in midwifery has been illuminated as a way to potentially enhance the efficacy of interprofessional practice, education and research. Moreover, the focus on student and registered midwives, both in the education sector and in the clinical environment is critical because, as the midwifery

workforce, they are charged with the ongoing development of midwifery as a profession promoting improved patient outcomes, their own professional identity and interprofessional practice.

Student Declaration

“I, Elvira Brown, declare that the PhD thesis entitled “Professional Identity in Interprofessional Education: Midwifery Narratives” is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.”

Signature:  Date: 1 May 2019

Acknowledgements

Undertaking doctoral studies can be daunting. Having the support of family, friends, colleagues, and of course, my supervisors, made the path less intimidating. This study was made possible through the patience, wisdom, guidance and understanding of all of the aforementioned persons.

First of all, I would like to acknowledge my family, Daryl, Alanah and Matthew (my in-house IT support), who were encouraging and supportive of the path that I chose to pursue. There were many occasions when it was suggested to "just get on with it" when it all seemed a little too difficult. All lovingly suggested of course.

This thesis would not have been possible without the invaluable direction, support, guidance and knowledge of my wonderful supervisor, Professor Kristine Martin-McDonald. I sincerely acknowledge her work, input and support as a colleague and student. It is her ability to guide that shone through for me as I travelled along the doctoral pathway, exploring and then discovering along the way for myself. The friendship will remain long after the completion of the thesis.

I owe a debt of gratitude to my associate supervisor, Dr Gina Kruger, friend and colleague of many years standing. Her kindness, gentleness and insightfulness in providing support and input is deeply appreciated and acknowledged.

To my participants who cannot be named but without whom this study would not be. My heartfelt thanks for their willingness to engage with me to discover how we, as midwives, develop our professional identity. Together we have done so and I thank you sincerely for your time, patience and professionalism.

Last, but not least, I would like to acknowledge my colleagues in my former School of Nursing & Midwifery. Gina, Felicity, Melissa and Mary. Their camaraderie was a source of strength and support through the life of the thesis.

Table of Contents

Tables

Figures

Glossary of Abbreviations and Terms

A. C. M.	Australian College of Midwives
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health & Welfare
ALSO	Advanced Life Support in Obstetrics
ANMAC	Australian Nursing & Midwifery Accreditation Council
A. T. A. R.	Australian Tertiary Admission Rank
BMI	Body Mass Index
Borderland	A district near the border between two countries or areas (Soanes & Stevenson, 2008, p.161); An uncertain, intermediate district, space, or condition (Thesaurus.com)
CAIPE	Centre for the Advancement of Interprofessional Education
CCE	Continuity of care experiences
CP	Collaborative practice
CTG	Cardiotocograph
GP	General Practice / Practitioner
Grad. Dip.	Graduate Diploma
GTT	Glucose tolerance test
HR	Human resources
ICC	Interstate capital city
ICM	International Confederation of Midwives
IPE	Interprofessional education. That which occurs when “two or more professions learn with, from and about each other to improve collaboration and the quality of care.” (CAIPE, 2002)
IPC	Interprofessional collaboration

IPL	Interprofessional learning
IPP	Interprofessional practice
IPW	Interprofessional working
IUA	Interstate university A
IUB	Interstate university B
LCH	Large city hospital
LMH	Large metropolitan hospital
MH	Metropolitan hospital
NIS	Narrative inquiry space
NMBA	Nursing & Midwifery Board of Australia
OT	Occupational therapy / therapist
Relational	The way in which two or more people or things are connected or related.
RH	Regional hospital
R. M.	Registered midwife
R.M.O.	Resident medical officer
R. N.	Registered nurse
SIM	Simulation / simulated
ST	Student midwife
Scope of practice	Refers to the procedures, actions, and processes that a midwife is permitted to undertake in keeping with the conditions set out in their registration with AHPRA.
Spatial	Relating to, occupying, or having the character of space.
STAT	Special Tertiary Admissions Test
Temporality	The state of existing within or having some relationship with time.

The interprofessional	Refers to the collective environment of interprofessional education (IPE), interprofessional collaboration (IPC), and interprofessional practice (IPP).
WHO	World Health Organization

Key to the study

In the presentation of this thesis the following conventions have been used:

Pseudonyms	all study participants, places of employment, and towns/cities were allocated a pseudonym to ensure confidentiality
Normal type and "…"	citation of quotes from the literature
Italics	citation of participants' words
…	material edited out
[square brackets]	researcher's comments, added to clarify or explain
' …'	emphasis on a key word

CHAPTER ONE
INTRODUCTION

1.1 Introduction

This thesis is concerned with the development of the professional identity of midwives- student and registered- within the context of interprofessional education (IPE). Midwives practice in a variety of settings, from Australia's public health care sector, private hospitals, interdependent practice to self-employed. Within these settings, they may work in birthing units, ante-and postnatal wards as well as community clinics. They work with a variety of health care professionals such as obstetricians, both trained and in-training, nurses, social workers, physiotherapists, operating theatre personnel and with medical imaging staff in some cases, and others in the course of their career. Thus, they are exposed to a plethora of diverse health care professionals who exhibit their own professional identity as a clinician through the manner in which they provide their care to the women, or indeed, portray themselves in the practice environment or the education setting. It is the premise of this researcher that a specific set of circumstances/intrinsic factors must exist through which student and registered midwives develop, extend, and mature their sense of professional identity, unique to the midwife, both through education and in practice. Therefore, the intent of this study was to explore what these circumstances or intrinsic factors could be.

This chapter provides the context of midwifery education in Australia at the time of the study; the rationale for the study and its significance are included. Finally, the structure of the thesis is presented.

1.2 The midwifery context at the time of the study

In Australia on any given average day, 850 babies are born in the health care system (Australian Institute of Health and Welfare [AIHW], 2018a), both in the public and private health care systems. Women giving birth to their babies have the option of several models of care during their pregnancy. Some of these are: private and public maternity care, team midwifery care, shared care with a

general practitioner (GP), caseload midwifery care, and in some cases, planned homebirths. The common denominator in these various models of care is that women are assisted by midwives for the most part. The literature abounds with evidence of the contributions to the reduction in maternal and infant mortality rates that quality midwifery care has made (Hartz, Foureur, & Tracy, 2012; Perriman, Davis, & Ferguson, 2018; Soltani & Sandall, 2012). Equally espoused in the literature is the importance of promoting quality midwifery education to enable this to continue (Bharj et al., 2016; Leap, Brodie, & Tracy, 2017; Luyben et al., 2017). In the words of Bharj et al. (2016, p. 3) "Midwifery education, … is the bedrock for equipping midwives with appropriate competencies to provide a high standard of safe, evidence-based care." How this is achieved is described in the following discussion.[1]

1.2.1 Pathways to midwifery education in Australia

The education of midwives in Australia has undergone various changes especially in the last fifty years. The middle twentieth century saw the introduction of a twelve-month post registration qualification introduced for registered nurses who wanted to qualify as midwives. This qualification was achieved through a hospital-based program of study and became known as a 'Graduate Diploma of Midwifery.' In some circles this was also referred to as the 'pressure cooker course," according to Ebert, Tierney, and Jones (2016), because of the intensity of requirements to be achieved in the short time frame. Alternatively, another pathway was through entry at a Masters level (Australian Government Department of Health, 2013). Both the nursing and graduate diploma of midwifery were relocated to the tertiary education sector beginning in the 1970s and completed by the early 1990s. Interestingly, this transition drew criticism in one Western country operating under the same model as Australia. It was also claimed that this "resulted in a large theory-practice gap" in that particular country according to McNeil and Silvey (2018, p.87), who also advocate for a return of 'training' to hospital and other primary care facilities.

[1] The World Health Assembly (WHA) has identified "midwifery education" as a high priority goal for 2019 (cited inMcConville, 2018).

Both programs of study continue to the present day and have evolved to offer various modes of entry to the study of midwifery (and nursing).

In the late 1990s, in response to the increased costs of health care, the costs and time involved in educating a qualified midwife, that is, a three-year nursing qualification, followed by a further year of a graduate diploma, and the voice of women demanding expressed needs, gave rise to the need for a midwifery qualification for those persons who wanted to be a midwife, not a nurse. Finally, in 2002 a consortium of three Victorian universities offered a three-year, direct-entry Bachelor of Midwifery program in the tertiary education sector as the pathway to prepare competent midwives for practice. This was followed by two South Australian universities. These direct-entry to midwifery practice educational programs were seen to have implications for the professional growth and development of midwifery students as their focus was based on the midwifery philosophy of 'wellness' as opposed to the predominantly pathophysiological illness focus of nursing (Commonwealth of Australia, 2010, p. 25). By extension, wellness-based philosophy acknowledges that pregnancy and childbirth are normal events in the life cycle of a woman and thus the need for medical interventions should take this into consideration. Today, there are various pathways into midwifery practice and these are shown in Table 1.1.

The underlying philosophy of the direct-entry degree qualification was based on the International Confederation of Midwives (ICM)' (definition of the midwife (see Section 1.3). It more accurately reflects the internationally recognised philosophy of practice of 'being with woman' (ICM, 2017) and providing woman-centred care (Ebert et al., 2016). Additionally, and most importantly, this was seen to be responsive to women's needs and reinforced the profession's strongly-held view that midwifery was a distinctly separate discipline from nursing. In fact, in some countries such as New Zealand, midwifery achieved autonomy as a distinct profession as early as 1990 (Guilliland, 2016, p. 22).

Table 1.1: Accredited midwifery education programs of study[2]

Program of study type	Length of program	Qualification
Bachelor degree	36 months	Bachelor of Midwifery
Bachelor degree (graduate entry)	18 – 24 months	Bachelor of Midwifery
Bachelor degree (dual degree)	36 – 48 months	Bachelor of Nursing/Bachelor of Midwifery; Bachelor of Science Nursing /Bachelor of Science Midwifery; Bachelor of Nursing Science/Bachelor of Midwifery; Bachelor of Midwifery/Bachelor of Nursing; Bachelor of Midwifery/Bachelor of Creative Intelligence & Innovation.
Graduate Diploma	12 – 18 months	Graduate Diploma of Midwifery
Master of Midwifery Practice	18 – 24 months	Master of Midwifery Practice

However, in some Australian states such as Victoria, changing societal demands, for example, the increasing burden of chronic illness in pregnant women and needs (Luyben, Barger, Avery, & Bick, 2018, p. 132) saw a review of how midwives were educated from 2015 to the present day. Maternity services consumers are increasingly presenting with illnesses which have the potential to complicate pregnancy. Examples include obesity (approximately 50% of women at first presentation for antenatal care), diabetes and hypertension (AIHW, 2018b, pp. 12-13), as well as rising maternal age (median age of 31 years in 2016), though not strictly an illness per se. As an example, these illnesses can cause complications for women such as an increased risk of thromboembolism, pre-eclampsia and post-partum haemorrhage (AIHW, 2018b, p. 12) to name a few. Should a woman require a Caesarean section, as a result, this further complicates her care and potentially that of her baby. For these reasons, the care of these women is considered to be high-acuity by

[2] Information sourced from AHPRA: https://www.ahpra.gov.au/Education/Approved-Programs-of-Study.aspx?ref=Midwife&Type=General

maternity services providers who claim that high-acuity care can be best provided by a dual-qualified midwife, that is, having the educational preparation of both a nurse and a midwife (Australian Government Department of Health, 2013).

For industry, this raised the issue of how best to provide a qualified and competent midwifery workforce that was able to provide the increasingly complex level of care needed by pregnant women with associated co-morbidities such as cardiac, renal, and other diseases in addition to increasing numbers of women with diabetes. This necessitated the decision by education providers to offer a dual-degree preparation of midwives for practice, in response to industry requirements. That is, a student would graduate with a dual-degree of Bachelor of Midwifery and Bachelor of Nursing, obtained over a four-year course of study. One university in Victoria continues to offer the direct-entry Bachelor of Midwifery. Another avenue of entry to midwifery practice is through a Master of Midwifery.

1.2.2 Accreditation of midwifery education programs in Australia

Prior to 2010 midwifery programs of study in Australia were accredited at the state level (Tierney, Sweet, Houston, & Ebert, 2018). However, since 2010, all midwifery education programs have been accredited under a national scheme through the Australian Nursing and Midwifery Accreditation Council (ANMAC).

The development and accreditation of midwifery programs of study is a lengthy and rigorous process. The program development phase must meet, first of all, the university guidelines for approval which involves various stakeholders, among them, consumers. Once developed and approved the program of study is submitted to ANMAC for accreditation. This process involves the proposed program of study meeting the Midwife Standards for Practice (Nursing and Midwifery Board of Australia [NMBA], 2018) which provide a set framework for the provision of midwifery practice in all the various contexts that midwives may practice. The use of the Midwife Standards for Practice ensures that the midwifery role and focus are clearly delineated in the program of study developed. In addition, a site visit to the university proposing the course is

undertaken to ensure that the appropriate facilities exist in which to conduct the proposed program of study (ANMAC, 2018). The NMBA regularly review the standards to ensure they reflect contemporary and best practice, both at the Australian and international level (NMBA, 2018). This in turn ensures that midwifery students graduate from programs of study that are inclusive of best practice, industry requirements, and responsive to changing health policy.

Once the course is accredited by ANMAC it is submitted to the Australian Health Practitioner Regulation Agency (AHPRA) for final consideration through its national board. In the case of midwifery, the NMBA will endorse the accredited program of study for commencement at an agreed time. The rigorousness of the approval and accreditation of midwifery programs of study at a national level ensures that newly graduated midwives enter the workforce with nationally-accepted levels of knowledge and skills, to enable the best provision of care for women and their babies.

1.2.3 Registration of midwifery graduates for practice in Australia

In order to gain registration to practice midwifery, students must not only complete the designated program of study, but also meet the requirements set out by the profession itself. These include a specific number of: normal births; births with interventions; episodes of attending women with analgesic requirements; pre- and postnatal examinations of the mother; continuity of care experiences and examinations of the newborn. Once these requirements are achieved, and the requisite clinical hours and academic components of the program completed satisfactorily, the student can apply for registration as a midwife to the NMBA under the auspices of AHPRA.

Once the graduate is registered, they can enter the practice of midwifery. Whilst the primary role of the NMBA is the protection of the public, it is also responsible for the registration of its clinicians and students. This process is a yearly occurrence.

Midwives with a Bachelor of Midwifery qualification in Australia numbered 5,209 as of 20 June 2018; those holding a dual qualification, that is, nursing and

midwifery numbered 28,277 (NMBA, 2018, p. 14). No distinction is made between those midwives with the dual qualification and those with a postgraduate qualification in midwifery. In addition, midwives comprise 4.8% of all registered health professionals in Australia and of those, 98.5% of midwife professionals are female (NMBA, 2018, p. 14).

1.3 Background and rationale for the study

Interprofessional education (IPE) is education which "occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (CAIPE, 2002). Much of the evidence on IPE over the last decade abounds with research conducted around the implementation of IPE in various health care education and delivery programs, mostly from nursing and other allied health perspectives. Little evidence exists however, with regard to how midwives at any level of expertise develop their professional identity within the context of IPE. Interestingly, the inclusion of IPE as an essential component of education for nursing programs was expressed by the Coalition of National Nursing Organisations as early as 2010, but was silent with regard to midwifery education (Dragon, 2010). However, the review of the midwifery accreditation standards by ANMAC in 2013 acknowledged the recommendation made by the 'Core Competencies and Educational Framework for Maternity Services in Australia Project 2010' (National Health Workforce Taskforce, 2009). The report recommended that IPE be an integral part of midwifery education, not only at the undergraduate level, but as ongoing professional development of maternity services providers (ANMAC, 2013, p. 8). In fact, the concept of IPE is encapsulated in the *Midwife Standards for Practice* (NMBA, 2018).

There is a paucity of IPE literature that relates to the discipline of midwifery with little evidence on how midwives "become midwives," that is, professional identity development. Luyben et al. (2017, p. 133) acknowledge the trend towards the inclusion and benefits of IPE in midwifery curricula, particularly from the point of view of "maintaining a professional identity among student midwives." There is also acknowledgment that IPE is part of the changing culture of midwifery education. Most of the IPE literature relates to education in

a way that strongly supports the notion that exposure to, or immersion in, IPE contributes to improved patient health outcomes, communication and collaboration between health care professionals (World Health Organization [WHO], 2010) and improved student learning. And, in some cases, a better understanding of the differing roles of the various health care professionals with whom they engage in IPE.

To discover professional identity formation in midwives, it is necessary to understand who they are in order to research it from the appropriate perspective. The ICM definition of the midwife is "… a person who has successfully completed a midwifery education program that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education, and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery" (ICM, 2017, n.p.). The midwife's scope of practice is that which delineates the types of care that s/he is qualified to provide (ICM, 2017). As such, this ensures an international standard/expectation by which all midwives adhere to in providing care to women and their babies.

Homer et al. (2012) and Harvie, Sidebotham, and Fenwick (2019) eschew that an effective maternity health care system is based on an appropriately educated workforce. One of the mechanisms through which the Australian maternity workforce can achieve this is by implementing "interprofessional learning and working together" as this leads to the best outcomes for maternity service consumers, that is, women and their babies (Homer et al., 2012, p. 125).

This study takes the perspective that professional identity and role refers to the midwife's view of her/himself within the context of her/his scope of practice, which includes IPE and IPP, and how s/he functions within any given situation in that context. Hunter and Warren (2014) identified the importance of midwives with a strong sense of their professional identity in order to build resilience in difficult workplace situations, especially with regard to workforce shortages.

Whilst this study was based in the United Kingdom, it has relevance for the Australian context which faces similar midwifery workforce shortages (Harvie et al., 2019; Homer et al., 2012).

Identification of the processes involved in professional identity development in midwives in the Australian context would contribute to educational strategies in midwifery curricula. This in turn would promote and strengthen professional identity development in midwifery students, enabling the new graduates to enter (and remain in) the workforce with a strong sense of their own professional identity, facilitating their interprofessional working in the clinical environment and thus improved maternity service provision (Homer et al., 2012). This is in keeping with the views of the WHO (2010). In its re-commitment to interprofessional education WHO (2010) stated that there are improved health outcomes where a health system is underpinned by its practitioners who have a shared understanding of each other's skills and knowledge. As the literature thus far appeared silent on the issue of professional identity development of midwives specifically, this study addresses this gap in knowledge.

1.4 Aim of the study

This study examines the impact of IPE on the professional identity of student midwives, educators (both academic and clinical), and clinicians. More specifically, the aim of this study was to illuminate how midwives establish, maintain and extend their professional identity within the context of interprofessional education and/or interprofessional practice. In order to identify how this process occurred, participants were asked: "How do you construct your professional identity as a clinician within the context of interprofessional education?"

1.5 Significance of the study

The significance and original contribution of this study lies in the exploration of the interrelated and intersectorial concepts of professional identity, interprofessional education, and the discipline of midwifery. It is this contribution which is notably absent in the literature to date. The intellectual

and conceptual significance of this study lies in the fact that there are few studies that relate interprofessional education to the discipline of midwifery. Furthermore, whilst there is a substantial body of research in the knowledge area related to interprofessional education, what is notably lacking are expositions of theoretical underpinnings of interprofessional education (Reeves, Tassone, Parker, Wagner, & Simmons, 2012). Thus, this study will contribute to both the explorative understandings of midwifery students and clinicians about interprofessional education, and contribute to the development and elucidation of theoretical understandings of interprofessional education.

The practical significance of this study lies in its potential to firstly, describe how midwives, both present and future, continue to develop their professional identity within the context of interprofessional education; secondly, to enhance the professional profile and identity of midwifery as a discipline; and thirdly, possibly reveal pathways for students and new graduates to be better prepared as the future health workforce in midwifery (Murray-Davis, Marshall, & Gordon, 2012). Last, but not least, this has implications for the design of midwifery curricula and its implementation (Engum & Jeffries, 2012).

1.6 The researcher

The researcher was part of the research process by nature of interacting with the participants with regard to documenting their stories and answering their questions. Similarly, the participants were co-researchers in the process. At the time of the study, the researcher brought forty-three years of nursing and midwifery knowledge, learning and practice in both academic and clinical environments to the study.

The university at which the researcher was employed introduced an IPE program to all of its health care courses (ten in total), amongst them, midwifery. It was an exciting and vibrant period to observe midwifery, nursing, and paramedic students, to name just three, to learn ‘with, from and about each other’ in the classroom setting. This piqued the curiosity of the researcher and culminated in this study.

1.7 Organisation of the thesis

This thesis consists of eight chapters. This chapter has introduced the phenomena of interest, that is, the professional identity of midwives in interprofessional practice. The background to the study, significance and aim of undertaking the research is also provided. The second chapter reviews the known literature on IPE as it relates to this study, and explores the literature pertinent to identity, socialisation into the profession of midwifery, attitudes, professional and role identity. This sets the context for the reader.

The third chapter addresses the study methodology and its justification. It provides a discussion on the underpinning theoretical framework of social constructionism. Narrative inquiry as a methodology is explored, and its congruency and fit with social constructionism and justification in the study is explained. In Chapter Four the various methods used in the study are presented and explained in detail, while Chapter Five is devoted to eight participants' narratives representative of both registered and student midwives. Due to the word limitations of such a thesis the remaining narratives are available in Appendix A.

The thematic analysis of all participants' narratives comprise Chapter Six in which five themes are presented. Chapter Seven presents the interpretation and discussion which arose as a result of thematic analysis resulting in the expansion of Clandinin and Connelly's (2000a) Narrative Inquiry Space (NIS) by the identification of a fourth element, fluidity - the new knowledge this study produced in the process of identifying how midwives' professional identity developed. Finally, Chapter Eight provides the strengths and limitations of the study; implications for midwifery education and practice; and recommendations for future research into professional identity development.

CHAPTER TWO
THE LITERATURE REVIEW

2.1 Introduction

Much has been written on the topic of IPE over the last decade on a global level. However, much of this literature abounds with research conducted around the implementation of IPE in various health care education and delivery programs, mostly from nursing and other allied health perspectives. Little literature exists with regard to how midwives at any level of professional expertise develop their professional identity within the context of IPE. It is for this reason that the following discussion turns to the more generic literature on IPE and professional identity in nursing and other health care professions. Where available the midwifery literature is critically incorporated. There is a paucity of IPE literature that relates to the discipline of midwifery and little evidence on how midwives "become midwives," that is, professional identity development. Most of the IPE literature, including that from the WHO relates to education in a way that strongly supports the notion that exposure to, or immersion in, IPE contributes to improved patient health outcomes, communication and collaboration between health care professionals (WHO, 2010) and improved student learning, and in some cases, a better understanding of the differing roles of the various health care professionals with whom they engage in IPE. Despite this global imperative there appears to remain a prevailing isolationist view of the development of the individual midwife. This study takes the perspective that professional identity and role refers to the midwife's view of her/himself within the context of her/his scope of practice, which includes IPE and interprofessional practice (IPP), and how she/he functions within any given situation in that context.

The pertinent literature and its relevance to the study is discussed according to the following framework: an historical overview of IPE; current theory surrounding IPE; the current knowledge status surrounding both IPE and interprofessional collaboration (IPC) / interprofessional working (IPW) in the clinical context; the development of discipline-specific role and/or professional

identity, and the socialisation of midwifery/health students to the discipline, particularly in the clinical context.

2.2 Interprofessional education

The term ‘interprofessional education’ has been confusing over time as there are many, and some seemingly competitive, definitions of IPE. Perhaps this lack of consensus of what IPE is has contributed to the ‘slow burn’ acknowledgement, valuing and uptake of IPE as a way of achieving better patient outcomes. However, in more recent years the literature has gained momentum and a large acceptance of a definition of IPE.

The Centre for the Advancement of Interprofessional Education (CAIPE) (2002) defines IPE as that which “occurs when two or more professionals learn with, from and about each other to improve collaboration and the quality of care” (p. 10). Yet despite this commonly accepted term there still remains a general mismatch of its use, resulting in many terms which appear in the literature included in this study that are used interchangeably with the CAIPE (2002) definition of IPE. Examples used interchangeably by those within the interprofessional scholarship space include IPP, IPC and IPW. This often leads to confusion for those that are not well acquainted with the interprofessional body of knowledge and could well suggest why other terms are inappropriately used, for example, multidisciplinary or interdisciplinary (Milton, 2012; Thistlethwaite, 2012), instead. It is the CAIPE definition of IPE which will be consistently applied in this study.

IPE is not a new phenomenon according to Barr, Koppel, Reeves, Hammick, and Freeth (2008a), who report the existence of IPE in many countries prior to 1988. However, the report of the WHO in 1988 cemented the importance of furthering IPE (Barr, Koppel, Reeves, Hammick, & Freeth, 2008b) and its belief that IPE improves the education of health professions (Barr, 2010). A significant aspect of the report lay in the articulation of the importance of a shared program of learning for health professionals in their respective educational programs with the intent of improving professional practice (Barr et

al., 2008b, p. 30). The WHO (2010, p. 10) reaffirmed its support of IPE in its position statement: “Interprofessional health-care teams understand how to optimize the skills of their members, share case management and provide better health care services to patients and the community. The resulting strengthened health system leads to improved health outcomes.” This position is supported by Gilbert (2010), who proffers that interprofessional education which results in collaborative practice has demonstrated its ability to lessen the effects of the various health challenges found in global health systems.

A study by Rodger and Hoffman (2010) and commissioned by the WHO, was undertaken to discover how and where IPE was being delivered in the global arena. Underlying this was the premise that knowledge of where it was occurring could allow both national and global health organisations to build on these efforts. This, in turn could lead to the development of best practice and at the same time identify where there was room for improvement in the delivery of IPE. This study also sought the reasons as to why IPE was considered valuable by providers. To know this was to have the potential to create ongoing champions[3] of IPE in the global context (Rodger and Hoffman, 2010). Participants consisted of individuals who worked with health professional students in either the educational or clinical setting. The data in Rodger and Hoffman’s (2010) study were collected by an internet-based survey which included the use of open-ended questions. Focal areas of interest were participants’ demographic information, particularly with regard to individual experience of IPE with students; actual IPE program content; and participants’ perceptions of IPE, centred on its benefits and how it might impact/influence clinical practice and policy development.

Results in Rodger and Hoffman’s (2010) study were gleaned through descriptive analysis of the surveys and content analysis of the data from the open-ended questions. The majority of participants (n= 360 out of 396) were

[3] A ‘champion’ is one who advances a particular cause of interest (Soanes & Stevenson, 2008, p. 235). In the context of this study, an IPE champion is an academic or midwife clinician with a particular interest in IPE, has credibility within their own discipline, and is able to advance the concept of IPE (Bluteau & Jackson, 2009, p. 187).

from developed countries. As with other studies, participants represented various health professions such as nursing and midwifery, medicine, and allied health professions (Rodger and Hoffman, 2010). Findings from the same study revealed that participants' experience with IPE teaching varied from less than 5 years (36%) to greater than 10 years (24%). Fifteen percent (15%) of participants reported having no formal experience in facilitating IPE teaching. Very few of the participants (29%) reported having had experience with IPE learning as students themselves (Rodger and Hoffman, 2010).

Participants typically delivered IPE through lectures, small group discussions and case studies (41%) with a further 34% using IPE in the clinical context. The majority of participants (78%) reported that their IPE programs were less than six months duration with most of it occurring at undergraduate level. Student learning was assessed primarily through written work (66%) with little variation between participants from developed and developing countries (Rodger and Hoffman, 2010).

Findings from the analysis of open-ended questions revealed that by far, IPE facilitation was provided by university academics (Rodger and Hoffman, 2010). Overall, it emerged that there was minimal training of IPE facilitators with some instances of no training provided to facilitators. Whilst 70% of participants evaluated IPE learning within their programs, there was no uniformity of evaluation strategies used, and furthermore, most were from developed countries. Given that the need for evidence-based evaluation in/of IPE was highlighted as early as 2000 by Hammick; a criticism of this study is given that 30% of participants reported a lack of IPE program evaluation, no further light was shed as to why evaluation of programs in developing nations was not occurring.

Providing insights and real-world experiences through IPE were the most-often reported benefits by participants. Knowing the scope of practice and knowledge base of students in other health professions was also a perceived benefit. The downside of IPE programs included the logistical issues surrounding the scheduling of classes for the various health professions (Rodger and Hoffman,

2010). This has been found in various studies by Morison, Boohan, Jenkins, and Moutray (2003) and Hammick, Freeth, Koppel, Reeves, and Barr (2007).

Other perceived benefits, common to participants from both developed and developing countries, related to improved access to health care, improved quality of health care and patient outcomes, staff workforce issues such as higher retention rates and improved staff morale. Overall, the data revealed that the use of IPE varied across the countries surveyed and, in some cases, IPE was not compulsory in some education programs (Rodger and Hoffman, 2010). Furthermore, according to Rodger and Hoffman (2010), there continued to exist a lack of theory underpinning the IPE education, a concept advocated as necessary by Hammick (2000) in earlier writings. Paradis and Reeves' (2013) research supports the need for not only the use of theory in IPE, but also research into IPE that emphasizes the use of theory in its methodology.

Findings from Rodger and Hoffman's (2010) study reiterated a lack of best-practice strategies such as formal evaluation of program content taught and lack of education for IPE facilitators, previously identified in studies by Hammick (2000), Baker, Egan-Lee, Leslie, Silver, and Reeves (2010) and also identified in a subsequent study by Reeves, Perrier, Goldman, Freeth, and Zwarenstein (2013). This has the potential to undermine the intent of a program from the perspective of its effectiveness for participants and whether the best facilitators are, in fact, those delivering the program.

A synopsis of the state of IPE in Northern America was outlined by Schmitt, Gilbert, Brandt, and Weinstein (2013), who claim that IPE began its evolution in North America from 1972. They found that there was an increasing world-wide interest in IPE specifically since 2007. They concur with other proponents of IPE such as Paradis and Reeves (2013), in the belief that all aspects of health care can be improved by IPE and IPP. Schmitt et al. (2013) further claim that global advances and influences in IPE are due to several factors: the creation of CAIPE; the birth of a recognised peer-reviewed journal in IPE; and the staging of global conferences with IPE as an underpinning foundation.

The study also found that the key aspects and drivers of IPE were the errors and questionable quality of health care attributed, in part, to the lack of appropriate collaborations amongst health care professionals (Schmitt et al., 2013). These authors believe there is a need for policy development to mandate IPE in health care courses and furthermore, leadership is necessary to promote IPE in both the academic arena and practice settings simultaneously. Another aspect of their (Schmitt et al., 2013) synopsis is that there is a real need for the professional development of both the clinical practitioners and academic staff in order to support the teaching and implementation of IPE in the clinical setting and the classroom. This, they believe, begs the need for ongoing provision of resources to support IPE to ensure that the education of health care professionals is responsive to the needs of the practice setting (Schmitt et al., 2013). Last, but not least, a reciprocal obligation by health care providers in assisting in the educational preparation of its future workforce is required according to the authors in the abovementioned study (Schmitt et al., 2013), and also identified by Hammick (2000). This, then, reinforces the dissonance of a coordinated and collaborative approach to IPE in both the clinical and education setting also identified in previous studies (Reeves et al., 2012).

2.3 Interprofessional education: collaboration in the clinical context

A study involving midwifery students was conducted by Murray-Davis et al. (2012), focused on exploring how midwifery students applied their pre-qualification IPE learning to practice. An important factor in their research was the stage at which IPE was introduced into the midwifery curriculum. A key finding was that the omission of IPE in preceptorship programs was found to be a barrier for role transition of students, as well as, their application of IPE learning in practice. Murray-Davis et al. (2012) made clear that whilst their research highlighted the benefits of preceptorship of students for effective role transition, the study did not specifically address how midwifery students developed into practitioners who ably incorporated the principles of IPE. Indeed, whilst participants knew broadly how the midwifery role had changed over time, the opportunity to delve further into what this meant for the individual

participant's transition from studentship to novice/experienced clinician was not explored. This could have provided specific information for the development of discipline-specific IPE program content in order to better prepare students for their IP clinical practice.

A similar study by Williams et al. (2012) which included midwifery students, was conducted to elucidate whether IPE was successful at the undergraduate level. The sample (n=418) also included nursing, occupational therapy, paramedic, nutrition and dietetic, and physiotherapy students. Data were collected using a questionnaire. Generally, whilst the findings were supportive of the inclusion of IPE into each of the respective curricula discussed, there was no discussion relating to the midwifery students and their curriculum.

Specifically, findings were discussed according to each participating discipline apart from the midwifery discipline with no mention being made of why it was omitted (Williams et al., 2012). This could be attributed to the small number of participants (n=16); however, this was not mentioned in the discussion. This presents a valuable but lost opportunity to understand the specific issues related to the midwifery discipline in terms of IPE's usefulness at the undergraduate level in that particular program at that institution. However, the discussion highlighted the need to include IPE in curricula before students were socialised into the culture of their respective discipline, a point of view supported by the findings of Bainbridge and Wood's study (2012) for the early inclusion of IPE into nursing curricula. The early inclusion of IPE into midwifery curricula may have implications for how a midwife develops her/his professional identity. This notion is reinforced by Reeves et al. (2012), prolific researchers in IPE. Their study found that students had a very strong sense of their own identity on entry to their degree program but this changed, during the course of their program, as they were acculturated in the practice of their discipline (Reeves et al., 2012). Likewise, Johnson, Cowin, Wilson, and Young (2012) found that the professional identity of nurses was shaped (rightly or wrongly) before they entered a professional education program. However, this professional identity underwent change as the students were socialised into the culture of nursing.

An investigation by Aune and Olufsen (2014) of nursing and midwifery students' understanding of interprofessional collaboration (IPC) in providing antenatal and postnatal care to women revealed that IPE assisted the students in understanding the differing respective roles and the development of a trusting relationship. Also reported was that the students felt challenged regarding their professional boundaries, and they better understood their own role in the health care system (Aune & Olufsen, 2014). However, the study stopped short of addressing how these roles developed, which leaves a deficit in our understanding of how best to address this specific issue.

Murray-Davis, Marshall and Gordon's (2011) investigation into the views held by midwives and midwifery educators regarding IPE and midwifery work revealed interesting insights into the midwifery profession. Midwives reported that whilst supporting IPE in midwifery education, having a clear understanding of the roles of other health professionals and a reciprocal understanding of the midwifery role by other health professionals were key to facilitating woman-centred care, rather than interprofessional based practice alone. Coupled with this was the participants' belief that it was as important that their profession was also understood by other health professionals. The research (Murray-Davis et al., 2011) also found that the participants held a strong sense of professional identity which was at odds with interprofessional working and, indeed was viewed as a possible hindrance to engaging in IPE. This was also found by Pollard, Miers and Rickaby's study (2012) who researched the views of nurses, midwives, physiotherapists and social workers with regard to their undergraduate IPE preparation for interprofessional working (IPW) post-graduation. These studies may be of critical importance to understanding, then addressing, any reluctance or outright refusal to move fully into an IPE model. If a discipline's culture is one that holds the belief and establishes firm boundaries around its perceived scope of practice, and then must 'guard' those boundaries from those who would claim the same area of practice, then this gives rise to 'territorialism', which is a strong claim and defence of their practice area resulting in a lack of genuine openness to IPP (Pollard et al., 2012). Ericson (1991) discussed territorialism with regard to the issues of power and control, specifically within the health care system where doctors have sought to

retain their ‘superiority’ based on their perceived view of superior education. The central tenet of the discussion firmly held the view that unless the needs of the health consumer formed the basis of health care delivery, then true collaborative and cooperative health care delivery could not ensue, overridden by territorialism and hierarchy. Research undertaken by Lawn, Lloyd, King, Sweet and Gum (2014) further elaborated on the concept of territorialism. Their study observed territorial behaviours by interprofessional healthcare workers in a primary healthcare setting. Territorial behaviours included ‘control’ and ‘establishment of rules’ for spaces designed as multiuse spaces. These behaviours were considered barriers to interprofessional practice.

There is a common misperception that the disciplines of nursing and midwifery are one and the same, however whilst they are closely related with some commonalities, it may be reasonable to anticipate that some of the research findings for nurses may be applicable for midwives, but studies into midwifery in its own right are essential. A curriculum that enables its students to develop their discipline identity alongside that of an IPE identity, may well have the potential to minimise, or even, eliminate, some of the disablers of successful IPE practice. Examples were described by Reeves et al. (2012) who found that midwives’ professional identities were challenged by students who incorporated principles of IPE into their practice. Supporting this stance were the attitudinal issues described by Murray-Davis et al. (2011, p. 380): “… I can’t say that we’ve seen anything different in the way they come out. But it may be there’s more hidden effects that they may be able to feel…”

Parallel to the discussion of the state of play of IPE and collaboration in the clinical context, is the necessity for a discussion surrounding firstly, theories underpinning IPE and secondly, the existing models and frameworks used to deliver IPE content in both the educational and clinical context. The following provides a critique of the current literature in these domains.

Barr (2013b) provides an overview of the theoretical underpinnings of IPE in existence currently and in so doing, points to the potential emergence of a framework that could accommodate various disciplines’ requirements in the

delivery of IPE. Extending the viewpoint that the use of theory in IPE has the ability to improve IPE both in practice and its evaluation, Hean, O'Halloran, Craddock, Hammick, and Pitt (2013, p. 10) sought to test the validity and evaluate the use of social capital theory, in the IPE context with interprofessional student groups. This was in response to Hean et al. (2013) view that theory is neither efficiently applied nor evaluated in university curricula nor in the practice setting The findings were reflective of those from Green's (2013) study in that IPE was perceived as more relevant if the makeup of the study participants' groups more closely mirrored that of the interprofessional health care team in the practice setting (2013, pp. 14-15). In other words, collaborative practice was not necessarily assured despite undertaking IPE in an educational setting. Furthermore, the stage of IPE in the educational setting impacted its perceived relevance by participants. This view is in keeping with other studies discussed. As a strength of this study, Hean et al. (2013) acknowledge that whilst the use of social capital theory may be useful in designing IPE learning opportunities, there exist other theoretical possibilities. A limitation of the study by Hean et al. (2013) is that no mention is made of participant numbers or, their composition of representative disciplines. In arguing for a theoretical stance on IPE, Green (2013), amongst other proponents, maintain that there needs to be a shift away from the notion that implementing IPE necessarily leads to collaborative practice (CP). Instead the argument is made that IPE must address three particular concepts: be understood from an intellectual perspective, the political, and the potential to be challenged experimentally (Green, 2013). This latter concept is in keeping with the intended purpose of the study by Hean et al. (2013). Green's study, composed of students and graduates, included nurses but did not include midwives. A key emergent category of Green's study was that of "relative distancing in IPE" (2013, p. 36), which represented how study participants constructed their respective professional identities and in the process of such, how they assigned their individual time and resources based on the perceived benefits to be reaped from the IPE experience or opportunity. In fact, participants viewed being interprofessional, with particular emphasis on IPE, as an aspect of being professional. Accordingly, participants (students and program leaders) accorded time and resources to the effort (Green, 2013, p.

36). In this researcher's opinion, this speaks directly to Green's (2013) belief that taking part in IPE does not lead necessarily to collaborative practice. (The construction of professional identity will be discussed in detail in section 2.4.)

In an attempt to increase the number of qualified IPE facilitators in the tertiary sector, Baker et al. (2010) designed, and then quantitatively-evaluated in the first instance, a blended learning program for mixed health disciplines (n=39) to better equip them to develop their own IPE programs at their respective universities (i.e. 'teaching – the teacher'). However, the study does not make clear whether midwives were included. Baker et al. (2010) used a model (Biggs' 3P model: presage-process-product) that demonstrated the relationship between facilitation approaches to IPE and its related outcomes. In common with Rodger and Hoffman (2010), participants from the study by Baker et al. (2010), whilst being well-versed in tertiary education delivery, had varied experience with IPE facilitation. The authors claim that using the conceptual framework (in program development) was key to clearly elucidating a key important feature of the findings, namely, that the "background experience of the learners" was a key factor on the outcomes of the program (Baker et al., 2010, pp. 599-600). In other words, those participants with the least experience in IPE facilitation, would benefit most from undertaking a structured program underpinned by a conceptual framework which ensured that appropriate content was delivered in the appropriate context. This view of utilizing conceptual frameworks in IPE is also advocated by Barr (2013a), Clark, Cott, and Drinka (2007) and Gordon (2009, pp. 59-79).

Adding to this body of work is the study conducted by Abu-Rish et al. (2012) which sought to provide an insight into trends in IPE during the 2005 to 2010 period. Key insights gleaned from this literature review of IPE studies (n=83) include multitudinous and diverse IPE models and lack of clarity surrounding the education of IPE facilitators, which also featured in the Baker et al. (2010) study discussed previously. Despite this, Abu-Rish et al. (2012) state that many of the IPE programs reported in their study were not underpinned by a theoretical or a conceptual framework. Furthermore, the nature of the student-mix in the IPE sessions, which was not sufficiently clear, was a distinct barrier to IPE

implementation. Other key findings described by Abu-Rish et al. (2012) included the logistics, findings also reported by Craddock, O'Halloran, McPherson, Hean, and Hammick (2013), of scheduling of IPE activities and the varying skill-mix of the individual students participating in the IPE sessions. A key recommendation from Abu-Rish et al. (2012) and supported by Craddock et al. (2013), is that any IPE research conducted and reported should, as a standard, be clear about its theoretical underpinning and the model used to implement the IPE content. The conclusion that can be drawn from this recommendation, is that potentially the failure to do so, has the capacity for proponents of IPE to not be working from the same page.

The key recommendation made by Abu-Rish et al. (2012 is mirrored by Benner (2012) in her writings on IPE. Benner (2012) makes the call for the establishment of what she terms 'civic professionalism' as a means to ensure that all health care professionals are working from the same page in terms of IPE and health care delivery. Benner (2012) believes that this will enable "common professional goals" that will better serve the health care system in achieving its aims of improving health care, first and foremost, and reigning in untenable health care expenditure. Could this "civic professionalism" be a broad framework for IPE? Whilst Benner's (2012) writings focused on the end product of IPE, that is to say, improved health care and health care cost; research conducted by Clark (2013, p.43) supports Benner's findings but from the premise of concretising IPE in the academic setting through the use of what he terms a "transtheoretical model of IPE ". Put simply, developing and using a theoretical model to enable the embedding and continuation of IPE at its foundational levels which will also allow for changes within the disciplines engaged and in the institution in which it is being conducted. In reinforcing the need for a theoretical basis to IPE and its continued sustainment, Craddock et al. (2013) highlight the need to temper the IPE outcome requirements with the learning processes that underpin or are required for IPE. Their study focused on elucidating the development of IPE curricula with a particular focus on theoretical constructs. Whilst their findings from study interviews did not support a true pedagogical aspect to curriculum development, the number of participants (which included midwives) was eight, and acknowledged as a

limitation by the authors. The overwhelming finding was that, at that point in time, there was no clear theoretical framework that underscored the structure of the IPE curriculum. Rather, it was driven by institutional logistics and the need to meet external requirements. This is not dissimilar to other studies mentioned previously. However, a key recommendation of this study that IPE must be based on sound theoretical underpinnings, supports previously reported research and is key to better collaborative working amongst health care professionals. This in turn supports the writings of Benner (2012) and Reeves and Hean (2013, pp. 1-3) on this topic.

2.3.1 Knowledge and status of models

A 2007 review by Xyrichis and Lowton (2008) of the pertinent literature on IPW found that there were two main enablers of health professionals working together to provide higher quality health care. These enablers were "team structure" and "team processes" (2008, p. 140). These authors reported that the literature, a total of ten research articles which included nurses and midwives in some of the studies, commonly advocated for the use of teamwork or IPW as a way forward providing continuity of health care since the latter part of the twentieth century and improved health care for patients. However, enablers and barriers were identified. Participants in the studies reviewed reported the need for team members to be co-located in order to be effective, otherwise they ran the risk of being isolationist in care provision (Xyrichis et al., 2008). Other enablers were identified as size and composition of the healthcare team with particular emphasis on the diversity of team members, and the philosophy of care espoused. A barrier to the perceived success of IPW was the lack/quality of team leadership, and the level of organizational support and recognition of staff, for IPW (Xyrichis et al., 2008).

The discussion surrounding enabler "team processes" found that effective IPW and a greater level of innovation were associated with health care teams that met regularly, which also increased the level of communication amongst health care team members (Xyrichis et al., 2008). This suggests that health care practitioners were working 'from the same page' in their delivery of patient care (Xyrichis et al., 2008). This view is in keeping with Benner (2012) and Clark's

(2013) research, and further extrapolated from the research previously mentioned by Craddock et al. (2013) and Abu-Rish et al. (2012). Whilst the discussion emanating from the review by Xyrichis et al., (2008) did not specifically identify a particular model or framework as desirable to embed the delivery and practice of IPE/IPC/IPW, the findings could contribute to a platform from which to develop such a model or framework. An interesting outcome of the Xyrichis et al. (2008) review is that related to professional identity (see section 2.4).

Another review of IPE literature conducted by Hammick et al. (2007) had, as one of its aims, the provision of methodology which could assist with the future-shaping of IPE. Their review was wide-ranging initially (n=884) but was condensed to twenty-one studies considered to be the most appropriate for the purposes of the review objectives. In addition to the standard method of systematic reviews, it included a "narrative synthesis" (2007, p. 735) drawn from their analysis using Bigg's 3-P model (presage-process-product) which was used in later work by Baker et al. (2010), presented earlier in this discussion.

The study participants comprised mostly doctors and nurses (n=13 studies) with few midwifery participants. However, a strength of this review, is the exclusion of articles in which study participants merely shared lectures, as this was not what true IPE represented. The use of the 3-P model allowed the reviewers to evaluate the chosen studies from multiple perspectives: the context of the IPE, including both learner and teacher characteristics (presage); the type of approaches taken to learning and teaching (process); and the competencies participants achieved by the end of the IPE (product) (Hammick et al., 2007).

Key to presage outcomes for this researcher was the importance of the mix of participants who came with a preconceived view of their own and others' professional roles. This aspect was particularly prevalent in the study by Meads, Jones, Harrison, Forman, and Turner (2009, p. 72) with regard to medical participants. Equally important was the need to acknowledge their previous life experiences as it had the potential to affect their interactions with the other professionals and thus the collaborative care provided. In the study

by Hammick et al. (2007, pp. 741-744) gender was also an influencer of attitudes towards IPE, with female participants having a more positive attitude. The standard of the facilitation of the IPE, both in the educational setting and the clinical setting, and the use of adult learning approaches were identified as key features of the process aspect (Hammick et al., 2007).

The adaptability of the IPE process to different scenarios, their relevance and recognition of participants' prior knowledge emerged as important features. The review by Hammick et al. (2007) identified that the studies reported positive changes in client care as a result of IPE (product). However, a correlation was evident between how closely IPC in the clinical context resembled the IPE in the educational setting (Hammick et al., 2007, pp. 745-747) and its continued reinforcement in the clinical context. This was also a factor in studies by Headrick and Khaleel (2008, p. 369) and Meads et al. (2009, p. 74). Common to both these studies was the valued existence of champions as key influencers in IPE, a view also shared by Missen, Jacob, Barnett, Walker, and Cross (2012).

Along similar lines was that reported by Pollard (2009) with regard to the value-adding presence and experience of senior nurses/midwives in the clinical context in promoting positive IPE experiences amongst student nurses (pp. 2846-2847). Whilst the emphasis of this research lay in explicating the type and quality of IP experiences of students, including midwifery students, during clinical placements, several valuable insights emerged of importance to this researcher. Whilst midwifery student participants did not report feelings or evidence of an overt hierarchy but rather an egalitarian working relationship between staff in the maternity unit, when medical practitioners tried to exert leadership in the interprofessional relationship, they met with resistance from the midwifery staff which then required negotiation (Pollard, 2009). Within the findings there was clear evidence that midwifery staff, including midwifery students on placement, demonstrated a greater/higher degree of independent interprofessional working or collaboration as opposed to some of the other health professionals in this study. Finally, one participant reported the importance of being cognizant about the roles of each health professional who

worked on the ward (Pollard, 2009, pp. 2852-2853). This was a feature also reported by Murray-Davis et al. (2011) earlier in this section. This will be explored further in Section 2.4 which follows. In this researcher's view a limitation of this study lay in the fact that there were relatively fewer interactions and reports from the midwifery perspective compared to nursing and other health professions and thus offered fewer insights of the state of play within midwifery practice. Notwithstanding this limitation, the situation is mitigated by the accepted notion that qualitative research does not seek replication of findings nor large numbers of 'subjects.' However, what emerged from the midwifery perspective were valuable insights that may be of significance when considering and planning IPE programs. These are all important factors to consider when proposing frameworks or models for IPE.

A systematic review by Reeves et al. (2010) designed to add to the growing body of evidence for IPE development, implementation and evaluation/outcomes located only six IPE studies which met the inclusion criteria. All of these studies included various health professionals; however, midwifery participants were not represented. Common to four of the studies was the activity of role-playing, with two of the studies providing skilled facilitators to assist with implementation and promotion of teamwork. However, all of the studies involved interactive components. Of key interest to this researcher is the lack of any structured framework/model for the delivery of IPE in the studies included in the review by Reeves et al. (2010). In fact, the review authors concluded that this is necessary from both a qualitative and quantitative perspective (Reeves et al., 2010) in future research endeavours in IPE.

A study by Conway, Little, McMillan, and Fitzgerald (2011) sought to develop an IPE framework as an effective strategy to further ongoing professional development of staff (midwives not included) in a health care network. This study noted the call for such framework(s) as far back as 2004, especially with regard to ongoing postgraduate education of health care staff. This study is of note, in that it identified the need to develop core competencies for health professionals for IPE and practice before any IPE and/or IPP framework was developed. Furthermore, clearly identified in the data was an emphasis for

each health care professional to have a sound knowledge base of their own profession but to be cognizant of other professionals' knowledge as an integral component of the core competencies attained, and any framework developed, as a consequence. This finding was also supported by Murray-Davis et al. (2011), Missen et al. (2012) and to a lesser extent, Steel and Adams (2012). The need for core competencies is also espoused by Engum and Jeffries (2012, p. 149) as a means for effective performance of an IPE In addition to the core competencies for IPE, Engum and Jeffries (2012, p. 150) and Thistlethwaite (2012, p. 62) advocate for the inclusion of learning outcomes and/or goals as a necessity for any IPE framework. These findings could be a key springboard for future developments in IPE conceptual models or frameworks for actioning.

Blanchard and Krieb's (2012) report on a model for successful collaborative practice in midwifery and obstetrics provide useful insights on the qualities which enhanced the working environment. These could also be qualities necessary for developing models of IPE collaborations and/or frameworks. Such qualities as mutual respect, collegiality and flexibility amongst the various health professionals enabled interdisciplinary education which directly strengthened patient care and outcomes (Blanchard et al., 2012, Johnson, 2012). Along similar lines Stevens, Witmer, Grant, and Cammarano (2012) found that key elements for a successful collaboration were the equal valuing of each member of the health care team, communication, commitment to the guiding model in practice, flexibility and mutual respect (pp. 348-351). Also, of note in the report by Stevens et al. (2012, p. 353), is the need for each professional to be cognizant of the other's role and scope of practice, findings also reported by several other authors in the preceding discussion (Conway et al., 2011; Murray-Davis et al., 2011; Missen et al., 2012; Steel et al,2012). Whilst the abovementioned reports into collaborative midwifery and obstetrics practice do not describe IPE in practice per se, it is this researcher's opinion that the successful qualities described within both are viewed as useful insights when considering prospective IPE models or frameworks.

In the preceding section the concept of ‘role’ arose as part of the discussion in point. It is this, and the concepts of identity, professional identity, and socialisation, that the following discussion now turns to and elaborates upon.

2.4 Projection of professional role and identity

As the aim of this study is to illuminate how midwives establish, maintain, and extend their professional identity and roles within the context of interprofessional education, it is necessary that any discussion include a multifaceted conceptual approach. Thus, the following discussion includes literature related to the concepts of identity (both role and professional), attitudes, and socialisation to the profession. In addition, how IPE impacted the midwife’s learning within, and about the discipline, will also be included. What is apparent in the relevant literature is how the concepts are intertwined such that a connectedness / interdependence emerges and thus any discussion regarding any one concept cannot be had in isolation.

2.4.1 Identity

The literature abounds with multiple theories which attempt to explain the notion of identity which predate the Christian era (McKendree, 2010; Ramsey, 2010). However, diverse views exist and it is not the intention of this discussion to examine the many philosophical underpinnings of the concept of identity. Soanes and Stevenson (2008, p. 84) define identity as “the fact of being who or what a person is and/or the characteristics determining this’’. Along a similar vein Hogg (2010, p. 749) describes identity as a person’s conception of who they are and goes on to say that a person has both a *personal* and *social* identity. According to Hogg (2010), social identity describes the behaviours of a group(s) and between individual group members. The attribute(s) of identity is also supported by McKendree (2010, p. 4). It is this notion of identity which is referred to in the researcher’s study and the ensuing discussion.

In their study of how health care practitioners (n=146), including midwives (n=14), transitioned to the new role of university academic, Smith and Boyd (2012) believe that socialisation within a work culture strongly contributes to the

development of one's professional identity. However, the health care practitioner's primary identity remains steadfastly held. In fact, she/he encounters many challenges in acquiring/developing their new identity as tensions exist between the old and new role (Smith et al., 2012). These authors' narrative supports the argument that identity development is not a linear process but has a distinct connection with and, influenced by, the context in which the person practices and is also shaped by peers, colleagues and role models in the workplace (Smith et al., 2012, p. 65). A key contributing factor to identity development is sustained support from colleagues and the workplace (Smith et al., 2012, pp. 69-70).

2.4.2 Socialisation

According to Soanes and Stevenson (2008, p. 1369) the term 'socialisation' refers to "behaviour that is acceptable to (a) society". In the case of this study 'society' represents the world of health care practitioners, particularly, midwives, and their functioning as professionals within their respective professions.

Smith and Boyd (2012, p. 63) are of the view that professional socialisation is a significant factor that contributes to the development of one's professional identity. Their research also considered how the social nature of the workplace contributes to identity development (p. 64). These factors were mirrored in the study by Burford et al. (2013) which highlighted how doctors learnt about nurses', roles but concurrently 'learnt' about the hierarchy that reinforced medical hegemony (2013, p. 394). The study by Burford et al. (2013) (n=60) found that doctors did indeed learn about workplace expectations (i.e. socialisation to the workplace) from nurses, in addition to learning from nurses. Many study participants proffered the view that they were uncertain of their own role in the ward situation. However, their uncertainty decreased as others' (i.e. nurses) expectations of them (i.e. responsibilities as a doctor) increased, and respect was afforded them in their capacity as a doctor. Burford et al. (2013, p. 396) posit the view that " …consequent sense of responsibility was felt to be a positive influence …adoption of the role and identity….."

A strength of this study by Burford et al. (2013), is that it reinforces the prevailing issue of health professionals' lack of understanding of each other's roles prior to entering the workplace. In this study, participants ascribed their own workplace role orientation to the nurses they worked with in addition to learning about other health professionals' roles by observing nurses' "attitudes and behaviours" (Burford et al., 2013, p. 397), or as the authors described it, "in situ" or "implicitly." The authors concluded that the participants' development of their professional role and identity, or professional socialisation, was due, to a considerable extent, to their interactions and discourses with the nurses they worked alongside (p. 398). The authors also identified the importance of perceived hierarchical structures influencing professional identity development. Additional strengths of Burford et al's. (2013) study include the recognition of not having addressed explicitly the interprofessional aspect of the participants' education and of not having a bipartisan view (i.e. the nurses) of the research at hand.

A diverse view of 'professional socialisation' is discussed by Khalili, Orchard, Laschinger, and Farah (2013, p. 2). Whilst their research focuses on the development of an interprofessional socialisation (IPS) framework [this is not in the scope of the current discussion], by necessity they also provide insights into professional socialisation. They argue that professional socialisation is a developmental process that occurs in the individual, in this case a health professional who transitions from being a novice in one's profession to reaching maturity in the hallmarks of that profession (p. 2). They argue that knowing 'who one is,' in one's profession, is derived by the socialisation process. Furthermore, according to Khalili et al. (2013), socialisation into a profession begins at the time that a person starts considering a profession to pursue and may be influenced by cultural and societal expectations. This resonates with Smith et al.(2012), and Coster et al's. (2008) views with regard to the development of professional identity.

2.4.3 Attitudes

The literature (Coster et al.,2008) refers to research which indicates that beginning health professionals enter their course of study with already preconceived ideas about both their own specific field of study as well as that of other health fields. Thus, it is appropriate that the following discussion centres on the concept of attitude and its role in the health professional's conceptualisation of one's own profession and others as well as towards IPE.

The term 'attitude' refers to a particular way of thinking, feeling or a disposition about a matter according to Soanes and Stevenson (2008, p. 84). A longitudinal quantitative study (n=581) of ten health professions, including midwifery, conducted by Pollard, Miers, Gilchrist, and Sayers (2006) found that although students engaged with IPE during the course of their curricula, it did not mitigate against the formation of specific attitudes, some negative, towards other professions. In fact, the negativity in attitude with regard to IPE was more evident at the end of their course. Negativity towards IPE was more apparent in several professions between entry and completion of the courses of study according to Pollard et al. (2006). This included several areas of practice within nursing, midwifery, occupational therapy and social work. Issues of interest from Pollard et al's. (2006) study include the notion that students' attitudes towards IPE may be a product of the values held by the particular profession. Given that students 'want to fit in' with their peers, particularly so in the clinical area, then those values are adopted and in so doing, students begin to shape their identity within the profession and thus become socialised within, and to, the practice realm (Felstead, 2013, p. 22; Pollard et al., 2006, p. 549). Of note, a contributing factor to negative attitudes towards IPE for the midwifery students was the effect of poor IPC in the clinical area. For other health profession students, particularly occupational therapy, negative attitudes towards IPE stemmed from the belief that their occupation was poorly understood by other health professionals (Pollard et al., 2006). This is not an uncommon view in the literature. The study also reported that IPE opportunities were better utilised by mature-aged students and those with higher education qualifications on entry

(Pollard et al., 2006). The authors are of the opinion that it is imperative that educators harness and build on existing students' positive attitudes to IPE on entry to courses and that consideration be given to the timing of IPE exposure in courses offered and to the mix of students within IPE groups (Pollard et al.,2006, p. 550). Further, a key result from the Pollard and Miers (2008) study (drawn from the same cohort as the Pollard et al., 2006 study, but 9-12 months into their professional practice), demonstrated that including IPE at the undergraduate level was, in fact, critical for effective interprofessional working in the clinical context and thus IPE should be maintained in undergraduate curricula (p. 414). A strength of this study is recognition by the authors that quantitative methods cannot accurately reflect study participants' attitudes toward IPE and IPC.

The longitudinal study along similar lines, conducted by Coster et al. (2008) (n=1935) which included midwifery students, produced results not dissimilar to that of Pollard et al. (2006). Of note, the study found that students' sense of professional identity was well formed at entry to the course but diminished over the duration of the course as did the attitudes towards IPE (Coster et al., 2008, pp. 1667, 1674). Nevertheless, they remained positive. The exception was the nursing student's cohort who rated more highly with regard to attitudes to IPE (Coster et al., 2008, 1677) which was similar to Hind et al.(2003, p. 33). This was not the case for the midwifery cohort. However, the study showed a more positive correlation for midwifery students between increased IPE contact and increased attitude towards IPE (Coster et al., 2008, p. 1676). Parallel to this correlation, the more keenly developed the sense of professional identity, the more positive the attitude towards IPE. Attitudes were more positive towards IPE in the later stages of the course if students were exposed to IPE early on in their program of study (Coster et al. 2008). The reverse was also found to exist: students who had not had exposure to IPE in their course had a less favourable attitude towards IPE. In fact, results suggested a correlation between lower levels of IPE contact as the course progressed and a subsequent decrease in positive attitude towards IPE (Coster et al., 2008). However, overall, the early exposure of students to IPE had little effect on the students' long-term attitudes to IPE (Coster et al., 2008, p. 1678). This study by Coster et al. (2008, p. 1679)

as with Pollard and Miers (2008) and Rosenfield, Oandasan, and Reeves (2011) studies, supports the introduction of IPE early in pre-registration courses and maintained throughout curricula, rather than only isolated instances. Likewise, regarding Pollard and Mier's (2008) study, Coster et al. (2008, p. 1679) argue that a strength was the recognition of the need to qualitatively explore attitudes to IPE and IPC.

A pre- and post-evaluation of student attitudes to IPE conducted by Wakely, Brown, and Burrows (2013) (n=38; included nurses but not midwives) using the same questionnaire as Coster's study also found that attitudes to IPE improved after IPE exposure. However, notably the timing of the evaluation was conducted with students later in their chosen course of study. The authors raise the issue that the students may have a more strongly-held view of their own professional identity than beginning students and thus their responses are different (Wakely et al., 2013, p. 425). The small sample size could be considered a limitation of this study. A later study (n=48) by Miller, Morton, Sloan, and Hashim (2013, pp. 532-533) and using the same questionnaire as the previous study, returned similar findings with regard to enhanced attitudes to IPE by both medical and nursing students at similar stages of their courses of study. A mixed methods study (n=80) by Robben et al. (2012, p. 202) of practicing health professionals, not students, in the aged care sector also found that IPE had the potential to enhance participants'/subjects' attitudes to IPE/IPC. Interestingly, they reported the usefulness of IPE in becoming more knowledgeable about the roles and skill sets of the other health care professionals (p. 200). This is a commonly reported finding in several studies including Earland, Gilchrist, McFarland, and Harrison (2011, p. 138), Wakely et al. (2013), Rosenfield et al. (2011), and Miller et al. (2013).

2.4.4 Role identity

According to Stets (2010, p. 648) a person's 'role identity' is comprised of various meanings that that person associates with themselves when carrying out or filling a particular role. As an example, the role identity of a midwife may encompass those behaviours inherent in the requirements eschewed by the

International Definition of the Midwife as " … a person who has successfully completed a midwifery education program that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery" (ICM, 2017). Thus, a midwife may describe her/his role, as someone who, in partnership with women, provides the necessary supports for women during pregnancy, labour and birth. This is just one carer facet of many that she/he is qualified to provide (ICM, 2017). It is the Scope of Practice that will direct the midwife in her/his role. However, role identity extends beyond a particular knowledge and skill set; it also includes those meanings that the midwife attributes to, and associates with, the behaviours she/he exhibits as a midwife (Stets, 2010, p. 648).

The literature suggests that a health professional's role identity can be challenged in the face of misunderstanding or ambiguity of that particular role by health professionals from diverse disciplines (Mills et al., 2010; Stets, 2010). This has the potential to affect the interprofessional workings of the team and in turn, subsequent care delivery (Mills et al., 2010, p. 590; 593). Stets (2010, p. 648) and Ibarra and Barbulescu (2010) proffer that the same person can assume more than one role, each with an associated identity. Research undertaken by Ibarra et al. (2010, pp. 136-137) using self-narratives addresses how a person may in fact change their role identity through the necessity of the workplace, in order to strengthen or more accurately reflect what the person perceives to be their role identity in that particular context.

2.4.5 Professional identity

There is a plethora of literature which seeks to define the concept of 'professional identity.' Many authors refer to the work of Ibarra (1999). Neary (2014a, n.p.), for example, provides a useful version of the definition of the concept as that "… which describes how we perceive ourselves within our occupational context and how we communicate this to others." Thus, the

question that arises from the literature in relation to this study is: how does a midwife describe who she is, what she/he does, and how does she/he exemplify this persona to the women she/he cares for in the context of where she/he practices midwifery? For the ensuing discussion, it is Neary's (2014a) view of 'professional identity' that is considered.

The literature around IPE in the practice context identifies the need to examine the professional role/identity development of the midwife related to IPE. Early research by Fagermoen (1997, pp. 434-435) provides a definition of professional identity coherent with that of Neary (2014b). Fagermoen's (1997, p. 435) two-part study (n=767 [survey] and n=6 [in-depth interviews]) using both narrative and hermeneutic analyses, found that firstly, professional identity development is strongly, if not directly, linked to the nurses' socialisation processes within the practice context and secondly, is underpinned strongly by the nurses' values and beliefs which guide their practice. That is to say, it is what the nurse believes underpinning the quality of her/his care with her/his moral principles, and this will portray who s/he is to the patient being cared for.

Two early qualitative studies by Larsson, Aldegarmann, and Aarts (2009) involving midwifery students (n=23), and Cook, Gilmer, and Bess (2003) (n=109), sought to elucidate how midwifery and nursing students respectively, formulated their identity in an effort to potentially better the student learning experience. Their findings did not exactly mirror those of studies that came later, but highlighted that nursing students did commence their course of study with an embryonic understanding of the concept of professional identity. The value of Cook et al's. (2003) study is that it recommended that longitudinal studies would further the exploration of professional identity development with the longer-term benefit of improving the health care environment (Cook et al., 2003, p. 317). This recommendation eventuated in longitudinal studies previously mentioned in the discussion on 'attitudes' and is concomitant with the expectations/outcomes of IPE.

Larsson et al.'s (2009) qualitative investigation (n=23) reported that midwives ascribed their professional role and identity to their own self-confidence and

extensive experience in the profession, and that challenges to this strong sense of professional identity and role included changing technologies in the workplace, other professionals and more knowledgeable clients. However, IPE was not a factor in this particular study.

The process of attaining self-confidence and gaining extensive experience is a facet encapsulated in a framework set out in the seminal work by Benner (1984) entitled “From novice to expert.” Her framework described five levels of proficiency to becoming an expert nurse. These are: the novice, advanced beginner, competent, proficient, and the expert (Benner, 1984, pp. 13-34). The key feature of the first level (novice) is the lack of confidence in the tasks at hand due to lack of experience, which is to be expected; the second level (advanced beginner) reveals a person with a marginally increased confidence and ability due to prior exposure to a particular situation; the third level (competent) sees a nurse with increased competence in any given situation due to the period of time spent in practice, usually two to three years; the fourth level (proficient) shows a marked increase in both abilities and perceptions of the situations encountered and what to expect, due to experience; and the fifth and final level (the expert) demonstrates a nurse with the expert ability to assess and analyse in a given situation and respond accordingly. Clearly the point is that becoming an expert nurse who possesses self-confidence and gains extensive experience, takes time. This framework can equally be applied to midwifery students.

Noteworthy, Andrew’s (2012) study into the professional identity of nurses found that identity is influenced by the relationship that the nurse has with the professional community in which she/he practices, that is, their specific Community of Practice (CoP). According to Lave and Wenger (1991, p. 35), context, and the culture of that context, can influence how its CoP members learn from each other. In other words, the culture of the context is the lens through which a midwife will perceive or derive a sense of her/his professional identity (Andrew, 2012). Andrew (2012) goes further in saying that how other CoP’s perceive a particular profession can also be an influencer for a particular member of that profession.

This notion of professional identity being influenced by other disciplines' perceptions was also evident in the research by Neary (2014b), albeit at the postgraduate level, and Yazdannik, Yekta, and Soltani (2012) plus early research into professional identity development conducted by Ohlen and Segesten (1998). Given that Neary (2014b) (n=58) and Yazdannik et al. (2012) (n=23) did not include midwifery students it might be inappropriate to attempt to generalise these findings to midwifery students; but given the close professional relationship of nurses and midwives, it might be opportune to incorporate some of the knowledge produced by Andrew (2012), Neary (2014b), and Yazdannik et al's.(2012) studies to inform midwifery practice. The common thread emerging from the literature is that of professional identity development being interdependent on the practitioners' socialisation within the practice context (Andrew, 2012; Felstead, 2013; Khalili et al., 2013; Neary, 2014b) either by observation and/or emulation of practices observed.

Interestingly, Johnson et al. (2012) found that the professional identity of nurses was shaped before they entered a professional education program. However, this underwent change as they were socialised into the culture of nursing. Midwifery students were not part of this study either. The findings of Merrick, Duffield, Baldwin and Fry's (2011) study into how general practice nurses derive (amongst other concepts) their identity, are supported by those of Andrew (2012), Johnson et al. (2012) and to a lesser extent, Larsson et al. (2009). They described the development of nurses' self-identity as a product of their work. However, professional identity per se was not discussed and this is in keeping with several of the studies reviewed thus far.

An alternate view of professional identity formation is described by Reid, Dahlgren, Petocz, and Dahlgren (2008) whose multi-disciplinary research across two continents highlighted that professional identity formation could be seen as a nexus between the learning and practice contexts with the respective communities of practice being influential in guiding professional identity formation (pp. 729, 733-734). Whilst their research was not centred on the traditional health care professional studies, nevertheless it was situated in the tertiary education sector with similar learning outcomes, that is, preparation for

the workforce, and thus may be applicable to the midwifery discipline by extension. An important aspect emanating from this study was that participants valued how theory learnt actually 'worked' in the practice context, and thus the perception of their profession heightened in their opinions, impacting positively in turn on their identity formation (Reid et al.,2008, p. 738). A crucial finding from this research was the importance of pedagogy for the various disciplines involved and thus should be considered when developing IPE activities within curricula. That is to say, how the content is taught within the different contexts should be very carefully considered.

An interesting review on the extant literature (n = 20) on professional identity formation was conducted by Trede, Macklin, and Bridges (2012) with the intent of exploring how professional identity development occurs from a theoretical and practice perspective in the tertiary education sector. Three of the articles were derived from health education journals; however, no further information was able to be gleaned as to which specific disciplines, apart from medicine, the research was conducted in. One of the goals of the review was to gain a better understanding of the key concepts of professional identity development with a view to better informing teaching and learning in the higher education setting. Unfortunately, the findings indicated little agreement amongst scholars with regard to the underpinning theories used in the teaching (Trede et al., 2012 p. 375). Of interest to the researcher are some of these findings from the perspective of what is discussed in the classroom with regard to professional identity formation. These include: self-reflection, agency, professional socialisation (both overt and covert), the work environment and the learning context (Trede et al., 2012, pp. 375-376). These concepts also mirror the findings in other research in the preceding discussion. Salient findings from this researcher's perspective and her current study, was that there was no consensus in the literature reviewed about the role of the tertiary sector in its curricula on addressing professional identity, let alone, how it develops from a student's perspective (Trede et al., 2012, p. 378). An observed strength from the review, which has implications for IPE, was the agreement "that collaborative, dialogic learning from practice enables and facilitates professional identity development" (Trede et al., 2012, pp. 378-379). The authors noted that

in the face of interprofessional education, attention should be given to addressing the issue of a “discipline versus a generic professional identity development” (Trede et al., 2012, p. 379). In the researcher’s view this has implications for midwifery and IPE, particularly with respect for the preparation of midwives for practice.

The WHO (2010) in its re-commitment to IPE stated that there are improved health outcomes where a health system is underpinned by its practitioners who have a shared understanding of each other’s skills and knowledge (p.10). Parallel to this statement is the need for health practitioners, specifically midwives in this case, to have a clear sense of their own professional identity in order to effectively exert agency in the clinical context. Trede et al. (2012, p. 382) make the case for further research into the generalisability of a ‘one-size-fits-all’ definition of professional identity development for all disciplines. As the literature thus far appears silent on the issue of professional identity development of midwives, this study will address this gap in knowledge.

2.5 Conclusion

Whilst there is a plethora of literature on the value and importance of IPE, it has become apparent that little research has been conducted in the discipline of midwifery. It is unclear why this is the case, given the practice of midwives is closely related to the practice of other health professionals, such as obstetricians. Perhaps there is a taken-for-granted attitude of this close professional relationship. Whatever the reason that IPP and IPE has little acknowledgement, perhaps it is not surprising, given the paucity of scholarship around professional identity of midwives.

How do midwives “become midwives?” And how do they develop their professional identity in the role of midwife? This thesis explores the theoretical underpinnings of this development and explicates them clearly through the use of social constructionism and narrative inquiry which guide this research. Through the identification of how this professional identity is born, nurtured and extended, the development and nesting of midwifery curricula clearly within an

IPE framework is enabled. This will also contribute to a clearer understanding of the midwives' scope of practice and their place within it. This will contribute to the existing theory surrounding IPE in general, but specifically what is known in midwifery. The following chapter discusses the theoretical framework and methodology used in this study.

CHAPTER THREE

THEORETICAL FRAMEWORK AND METHODOLOGY

As we relate together so do we construct our future.
Gergen (1999, p. vii)

3.1 Introduction

The use of qualitative research methodology and methods are well established in many of the health professions, especially nursing and midwifery. This is particularly evident as researchers strive to understand the experiences of health care clients and practitioners in order to give them meaning from an emic[4] perspective. As discussed in Chapter One, the aim of this study was to examine the impact of IPE on the professional identity of student midwives, educators (both academic and clinical), and clinicians. Thus, the theoretical framework of social constructionism and the methodology of narrative inquiry employed in this study demonstrate how professional identity is developed and maintained by student and practicing midwives.

The chapter begins with an historical overview of what Lincoln and Denzin (2003, p. 611) refer to as the 'moments' in the continuum of the qualitative research tradition. The chapter then explores social constructionism and its use as the theoretical framework underpinning this study. The methodology of narrative inquiry as described by Clandinin and Connelly (2000b) and its application to this study are also discussed.

3.2 Phases in qualitative research

Gergen and Gergen (2003b, p. 575) described the entry of diverse scholars into the qualitative tradition as the "qualitative harbour." They believe this to be the result of the better fit of qualitative inquiry to their research needs, as quantitative research methodology does not account for understanding or experience (Gergen & Gergen, 2003b, p. 3). The following discussion will provide insights into the history of qualitative research to the present day.

[4] The term 'emic' refers to the insider's or the 'native's' perspective. In other words, the researcher seeks understanding of the participant's point of view (Holloway, 2008).

Denzin and Lincoln (2011a, p. 3) have explored what they term “nine historical moments” in the evolution and practice of qualitative research. This evolution commenced in the early twentieth century and is ongoing to the present. They describe the first moment as the “traditional period” (1900 - 1950) where researchers used the positivist paradigm[5] approach to research. The second moment was termed the “modernist or golden age” (1950 - 1970) which saw a variety of new perspectives appearing in qualitative research. Such perspectives included structuralism, hermeneutics and feminism to name a few. The third moment was labelled as the “blurred genres” (1970 - 1986) and it was within this period that critical, interpretive theory developed. It was also at this intersection that qualitative researchers began to use competing theories and methods from other disciplines to address their research questions. Denzin and Lincoln (2011a, p. 3) referred to the researcher at this point in time as a bricoleur.[6]

The fourth moment known as the “crisis of representation” (1986 - 1990) saw the struggle of researchers trying to represent themselves in the research process known as ‘reflexivity.’ This period concerned itself, in research terms, with “…gender, race, class, ethnic, and Third World perspectives” (Lincoln & Denzin, 1998, p. 409). In the fifth moment known as the “post-modern period” (1990 - 1995), technology influenced and shaped how qualitative research was practiced (Lincoln & Denzin, 1998, p. 409). The “post-experimental inquiry period” (1995-2000) became known as the sixth moment which saw, amongst other developments, the rise of narrative inquiry which included the participants as co-authors in the research being undertaken. The seventh moment was referred to as the “methodologically contested period” (2000-2010) due to tensions existing within the qualitative community. This was a result of the plethora of qualitative approaches used to produce research outputs according to Denzin and Lincoln (2011b, p.3).

[5] A paradigm is a particular set of beliefs, assumptions, or world view that underlies the theories and/or methodology of a subject (Soanes & Stevenson, 2008, p. 1037).
[6] A bricoleur is a person who engages in bricolage by using a diverse range of available pieces to assemble a new creation, an ‘interpretation, or a new formation’ (Denzin & Lincoln, 2008, p. 558).

The eighth moment (2010-) represents an acknowledgement of the tensions that exist in, and emanate from, the seventh moment, labelled "the future." It is concerned with a growth in the sophistication of qualitative research methodologies and methods and competes with evidence- based research practices. This is centred on the premise that "…social sciences and humanities become sites for critical conversations about democracy, race, gender, class, nation-states, globalisation, freedom, and community" (Denzin & Lincoln, 2011a, p. 3). The authors predicted that the ninth moment, labelled "fractured future," will see "…methodologists…line up on two opposing sides of a great divide" (Lincoln & Denzin, 2008, p. 550) unless there is a change in how each view the practices of the other. There is agreement, however, on the view that qualitative researchers have the freedom to use aspects or practices of any of the eight moments. The authors believe this to be a strength of the qualitative paradigm, which affords the qualitative researcher the freedom to be non-conformist, and not beholden to any particular orthodoxy within the paradigm (Lincoln & Denzin, 2008, p. 541).

Thus, taking into account that there is by no means, a formulaic approach to qualitative research, the post-modern qualitative researcher has the opportunity to draw upon theoretical positions and methodologies from diverse disciplines, effectively becoming the bricoleur described by Denzin and Lincoln (2008, p. 558). This affords the qualitative researcher the ability to employ an eclectic approach, with an explanatory rationale, to addressing the inquiry at hand.

Notwithstanding an eclectic and justifiable approach within a particular qualitative paradigm, three philosophical principles will be instrumental in this research. These are: ontology, epistemology, and methodology (Guba & Lincoln, 1998). Ontology is concerned with the theory of existence or nature of reality (Whitehead, 2013, p. 23). Epistemology concerns itself with the philosophical or theoretical study of knowledge and the relationship between the researcher and the knowledge being studied (Denzin & Lincoln, 2011b; Whitehead, 2013). It also acknowledges the place of experience in the generation of that knowledge (Blackburn, 2005). Methodology refers to the manner in which the researcher seeks answers to the research question using a

theoretical underpinning as a guiding framework and a set of procedures to gain knowledge from the world being researched (Denzin & Lincoln, 2011b, p. 12; Flick, 2006a, p. 14). Put simply, the methodology "…refers to a model for undertaking a research process in the context of a particular paradigm." (Wahyuni, 2012, p. 70). Central to any research study is the need for compatibility between the philosophy or theory underpinning the study and its methodology (Creswell, 2013). In this study the theoretical perspective or underpinning will be that of social constructionism and the methodology, narrative inquiry. Thus, this study uses a post-modern approach which emanated from the sixth moment as described by Denzin and Lincoln (2011b). The following discussion explores social constructionism as the underpinning theoretical framework used in the study.

3.3 Social constructionism

According to Whitehead (2013, p. 27) a theoretical framework is underpinned by already known and tested theories which allows the researcher a particular manner, orientation or lens with which to examine an issue. As such, "…the focus of inquiry is determined by the framework within which one is operating and findings are interpreted and given meaning from the perspective of that preordinate theory" (Patton, 2002a, p. 131). In this study the theoretical framework of social constructionism is used as the theoretical lens or perspective with which to guide the inquiry into professional identity of midwives in IPE.

The post-modernist stance has contributed to the shaping of constructionism in that, it steers away from an ontological basis for the existence of absolute truth thus inviting the premise that any truth or aspect of existence is constructed by persons through interactions (Patton, 2002b, p. 100). The term 'radical constructionist' has been attributed to Gergen, a proponent of social constructionism, for his particular view that "…social constructionism is mute or agnostic on matters of ontology" (Schwandt, 2003, p. 306 & 310). In other words, there is not a preoccupation with the theory of existence or the nature of reality. For Gergen constructionism is a vehicle by which people through interactions, give meaning to the result of those interactions, that is, the reality

that emanates out of the interactions. This reality may change based on ongoing interactions.

According to Schwandt (1998) social constructionism is, in a sense, borne out of constructivist philosophy and credits the clear explication of this position, in part, to the work of Gergen and Gergen (1985, p. 266). Where constructivism seeks to understand how an individual constructs knowledge, constructionism is concerned with "…the world of intersubjectively shared, social constructions of meaning and knowledge" (Schwandt, 1998, p. 240). Gergen and Gergen used this term as they believe social constructionism is a better description of the world created by people through their social exchanges. The reality of that constructed world was referred to as "sui generis" meaning that it has its own reality (Schwandt, 1998, p. 240). There exist other researchers and authors of note, such as Lincoln, Lyneham and Guba (2011, p. 100), Flick (2006b, p. 78) and Patton (2002b, p. 97) who tend to use the terms 'constructivism' and 'constructionism' interchangeably. Schwandt (2007, p. 39) refers to 'constructionism' as a second strand of constructivism. However, they agree on the tenet that it is through the action of social interchanges that knowledge is constructed (Flick, 2006b, p. 80). The researcher agrees with this position and in this study, social constructionism espoused by Berger and Luckmann, and Gergen and Gergen guides the inquiry.

Social constructionism allows the researcher to "… study the world always from the perspective of the gendered, historically situated, interacting individual" (Lincoln & Denzin, 2003, p. 612), a central tenet of many qualitative methodologies. There are many proponents of social constructionism and each ascribes to certain beliefs. Thus, it is imperative that this study is consistent in its application of a particular social constructionist framework. The seminal works of Berger and Luckmann (1966), Gergen (1985) and Schwandt (2003) are ascribed to. These works strongly refer to the constructed aspect of knowledge. Berger and Luckmann believe that social constructionism is "… concerned with the nature and construction of knowledge," in particular, "…how it emerges and how it comes to have significance for society" (Berger & Luckmann, 1991, cited in Andrews 2012, p. 40). Schwandt (2003) believes that

knowledge is constructed through the interaction of individuals in any given society. Indeed, Schwandt (2003) emphasises that from a constructionist point of view, knowledge and truth are not a discovery of the mind. In fact, he believes that knowledge has a sociocultural element and thus may change based on one's experience.

Burr (2003), another proponent of social constructionism, argues that truth is not a product derived from empirical evidence; rather it is the result of the interactions of persons in society. Furthermore, Burr (2003) argues that as interactions between individuals change, there exists the possibility of more than one 'truth' and worldview (p. 5). This is also supported by Gergen and Gergen (2003a) who describe social constructionism as the vehicle which explains how people make sense of themselves and their world. In Gergen's words, "the terms in which the world is understood are social artefacts, products of historically situated interchanges among people. … the result of an active, cooperative enterprise of persons in relationship" (1985, p. 267). Schwandt (2003), Burr (2003) and Gergen's (1985) particular view of social constructionism closely mirrors that of Berger and Luckmann (1991), who are credited with the spread of social constructionist language to disciplines other than sociology according to Best (2008).

Crotty's (1998) writings on social constructionism highlight similar beliefs in that humans, in their interactions with each other, in a particular context, construct meanings of their world at that particular time. These constructed meanings or 'truths' are a combination of both the objective and subjective experience(s) of the humans engaged in the interaction(s). There is no single truth as such and continued interactions will construct new meanings and therefore, truths. However, both Crotty (1998) and Young and Collin (2004) attempt to make a distinction between constructivism and constructionism. In their view constructivism reflects how an individual makes sense of her/his world, whereas constructionism acknowledges the importance of context in shaping the view or effect of interactions that the individual has with her/his world. This reflects Gergen's view of social constructionism. Gergen's (1985) discussion clearly explicates that social constructionism is concerned with how persons in society,

through interactions with others, describe and make sense of their world, in the present as well as the past and the future. It is this position that the researcher uses in this study.

Social constructionism enables an insider's perspective on how the research participants construct their professional identity in a way that has individualised meaning drawn from contextually-based experiences or interactions. This is supported by O'Neill (2010, p. 739) who states that "… social constructionist perspective conceives that personal identity is established within the perception of self as derived from thoughtful reflection on communicative interactions between oneself and others from the societal environment." Thus, it is argued that it is an appropriate and legitimate means of explicating and understanding the creation of professional identity for the student midwives, midwifery educators and clinician participants in this study. As such, it was deemed an appropriate theoretical framework to use for the study.

3.4 Narrative methodology / inquiry

Human beings have lived out and told stories about that living for as long as we could talk. And then we have talked about the stories we tell for almost as long.
(Clandinin & Rosiek, 2007)

The tenets of social constructionism of constructed knowledge/truths, the importance of context in which these truths/knowledge occur and emanate from and, the concept of the time at which they are constructed are in keeping with the central concepts of Clandinin and Connelly's (2000b) metaphorical three-dimensional narrative inquiry methodology. These concepts relate to *situation* (the context), *interaction* (the exchanges/interactions of individuals in meaning making/knowledge/truths) and *continuity* (temporality or present, past and future). Given that a participant's story will reflect the time (continuity) and place (situation) in which it occurs or is 'told' it follows that how the participant constructs their view of their role will necessarily be influenced by where each participant works/practices and with whom they work/practice. Thus, narrative inquiry is an appropriate and legitimate means of explicating and understanding

the creation, maintenance and extension of professional identity, for the student midwives, midwifery educators and clinician participants in this study.

Narrative inquiry as a methodology emerged from social science research and is an important methodology in the health sciences. As with other types of qualitative methodologies, there are many strands to the practice of narrative inquiry (Pinnegar & Daynes, 2007) and just as many definitions of the term 'narrative' and what a narrative is (Holloway & Freshwater, 2007a). The increasing use of narrative as both a methodology and research method has been described as the 'narrative turn' (Holloway & Freshwater, 2007a; Reissman, 2008).

More than any other qualitative approach, narrative inquiry centres on participants' stories and it is the meaning of the story which is important. In other words, the narrative is the person's expression of their own experience (Holloway & Freshwater, 2007a, p. 4; Kear, 2012; Savin-Baden & Niekerk, 2007; Webster & Mertova, 2007). It is the understanding of the situation and the processes experienced by the participant that are a central focus of narrative inquiry (Holloway & Wheeler, 2010).

This study will use Clandinin and Connelly's (2000b) narrative inquiry methodology and thus subscribes to their view that the participants "lead storied lives" and recount the stories of their life. The researcher through narrative inquiry describes the stories of the participants' lives and "writes narratives of the experience" (Connelly & Clandinin, 1990, p. 2). According to Clandinin and Connelly (2000b) narrative inquiry as a methodology is a particular way of looking at the phenomenon of interest, in the case of this study, the construction of participants' professional identity and their experience of it. Their research framework is what they refer to as a "metaphorical three-dimensional narrative inquiry space", (p. 50) the elements of this being interaction, continuity and situation. This is the defining feature of their framework. Within this methodology the data collected via interviews are referred to as 'field texts' and must be located within the three-dimensional narrative inquiry space (Clandinin, 2006). What this narrative inquiry space framework means for this study is that

it will focus on the participant's social and personal aspects of her/his present, past and future professional self, acknowledging these are particular to context.

Within the paradigm of narrative inquiry lies the issue of where the researcher places herself in the research process. Given truth/knowledge is a co-construction between interacting individuals (Crotty, 1998), it follows that the researcher is part of the research process. This view is espoused by social constructionists Gergen and Gergen (2003a) in their discussion on reflexivity. They hold the view that the researcher brings to the interaction their own view of the world and as a result, an exchange with a participant will result in the participant's story being told through the knowledge held by the researcher. Thus, in narrative inquiry the researcher cannot bracket themselves out of the research (as with some other qualitative methodologies). What this means is that just as our "world" shapes us, we also shape the "world" we are researching (Clandinin, 2006, p. 47). Put simply, the narrative inquiry researcher cannot, and is not, a neutral being in the research process. This standpoint is supported by Andrews, Squire, and Tamboukou (2008) who view interactions between the researcher and participant as a key element of narrative inquiry. Indeed, by virtue of being the "researcher" one becomes part of the research process (Chase, 2005; Holloway & Freshwater, 2007a, p. 3).

3.5 Conclusion

As the intention of this study was to identify and understand the impact of IPE on professional identity, it was seen as appropriate to locate this study within the qualitative research paradigm as the field of knowledge in IPE in Australia is relatively new and emerging. Social constructionism is the theoretical framework and narrative inquiry the methodology for this study.

CHAPTER FOUR
DESIGN AND METHODS

4.1 Introduction

The previous chapter discussed the theoretical framework and methodology adopted for this study. In this chapter the research methods adopted to explicate how midwives develop their professional identity are discussed in detail. The location of the study, how participants were recruited, the narrative methods of data collection and analysis, are central to the discussion. The relevant ethical issues and how rigour was ensured are also addressed in detail. Thus, as the methodology is congruent with the theoretical framework in the previous chapter, the discussion in this chapter demonstrates the congruence of the methods employed in this study with the methodology (van Manen, 1990).

4.2 Methods

4.2.1 Selection and recruitment processes

Universities that offered IPE in health-related courses including Bachelor of Midwifery programs, and health services that practise interprofessionally in three Australian states were targeted as potential sources of participants. This was an intentional strategy offering two groups of potential participants. First would be either students of an education program with embedded interprofessional teaching and learning. Second would be midwives practising alongside other midwives or student midwives who were exposed to IPE or practising in an institution where IPE was well established.

Furthermore, participants enrolled in a Bachelor of Midwifery course normally would not have been exposed to any nursing education and/or clinical experience in nursing; thus, there is a greater possibility that these students in midwifery had not been socialised to the practices of any particular health care system. The potential is there, then, that any conscious knowledge of professional identity is not yet self-evident. The researcher was mindful of her own role as a lecturer in midwifery so as not to impact the participants' decision-

making process to participate. (This is addressed in section 4.6.4 in the discussion on reflexivity and as part of the ethical considerations of the study in section 4.7.)

Recruitment of participants who are considered to be information-rich in the phenomenon of interest is a common strategy in qualitative research and referred to as purposive sampling (Liamputtong, 2013, p. 14). This was the case for this study as the aim was to illuminate how midwives established, maintained and extended their professional identity within the context of interprofessional education and/or interprofessional practice. In the current study this occurred by focusing on recruiting midwifery students, educators and clinicians to address the research question. Quantitative researchers have levelled the accusation of qualitative research bias (Holloway, 2008, p. 33) due to the subjective nature of the recruitment of the participants and the nature of data collected. This concern has become less of an issue as increasingly discussions of reflexivity are included in qualitative studies (see section 4.6.4 with regard to this study).

The IPE champion(s) in the midwifery discipline at each university who met the criteria outlined above was contacted by the researcher as the first point of contact for recruitment purposes and the study was explained. Permission was sought to send both hard copy and electronic copy of the participant recruitment flyer (see Appendix B) outlining the study for display in the relevant midwifery education units. An electronic[7] copy was sent to the Head of Midwifery in each School responsible for midwifery education in the targeted universities requesting the participation of qualified midwife academics, clinical educators and student midwives. Permission was sought for the researcher to directly email the interested student midwives, midwife academic and clinical educator participants, once they had self-identified, to explain the study in detail prior to consideration of giving consent to participate. This strategy was deemed acceptable by the IPE champions at participating universities.

[7] IPE champions and heads of midwifery education chose electronic copy of correspondence in preference to hard copy.

Potential participants who agreed to participate returned their signed consent forms to the researcher and once this had occurred, a mutually convenient time was established for an interview to proceed with each respective participant. Prior to the commencement of the interview, the researcher once again fully explained the procedures associated with the study. This allowed potential participants the opportunity to be fully informed.

Through word-of-mouth from the Head of Midwifery in the participating universities, qualified midwives currently practising in midwifery health agencies associated with the particular university, self-identified and contacted the researcher by email and thus participated in the study. This particular strategy of snowball recruitment was invaluable for attracting participants with a very specific knowledge base pertinent to the study (i.e. interprofessional education) and who would be pivotal in answering the research question as to how midwives developed their professional identity (Hennink, Hutter, & Bailey, 2011, p. 100). Inclusion criteria for the study were that participants were either student midwives (i.e. not registered midwives as yet), or registered midwives with the Nursing and Midwifery Board of Australia (NMBA).[8] All participants were English-speaking. No exclusion criteria applied.

4.2.2 Participants

The participants were drawn from two main groups: student midwives and qualified midwives. The latter group included two sub-groups of midwives: academics and clinicians. The groups included in this study were selected because of their different locations on their career trajectories, experience and roles within the discipline. The group of student midwives was chosen because of their neophyte status and was a mix of first- through third-year students. The first sub-group, the midwifery clinicians, were both qualified and experienced which could substantially vary within the group. That is, whilst qualified, the experience varied from newly graduated to participants with many years of clinical experience. In addition to this experience, they had been exposed to, or

[8] All midwives who undertake a prescribed course of study in midwifery are required to be registered with the Nursing and Midwifery Board of Australia by law in order to practise in the discipline.

worked with, or have worked with, Bachelor of Midwifery students. The second sub-group, the midwifery educator (academic), was ideally situated in an academic setting and taught midwifery students. They had both qualifications (education) and substantial experience (practice) in the field. As part of this sub-group, the clinical educators' work is primarily based in the hospital context supervising Bachelor of Midwifery students. It was therefore anticipated that the second and third groups would reveal how they maintained and extended their professional identify and roles. Narrative inquiry as a qualitative method relies on the richness of individual participants' stories rather than the number of stories collected. In addition, it is not the intent to generalise the findings of the study (Creswell, 2013, p. 157). Hence there were fifteen participants with eight drawn from the student group and seven from the qualified midwife group. These derived rich, meaningful data. Their midwifery experience ranged from one year to over twenty years practice in hospital-based clinical settings, academia and community-based settings.

4.2.3 Location, setting and time of interviews

As all participants were recruited from interstate universities and health agencies, interviews were conducted by telephone at the researcher's expense. Participants chose a convenient time to minimise distractions. The duration of interviews was one to one and a half hours each. Each interview was digitally recorded with prior written consent of the participant.

4.3 Data collection

4.3.1 Interviews

Sampling took a purposeful approach with the aim of attracting information-rich participants. This involved the inclusion of participants who were deemed to be knowledgeable in the topic being researched and allowed the researcher access to participants who may not have been otherwise available to the researcher (Creswell, 2013; Holloway & Wheeler, 2010). The data was gathered using in-depth interviews (Kvale & Brinkmann, 2009) which is a strategy of collecting data through conversation that has a specific purpose in mind.

It was expected that each participant would engage in three interviews. The first for them to share their stories, the second to probe and elaborate those stories, and the third for member checking (Holloway & Freshwater, 2007a) for trustworthiness and authenticity. Member checking refers to the strategy of returning to the participants with a transcript of their previous interviews in order to find out whether their story has been captured in the way the participant intended (Holloway & Freshwater, 2007a), and is considered to be a critical strategy in establishing credibility of a study (Denzin & Lincoln, 2011a, pp. 120-123). That is, the researcher presented the participants' experiences and their meanings as shared by the participants themselves. It is these transcripts of the interviews which became the participants' narratives or stories. The use of an audit trail and reflexive thought are procedures that ensured trustworthiness and authenticity (Reeves et al., 2012) and achieved rigour for the study.

Whilst the use of interviews is a common strategy for data collection in qualitative research, it is worthy to consider Kvale et al.'s (2009) notion that a "power asymmetry" exists between the researcher and participant. That is to say, an interview is not merely a conversation between two persons of equal standing, but a professional one with a specific purpose in mind. This is echoed by Creswell (2009) who cautions the researcher to consider the interview very carefully in order to be fully cognizant of the potential effects on the participant.

Prior to commencing the interview, each participant was asked for verbal consent to confirm their previously provided written consent in order to ensure that they fully understood what the interview entailed. Following this, each participant was asked: "Would you start by telling me your story of how you came to be a student midwife / midwifery educator / midwife?" At particular points during the course of the interview, certain probing questions were asked for the purpose of clarification or to expand upon what they were saying. Examples were: How have you participated in education / practice in an interprofessional way? What is your view of IPE? How has IPE impacted your view of professional identity? (see Appendix C). All participants were agreeable to be contacted for any further clarification should the need arise after the final

interview. This was not necessary for any of the participants as the process of three interviews permitted the establishment of rapport and clarity.

An additional strategy of data collection was the recording of memos during the interviews. This served a two-fold purpose: first, it enabled the interview to proceed without interruption when statements or issues of interest arose during the interview; second, it allowed further exploration of the particular issues at an appropriate time in the interview process or at the completion of the interview and was of assistance with data analysis.

4.3.2 Transcripts

Each interview was digitally recorded and then transcribed. In narrative methodology, transcripts are known as field texts (Clandinin, 2006). Interviews ranged between one and one and a half hours' duration. However, during the process of setting up of the agreed upon time for each interview, several episodes of electronic (email) and verbal correspondence (telephone) occurred between the researcher and participants. This enabled a rapport to develop before the interviews took place and thus enabled 'ease' of conversation during the interviews. Indeed, developing rapport with the study participants is viewed favourably in the research literature and refers to the building of mutual trust between the researcher and the study participants (Hennink et al., 2011, p. 92).

The field texts were transcribed by a transcribing service as soon as practicable following each interview, then read and re-read, which allowed the researcher to become fully immersed in the data. They were then converted into a narrative before the second interview with participants. The field texts of the second interview with participants were also transcribed, read and re-read and then converted into a final narrative for each participant, prior to being sent to the participants in preparation for the third interview. In total there were fifty hours of interviews recorded, transcribed and narrated into fifteen stories.

4.4 Data analysis and interpretations

There are many differing sets of guidelines for analysing qualitative data. Thematic analysis is described as "… the simplest form of analysis and hence its common use in health care research" (Pope & Mays, 2008, p. 184). According to the authors (Pope et al., 2008), data are grouped into themes and described as they appear. These themes are derived inductively from the data according to Creswell (2013) and Pope et al. (2008) and they are not predetermined (Ezzy, 2002). Put simply, thematic analysis is the culmination of the content analysis of the data by virtue of information appearing recurrently and, by deep interrogation of the data, the researcher is able to derive rich, in-depth understandings of these emergent themes emanating from the participants' experience (Green & Thorogood, 2004).

As this study examined the individual stories for revelations into the meanings drawn by each participant, thematic analysis (Gibbs, 2007; Liamputtong, 2013; Pope et al., 2008) was used for individual stories before applying narrative analysis across all stories (i.e. before examining the commonalities and differences of meanings drawn across all of the participants). Accordingly, data were grouped into themes and described as they appeared. This enabled the researcher to make sense of the stories as told by the participants themselves.

During the process of thematic analysis, as described by Liamputtong (2013), the researcher returned to the recorded interviews to verify what was written and, in repeated instances, to re-listen to the nuances that participants injected into their respective interviews. The pragmatics of thematic analysis of each field text involved the development of codes emanating directly from the participants' words. These were written in the right margin of the field text and later grouped together by identifying similarities and differences.

Following the thematic analysis of individual stories, an "across-participants" analysis was undertaken, congruent with Clandinin et al.'s (2000b) narrative inquiry approach. This focused on the interaction (the dialogue), continuity (the time in which it is occurring), and situation (the context) elements of the

narratives. The “across-participants” analysis was done as follows: each participant’s transcript (story) was read several times over a period of time in order to really grasp what was being conveyed; any probing questions or comments by the researcher were removed as were any words that seemingly detracted from the key concept(s) being relayed by the participant; a re-reading of the remaining text was done to ensure that it made sense; and the preceding steps were repeated three to four times to ensure key elements remained.

What followed was the identification of the constituent themes from the transcripts, that is, expressions that related to what Clandinin et al. (2000) refer to as “narrative coding” of the field texts (interview transcripts). This takes into account where participants placed themselves at particular events described during the interview (spatial), other significant characters appearing in the field texts (relational) and changing situations (temporality) that manifested in the field texts. Once these constituent themes were identified from each participant’s story, they were then grouped together to form one coherent story with emergent theoretical underpinnings.

At this point the story was returned to each participant for verification that it was, in fact, how they chose to share their story. The participant had the choice to delete, modify or add, as they remained the owners of their story. This thorough scrutiny of each participant’s story served to identify commonalities across all of the stories which led the researcher to construct all of the constituent themes as one story and make sense of it (Roberts & Taylor, 2002b, pp. 435-436). Also taken into consideration were the emergence of tensions and silences in the field texts (Clandinin et al., 2000b; Kear, 2012). Thus, thematic analysis was used for individual stories before narrative analysis was applied across all stories.

4.5 Rigour of the study

Particular to any qualitative research is the demonstration of its worth, methodological adherence to accepted processes in producing the study findings and how well these represent the views of the study participants. In

other words, how trustworthiness or authenticity is achieved. The term 'rigour' is concerned with the quality of the study and is used interchangeably with the term trustworthiness according to Liamputtong (2013). In quantitative research, there exist long-established procedures to demonstrate the validity and reliability of such research (Creswell, 2013, pp. 244-245). This is not the case with qualitative research and the literature abounds with discussions on the ongoing conundrum of rigour in qualitative research with regard to strategies, terminology, and in fact, whether to even attempt to reproduce the equivalence of the quantitative elements of validity and reliability to qualitative research (Creswell, 2013, p. 245). However, there remains little consensus on how to achieve this and thus it is up to the individual researcher to make explicit how rigour is demonstrated in their individual study (Padgett, 2012b, p. 217).

According to Liamputtong (2013), Guba et al. (1998) formulated criteria for qualitative researchers to use to demonstrate the trustworthiness of their research. This was extended and the term 'authenticity' was added to further enhance rigour by fairness in reporting of the participants' views (Holloway, 2008, p. 238; Schwandt, 2007, p. 299). Trustworthiness can be demonstrated by using Guba and Lincoln's elements of credibility, transferability, dependability, and confirmability (Creswell, 2013, p. 246). Given the evolving nature of qualitative research, Creswell (2013, p. 250) argues that the terms 'trustworthiness' and 'authenticity' are historical and thus calls for the use of 'validation strategies,' a term referring to strategies used for documenting the accuracy of the study. He advocates that at least two strategies should be used (Creswell, 2013, p. 253). However, this terminology does not sit well with the researcher as it has positivist undertones, albeit slight, and thus the term 'trustworthiness' is preferred.

It is incumbent on the researcher to ensure that "strategies for rigor, *trustworthiness* (emphasis mine) are pursued during the study" (Padgett, 2012b, p. 204). Additionally, these strategies must be congruent with the epistemology underpinning the study (Liamputtong, 2013, p. 24). As this study has a social constructionist approach as its theoretical framework, then strategies compatible with this approach must be used to ensure trustworthiness. Thus,

the criteria of credibility, confirmability, verisimilitude and reflexivity were adopted to ensure trustworthiness and authenticity within the social constructionist approach. The following discussion addresses each of the criteria above with particular emphasis on the application and techniques used in this study.

4.5.1 Credibility

This concept refers to how well the researcher has represented the participants' social reality (Holloway & Wheeler, 2010, p. 303). In other words, the participants are able to recognise their 'story' as told to the researcher. Padgett (2012b, pp. 203-205) discusses techniques used to assess credibility and include prolonged engagement, various types of triangulation, peer debriefing and support, member-checking, negative case analysis, and auditing. In this study member-checking the participants' stories/narratives and a modified version of peer debriefing and support were used to ensure credibility was achieved.

The technique of member-checking requires the researcher to return their study findings (stories/narratives) to the respective participants so that they can verify the findings as being an accurate account of what they discussed with the researcher during their interviews (Creswell, 2013, p. 252; Holloway & Wheeler, 2010, p. 305; Padgett, 2012b, p. 212). As this is a narrative inquiry study, data were collected over two and sometimes three interviews. In keeping with the methodological processes for this type of inquiry, participants' stories (obtained through the interviews) were 'restoried' into a chronological narrative. These became the findings. As such, each was returned to the respective participants for verification that what was presented to them by the researcher was, in fact, a true representation of their story. Each participant was free to add, delete, or change any aspect of their story as they felt necessary.

In this study, two participants amended their respective story: the first chose to remove a section of her story as, after having re-read and reflected on her story, she felt that it would sit more comfortably with her if a particular section was withdrawn from the narrative. The second participant chose to change a

particular year that was mentioned in the story to an overall decade in order that her position in the education system would not be identifiable by time. No other aspect of her story was changed. Whilst these two participants changed an aspect of their story, both these participants and the remaining participants validated their respective stories through the technique of member-checking. All provided a written statement that their respective story was an accurate representation of their reality with regard to IPE and the development of their professional identity. This demonstrates that the criterion of credibility was fulfilled.

The strategy of peer debriefing and support is described as being a mechanism for ensuring that researcher bias is minimised and to keep the researcher honest (Padgett, 2012b, p. 211). Furthermore, it is also a useful strategy to assist with any concerns the researcher may have with regard to the findings or ideas related to them (Holloway & Wheeler, 2010, p. 308). During the conduct of this study the researcher met regularly with co-researchers (supervisors) who provided valuable feedback and critiques on all aspects related to the study with particular emphasis on data analysis and the appropriate use of narrative methods described in section 4.5. The researcher presented the early findings of the study at an international IPE conference which provided valuable critique of the methods and methodology adopted for the study by peers who were able to identify and discuss parallels with their own research. This particular strategy also contributed to the criterion of credibility.

4.5.2 Confirmability

The criterion of confirmability requires study findings directly emanate from the data and are not as a result of the researcher's perceptions or prior assumptions (Holloway & Wheeler, 2010, p. 303; Schwandt, 2007, p. 299). The use of an audit trail as a strategy lays bare the researcher's thought processes and decision-making throughout the data collection and analysis phase(s). There must be justification for the methodology adopted by the researcher and thorough descriptions of all research processes throughout the study (Holloway & Wheeler, 2010, p. 310; Schwandt, 2007, p. 299). According to Schwandt (2007, p. 299) and Holloway and Wheeler (2010, p. 310), using this audit trail

ensures that the criterion of confirmability has been addressed thus contributing to rigour of the study (Padgett, 2012b).

In this study the methodology used is described in detail in Chapter Three and the methods used are described in Sections 4.2 to 4.5. of this chapter. Furthermore, the raw data is available for scrutiny by the supervisors as are all the coded transcripts of data analysis which detail how themes were arrived at. Section 4.6.4 discusses reflexivity and the role of the researcher in the study. These contribute to achieving the criterion of confirmability.

4.5.3 Verisimilitude

As a criterion with which to judge narrative inquiry, the term verisimilitude refers to the researcher's ability to present the participants' narratives as life-like, coherent and plausible (Ellingson, 2011, p. 599; Schwandt, 2007, p. 313). Schwandt (2007, p. 313) also posits that for verisimilitude to be fulfilled, the study must adhere to accepted standards of methodological processes. According to Creswell (2013, p. 219) the reader should be able to place her/himself within the story being told. Furthermore, the inclusion of discussion on reflexivity by the researcher should make clear that the stories presented are those of the participants without being overshadowed by the researcher's position in the process of restorying. The criterion of verisimilitude has been met through the following actions: the methodological processes used in this study are made explicit earlier in this chapter and have been strictly adhered to; and, the narratives have been presented as they were intended by the participants and verified by them. In fact, many participants commented on how real their story appeared and how it took them back to the experiences they described; and a discussion on reflexivity and its implications for this study follows. Furthermore, delegates at the conference at which the early findings of this study were presented commented on similarities between their own research and this study.

4.5.4 Reflexivity

Much has been written in the literature about the concept of reflexivity. Whilst there are some disagreements about the effect of the role of the researcher in

the study and thus the 'truth' about the findings, there is consensus on many levels as to the responsibility of the researcher to declare their own position in the research.

A simple definition of reflexivity is that described by Gibbs (2007, p. 91) who states that "… reflexivity is the recognition that the product of research inevitably reflects some of the background, milieu and predilections of the researcher." In the methodological sense, reflexivity is given to understand the self-critique of the researcher with regard to their role as the instrument in the collection, analysis and reporting of the findings of the study (Schwandt, 2007, p. 260). This approach is in keeping with the tenets of social constructionism, and the methodology underpinning this study. Additionally, it is congruent with the cautions issued by Lincoln et al. (2011, p. 115) who acknowledge that the researcher also impacts on the research. Therefore, the researcher needs to consider their position in the collection of the data.

Hennink et al. (2011, p. 19) argue that as the nature of interpretive research includes the notion of subjectivity, it is important to acknowledge one's position with regards to data collection and analysis by way of disclosure using the strategy of reflexive thought or discussion. This view is advanced by Creswell (2013, p. 47) who offers suggestions as to how the researcher should make explicit where she sits in the study, disclosing her position and why she is interested in the topic. He claims this extends beyond verbalizing these aspects and so must be written up in the study, for example, how the researcher's background informs the data collection, interpretation and discussion. This is also echoed by Grbich (2013, p. 11) who offers a framework with which to do this.

Both Holloway and Wheeler (2010, p. 311) and Liamputtong (2013) contend that as the researcher is the main tool for data collection, and therefore part of what is being described, then by adopting "a self-critical stance, the study will become more credible and dependable".(Holloway and Wheeler, 2010, 311) This, they argue, enhances the quality of the research output.

Throughout the course of data collection, analysis and discussion of the findings, the researcher was aware of her own views with regard to both interprofessional education (IPE), and midwifery education and practice. The researcher brought to the research process forty years of midwifery knowledge and experience, fourteen of those years as a midwifery academic, and at least four years' intimate knowledge of IPE. It was this prior knowledge that prompted the current study into IPE and professional identity development.

In the course of data collection, the researcher's views of IPE were, at times, challenged by several of the participants. This related to their description of what they understood to be IPE and by their questioning as to what the researcher's own views were. Through careful use of language and negotiation the researcher was able to not influence the story being told. Given that data collection was over at least two interviews for each of the participants, what was not able to be avoided was the possibility that participants reviewed their knowledge of IPE between interview appointments. However, memos were written as part of the interview process for each participant and their interviews and these later reviewed following the transcription phase and the analysis of the narratives. In several cases where there seemed to be a discrepancy between the first and second interview related to questioning the researcher by participants, the researcher asked for further elaboration.

On several occasions participants asked the researcher questions such as 'is this right?' and 'is this what you want to know'? By careful reflection on how the researcher may have posed the question, subsequent probing questions were more open-ended. The transcripts of these interviews were carefully scrutinised to ensure researcher bias was not part of the analysis.

Discussions with the researchers' supervisors surrounding the findings and the emerging analysis enabled the researcher to become more reflexive in that, whilst data supported what was already known about IPE and professional identity, the data were not overlooked simply because it was known. It was the participants' construction of their identity and as consumers of IPE which was the focus of the study, rather than trying to elucidate what was not the same, or

even, present. Thus, the researcher had to re-examine her own views of IPE, professional identity and refocus on the content of the narratives.

Taking the concerns expressed above, the researcher used reflexivity throughout the study to make explicit her own role in the study and acknowledged that she is subject to the same critique of self as all other aspects of the study.

4.6 Ethical issues and considerations

This qualitative study was granted approval by the Victoria University Human Research Ethics Committee (Application ID HRE14-115) (HRE). Gaining access to the health and educational institutions from which the participants were drawn was accomplished by the sighting of the Victoria University HRE (VU HRE) by the respective institutions. The VU HRE was provided to the IPE champions prior to the commencement of the recruitment process.

Two of the basic principles of ethical practice with regard to research are firstly, to do good, and secondly, to do no harm during the conduct of the research (Woods & Schneider, 2013). Thus, all aspects of the study were planned in accordance to the National Statement on Ethical Conduct in Human Research (Australian Government, 2007) and the Victoria University Application for Ethical Review of Research Involving Human Participants (Victoria University, 2012) with built-in strategies should dilemmas arise.

As this study involved human participants there was the potential for ethical issues to arise. The potential concerns for participants related to the nature of the study, their privacy, confidentiality and anonymity, and the examination of their work or health care practices. Thus, there needed to be respectful and courteous consideration given with regard to how they were treated as research participants (Macrina, 2005). As discussed in section 4.2.1, this study used a purposive approach and snowball sampling. Participants self-selected which eliminated the possibility of undue pressure being felt by the prospective participants (Holloway & Wheeler, 2010).

In this study there was also the potential for conflict to arise with the different and overlapping scopes of practices of health practitioners involved in interprofessional education. This is supported by Milton (2012) who argues that without respect and dignity (for each individual), then the potential exists for an imbalance of power between health care professionals. This potential situation had the capacity to influence some of the prospective participants (midwife clinicians and educators) who work predominantly within an eclectic style of leadership. Other participants (student midwives) could feel threatened by the other disciplines' manner of working. Thus, it was necessary to carefully plan the research study. These risks were managed by taking a non-judgemental view of the participants' perceptions, and honouring their viewpoints through respect, valuing, and dignity and ensuring privacy at all times.

Essential to this study was the establishment of a trusting rapport/relationship with the participants. This related to the ethical issue of informed consent and right to withdraw from the study, privacy, and confidentiality (Oliver, 2010) and the role of the researcher in the research process. (The relationship developed between the researcher and the participants is presented earlier in this chapter in section 4.2.1.)

4.6.1 Informed consent and withdrawal from the study

The concept of informed consent is underwritten by two crucial premises: that a participant has the undeniable right to know what the research is about and any potential consequences to them should they participate, and that any decision to participate is done so voluntarily (Christians, 2011, p. 65). Furthermore, participants should be made aware of how long their participation will be required (Tappen, 2011, p. 179). Participants must also have been afforded the opportunity to ask questions of the researcher before any decision is taken to participate and that they are free to exercise the right to withdraw from the study at any point in the study without repercussions (Munhall, 2012, p. 496)

In this study prior to any request being asked of potential participants to agreeing to take part in the study, they were provided with a written, plain language information sheet (see Appendix D – *Information to participants*

involved in research) which provided the information discussed above. Prospective participants had the opportunity to ask questions about the study before deciding to take part. It was also explained verbally that three interviews would be required and the approximate length of the interviews was also pointed out. They were free to refuse without the need to provide an explanation to the researcher. Furthermore, they could withdraw from the study at any point without prejudice. In fact, each participant was asked at the beginning of each interview if they still wished to continue with the study. This ensured that all participants continued to participate voluntarily and without coercion. None of the fifteen participants withdrew from the study.

4.6.2 Confidentiality and privacy

In the context of research, privacy and confidentiality refers to the requirement that information disclosed by participants to a researcher must not be disclosed to a third party nor should participants be able to be identified through the research data (Streubert & Carpenter, 2011, p. 63). The term anonymity in the context of a research study refers to the ability of participants not being known to any person including the researcher (Woods & Schneider, 2013, p. 86). In qualitative research that involves interviewing participants by the researcher this is not possible to the full extent that is possible in quantitative research. This is especially the case when using repeated interviews as a data collection method which requires the researcher to have a certain level of rapport with the participants (Padgett, 2012a, p. 85). However, assuring anonymity from third parties is possible by the use of pseudonyms in place of participant names and therefore required (Christians, 2011; Woods & Schneider, 2013).

The following describes the manner in which privacy and confidentiality were addressed in this study. Documents containing personal details were stored separately and in a locked filing cabinet as required by the institution granting ethics approval and only available to the researcher and the study supervisors. Prospective participants were informed that the interview transcripts would be coded and allocated pseudonyms to which each participant was privy to their own. In addition, pseudonyms were given to participants' places of education

and employment. Interview transcripts labelled with participant pseudonyms were kept separate from those that contained personal information.

Prospective participants were also informed that the information derived from the interviews would only be accessible to the researcher's supervisors and the researcher. In addition to this it was explained to the prospective participants that the computer files of the transcripts would be password protected, the interview recordings and the transcripts of the data would be kept separate in a secure location, and that the final report of the study would not contain any identifying information about the participants or their place of study or employment.

Only when these issues were discussed with the prospective participants were they asked to sign a consent form if they agreed to participate in the study (see Appendix E – *Consent form for participants involved in research*). Thus, the issue of informed consent, privacy, and confidentiality was able to be assured. This then speaks to the fairness of the strategies and procedures used in the study as well as the treatment of the participants (Roberts & Taylor, 2002a, pp. 99-108).

4.6.3 The researcher and the participants / co-researchers

The role of the researcher has been addressed in depth in the discussion on reflexivity in section 4.5.4. However, there were other potential tensions that could have arisen in the course of the study that required acknowledgment. These related to the following: the researcher's role as a midwife and the researcher's role as an academic with knowledge and teaching experience in IPE.

In the very early phase of data collection, the researcher was concerned that even though participants self-identified, they might have a reluctance to be open about their experiences once they were aware that the researcher was a midwife and an academic, especially those participants who were students. However, this was not the case apart from the issue of participant questioning of the researcher as discussed in section 4.5.4 on reflexivity.

A challenge for the researcher was the need to refrain from offering clarification for terms and expressions used by participants with regards to IPE. This was achieved by re-focusing on the intent of the research, that is, the participants' respective stories. Some participants wanted to know how their course compared to the researcher's. This needed careful consideration and 'thinking on the spot' so as not to introduce content and experiences that might impact how the participant relayed their story.

The converse of the concern regarding the researcher's perceived reluctance (on the part of the participants) to be open about their story was that related to participants who were involved in education and supervision of student midwives. There was initial concern that there would be an expectation from these participants that the researcher would not need the 'full story' as the researcher would be 'au fait' with the topic at hand. Comments such as 'you would know all about this and so I won't go on' required careful consideration and then asking for their elaboration of the particular issue. For the majority of participant interviews this concern turned out to be an unfounded fear due to the generosity of full disclosure by all participants.

4.7 Conclusion

The methods used in this study have been presented in this chapter. The discussion includes: how participants were recruited and how the data were collected through multiple interviews and the development of the field texts into narratives. The two levels of analysis congruent with narrative inquiry used in the study (i.e. thematic analysis and "across-participants" analysis), in keeping with Clandinin et al.'s (2000b) narrative inquiry approach, are also discussed. Finally, how rigour was addressed and ethical considerations as they relate to the study are also included. The next chapter provides the reader with the opportunity to personally experience participants' stories.

CHAPTER FIVE
THE PARTICIPANTS' STORIES

5.1 Introduction

This chapter presents the participants' stories as told to the researcher by the participants in their own words, over the course of two interviews. There are eight stories/participants in total: Derya, Georgina, Holly, Lorraine, Penny, Sonya, Thalia, and Valerie. The remaining stories are included in the appendices, as the word limitation of this thesis prohibits their inclusion. These stories belong to: Fanita, Jayne, Jenny, Jordan, Lina, Phoebe, and Alicia. Those stories included here are thought to be representational of student midwives and registered midwives, both from the clinical environment and the tertiary education sector.

Each interview commenced with the researcher introducing herself, reiterating the process involved in the forthcoming interview and asking whether participants had any questions or concerns. Acknowledgment of their previously obtained written, informed consent was reinforced to ensure they truly understood the process. No participant withdrew from the study.

5.1.1 Derya's story

I am a midwife. I started studying in 2009 and graduated in 2011 and I experienced interprofessional education. I have not supervised students in my current role because I'm doing community midwifery and there is no opportunity. Birthing stopped in our rural town hospital a few years ago; they provide a home service and a community midwifery role. When I was doing my grad program in 2012 and working down in Hospital X in the south of the state, I had students under me, but I only graduated in 2011. There were also medical students doing that rural training program. But in my current role I don't [have any students].

I started [midwifery] in my old age. I was forty-four when I went to uni. I reached that point in my life because I'd had children young and bringing children up kept me busy. What motivated me [was] I suppose I started to see

a difference, there seemed to be a lot of women [who] were having babies and a lot [of] intervention and I thought, what's going on? I've always had that interest in mother/child sort of thing. I have worked in admin roles in schools because they were school hours and I had children, but I've also run a home day care and worked in day care and started off, back in 1984 [in] mothercraft nursing. So, I've always had that interest in the importance of nurturing mothers, you know, strong mothers, strong families, and I just reached that point in my life where I really reassessed and thought, if I don't start doing it now, it's going to be too late.

I live in a rural town three hours south of our capital city. Town A is two hours south of us; I went down there to see if I could do my nursing and study midwifery the long way, and that's when they told me that there was this direct entry course that had just started in our state. Our group was the second intake. So, I started studying health science externally online and picked units like human biology that would also be generic across the midwifery degree to see if I could cope with tertiary study. I managed that and then I applied for the midwifery degree. In the end I thought I would just go to our capital city and commute and live up there, and I applied to do both nursing at University Y and the direct entry course at University X. I didn't know what my chances were getting into the direct entry course, because they only took twenty students at that time.

In the end I thought I'd have more support if I went to our capital city because I had more family up there and I applied for and I got into the University X one. I chose that [one], which probably made me a really awkward case because you don't have direct entry people working rurally. They like you to be dual degree, Registered Nurse and a Registered Midwife, so that they can use you in quiet times on the general ward because it crosses over, but it worked in Town A because it's a very busy maternity ward. So that worked, and I was allowed to practise, when it's quiet on the ward you would get a general patient, it might be postoperative, and I was allowed to care for them within my scope of practice considering what I had learnt in my degree as long as that other person on was an RN. They're all nurses or nurses and midwives so it made me an awkward case but I am so glad that I did do that course. I found it to be a very holistic course. I got accepted and did it and I just love it.

I've done it in my old age. We had three whole years of midwifery but there were also the relevant nursing components in there. I think we were exposed to lots of different models of care compared to when you do a postgraduate [course] and you're assigned to one hospital. Whereas we were assigned to homebirths, Family Birth Centre as well as LMH doing the high needs and then a hospital that might have been closer to where we were living. We also had the follow through journeys of thirty women through their pregnancy journey. So, you were going along to antenatal appointments and the postnatal appointments and to where they were birthing, so that might have been another hospital again. So as much as it was probably a lot to take in, you also saw how a lot of different midwives practised. I liked the course [being] holistic in that we did the Aboriginal health and the multicultural units, and as I was saying [that] we were exposed to a lot of different models of midwifery care.

I feel passionate about supporting mothers and the woman-to-woman continuum; I suppose [that] sounds a bit clichéd. I know how hard it was for me, too, mothers being mothers, I suppose. It's a society, you know, looking after our community, continuity of care, that sort of thing.

I had done it [the course] in my old age realising how I appreciated that link with woman to woman to get that support through those early transitional periods to motherhood but also through your pregnancy. Having that connection and maybe I'm thinking as an older woman I realise that worth.

There were twenty-four that actually started, they normally only take twenty, in the end seven only finished, some ended up falling behind in the group. We weren't allowed to go part-time, but in the end, they did let some go part-time. I think following behind there might have been two or three others of us, but seven finished within that three-year degree.

I think there was a big dropout at the beginning; maybe four of five didn't pass the science, the human biology. One person shifted interstate, others found it very hard to do the follow-throughs because following through the woman, you'd get up in the middle of the night to birth and juggling things like that and because there was a percentage of us mature age [students] that had families too they found it hard to juggle.

[How I participated in an interprofessional way in education in the B.Mid] we had social perspectives on health, learning about multiculturalism. My University was big on Indigenous studies, and so we also had a unit [on] Indigenous culture. We also did behavioural sciences. I found it really good, I know that some of the women were disgruntled at the course. They couldn't see the relevance in the Aboriginal health and the multicultural studies. I think they got frustrated and just wanted to learn about midwifery. For some it was hard to see the relevance that it all comes together because women are complex. Some were also a little bit disgruntled because it was quite heavy doing the follow-throughs, which, really was the best part of the course, though, the following-through of the women; we had to follow quite a few. It was a big commitment, but I found that that was probably the most in touch you are with women and the most that you can bring back to the course to say "well this is what actually women are looking for." So, they have dropped the numbers down, maybe thirty was a lot to follow through. I think it's down to twenty now.

There's so much more involved than just having a baby. So, I really enjoyed all those things especially learning the social cultural things. behavioural sciences weren't really in depth but it still gave us a bit of a background. The experience of learning with other students from other disciplines; the Registered Nurses were in some of them because we broke off into little groups when we were doing bioscience, [but] most of those units it was just our group. There was probably only one time, it wasn't very common, I think that we did an assignment together with the RNs.

There were also the research units. I didn't enjoy these; however, I enjoy reading research now and I'm glad that I did do those research units because it makes me understand when I am reading research papers, but I didn't enjoy [it] at the time. I'm grateful for the little bit of knowledge I've got of how it all comes together because otherwise you wouldn't understand.

I suppose the thing is, did they enhance it because they come from different perspectives than what we were coming from, and I suppose because midwifery was very fluid and it's more, ~~not~~ spiritual, thinking a little bit more along the emotional lines and maybe those other disciplines were a bit more black and white to me. I mean by fluid [that] it's not a static line I suppose. If you're a dietician, everybody needs similar treatment. It's dynamic and it is

spiritual for some women, some women need a lot more social support than the obstetrics support if that makes sense. I think it's a very intimate time too, that you're in somebody's life so that can involve a lot of emotions with different things for them to be happy or angry. So, it's dynamic.

Professional identity means how I feel or how I deliver my care to women, I suppose what you expect of someone, what I should be providing. What I would expect to be doing as a midwife, making sure they come through the experience healthy and safe. I think antenatal care is the major, really important issue, the physical health I suppose, and concerns with mental health because that's actually a big area of midwifery and mothering too, making sure they're interlinked with those sort of services, if they need that, if you've got good counselling skills, but I always thought that sort of goes hand in hand with midwifery and also public health promotion, keeping yourself healthy. Antenatal [care] is important across the board, it's the major aspect of care provided for the community; I think there needs to be a lot more importance placed on it because a lot of the baby's life-long health issues can occur if the mothers haven't had antenatal care. Accessing disciplines like physiotherapy and keeping in tune with integrating other health services that support the woman's physical health is part of good antenatal care. Alongside things like physiotherapy, I suppose you have to keep in tune a little bit with integration with physical things too.

My view of interprofessional education, [I think] it's important. In my role that I do, particularly at the moment, accessing and linking into other professionals' resources is invaluable. I work with Aboriginal health and I've taken on a new role with community midwifery with the rest of the population, there are a lot of social issues between the indigenous population and the huge migrant population.

So, I think that interprofessional education is really important. I've gone off and done a couple of courses within my role now on Foetal Alcohol Spectrum Disorder and then I'm going to do another one about counselling and cultural diversity. So, there's a lot of input from professional people that you've got to link in with because of the clientele in my town, but I don't think it's unique to my town. I think it's really important that we have those links because you need to be able to link into the expertise of somebody that's focusing more on a

particular area. You can't know everything. I think that it's really good, especially in the role that I am [in], that I have these interprofessional links. I think it's essential because it gives holistic health care for each woman. Some women don't need [as] much, as complex, but one or two of them might need the dieticians or the physiotherapy, different counselling. I often need social worker intervention, need referrals to social workers.

Then at the end of the day how important the education is in relation to how you work as a midwife, when we worked with other disciplines out there, I think it is important, because the more I'm in these two roles the more important implementing it is. Just yesterday I had to do another referral and talk to X Organisation who is the drug and alcohol [organisation], I've had to talk with the social workers, [the] dieticians come into play and the physiotherapist too. It's good to know because I know that the woman needs a bit of support within another disciplinary area. For example, the physiotherapist can tell me how a support brace actually works with supporting the ligaments and goes into more detail. I can then explain to the woman. So, I'm learning a lot from them. So, does interprofessional education when you're learning at uni help? I strongly feel that it helps so that you'd know who to link into when you are practising, and what support and advice you can get from them. That was the other thing, the very experienced midwife that I'm working with, while the physiotherapist happens to be there, she had another question. So, I think it is important to have that education together so you can relate it to your practice later because you're more aware of where your role and their roles start, where your role finishes and their role starts. Or where you can access that extra [help], because you just can't keep everything in your head, you just can't have all that knowledge. You have to have that professional that deals with that specific area and with midwifery, there's so much of the social side you're dealing with more so, as well as the physiological but then you get the physiotherapist who can really nut down [sic] to those muscles and those ligaments and the pain that the woman's having, I can only suggest a few ideas, it's good to be able to go to her to get that confirmation you're on the right track. I think that's practising safely too.

[Interprofessional education or collaboration] has impacted on my own [professional identity]; I suppose it makes you think a little bit more broadly, it makes you think outside of your own scope, your own training, your own view, I suppose. I think that it brings another perspective, especially probably their experiences that they might have in the other disciplines, the things that they might see and have seen that have worked that you don't see all the time. I think [that] how has it affected my view of my identity; it makes you realise how little you know probably. I think it makes you realise how much you all have to interlink, and I suppose that it probably does make you think a little bit more broadly about things other than just thinking of a woman having a baby, all the complexities that are involved. Other disciplines I have collaborated with in my time as a midwife are the physiotherapist, the dietician, social worker, [and] child protection department involvement. There's X Organisation in town and a few other different organisations. There's also something called Y Organisation in town, I don't know if that's an Australia-wide thing but it's more or less for social support. I've been in touch with them and they might run a family group, like a playgroup down in smaller communities too. So may-be at-risk women attending who might have drug and alcohol problems or depression. They're a big force in the town, they do some good things. Being in touch with GPs of course is part of the same thing I suppose. This is my fourth year as a midwife as such because I did my graduate year in 2012. In 2011 I graduated from uni and [in] 2012 I did that grad program down in Town A.

Has my view of professional identity changed over time? I've always thought that doing that study, we had the different disciplines, we did the social cultures a fair bit and [it] made me realise, probably while I was studying, what was involved. I think the reality of it becomes apparent when you start working, but it's all relevant learning all those different things, I keep going back to the sociocultural things and then that social side of things and those behavioural sciences. I think that becomes a reality maybe, you start realising the relevance of it all and I'm really grateful for that Bachelor of Science (Midwifery) course. I think it was really in depth, I think it gave us a good, broad [education].

Anything in the workplace that impacted on my identity? My identity was squashed a little bit when I first started practising as a rural midwife, because I wasn't a nurse, I was a midwife only, and I think it was hard for others I was

working with at the time to get their head round. It's a lot different now and I ended up having a lot of support and I love the position that I've got now, but it was hard work proving "my scope of practice".

Are there any barriers [to working in an interprofessional way]? I suppose you start treading on each other's toes in a way. Sometimes you'll double up and sometimes I wonder if the women get too much information. I think you have to be careful sometimes with women with social needs, that they don't get bombarded with too much input. Then they don't disclose some things, offer anything because it's all too much. And help that is really needed may get pushed aside.

I suppose that's where we really need to understand what I was saying before, understand where that line is where the other profession does take over. If I'm starting to give her [the woman] advice [and] that I'm not really 100% sure, I should say, "look I'll refer you to the physio and let's clarify that." I think we start giving advice, and things change all the time in the health field. They're always updating you know, "oh we're not doing that anymore, we recommend this now," and the people in those other professions would be keeping up with changes. Things change all the time and [you] talk to the people in the know, so I think it can get confusing for some women if you're getting bombarded with too much advice, so that's probably why it's good to get it from the horse's mouth.

If getting the social worker involved with a young girl because we don't birth here, you also need birthing hospital involvement, so then you get their social work involvement. Another scenario with a young Aboriginal girl who was suffering hyperemesis, she needed dietician involvement but she also needed social work involvement. She's also seeing a GP and then we access services from Aboriginal health. Too much information for some women is not a problem; I think some women relish in it but I think women with high social needs need you to be a bit more careful setting up those [services] and we have to all be on the same page. We all have to agree [on] what we're trying to achieve for the woman. Especially in Aboriginal health [the workplace supports interprofessional collaboration].

This new community midwifery role is quite new, it's a department health funding initiative and it's very new, it's only just happened in the last few months

but I think it has the scope to promote interprofessional [collaboration]. It has actually, because the other midwives up in the wheat belt area are doing it too and we have meetings every week via video conferencing (VC) and I'm saying that different things have come up, how they have interacted with different agencies, so similar to what I'm saying.

They do have some issues that are different to ours because they're dealing with a huge geographical area so their issues become different. They were still talking about when they've had to refer a particular woman onto the social worker and different things like that. So, we're still talking about those sorts of things, it's generic across [sic].

In my current role [interprofessional collaboration] enhances [my practice]. Because, as an example, when you might have had a woman who has birthed and is needing to go home and then things come up before she leaves and we think, what sort of network is she going to have around her when she leaves [the hospital]? I keep harping on about the social worker involvement but, the interprofessional goes over into that when we refer them to child health. Lactation consultants and things like that [because] it's a continuum because midwifery is dealing with the early stages from conception through to just a few weeks after, and then we're not really there anymore. So you need to have that continuum, you can't just say, "alright, good, you've had your baby, off you go," but some of them are obviously alright, some women go off and they're fine, but it's that continuum making sure that they've got those networks in place.

We've just recently started having what you call CALD meetings, which is culturally and linguistically diverse, because we've got quite a high population of multicultural people here. We've got asylum seekers and ex refugees and so we've started to have CALD women's meetings, not actually meeting with the CALD women, but community health professionals and interagencies. There's one young worker who worked specifically helping the multicultural group, the CALD group, and she does drug and alcohol too. There's another one that does health promotion and they come along to the meetings too just so that we've got the full story of [whether] we're getting the message out there correctly to the CALD women, that this service is available, that they can't birth in our town and if they want antenatal education, how do we deliver it? They've

done surveys with their groups and saying how confused these groups are so that's been really good too. I'm trying to think how my workplace promotes interdisciplinary things. I think there becomes a need for it because when you're sitting there, [and I] started talking to this young Aboriginal girl yesterday; she disclosed more drug use that she hadn't disclosed before. So, it was good because I could say, "well, you know…." [And] she said she wanted to stop; she gave me that information so I was able to refer her to Town B. I'd already used the social worker because she had a lot of financial problems. I would also need to ring the Aboriginal health worker, she's going to go and birth in LMH away from here, and so I've got the number for the Aboriginal health workers in that hospital who will take her under their wing while she's up there. I suppose how my workplace [to] promote that, sometimes there's a need and you just have to start thinking how am I going to help this woman, what can I do here? Different things, because Aboriginal health is a lot of health promotion, I almost feel like I need to do another degree in health promotion. You get invited to town activities, like a drug and action group where we did an awareness day down the street, so you get invited to go to those things and that's when you start seeing all the other stakeholders that are out and about too.

I really saw the relevance of [interprofessional education] when I was at uni. I [was] really empowered [by] that because I probably enjoy it in older age, the social side of midwifery more so than the medical side. I keep saying that's where interprofessional comes into it, but it's not just in that area. There is interprofessional [education] on the medical side too, of course. I suppose I keep thinking of those sorts of issues because all the social issues that are around in the roles that I'm doing at the moment that seems to be my fall back. I think it should go hand in hand, but I'm wondering if the other interprofessionals feel that our input as the midwives is important. I think as midwives, we need that input for her [the woman] from all aspects and other agencies.

5.1.2 Georgina's story

A long, long time ago I applied to do midwifery in a big capital city hospital but I didn't like the people interviewing me so I didn't go then. Then I had a baby when I'd been a nurse for ten years and in the middle of my labour I

think, I'm going to go and do mid after this. So, when he was two, I did it at a metropolitan hospital (MH). That's what made me do it, really.

Before that when my baby was a year old, I decided I wouldn't be a nurse or anything anymore, I'd go and be a secondary teacher. So, I did a year of secondary education and after a year I went "no that's silly I don't want to do that" but I did fall in love with education at that point. Then I did a year of nights and then I went, "No, I think I'll go and do Mid."

I taught midwifery in the hospitals before it came to university which was in the late '90s. I always had a fancy for it [education], so when I'd been a midwife for about five years, I transferred some of those education units over into my conversion degree in Nursing Science and then I did some more. In those days it was two full years, and you could do an elective across the university, a minor they called it, four units, so I did education.

Then not very long after that I had a run at teaching. I did a lot of staff development midwifery. In the hospital I worked in there was a lovely middle management level 3 education position which was staff development, it was a great job, so I acted in that off and on for a long time, a few years. Then in the middle of that process the educator for the midwifery course went away for a year and they gave that to me, so that was really cool.

I had taught the 1990 hospital group when the substantive person went away for a year, so I loved that. I spent the next couple of years trying to get that back and I did one more group in the hospital and by then the other courses had gone to uni, midwifery had gone to the tertiary sector in a lot of places by the middle '90's. So, I went back to the birth centre, and said "well if you ever transfer it to uni this is where I am, I'll come with you if you give me a job," so they did. I also taught the last hospital group, but at that point we wrote a woman-centred curriculum because I said we couldn't teach on the old curriculum anymore. We wrote a beautiful woman-centred curriculum and taught it once as we were supposed to go to uni [but] we were slow going because they just couldn't get the details right: that's why we wrote the woman-centred curriculum. It turns out we had this luxurious year, a full year [in which] people had plenty of time to teach.

It wasn't really a joint appointment; it was a paid position by the hospital but to the university, to convene the Graduate Diploma Midwifery. We brought

the curriculum to University X in ’97 when we started the Grad. Dip. It was paid for by the hospital; they funded that position but I had Lecturer B status actually at University X. So it wasn’t called a joint appointment because it was funded, but it was for all intents and purposes. I had access to everything here and we ran the Graduate Diploma at University X, but I also had full access to the hospitals, we also added Hospital A at that time. Getting placements was easy because everyone changed, we had a full-time model in the hospital where the students got a full-time job and were paid one day a week to study. [They] came to class for a day a week. When we came out to uni we changed our model; I wrote to everyone who was teaching a Graduate Diploma at that point and some people were really helpful. The two people who were most helpful were Person A from a regional hospital (RH) and Person B from [an] interstate university A (IUA). Then we talked to interstate university B (IUB) as they had four days a week, and we went for three. So, we did a three-day-a-week employment model and two days at uni, and that worked for a very long time until we stopped our Grad. Dip. We had a great partnership in those days.

They [large city hospital - LCH] do a lot of interprofessional, collegial, shared in-services; they’ve worked really hard to make that happen, and our students go to those. We’ve had an undergraduate midwifery program here since the late 2000s and the day that happened so much changed in the way that the medical obstetrics staff interacted with our students. It’s so interesting, it took me ages to work out what [had] happened, and I think what happened is that they recognised those students’ way of learning because they were undergrads. They have been very good to us really in a general sort of sense and in a specific sense. Our students, for example, suture and they’re taught in the classroom obviously, we have practice support midwives, but often-times it’s the registrar. He’ll teach them how to suture. They’ll go through it with them; they’ll watch them do it. So that’s true of several other things as well but probably suturing is the most important. So that works quite well I would say. In terms of shared classroom learning, there isn’t any.

We always had a complicated but good relationship with the multidisciplinary team. I would say that students in the old system, when they were employees, and they were student midwives and registered nurses, they were treated the same as everybody else pretty much; not every single day, not

perfectly, but pretty well. Sometimes they would be taught well by obstetrics and sometimes they wouldn't be. What we saw happening when the BMids came in was that sometimes, especially the registrars, but sometimes the residents as well, sometimes the consultants too, spent time describing their work to the BMids and including them as well. So, it [was a] kind of interesting phenomenon which we don't notice anymore, I have to say. It's just normal to us now I suppose, and sometimes it's good and sometimes it's not. But we did definitely notice that there was a change. It was like maybe the students, [and] we thought because they weren't taking a load, they looked slightly different, they weren't another kind of health professional, they weren't nurses, they probably looked a bit different but they also maybe had a bit more time to hang around and so they had time to listen and maybe they asked more questions. I don't know what the cause of it [the change] was but we used to talk about that.

They're [the registrars] still doing that, some better than others of course; some people like teaching. But we have some midwives who suture and they teach, I'm talking about in practice, but the registrars probably do the bulk of it. But for us of course, because our students do a lot of practice, they know the registrars by then. That's probably the main skill [that the registrars teach the BMid-ers]. It's the main shared midwifery, medical, technical complex skill that they share I would say. We decided that our students were going to sew, so everyone knows they don't get out of here unless they've done suturing for three women, and they've done a workshop and they've watched and done [it] properly. So, the registrars have been very, very good. What we're trying to do is build up a bank of more midwives who sew and over the years that goes up and down: depends who's around. Depending on the politics of the day sometimes they are observed in practice and then credentialed sort of on the spot, knowing what we've done, and sometimes they have to redo the whole thing. We find that incredibly annoying that they have to redo the lot, but that's how the world sometimes is. It just completely depends on the politics of who's running what. And some people, of course, are more capable. If people have not stopped at three women and just kept going because they have lots of opportunity, they can keep going, they don't have to stop at three. They are more inclined to be the ones who are proactive when they are new grads, but

the actual policy around that, they have to be credentialed by the hospital, which is perfectly reasonable. How that credentialing happens, changes.

[The course shares subjects with other health professionals], but it's not obstetrics. Medicine gets taught by the other university here. We have a multidisciplinary health faculty though; everything else is here, [but] not dentistry. We don't share [subjects], although we have got a new obstetrics leader in the major maternity unit, and we've just started to talk about, it's very early days yet, but he's very collegial apparently and so I have hope that next year we might be able to set something up for the year after.

They do the two anatomy and physiology units that are common everywhere. It gets taught by the sports studies people really, really well. They also do indigenous health with everybody else including nurses. We used to share ethics and law but we don't anymore. That's all. So, there is an element of that interprofessional education with other health professionals. I think I worked it out to be sixteen percent or something, someone worked it out when they were doing another project; I think it's sixteen percent of actual formal face to face.

The nursing curriculum changed and they have a cross-curriculum theme of ethics and law in their undergraduate program and not a specific unit, so we kept our specific unit. It's hard to share because the exemplars are nursing ones overall, if the teaching staff is nursing. We had a kind of reasonable hybrid by the time we'd had a few years of it, but it's better for us now it's not shared. But there's talk that they might go back to a stand-alone unit or that the faculty wants to share it, so we'll have to manage that. I read a really interesting thing when we were doing the BMid here, that work that Fraser did in the UK towards 2000. That series of articles of hers said [that] one of the things that sharing units brings is exemplars that are not related to the small disciplines.

I've taught in other universities and sometimes, either postgrad midwifery or undergrad medicine or whatever gets together and do some stuff, I haven't found that terribly successful in other places and we don't do that here, but I think we'll have another go at it. [With a new curriculum], that's my intention. My experience on this is really limited; I'm not a person who's a whiz at interprofessional learning, not at all. That one other university I worked at, they

were very big on it, and we tried quite hard to collaborate, in a small way, with obstetrics because that's the obvious place as far as I'm concerned to go, and they had a desire to do that, but the practice around it was quite hierarchical I thought and not terribly collegial.

We might try and have another go at it in a different format. There's talk about it in the hospitals that we share, and we'll be very much boots and all in there as well. So, we're going to try and do two different things. One of the hospitals that our students go to frequently has interprofessional learning, and we really encourage our students to go to that. But it's very, very hard. Apart from the whole gender thing, and class [that] complicates midwifery and obstetrics, there is also the whole issue around numbers. So, if you run an in-service, at handover, at changeover time, you get a whole lot of midwives and just a couple of registrars, and that skews [it], but if you want to go one-to-one then that's a very sort of tricky way of doing that.

Some people here are doing a common first-year unit, or units; they're more and more pushed to do that, but I don't want to do that, because I know programs that don't do very much midwifery in the first year and people [students] leave.

My own personal definition of interprofessional education, I would say that anything that's shared, that's not straight midwifery. That's what I would call it, although I'm not the expert. When you think about our course, we've got one, a lot of practice hours, that's in a way all interprofessional, when you think about it like that. But the theory's not.

We have both a full-time and a part-time system so people can do a five-, four-, or a standard three-year program. Our curriculum is spiral [type of program] so it's wellness in first year, complex theory in second year, sort of combined in third year. And our practice goes working with ten continuity women in first year, lots of hours of rostered practice in second year across multiple hospitals and all parts of maternity, and then back in third year with fifteen continuity women from the first visit. So, the third-year continuity looks bigger than the first-year continuity from the first visit to three postnatals, so five or six antenatals. They have to do half the women's labour and birth at least and three postnatals, one of those can be the handover to maternal and child health, and then a three-week block at the end. That [unit] we're calling a

Capstone [task] and that really came about because they learn a lot in continuity obviously but they haven't been on the wards for a year. It [doesn't present problems] it just gets fixed by the three-week block really. It's a hard course.

They have to apply to come in. They have to tell us what they're good at. We have an open day; we tell everybody who'll listen that it's hard but you can't know – like about how to have babies, til you have them - how could you know. But we have high quality students who are highly motivated people [who] get jobs at the end. So, it's still a course that people want to do. We [don't have problems filling the numbers], we could [even] have four groups a year. We have about fifty students come in, not all of them are full time, so about thirty full-time. We do this strange juggle because if you come in as a part-time person you do theory in the first year and practice in the second year. It's our practice spots that get filled up, so we just juggle the numbers so we've got about somewhere around thirty-five people coming into new practice each year.

I would have [participated in education or practice or both in an interprofessional way]. Of course, I suppose an example of that is wherever I've worked I've done a lot of ward-based education, multidisciplinary. I've taught into a pharmacy unit here about midwifery. We do multidisciplinary research sometimes. Sometimes we run an in-service at the hospital and everybody comes, sometimes something's happening and they ask us to come give an opinion about something.

What I think professional identity means, when it works, is that people in society know what a midwife is and respect midwifery as a useful thing to society. As I'm always telling the students we have a legislated profession and the society thinks that it's important enough to legislate around midwifery and to give you a certificate that's built in law. So, I think professional identity is all tied up in that idea of usefulness and value to society and therefore it comes with responsibility and that comes with identity. But the identity stuff to me, what matters the most is usefulness to women [and] one's useful contribution to society. Then making student midwives who are useful to women and babies and families as it goes down the line. It's the professional identity that matters the most to me. The other thing I mean about professional identity is, that it's at every level, so at the level of the woman and at the level of education and at the

level of policy, like national policy development and getting money out of the system for best care. That's what I think identity is. I think that policy is really important. I suppose it's from living in a [mad town] for so long, but I mean national policy, legislation, common law, even down to unit-based policy for women. I think all of those [policies] matter. I think it matters what gets written down. I think it should be collaborative, I think it should be argued around the table, agreed to and then [used] as a guideline, but basically adhered to. And I think that makes students safe, it makes women safe, and I think it makes clinicians safe, as safe as you can be.

I don't think my view of professional identity has changed over time. I got taught by a bunch of midwives who were very proud to be midwives and even though they were all nurses they really, really had a strong midwifery sense. That was in the mid '80s. They were very clear about when you came to mid you sat on your hands until you had to get off them, that was the flavour I grew up with. That was from young midwives and older midwives. Now I think it's certainly changed. We've got structures that are new, we've got Medicare, we've got prescribing that we didn't have, we've got undergraduate courses, we've got continuity models all over the country, we've got Cochrane Reviews that say if this was a tablet, you'd have to prescribe it. So, it's really different. There was a philosophy of that [non-intervention] in the [midwifery] unit, even though the unit I did my mid in was quite interventionist. So, the leadership in that unit was [that] you couldn't always see that philosophy, but from some leaders you could.

From the time I started there and for the next fifteen years quite major changes happened in that unit. It was complicated. It was friendly and warm and small, and it had some quite good practice sense in it, but it had private consultants in [the unit] who often dictated the obstetric care and an interventionist midwife running [the] birth suite and it took a while to get that sorted. But we were very influenced by some leaders who went, "No, we shouldn't be doing it like this," and they would do it like that and we would go "Yes, I like that."

When I started teaching, I did my first group in the early '90s, I used to say to my students in handover in delivery suite "stand next to this person," so whoever is dishing out the women and allocating would look up and see you

both together and say “do you want to work together?” And now what I can say is I can give you this whole model to work in and you’ll get it and I can send you to this whole hospital. Quite different. But that being said I don’t think it’s safe because there are some places that are going backwards and we’ve got one of those at the moment. We had one I thought would be safe in terms of care and best outcomes and evidence based practice and a few personalities and things change quite dramatically so, it goes back to being personality based or whoever’s got the power to make something happen and then the policies don’t stand up like they used to and people go ‘it’s only a policy’ when it used to be like the bible because it was written with everybody and put in with evidence. It’s getting fixed, it’s on its way up again so it’s going to get sorted now but I think we were a bit surprised at how that even happened, let alone how fast. But it’s on the improve so that’s the human [aspect] of it. But I think I didn’t get that, I was a bit naïve, I think. I thought once we fixed it, it would stay fixed. There are situations [like that] all over the country.

There’s a place some distance from us where the first thing somebody did when they went there was they had to save a million dollars and so they shut their birth centre, so it’s not safe, everything’s dangerous, because the changes we made didn’t stay changed. Some of them have reverted to a sort of default position that we thought was gone. We did work really hard in the ‘90’s and the 2000s to have a particular kind of midwifery and obstetrics work, and then we thought it would stay. In some ways it hasn’t, I would say going backwards. But what I didn’t realise then, it’s probably going to be cyclical; I just thought you’d fix it, not just me, we all worked together. I did a lot of the education stuff, but at the same time there were people, continuity models, we had a really early birth centre, we made changes to our birth suite, all sorts of things, as everyone across the country was doing at that point. But what I didn’t know was, we didn’t know in practice, it wouldn’t necessarily stay stable. So that’s been learning, I mean I don’t know what you’d do with that learning. I talk to the students about that, when you want to make changes think about how you’re going to try and keep them there and who’s going to keep looking, some of it is personality-based. That’s quite clear across the country and really across the developed world. Someone with a strong personality who is a good leader can make a difference. It’s hard for people to resist when someone else

comes in with a different idea, when there's a bit of them that maybe is more comfortable with that idea, or it just defaults back to what we all got taught, [it's] complicated.

You can feel despair; recently someone out here at the uni saying, "Do you think this [midwifery course] is sustainable?" I say, "Would you like me to start with the pictures on the cave wall?" The university might not be, midwifery might not be here, but women are always going to help women. It's very neo-liberal the world, and it's hard to count some of the things, although we've got evidence for this, we've got the clearest possible evidence about continuity of midwifery care, and if it was a drug, as we always keep saying here, it would be unethical not to give it. Forty percent less prems[9], and yet they don't want us to do it in this particular way.

And it's what people default to; they just can't see that something is better done a different way because we default to that old way all the time. It is hierarchical, and it makes people feel safer up the top I think. You get sick of fighting and you get squashed from above and below when you're in the middle of something. And you know, you don't want to get sick of fighting because I've always said if you get sick of fighting it's time you weren't here. So, I'm really careful of that. Sometimes you have to start with a new manager, and if it's about the degree, you have to go, "And midwifery, and midwifery, and midwifery," at the same table even though ten years ago you had it sorted.

That's how in the '90s we set up our birth centre and we went to an interstate capital city (ICC) to look at the two that were there and we saw that birth centre and went 'oh we need a house.' We're about to have homebirth trials here in the public sector. Even though I feel like sometimes we're going backwards, actually when you line up the last twenty years, oh my goodness, it's amazing really. It's twenty-five years for me [that] I've been teaching students this year, off and on, mostly on, and when I think I used to have to think of who was on a shift and it's so different now when you think whole systems. But it's not safe either and that's what we have to get smarter about. When that birth centre closed due to budget cuts, the person who used to run

[9] Prems. A term commonly used within the midwifery, nursing and medical professions to refer to premature births.

our beautiful unit came home from a meeting and completely changed the funding model and the way things got written down so the birth centre wasn't separate. Which is safe and not safe, because now it's not separate.

Definitely [there've been factors in the workplace that have had an impact on my view of professional identity]. It's hard to tell. I came to mid as a very clear feminist and I was very sure about what was right for women and stuff, but then I did land in a place that even though it wasn't perfect, it was quite an obstetrics unit strangely run by midwives. It was a funny complicated place. But I think absolutely, things have happened and what I've seen and people I've worked with have had an effect, definitely. I think it's certainly true that the path I've chosen, an academic path, affects my idea of identity, but my idea of midwifery identity affected the path I chose as well. I did it on purpose. I thought that you could make a difference if you set up a course, with other people, not on my own obviously that taught the kind of midwifery that we wanted to have. That's what I did it for.

Factors that might have had an impact, I've never liked the power plays of obstetrics. I've never liked the idea that they just own the high moral ground, I think that ground is for sharing. I never like anything that doesn't put women first; it doesn't matter what that is, I spend my life arguing about that, or not arguing, you know sometimes you don't have to argue it at all, it just depends on how the world's turning. So definitely people first. There've been highlightable people in my workplace both at the hospitals and at the universities that I've worked at, that definitely affected my view of my professional identity. And that goes both ways. So, there are people that I've role modelled myself on and people I've said I don't want to be like that. I think my studies made a really big difference. I've always done a lot of study in education and sociology, a Sociology of Education really; my PhD's in education, so I've always been outside as well as inside the midwifery literature, and that's been highly influential on me as well. Then I've looked carefully around at practices too. I looked carefully at models of education, I looked as part of the process here, at a big group of people, a long-term stable group of people, who changed models here and who worked hard on policies and who worked hard to get evidence-based practice in really. So, the other thing that really affected us was research. So, when Effective Care first came out our

branch of the College of Midwives bought the first $500.00 two-volume Easy Peasy [original Enkin] and put it in birth suite.

That was a very political move on our part. We used to do a lot of stuff through the College because city's a funny place, it's a little bit like you can put one hat on and then you're that and you take it off, put another hat on, then you're that. So politically we used to do a lot of stuff through the College because we were all public servants and there are rules around that. And that worked a treat. You put your college hat on, no trouble at all, you could say whatever you liked, have the biggest stir, suggest lots of stuff. You know we used to run special campaigns, we did it here for a few years because we decided no one knew enough in the community about what a midwife was or could do. We went to markets; we did all that stuff, raising the profile. So, from the workplace the effects of that, we could see we could make a difference, and then other people joined us and we got good consultants who believed in research and evidence as well. That came with the new curriculum, interestingly. When I said we rewrote the woman-centred curriculum, at the same time we got some Commonwealth money, Alternative Birthing Services money to set up our birth centre and a community continuity program; we had three continuity midwives in a program for a year and they were boots and all in with our students and us doing that campaign. And it was timely; it was the '90s and 2000s. Then I think I've been affected definitely by academia in two ways really. One is I love what you can learn out of a person, a book, a degree, a theory; I love that, that's very important to me, and I love passing that on if we can do that in a practical way but I also like tying that to practice. So, I think it's helpful in a practice-based discipline in a university that you just don't float off into cyberspace somewhere and at a meeting you go 'well has anyone really, has anyone not fed the baby really.' So that's been really helpful to me as well, to kind of keep a practical focus. I have never really lost the idea that practice is what matters the most, and that the real world is the really important thing. It's not that academia is not real and that people here aren't real and the students aren't real, but the issues that are vital relate to people.

My view of interprofessional education, I think it's hard to do well. I used to work in another university that had midwifery and obstetrics and a heap of other stuff all together. An obstetrics person came from another country that

was well known as being published in interprofessional education, it was on the university's plan, as one of the key learning objectives, had been for some time and we hadn't been doing anything about it. I went 'oh this is a good opportunity' so we'll run some days together. So, we did that with obstetrics as that profession and those particular people they were invested at the time. They did no prep, they did no work, they came unprepared to the day. They didn't help us clean up. It made me beside myself I have to say. He was published and I think his intent was perfectly fine when I look back on it, but in the daily working out, the days or the sessions, he wasn't quite as prepared as we were. He would swan in a bit and do something off the top of his head and, he did make that medical program agree to it, the med students, some things he did make happen, definitely; but he didn't role model collegiality in the way that we believe that teaching should happen, because if he did he was fed up with it, and he would have packed up with it, and he would have been in boots and all. I've done other stuff with obstetrics that is like that. Sometimes you don't need to work with an obstetrician to know they'd never leave their needles on the thing, and they'd never walk away and leave the trolley dirty from whatever they'd done, that sort of stuff. So, I just think that there's the subliminal stuff around the hidden curriculum that just didn't look that flash to me.

I think I wasn't invested in it enough to go back and have a talk to him about that, and had I done that it may have made a complete difference. I do think he probably may have been open to it, but I am a bit of a separatist and I think that he should know that and I haven't got the energy to fix it; not going to fix him, can't be bothered. But had I been in a different space at that time, or younger or older or whatever, different person; really, I'm a separatist. I think everyone should be really good at what they do, and then come to the woman, to the table as equals.

It doesn't mean it's right; just that I think we should get our own house in order first so it's easy for me. I'm not practicing so I'm not the one who has to be in the same room altogether. You do get a different view when you're not over there [the hospital] every day. I think that you get a bit of a skewed view about how the world could be.

The other thing that happened was that the medical students and our students, at that time were postgrad nurses, were in the groups in the

interprofessional learning, and we did a big session twice. I thought maybe it was just a one off, [but] the medical students wanted to take the role-playing power roles. I went no, no, no, you know it's really good to swap. And so, the same issues that are in the workplace were just in the classroom and that's okay [but] why would you bother. Why would you want to replicate the thing that you're trying to do something about? So, there was quite a fuss when I wouldn't do it again. But I was Discipline Leader then [and] I wouldn't touch it with a barge pole. I said "I'll do it if it gets done differently" and it didn't.

That's not the only way to do it and as I said I'm going to have another go at it. A few years ago, we got a new director here of obstetrics and I got a message that he wanted to see me so I just ignored that, he can pick up the phone. Eventually I saw him in the coffee line at the hospital and I met him then and he said he wanted to talk to me about what I was teaching. I said I'd be very happy to do that if the conversation was also about what he was teaching. It didn't go very far after that. That was a very specific person. I don't think that's common and I don't think that person's typical. I think that person's atypical. I think he was definitely the exception to the rule because I don't think that happens to people anymore and that's why I'm going to have another go at it. Things have changed here; there are different people in charge now and I know that the reception I get around interprofessional learning will be completely different now, which is why I'm going to have another go at it for 2016.

We're going to do a few [new] things. What we're going to do in semester two for the third years who are getting ready to fly the coop, we're going to have a panel of every health discipline and talk about their input into maternity services. That's the first thing. We should have done that ages ago. We've been doing it informally, but we've never done it formally and it's a waste because we've got this beautiful multidisciplinary health faculty here, it's a great place filled with really good people. That's going to be easy because I know that'll be useful and so we're going to formalise the input of the other disciplines just into one session and if the panel works well, we'll try and turn that into a workshop, but we'll just start small and see what happens.

The other thing we're going to try and do is go and talk to the people at the other university that's here that teaches medicine and see what comes of

that. I don't know what we'll be able [to do] but we're going to try for some formalised, shared learning. I think there's a change in the wind with the new leadership and I think that would work. In the recent past it would have worked too; I just wouldn't have liked what was there.

We didn't do it this year; what we did was get our new obstetric director to come and speak, about obstetrics thinking and decision-making, so the students have got an idea about what happens when someone gets called and what they're thinking. I've always loved that model of theirs, although it's a bit funny, that they do that sort of analysis, do an assessment and get an impression, and then follow on from that and work out treatment. I think it's useful to understand that model. We did do that and it was very successful because he's new; I don't know him very well but he was generous in the classroom, and that's what we're hearing that he's like. I would like a combination of both when we run that next year, that panel, I would like a combination. There are people here in every discipline who work as well, a lot of people in the health disciplines here have a practice as well. We'll probably try for them. For example, the fellow who used to ask me to come and speak to pharmacy, he's stopped lecturing for the moment, so there are people with a bit of both. There are also hospital pharmacists who we know, so we'll try and get both.

I've taught in the pharmacy unit, [and in] nursing of course, they're our sister disciplines here in our school. I have taught some med[10] students and registrars in the past, but only by invitation and only sometimes, depends who's on and who's setting up things. That's been very hit and miss, I wouldn't call it formal. Interprofessional education with the other disciplines was with obstetrics and actually nursing too of course. We used to teach in the paramedic course. All ambulance officers are paramedics here. Have been for years because our jurisdiction's a little different and I did it for years, probably ten years in the ambulance officers training about birth and everything that can go right and wrong. We did a whole module for years. I don't know how they run it, it's different now, and they do it out of University Y. I do know midwives still have input in that course but that's from the hospital, not from a university's

[10] Med students refers to "medical students."

perspective. Of course, what else happens is that people on the wards who we employ often will take a student medical officer or somebody; I mean they have paramedics, they even have army medics over there. So, if our staff is around, or if it was me in the old days, we would just take them with us wherever we were going, I worked in birth suite, that sort of informal stuff. It's not the norm, but that does sometimes happen. It's just that sometimes that place works in such a lovely, collaborative way and we're part of that team. It wouldn't be every day, but there would be every day where there'd be a conversation at the desk that would be a good learning for the students.

Interprofessional education or collaboration has impacted on my professional identity in [that] I think it's made me a stronger midwife actually. I am a separatist but I'm only a separatist in that I think you need to be very sure and clear of your own position and then you can collaborate as equals. That's what I think. That's how I was brought up in midwifery and that's what I have done all my education work around, it's how we run our program, it's that collaboration between equals. It works best when the power's equal and that it's based on respect. But in order to get that you have to be really good at what you do. You have to be sure of yourself as best you can be. You have to be clear about your scope of practice, you have to be clear about the evidence, you have to be able to speak from a midwifery voice, articulate your work, articulate your request for consultation or referral or even just a discussion. You need to keep the woman by your side while you're doing that. So, I think they've made us stronger in a way. The opposition to midwifery has made midwifery stronger. With regard to the midwifery scope of practice, I would just say the international definition; that's as good a definition I've got for the scope of practice for a midwife. A cross between that and the Australian College of Midwives (ACM) philosophy; they're my two, I mean obviously the standards by law, but just as defined, I don't love some of those, I like the standards. I don't particularly like some of those other documents out of there, but I think that I would say being with women from pregnancy to six weeks postnatal or three months, whatever you want to think of your definition, either on your own for well women with clear guidelines for consultation and referral, which I think we have through the college, or in collaborative practice for women who are complex. That's how I see it.

I think there are lots of barriers to working in an interprofessional way. Depends who you're talking about [and] I think it depends on what you mean by working interprofessionally; everybody works in an interprofessional way every day, including in a university. You walk out of your office, you're dealing with people who aren't midwives or who aren't in your profession or discipline, it's just normal common standard practice, it's easy. That's what I think. It's easy to deal with people; it's easy to deal with administrators, that not really hard, that's just normal. The same in a hospital. In the dailiness of a shift you might run into 20 different kinds of people and the dailiness of that should be easy and I've always liked to work in places, and I've been in health 40 years next year, where that's really doable.

I think power's a barrier. I think class probably is. I think there is a hangover of gender, even though I know the gender balance is changing, it's not changing the power stuff around those structures, I don't think. I think management can be a barrier. All these things obviously, they can be facilitators too, but they're probably barriers. And I think our connection to nursing often doesn't do us favours in the big scheme of things. I mean individually it's fine but I reckon there's push-back from nursing at the moment. I think there's the sort of professionalization stuff that we're still embroiled in that is complex for us. We don't have our own board; podiatrists have a board. We don't have a board. It drives me mad. We don't even have a designated midwife position on our current board anymore. It is really important to me. But I think midwifery's got its own very specific issues and it's with obstetrics and sometimes it's with management and that is around people disrespecting what we can bring to pregnant women, and labour and birth and postnatal. I've always tried to get the situation changed to people respecting midwifery because I think it's good for women. That doesn't mean some women don't need medicine, of course they do; some women need obstetrics and when you need it you need it fast; you need them to be pleasant and you need a really good relationship with them. But I think that's got to be equal or it's not a good relationship. So, the stuff around power, I think a lot of it's about power and who owns the ground, that's what I really think. It really is. And people taking up their right as a health professional. I think it's a very specific 400-year-old issue, between obstetrics and midwifery that some people think is fixed, it's not

fixed. But sometimes it's good. Depending on who the players are it can be magnificent.

This workplace really believes in interprofessional collaboration. Our Dean's a scientist, so I really think they really believe in it and so interprofessional learning is encouraged across units, shared learning, big units are encouraged, preliminary research is encouraged. There's no formalised learning about each other's discipline. We can do faculty practice; we can teach into other people's courses. IPE for midwifery would be supported by faculty definitely [but] it can't cost too much. We'll have to do it [with]in budget, I'll have to work out a way to do it. If it costs something, I could argue it. I might have to rearrange the dollars to fit it in and it couldn't be more onerous on the students than the normal standard stuff. There'll be parameters around it, but that would be valued. I am researching with other people from other disciplines sometimes. I think when the hospitals and the university have interprofessional collaboration that's working really well, my job is easier. When it doesn't work as well, and sometimes we get caught up in that, the students get caught up in it. I would say I identify as a midwife academic. My entrée into academia was midwifery and I'll always be a midwife because of that. I teach it, I love it, I believe in it, but I'm not the one doing a late and an early [shift] or being on call anymore so I couldn't say I identify as only that first. I'm so mixed up now, the two [are] entwined, and it is not separable.

I think the only thing we haven't talked about is funding, federal funding. I think that we need to do something really serious about midwifery funding from the Commonwealth in order to get us some more paid time, so then we could do inter-collaborative interprofessional learning better. That's one of the things. They're funding medicine at 6.4, or whatever it is and we're 1.4. Even if they doubled, which is what they did in New Zealand, they got more money for education, we could run our programs differently if we were funded differently and that's what I think we should be going for. When they're [medicine] running tutes of 12 people still, they're still running problem-based learning stuff with eight people, it's really hard to work out how we're going to manage that. Not that it's not precious, it is, it's because it's precious I think we have to fund it; we have to be funded differently. I think we're not strong enough about it. It's like if one state loses its Bachelor of Midwifery it's because nationally we're not strong

enough about it. We've got a responsibility here; we can't go leaving it that some states aren't going to have undergrad midwifery anymore. It seems, and that's the same about funding, doesn't give you enough hours and it doesn't put you on the right level. You've got to be on the right level to collaborate. It's intensive [undergrad mid] isn't it, because you've got to make it work for so many people and it takes people.

If we got a big grant here what I'd do is wander over to the hospital and run some stuff over there because I think that would work as well. But it's hard to get people off a busy shift, all those things. It's hard to be collaborative in the hospital when you open something up, which is what happens a lot, to all the disciplines and there might be ten midwives in the room and two registrars and a resident. Well it's really good but it's not equal is it?

5.1.3 Holly's story

I thought "How did I end up here?" Basically, like a number of people I was a clinical midwife, I had a bunch of young kids, and I was working part time, and I decided to do a Masters, just because I was getting a bit bored, because I was at home a lot. I did a Masters, and I got invited to do some teaching, and I didn't plan, it wasn't any great career path. I did a bit of it and I enjoyed it, and I thought I can do a bit more of this.

And over a period of a number of years, I started doing some sessional work, I went back to work more clinically, I did some sessional work, and somehow, I've always been quite interested in research. I did want to do a PhD for quite a while, so I wasn't pressured to do it. Now you probably would be pressured, but I wanted to do it. So, it's just, it wasn't any grand plan, but I'm here from a clinical background and an interest in teaching and in research. But yeah, no grand plan.

I still do a bit of clinical. I guess overall I don't find the clinical hard, but [on] the whole, overall I find it hard, because you feel as if you're a fraud, in every department they would… Did I say that? Well, you know it's interesting. I've just got re-employed on the nurse bank to do clinical shifts again. Because what, when I feel [like] a fraud sometimes is if I'm teaching something that I'm not doing it all myself… I feel I want to be able to, not do it at the, but I'd sort of like to, to be able to teach something that I can do myself. And I feel like if I

leave it for too long, I won't be able to do it myself. But more that standing in front of students saying I am a midwife, oh but I haven't actually touched a pregnant belly for three years, I find that uncomfortable. And I just miss it.

I would self-identify as a midwife, a clinical midwife, before an academic. However, if I'm describing myself, I say academic, because I'm so, I do so few clinical shifts now, I feel like it's not a genuine reflection of what I do now, but it is who I am. Whether I'm doing it or not, I'm very committed to the role of a midwife and I value that role and want to keep connected to it. So, I still do a little bit of clinical. But it is actually quite hard, because I feel like I'm a fraud in every department. I think it's an issue in [the] clinical role, you know when you're teaching clinical skills. It's one of the balancing things it's very hard to keep competent at these multiple roles that we're expected to do. And I don't know about where you work, but where I work, they say, you know they want you to be clinically active, but at the end of the day you've got to end up, you do end up doing it in your own time. So it makes it really tough, especially with family and so forth. So, I am just doing it. I'm not doing it for any other reason than for my own sense of, I don't know authenticity or something.

That's, yeah that's the issue is it? You can't, you can't do a full-time job and then do weekends on clinical. It's ridiculous. But that's what I'm trying to do. But anyway, I tried to go part time but that didn't really go far. No, sometimes you end up doing a full workload in less time. Or [for] less pay.

Well I think you practise in an interprofessional way all the time because you're working alongside doctors, OTs, physio, social worker, a lot of times the social worker, sometimes nurses. In the clinical environment I think a good team is an intra-professional team. Most of my experiences have been in one of two places. One was a very small midwifery run clinic where we probably did less interprofessional work because we had low risk women and a number of [diabetic women], so the diabetic educator wasn't there. In the large place where I've worked a bit there was a lot more Allied Health involved because you had more complex problems to manage.

At the most basic level if a woman came in, in the smaller place we would always let the doctor know, I mean collaborative practice was fundamental. You would never, we used to do inductions for example, but you do it with the doctor. Even if they weren't physically present, and you would

keep them informed of what was going on. Because it was a smaller place you knew people; people knew each other well and there was a trust there that in the larger place there isn't, because people don't know each other as much. In the larger place well, the baby's born and is a bit flat, you get the paed[iatrician]s involved. The woman has social issues; you get the social worker involved. The woman's a vegan, you get the dietician involved. Sometimes you're working alongside people, physically alongside [them], and sometimes you're not, but you're always working.

It depends on the model of care you're doing. Although I do think the best outcomes come from a strong interprofessional team where there's respect for each person's knowledge and abilities and, and it's clear who does what, and there's good communication amongst that team. So that's the ideal, and sometimes it works really well and sometimes, there's a strong hierarchy which means that people's knowledge isn't respected necessarily. Its teamwork; I can't ever imagine working as a midwife without working with other health professionals. So, to me it's fundamental in terms of IP, or interprofessional education and your role here as a midwifery academic.

With regards to the program we have here, we run interprofessional workshops between midwives, student midwives and medical students, we do little bits, but as I sort of flagged a bit earlier, the logistics often get us. It's just the logistics of it because we don't have med students on campus here. Whereas we do have nurses, midwives, paramedics. We haven't done any intra-professional workshops with paramedics and midwives and medical students.

So, we have students that do workshops with med students, they go out to a metropolitan hospital and they spend a half day, so we rotate them through a number of days, and they're I think fourth-year med students and third-year midwifery students, which is fantastic. We've done some research with paramedics and nurses and midwives and looking at how they work together, which is interesting. And they often work alongside the midwives now in the program; we did have a Bachelor of Midwifery, we're teaching that out now, they're double degree students, but of course nursing, they work with the nurses all the time. But with the double degree they're nurses and midwives

now. We've done stuff with paramedics, so we've got Allied Health all around us.

The thing that stops us is not commitment, it is logistics. Because of clinical placement and timetabling, so we do have some interprofessional workshops, it would be fabulous to have more, I do think it's really productive, the workshops we do at the metropolitan hospital are so good for the midwives and the med students; they learn that the midwives usually have a much better understanding. We go through pap smears, normal birth, PPH *(post-partum haemorrhage)* and VEs (*vaginal examinations*). The midwives have it, by the time they've got there, they've had it, been in primary care for a number of women through labour and birth. And the midwifery students do really well. And I think it helps them understand, it's not just the medical students, it helps the midwives understand oh we know, we know some stuff.

A lot of the med students haven't, they're just at the beginning of their obstetrics rotation. It is really powerful, I think, to see the dynamic, because the midwifery students end up teaching the medical students, and it, I think it breaks down a lot of barriers at a very early stage, yeah. When we look at the medical students and the student midwives, the student midwives usually are a bit more up there, because they have followed women through their course etcetera. And the midwifery students end up teaching the medical students. And the fact that we have this intra-professional collaboration, or you know education between them that it helps to break down a lot of barriers.

Okay, so the barriers are between having the best outcomes for women and their babies can sometimes be related I think to a hierarchy of sort of power and for want of a better word, politics around who's in charge and who knows best. Well I do think it's reasonable that medical people want to work collaboratively and medical people, I suppose in any complex situation, to have the last say or whatever, well the woman does but in the health care profession. However, it's particularly, I think frustrating, if there isn't recognition of expertise, and for us, the midwife really has expertise around normal pregnancy labour birth and postnatal. And medical doctors don't. I just don't think that they see it enough.

And just because the med students got a higher A.T.A.R. score or whatever it doesn't mean they know everything about everything. So, they have

a fair bit of fun around it too, you know there's a lot of laughter and so it's a positive experience that I hope that they gain from it. Oh okay, we have different skills sets here. We can hopefully respect that fact and work together, rather than always look to the medical person to have all the answers, because they don't, I don't think anyway.

So that started as a big research project that was funded by somebody through there, and we've just embedded it into our curriculum, because it's so good. There's no funding anymore, but it's worth the effort.

There will soon be a paper on IPE, but I'm not on it. The lead midwife's name should probably be on it. So, it started up when she was here, but it's led by an obstetrician at the health centre and don't ask me her surname, I've forgotten it. Women's health in a professional, learning, something or rather, I can't remember. But there was some money, they got a big grant. And there'll be papers out of it.

Interprofessional collaboration has had an impact on my professional identity as a midwife and also as an academic when I'm working personally as a midwife or as an academic. I think it does help, it helps to firm up what our scope of practice is and our area of expertise, and particularly my role as an academic; it helps me to explain to the midwives that they are the experts in normal labour and pregnancy, and because even the students I think see the doctors as knowing everything about everything. And when they're exposed to simulation around things like normal birth, it becomes obvious that the med students are focusing on complex problems, and you just have to ask them how many normal births will they see through their education. It becomes clear that that's not their area of expertise. So, because the hierarchy of the health system that we all work in, there is this sense that the doctor knows everything about everything, even for students and, and for many midwives too.

Look, I think before I got into academia, I didn't really use that language, IPE or scope of practice or think about it. It was very interesting to me that when I got interviewed to get back onto bank, and it was like a proper job interview thing. They asked me about scope of practice and I've never been asked about that before. So, it makes me wonder if it has filtered down to the clinical world that some of this kind of language about what it is we do, and what it is we don't do, and what's reasonable that we should be expected to be able

to do. So, I don't think I thought about it in those terms, but I do think we have a sense of what's appropriate and what's not. But it just wasn't where my focus was at all that sort of professional stuff, it was all about just doing stuff.

I think it helps establish a certain area of expertise that midwives should claim and hold on to and be proud of, and it also helps to establish some barriers, some boundaries around that, that actually, once you become that a number of things are outside of our area of expertise, and we should be referring or collaborating. So that is an issue too, isn't it? So yes, I think it's quite a powerful way to help to draw those lines in a practical sense.

That scope of practice is really about what you see in clinical practice, you see it, see it, certainly, so you don't have to just try and explain it, they can experience it. For many midwives IPE helps establish a certain area of expertise. This IPE in the course tends to highlight who they might be as midwives, or what they might do as midwives versus not having it. IPE helps to clarify boundaries and really reinforce the role of the midwife especially where the norm is involved.

I think the practical workshops are an excellent way of having them experience obviously about their scope of practice, and all the sort of regulation and so forth around it. I think it has an impact on the student midwives for example, last year with these workshops, because of changes in the courses, all the student midwives had done our interprofessional workshops, and we said "Well, would you mind doing them again?", and they all came back and did it again. They actually really enjoyed the opportunity to shine if you like, because they do shine in that, they had enough experience to be quite confident, or most of them. Not all of them. I think it helps them understand, and hold on to the knowledge that is primarily midwifery as opposed to maternity care more generally. With these workshops the student midwives really enjoyed that opportunity to shine; I think that's probably due to the IPE component. I think it is a bit of a wakeup call to them; and when I first started doing it, I was quite surprised too that actually they know a lot more, and have had a lot more experience at that point in the course compared to the med students.

I think it is that they found it a positive experience. And also with it, the pro [IPE], so the little research project we're doing here is with paramedics, midwives and nurses, and once again, it's quite interesting to see the dynamics,

not just what people know, but who they think you know, how they'll step back for the person they think should know, it's very powerful, I think. But when actually in a practical situation with other health care providers that's when it, particularly with their little research project with the paramedics and the nurses, that's when you could see that they really had to stop and think about who should be doing what now, is it clear who should be doing what now? And who's going to take charge and that entire sort of stuff. So very useful there. And they, you know, they sort of are quite surprised by it, mm.

Well the role of midwives and scope of practice. I think they're much the same. I suppose when I think [about it], I spend a lot of time with the students encouraging them to hold on to their scope as broadly as possible, to not give away their scope of practice because they're busy or whatever, because they'll end up with a very narrow kind of view of pregnancy and birth if they're not careful. But I think that role is the expectation maybe from somebody else. But their role should be to behave appropriately within that scope of practice though; I don't know, there might be technically a different in that term, but to me they're similar.

Look, what I'd like to do and what we can do are two different things, but let's forget about what we can do. In my view, it [IPE] should start, you need an opportunity to establish some professional identity within your group early on. We've got a four-year program here now with nursing, a midwifery double degree. So, I do an orientation session with them so they get to know each other a little bit, because there's not a lot of time for them to do that. To actually give them an opportunity to say "Well, what is it that makes you a midwife here, rather than a nurse?" but of course they're both now.

Oh gosh I can't remember any specific sort of anecdotes as to what students might say to me. I had a student do a talk the other day about being a student in a degree which is nursing and midwifery, and she spoke about the whole cradle to grave experience about that. But she didn't really identify the focus on wellness and all that, it was more about the lifespan kind of view of it, whereas I might see midwifery as coming from a different kind of framework to nursing. So, I haven't specifically asked them and I think if I asked them at orientation, they would have no idea. They really don't know what they've got themselves in for.

But “What’s the difference in your role as a midwife?” I suppose you need a little bit of time and exposure and to have conversations around that for the first year or so. But then it would be great if it was possible to do it all the way through the curriculum, because it is the way, team work is the way health care it’s the reality of the world they’re going to enter. So, none of them are an island, are they? Even if they go into private practice, they have to work collaboratively. We need more time and exposure to have those conversations in that first year or so. It would be really interesting to hear what they’ve got to say. So, to understand, and it is scope practice, but it’s also about power dynamics and conflict management and all those things. It’s really important to have some sense of conflict management.

I think that midwives are actually a fairly oppressed group, and I think it helps them gain an appreciation for their own knowledge and skills, you know. I can’t say that strongly enough. I don’t think they appreciate their [knowledge and skills], and I'd say the same for nurses too actually, but since we’re talking about midwives, I don’t think that they, it's a bit like you know the expression ‘fish out of water?’

So yeah, I suppose, in the first year perhaps not, but soon, give them a little bit of a chance to find their feet, and establish their professional identity and then they’ll help establish it more within the team. It will become clear what their role, their expectations of their role are.

I suppose I mean by ‘professional identity’ the role, the expectations, the legal and ethical boundaries around being a registered midwife in Australia. So, what are the expectations of a midwife who works in Australia, and how do they fit in that, so it’s not necessarily their personal views, because of course some of their personal views might be a bit different. But it’s the expectation of that role within the context, so for us it’s [midwifery] in Australia, and it’s national now and it would be different in different countries. But we spend quite a bit of time talking to them about that to try and, well, to inform them but also to protect them, so they don’t start doing things that are not appropriate and that are not within their scope of practice. How we might get them to appreciate their worth as a professional, wouldn’t that be great?

I also don’t know how much of my feelings are about, as you get older you reflect a bit and I don’t know. You know it's the woman saying, or the new

Dad saying or whatever, look it gives you your little kick, but it's all fairly contained as a profession to say you know mid, I think it is improving. And one of the ways I think it's improving is through the media. The other day I was watching Wonderland with an 18-year-old girl, and I was absolutely wrapped that the pregnant character on this show said, “Oh, I want to introduce you to my midwife, she's fabulous. Now a few years ago it would’ve been I’ll introduce you to my obstetrician, he's fabulous.” So, I thought oh, some of these shows [are] actually helping to raise awareness of the work of a midwife.

Midwives as a group are probably oppressed. I mean by that that perhaps they’re not comfortable, the system has oppressed them. Ultimately a medical person will be in charge, even if the midwife has a lot more experience, understanding, education and knowledge. You get, about this time of year the new residents and registrars come rolling around, and ultimately they’re in charge, even though you’ll say “Well, actually normally we don’t do that because of blah, blah, blah, blah, blah”, ultimately, so, but having that conversation, I haven’t been comfortable to actually even have that conversation, I think a lot of midwives aren’t.

And probably this has come out of some of my research, because I looked at the use of complementary medicine in a maternity context, and a lot of midwives use it, but they keep it quiet. And when you ask them why they keep it quiet, they don’t want to deal with the potential conflict, not just actually with medical colleagues, but also sometimes with their midwifery colleagues. So they might be doing a bit of acupressure or whatever, but it’s under the radar. They don’t want to step up and because I suppose experience has told them that when they do step up, they often get torn down.

Professional development around interprofessional work might help. Well I know that at this hospital here, the foetal surveillance workshop and those sorts of things are done as IPL, well it's not really IPL but doctors and midwives turn up. There are quite a few things like that. But something specifically geared might, but I know when we've looked at education and also we've done some, trying to help them with some research and things, they’re so busy with the day-to-day management of women coming in and out of the unit, because the women are in and out so fast, they have education days that get cancelled. We've had presentations that we can't do because the ward’s busy and all this

sort of stuff. So, it might be great, but I'm not quite sure how we do it. And we had somebody here who does a lot of work with bereavement, and she was offering a free workshop for the midwives around bereavement care for themselves. And that never went anywhere, and this was a few hospitals and that didn't go anywhere because they couldn't find time to do it. Which is so sad isn't it? That we have no time to look after ourselves.

The beginning of the year new doctors come and new residents, new registrars, everybody. And some midwives, myself too, might not be comfortable with telling this brand spanking new doctor that look we don't do it this way. That it's an uncomfortable conversation to be had, and that other midwives don't want to deal with the potential conflict, even amongst other midwives.

So, I was actually a bit surprised how, because I don't remember that when I was working as a midwife, and most of my time as I said was in this small very supportive unit where everybody felt valued. And things still went wrong; most of the time they went very well, but when they went wrong, people were valued, whereas now it's much more risk adverse, and I don't think it's done. I think midwives are actually recognising themselves, and the work they do is really important and their voice isn't really getting heard. It's become worse over the last, I'd say twenty years, than it was say in the '70s and '80s. It was recognised that the midwives looked after all the women that were normal labours and births [and] doctors looked after the complex ones. People were respected and valued for their knowledge and level of experience.

I think the juggernaut of biomedicine have swallowed up a kind of midwifery social model of birth. And there's such litigation and so forth [and this] has had a big impact, so that risk paradigm and you know, you've got to do this, this, this and this in case something goes wrong is quite pervasive and very dominant in my experience. As I say, I haven't been working clinically much but I've really noticed a change when I first started to be a midwife in the way people practice, and it's not actually, even biomedicine, it's about you know crossing your t's, dotting your i's and making sure you've done everything that can be done in case something goes wrong and you getting litigated. So of course, the fallout from that can be, we all know, more adverse effects than less but you don't get sued for over service.

So, I think that's really had a big impact on the way people do things, and there's a lot of pressure within the culture of any particular unit to do things a certain way you know. So, whether it's midwives versus doctors, it's perhaps a biomedical view of birth for a healthy woman as opposed to a midwifery birth for a healthy woman. Some midwives are very much in that biomedical kind of paradigm, [they are] absolutely fabulous with a complex or higher risk. But I have concerns about it.

Viewing everybody as a potential disaster kind of thing has a cost attached to it, I think. It's pretty pervasive and it's hard to be the lone voice if it is a bit pervasive, so it's difficult, this is where professional kind of leaders can make a difference, like this is where we need to build our professional strength and resources. Because certainly the medicos have haven't they, through their colleges. I find it quite easy, I do quite a bit of work in integrating medicine and I look at the difference of the way some of the different complimentary therapy practitioners, the ones that have registration and some don't, and the way that they've got themselves organised, and you need a few champions to really get things going for you. Then you're kind of legitimate and it's fine, but if you don't have that, you're not.

We're going to end up as maternity nurses, that's what we're worried about, isn't it? And I think it's got busier and busier and busier. And I mean some of the things that happen, you're kidding me, you know, no wonder women are traumatised by the end of some of this. And I can see midwives doing things, like if a baby's not going straight on the breast, well, let's get the lactation consultant involved. And you can understand why, it's a time management thing; it's a strategy that helps them in the moment.

But it's like the experts become more available, the so-called experts, the midwives are giving away some of those skills. And it's like this is core business, and if you give all that away, you're going to end up by the machine that goes 'ping', is that why you want to do midwifery? So, although the students themselves are probably more confident and more outgoing, that generation I think, it's broad, it seems to be happy to say what they think, yet you walk into a hospital environment, particularly the bigger hospitals, and to me it's like stepping back in time. It's just very, there's very strong power dynamics that actually make it very hard to speak out.

So midwives, there's probably a lot if you looked into the history about where we're at now. New Zealand, they went down a different track, didn't they? We're quite different. That's the thing; a single person won't change it. It's kind of policy, politics and I think [the] media actually has a strong input, has a big way of swaying the population's view of certain things.

From an interprofessional perspective, if we started embedding IPE early, or if our students learnt to work and study interprofessionally with other disciplines, you think that might help to change some of those behaviours that happen when they step foot inside and become socialised. The early implementation of IPE versus late, absolutely, I think it would be a very powerful way of doing it. You know, it does remind me when I was a midwife doing a, I think it was CTG workshop and I sat next to some of the doctors [who] did it, interprofessional, and it was really powerful, because we were presented with various CTGs and we'd say "Oh, well, we'll have to go and tell John about that one", and then he'd say "Well, then I have to, if you do that then I have to blah, blah, blah", and it became very obvious that okay, the midwives were feeling that they had to report a potential problem, and once the doctor heard a potential problem, he felt that we were asking him to act on it. And it was like "No, no, no, we just want you to know about it". And he was like "Oh, but why tell me if you don't want me to do anything?" It was very powerful, because you could see why women were just going down the corridor to the Caesar, basically, because his expectation, his role, was that he had to do something. Whereas we wanted him to know something and be ready to do something, [but] he wanted to do something. And because we thought "Oh, do we tell him?" That was like, I can't remember what, but it was a real eye opener, and a moment of clarity about why some of these problems happen, because we have different expectations about it. The role expectations are very different. There's a real misfit between one health professional and another there.

They're thinking the legal aspects whereas we're thinking about okay, we're letting you know, let's keep an eye on it together rather than let's go chop, send it off to a Caesar. And I do think the medicos, happily, most of the time do see that they should be doing something. Because if they're only involved in pathology and when things go wrong, well, you would want them to do something. But when there's just a little something on the CTG, and it is

probably nothing, but it might be, and we feel because of the guidelines and our workplace, have to report it, you can see how it all goes pear-shaped and it doesn't benefit anybody, let alone the woman. And at the end of the day it's not, it's not serving the woman very well or her child. So there's that overlap about what we do; we're all in our little silos, and we need to talk, we need to communicate.

Well this is where the IPL workshop was good, because in that conversation we report it to you because you're the doctor in charge today and blah blah blah, and the doctor that was there saying, "yeah but now I've got to do something about it." So, we had a conversation around that, and it's like oh okay, we just want you to know and he's "I have to do something." So that's a good example of where IPL can help I think, because it became clear to everybody that when we let this doctor know that we've got potentially something on the trace [CTG] that might be worth [following up], we just need to be clear that we're just alerting him but we're not concerned at the moment, we're just going to keep the motor on or whatever. We just try and help him to feel comfortable about not rushing down to a Caesar straight away. So that's where those conversations, that's the context of which it becomes evident…the differences. Because we work together in a team, I think we absolutely have to learn, keep doing those things together. Actually, the policy makers need to understand that it's a group of people, not just doctors telling whoever, so it might also include Allied Health.

IPE probably has impacted on my view of professional identity. It has changed over time to now, that perhaps I've done research in the area and implemented IPE in an academic situation. I think the older I get the more things I do, the more I respect the role of the midwife, and nursing as well actually. Whereas when I did midwifery, and when I did my nursing, I was just the worker soldier doing my job, and I look back at some of the things that happened and some of the emergencies you're involved with and some of the good work you did. And now, as I'm older, I think I have high regard for nurses and midwives, I think what a good nurse, a good midwife, these people make a huge difference in people's lives. But it's not a prestige sort of career. That's one of the things I like about midwives and nurses, they're not walking around going "Oh, gee, aren't I great, I helped a baby come into the world today",

they're just getting on and doing it. So over the years my sense of professional identity has made me more proud I suppose, more overtly proud to say "I'm a midwife, this is what I do, and what I do matters, I make a big difference to people". So, that's on a good day. And actually, on a bad day I make more of a difference probably. Ah, but as I've got older and I suppose some of that comes from your own personal experience of having had your own children, or, in the nursing situation when you've had a good nurse help with somebody you care about, you start to really feel it as you get older, that actually this, the doctor who everyone has great regard for, and I do too, often isn't actually there. The person that can often make a huge difference is the person that's there, and the person that's there is often the midwife.

So it has changed, since I've been exposed to IPE, I've spent more time reflecting on what it is to be a midwife and also instilling that type of positive view of midwifery in my students. I just used to do it, and now I reflect on it and as an educator, I reflect on it a lot. And I hope that I try to instil some pride in our students to say, you know, "You mightn't be super wealthy, you mightn't have had the highest ATAR, you mightn't of blah, blah, blah, but actually what you do matters and makes a big difference to people, and you should be proud of that and hold on to it". So yeah, it has changed. I've certainly got much more committed to getting that message through than I used to, I used to just be too busy doing the stuff rather than thinking about it, okay.

There are factors in the workplace and clinically or even in academia that have impacted how I identify as a midwife. Clinically a lot of it is about the woman, you could often do a shift, walk out with your hair all scrunched up, you haven't had anything to eat for eight hours, you're absolutely exhausted, but the woman and often her partner might be the ones that say "Thanks, you made a difference", and even though no one you work with notices or the system doesn't acknowledge you, midwives, clinical midwives don't get a lot of pats on the back I don't think. The woman says "You made a difference for me", and so that helps [you] say "Yeah, I'm a midwife, this is what I do and it matters".

So that's where it comes from predominantly, I suppose I spend my time in academia saying don't forget the midwives because people, even at the School of Nursing and Midwifery, people were very dominated by nursing. I think a lot of people see midwifery in a, my lovely nursing colleagues would, a

lot of them would see it as a specialty of nursing. And I don't. So it's made it clear for me what's different. And I teach nursing units as well sometimes by teaching to them. So I'm a very proud nurse as well, but for me they have quite a different view. So that's solidified some of my view a bit when people say things I think, oh no that's just not how I see it.

In academia I suppose because you have to think about it and we've just come, moved from a building with OTs, and that's the best thing about moving to that building for four years, was getting to know the OTs and actually starting to learn a bit about what they do, and it's when you start to think about the commonalities and the differences and your philosophy or your ideology around it that that helps [with] the [next] step "Oh, okay, yeah, no, we would look at it differently", or there's some things we're very similar. So as I've gone through, you're teaching so you think about it, you're reading things, and you're firming up your own philosophy about what midwifery is, I suppose.

And in the clinical setting, I've worked in a true, well a small midwifery, midwife run unit which got closed down. I worked in a private [hospital] and I've worked at this hospital which [is] much more medicalised. So that helps me identify, and I think it's actually probably [one of the] few places where you really can fulfil the role of midwife at the moment in Australia. Or certainly [in] Victoria, it's become quite medicalised, I think. So it's clear to me what I'd like it to be, and what I believe would be best for most women. But I'm not in charge of the world. That's just the way it is. So I just figure, well we just try and do the best we can in the context we find ourselves and hope women start to say hang on a second, because they're the ones that are going to lead the charge, [the] midwives, I think.

This university promotes interprofessional collaboration. There's a really big push to be innovative, it would be the same everywhere, IPL, there's quite a push. I mean, I'm doing a chapter at the moment with someone in education; it's definitely identified as something valuable and worthy. The thing that stops it I suppose, educating undergrad students is clinical placements, timetabling. Even with the workshops we do at the metropolitan hospital, we say "Look, sorry, this is the way it is", but actually, potentially, if somebody carried on, probably we can't force them. Because it's not, but to align it all up, we just have to do [it]. So we tell them early on in the piece and we give them an option

about which one they want to do, and fortunately so far for some of them it's quite convenient to do it then. But if they said "No, that's my break, I'm not doing it", we couldn't force them.

We're actually writing a curriculum and we're really starting from scratch, pretty much, we're doing a theme-based curriculum. And it's early days but IPL will be there, you sort of almost have to have it even if you don't think, or like it, because it's embedded in the culture of this university. And you know that there should be some there. But as I say, people have some really good ideas, and you get excited and if you could all sit in a room together it might be a bit easier but it's the clinical. "We'll have all this organised", and then "Oh, something", they can't get, and then clinical, and that's one of our issues, we see the clinical's starting to drive everything here. We've got to step back a little bit and have a look at how we can do clinical a bit differently, because everything revolved around clinical, because it was so hard to get placements. And it was the same thing everywhere, everybody was having the same issues, you know.

It's a bit like where I used to work and they closed the maternity unit, it was such a wonderful place for women, this hospital, and for midwives. I had a baby there, and I worked there as a midwife, and it was a fantastic community, lovely place to work. Ah, I don't remember that anaesthetist, but you see this is the nice thing; you hardly ever went to theatre because people had normal births, and they had normal labours. It was such a different, it really was midwifery practice. And the odd thing happened; you transfer up to the large hospital usually. They did have Caesars[11] once a week, electives, but not everybody [who] went off to Caesars came in for an induction of labour or a normal labour. And the inductions of labour were done as needed. But then they said "Oh, you can't do induction of labour," they just got more and more thingy about it, and if she sneezes, she has to be transferred sort of thing, so the numbers got smaller and smaller. It's such a shame, and breastfeeding, I'd never really seen problems with breastfeeding till I came up here, to a bigger [hospital] and everyone seemed to have breastfeeding problems, because of course there was no time, and they go home on day three or day two and that's

[11] Caesars refers to the term Caesarean section.

part of the problem, I'm sure, because milk doesn't usually come in till about then, so no, no. It's just a very different world, yeah.

Interprofessional learning or collaboration affected my individual practice, I suppose the example I gave you before, I realised that every time I say to a doctor, "CTG" or whatever, every time I reported something, the doctor, that doctor anyway, and I suspect he's not alone, felt he had to act on it. So yes, after that, I thought "Oh, I need to be clear, to say 'Look, I need to report this to you, but she's doing well, there's no other signs', and just put it into a context", so I sort of give them permission to not do something [so] dramatic that my clinical judgment would say that they didn't need to do at that point. But maybe it would develop.

So that was a really good example. But probably there are millions of them that I don't think of. Really basic stuff like if there is a high risk pregnancy and the baby might be in trouble, I/ we'd ring up the paeds beforehand, and we'd say "This is the, what do you think, blah, blah, blah, blah", and we'd have a plan of action about when we'd call them, or they might come up and whatever, and then go away. The social worker where I worked more recently, was very involved, because there's a lot of complex social issues. I spent a lot of time with the social worker and they've got a lactation consultant there who's actually not a midwife, she's very good at her job, had a fair bit to do with her, but only when it's complex. It's just absolute part of day-to-day functioning, basically, as a midwife, just part of what you do.

We've looked at things like doing childbirth, various dreams about what we get students to do and things like well that's really encouraging to hear, because if somebody can do it, then you say "Well, it's done, Uni X are doing these clinics, so why can't we?", because we actually have clinics here, we physically have clinics, and the physios use them. And even if it's simple checking blood pressures or whatever to start with, some of these things. So, there are a number of little things that they've tried at various different places, like the smaller hospital, [they have] done a few things with going into aged care facilities with the nurses and stuff.

But the IP, I think it's great, and I do think somehow we've got to all sit at the table to deal with [issues], if we plan it ahead of time then it's quite manageable, but what tends to happen is everyone's in their own little silo, you

plan your thing and then what a surprise, it all clashes. So clinical placement is an issue for a lot of reasons.

5.1.4 Lorraine's story

I've been a midwifery academic for a number of years but mainly in Europe and there the course was really midwifery focused. When I came to join University X in 2008 the Bachelor of Science Midwifery had already been set up to be as interprofessional as possible. When I first started the first year, in fact all three years of the course had 50% midwifery units and 50% interprofessional units. But it was decided that the first year needed to be more interprofessional, more of a mix between all of the schools within the Faculty of Health.

Because of that it was designed that 75% of the units would be interprofessional units and that reduced the midwifery units to one. So in the first year only 25% of the units are midwifery specific and all of the rest are for all of the schools within the Faculty of Health and that includes health sciences, physiotherapy, podiatry, chiropody, social sciences, psychology, so there's a big kind of overlap really. It is a common year. Except, that after doing the common year you are still career specific, because you can't do the common year and then move into one of the other fields, because there's one unit that's specific to that field within the year. If they wanted to move into another Health Science course then they would have to do the extra time to make up for the [midwifery] unit that they had done. I think it's going to continue exactly the way it is. It also gives the students who have been in the first year 75%, which is exactly the same for all disciplines [so] it means that it's easier for them to change to another course. Although it adds time on, it makes their second year a lot easier because they have covered all of the subjects. For instance, I get people transferring into the Bachelor of Science Midwifery who've done the common first year under Nursing or under Health sciences. It means [that in] their second year, they only have their midwifery unit to do. So it makes that second year really much more comfortable for them.

This mix of IPE and midwifery for the midwifery students, midwifery is their chosen subject so they would prefer to have more midwifery units rather than three quarters of it being mixed. So from their perspective they're a bit upset about it. But from our perspective it's great to have some mixing with

other professionals right from the beginning, so that they're aware that in the clinical environment you'll be working with all of these different professions anyway. So it's a good idea to start off right from the beginning, understanding the different professions. And understand the kinds of people who are working within these professions, and more importantly the fact that so much of what we use in our day-to-day practice is overlapping with other professions. In my country the course that we ran was a midwifery course, and it didn't have interprofessional components to it, only student midwives were on the course.

There's mixed feelings [about IPE], really. There are some people who think it's a fantastic idea and others who say, well, the students don't mix anyway. They all sit in their own groups and they don't really have a great deal to do with each other. Also, because it's right from the beginning, they haven't really appreciated their own career yet, before looking at others. They haven't even considered, got in depth, with their own philosophy and what the career means, their own scope of practice, so they don't even understand that. It's a bit overwhelming for them to be subjected to all of the other professions before they understand their own.

I have participated in an interprofessional way; well for instance we set up an interprofessional SIM day with the social work department. We actually got actors in for the day to act out a scene of domestic violence on a postnatal ward. And it was the scene running up to the event, so it was the woman's labour, then the scene of the event and then the scene after the event. And we had both student midwives and social work students; they were all second-year students. The aim of the day was to give the students an overview of the whole situation rather than look at it specifically from their professional view point, because usually with domestic violence or any social work situation the midwife talks to the woman about it and then refers to the social worker. Whereas what we wanted to happen was for the midwife to then understand what happened after referral took place and what the end of the story was. And from the social worker department it was the opposite situation and so, it was a very successful session with really good evaluation and feedback that they benefited from it. Everyone involved thought it was a fantastic day. It was quite confronting for some of the students because it did involve a scene of domestic family violence. Some of the students were quite confronted by that, but they said that it would

obviously help them to deal with that in the future. But the important thing from an interprofessional perspective was that generally with a situation like that in the clinical area or even at home, the student or the midwife, the first thing they would do would be to refer to social work. Whereas they felt now they had more awareness of what social work do in that they take some of the initial stages; some of the social workers said it would be really useful from their perspective for some of the initial counselling strategies to have already taken place simultaneously or prior to the referral. But just from the students' and midwives' perspectives, it was very useful for them to see what happens after that referral takes place. So it wasn't like the closing of the gate. It was just having a look through to see what took place afterwards. It was done in the first half of the semester, so we will probably do another one next year, I should think. They loved it. We do an emergency scenario day for each group in their third semester or third year. It is an enormous amount of work and they all say, "Oh, could we have another one? It's a shame we didn't have this earlier." You're thinking … because you know what goes on behind the scenes.

Social work and other health scientists such as osteopathy, podiatry, I don't work with them, they happened to be in the same units that my students are in. It's not that I teach them it's just where my students go; for instance, when they go to their human structure and function lecture there are going to be students from all the health disciplines there, not just from midwifery, but I don't teach it myself. I teach midwifery. Other disciplines I have collaborated with in this capacity, I've only taught social work students because of our SIM day but the students mix with probably about six schools in the health faculty.

I think interprofessional education is a fantastic thing. I think it's really worthwhile to demonstrate to everyone that it takes a whole group of professionals; it's not just dependent on one person. I think it's a good idea. We have already graduated students from this course. In terms of how they practice I would say they're definitely more broadminded, but that might be because they also come from all walks of life to do midwifery. It's a different kind of person that does midwifery as opposed to someone from some of the other professions. In this course we've had people that have been lawyers, physiotherapists, counsellors and so these are the kind of people that are already broadminded. So whether that has a bearing on it I don't know. But I

would say from their perspective they do seem to appreciate the professional model. But, having said that their favourite class is midwifery and they wished they had more midwifery. The majority are mature age students. We have a handful of school leavers in every class.

The term professional identity means that your chosen career, that the practice that you are most interested in and the practice that you want to pursue, and the practice that you want to focus on. So thinking specifically about the role that you want to play in society and focus in it, on that role. That's my view. But obviously a part of that is interacting with other professionals as well.

I think that interprofessional education has impacted on my particular view of professional identity. It has certainly kind of made me more broadminded compared to how the education ran in my country. We wouldn't even have considered inviting anyone else onto the course, but now I can see the value of the students mixing with other professionals and being aware of their existence. Never mind their practice and the viewpoint coming from [it]. So, it's definitely more advantageous, I would say to the education of midwives than without it.

I'd like to think that with these midwives that we're educating in this particular model, that they wouldn't then go on to espouse these particular views of being easily socialised to some bad practices once they go out [start practising] or once they graduate. I'd like to think that we'd given them more [of a] broad base and more of an open mind. Speaking to past students in the clinical area, it does seem to be that that is the case; they do seem to be more open-minded and prepared to involve other people and prepared to just be more open generally really. I think that the fact that they're exposed to more interprofessional education means that they have it from the horse's mouth. So because they are educated directly from different professions, it's not like Chinese whispers. I've overheard midwives, for instance, talking to students about, for example, pelvic floor exercises incorrectly. I thought, well, to get it directly from the physiotherapist is going to make a big difference to the students, rather than second-hand through people who haven't really understood it themselves.

My view of professional identity probably has been impacted by interprofessional education and it has changed over time, I am a bit more broad minded about things. For example, in my country, a midwife is an autonomous practitioner and, if everything's going well, she doesn't need to refer to a doctor. Whereas in Australia, a midwife has to work in collaboration with a doctor and would also refer to other professionals. And in my country I wouldn't see the value of that but as a consequence of the interprofessional education, I can see the value of involving other people so that you don't have such a narrow view and become inwardly focussed. But you're more likely to step outside of the box and have more of a helicopter view, see things from other perspectives and be able to appreciate other people's viewpoints.

I think how others practice always has an impact on my particular view of professional identity. The feedback that the students give is that they see really good practice and they see really poor practice. And they're working with midwives who they really appreciate everything that they do and others who they think, well I don't want to practice like that when I become a midwife. And obviously the same is true for me as well; I've worked with some fantastic people and people I would not want to mimic and so that's probably true too of every professional really. A lot of it is down to the individual person on the day, and I say to the students "if you have a bad day with someone that hasn't appreciated you working with them, then just don't take it to heart because tomorrow it'll be someone different and you'll have a completely different perspective". But even working with the people that you don't particularly think are doing a great job, you're not going to emulate that, you're going to learn from it and be able to change your practice or model your practice on not doing certain things, as well as actually doing certain things.

In my country there are no midwifery programs that have an interprofessional component. Let me tell you why it happened here at University X. It happened because the university would not agree to have a midwifery course, because it was too expensive and the only way they would agree to it is if there were lots and lots of shared units. And so even though the founder of the course would had preferred it have more of a midwifery focus and less, fewer of the interprofessional units, there was no choice because of financial reasons. The university said they weren't prepared to fund a midwifery

course that had mostly midwifery units within it, because it would be too costly and they couldn't justify it. So, to cover that, she came up with a course that then used a lot of the already present health units, and kept the midwifery ones to a minimum.

So, at the moment the Bachelor of Nursing and the Bachelor of Midwifery are identical apart from two units per semester. So, they have two units which are identical and then the other two units are nursing specific or midwifery specific. The Bachelor of Nursing participates in interprofessional education in exactly the same way. Bachelor of Midwifery courses are more expensive; I suppose if you are running four midwifery units every semester then you're going to need more staff to do that. If you're two running midwifery units and two of them are interprofessional then the school only needs to do one lecture and however many tutorials and so it makes it much cheaper. Of course, clinical becomes expensive and that is the case with our course actually. The nursing students do 800 hours over three and a half years and the midwifery students do 1500 hours over three years. So, we have a Bachelor of Science (Midwifery), and the nursing course is a Bachelor of Science (Nursing) because of the commonalities across the various disciplines.

In my opinion there are barriers to working in a truly interprofessional way and over time we've actually changed a few things because of that. So for instance, in our Imagining Health in Social and Cultural Context unit we now have one tutorial quarantined for the midwifery students, because then they can use midwifery examples. The same is true for integrated systems anatomy and physiology because then they can use midwifery examples as well. So, it started off completely interprofessional and it just didn't work out because they were using examples that had nothing to do [with midwifery], like an elderly dementia patient. We decided then, yes although it was an interprofessional unit and they'd still go to the same lectures, when it came to the tutorials it was better to quarantine the midwives into their own group. So we'll have midwifery specific tutorials because it makes more sense and [if] they get more out of it, they're going to be more engaged. Whereas [with] some of the absolutely interprofessional units, they don't engage quite so well, because they think it's all a bit vague and not midwifery specific enough for them.

Some of the barriers for me I guess are that there were probably people that did not buy into it and were resistant to this type of education at the beginning of the course, but I think it's such a standard situation now that everyone just takes it for granted; this is the way it is. So no questions asked. So, no I wouldn't say there were any barriers to it. I mean the students do complain that they don't have enough midwifery, so if there's any barrier it's from the students themselves. They would like it to be 100% midwifery content and all focused on the midwife and midwifery examples and [then] everything else. But having said that they do appreciate having the knowledge around other systems as well and they're going to use that in their clinical practice.

My workplace is very pro- interprofessional collaboration to an enormous extent, hence the reason the whole course has changed to become much more interprofessional and the first year is now 75% interprofessional. That was just because it's a big belief. A new SIM lab has been built in our building and it's open to the physios, the social workers, all of the other professions as well, not just the nurses and midwives, with the view that it would be great to see some more integration and more interprofessional learning and they all use it. [However] the only mix we have had is with the midwives and the social workers. I'd like to think it would change in the future. We've also got a new GP practice that's opened up, a little bit south of the university and they have a clinic which is the interprofessional clinic, where they're aiming to get all the professions involved and have space for them to deliver some holistic care but from different professional perspectives.

On clinical the students are not allocated alongside other health professional students; however, in their continuity of care experience the students are encouraged to go along to physio appointments, social work appointments, ultrasound appointments, obstetrician appointments, so they're encouraged to follow their women to all of the appointments they go to in order to get an interprofessional component into their continuity of care experience, so they are exposed that way. The students have twenty continuity of care experiences but this is going to change soon. It's going to reduce to ten. We're just doing our interim ANMAC accreditation at the moment.

The students certainly see the value or the worth of going along to these appointments [as] they learn an enormous amount from these appointments.

And it's not just the antenatal period, in the postnatal period they might see a lactation consultant or a social worker, or a clinical psychologist for postnatal depression. They also have a placement in the mother and baby unit as well, so that's helpful. But no, just from another professional's perspective it would be GPs also involved, the child health nurse, they're encouraged to go to the child health nurse visit with the woman. We encourage them to go to as many appointments that the woman has, as possible. So, whatever the woman goes to the student is aiming to go to as well. They go to aromatherapists and homeopaths and acupuncturists as well.

Interprofessional collaboration might have affected my own individual practice if I were to be in practice or in relationships with clinical partners by having an awareness, after the referral has been made, of what happens next rather than just thinking, okay this woman needs to see, and then just handing it on to the next person. So it cuts both [ways] more in overall involvement rather than compartmentalising for different professions' input.

If I were to go back to my country I would be advocating for IPE in programs. I see myself as a midwife first and an academic second. I'm a midwife. That's how I always describe myself to people. This is my first year of working full time; I normally would do 0.5 of each [midwife/academic]. So for me it's very recent that I have actually been a clinical midwife. And even this year I plan to take a case-load of one woman. I'm going to book her in June and then for her to be due in November and do her care. And my workplace supports this. It's worked out very well actually because we're trying to approach the best way of making it work for both parties. And from a university's perspective I've argued that it keeps my credibility with the students and, you know, everything else. From the centre where I'm going to be booking the woman; it's worked out with them that what I'm going to do is mentor a graduate midwife. So she will come along to all of the appointments and the care with me, and just observe with the idea that sometimes, as a midwife, it's good to stand back and watch someone else practice, which you don't always get the opportunity to do once you've qualified. You're just so immersed in yourself that you don't actually ever stand back and see how someone else does something. I'll go back to my old haunt which is the family birth centre, a low risk birthing centre. It's built alongside a tertiary referral unit.

With regard to my view of IPE and midwifery practice here at University X, I think that they're very forward thinking and although they may have kind of brought it all into place for financial reasons, it's always worked out very well and I think there's no doubt that everyone benefits from it. That you know the other professions as well, it means that everyone has a view point. Everyone is able to see through the eyes of the professionals and how they work. And so, I think it's absolutely a very positive thing from every perspective. There hasn't been any research done with our students and with our program, with regard to IPE.

5.1.5 Penny's story

I've always had almost a phobia of needles so nursing or any profession to do with nursing has not even registered anywhere on my agenda. And then I had two children of my own, and I have protein C deficiency, so I needed to take Fragmin during the pregnancy to thin the blood, and my first pregnancy, my husband gave me all the injections, and my second pregnancy, I actually went away for a little while, so I was flying, so I knew I had to take them more, and I just actually had to conquer the fear of it. So, in that sense I just had to deal with that, but I must say I went in[to] hospital last week [as] one of my sons had grommets and he had the cannula in his wrist when he came out of surgery and I couldn't watch them take it out. I'm still concerned about reaching that point in the course. I'm concerned about having to actually do it. I think I will cross that bridge when I get to it. And once I did that, I got over the needle thing.

It opened up a whole world of opportunity but alongside that, I was absolutely petrified of giving birth to my first child and he was actually born at the Women's Hospital in Melbourne. I only saw an obstetrician twice, but mainly saw midwives. He was born with the midwife, there was no obstetrician there, and the midwife was and the whole experience was just amazing. I just thought I just hate the fact that we have this horrible fear of birth, and everyone I speak to has this, or who's pregnant for the first time and having their child, seems to have this horrible fear of birth, like it's just the most horrendous experience. And then I had my second child, and again, completely done by a midwife, and it was just so beautiful and so amazing and I thought, we actually

have to change this. This has to change. We have to empower women [so] that it's not this horrible experience. It can actually be a beautiful, well it is a beautiful experience, and taking the fear out of it is part of making that a better experience, so I thought, hmmm, maybe this is something I could do on a part-time basis so that's why I decided, let's get into it, let's try.

I actually started it [the course] last year, but I wasn't in midwifery so I entered through Health sciences and I did all the units that count towards midwifery except the actual midwifery unit which is the one that I'm doing this year. So, I'm actually only doing one of the four units this year, and all the other units I already [completed] last year.

I would say that, especially for the first year, interprofessional education is understanding that for all the people studying health there's so much common ground, and it's about understanding that we're all coming from the same sort of basis. And then we branch off into specialities, in essence, we're all after the same thing for the clients, we're after looking after them, and it probably involves a bit of everything to keep someone well and healthy, and you're just a small part of that. And understanding that you need to work with everybody, and understand where everybody's coming from in order to achieve the best outcomes, I guess.

The one unit this year involves the clinical placement. All the interprofessional bits I did last year. So, throughout the whole year I did not come across one other midwifery student, or one other student that I thought was going in that said to me that they were going into, or looking to change into midwifery. So all of that was with people from other disciplines, or people going into other fields. There were quite a lot of occupational therapy and physiotherapy [students]. There was someone that had worked in a group, he was going to paramedicine. Health promotion. I'm trying to remember what the other ones were doing. I think they were probably the main ones really. There was a couple in nursing in one of the anatomy units that I did.

All the group assignments that we did were based on just general health as opposed to midwifery. I think everybody just came at it from a different angle. I know when I was doing assignments, I was always trying to relate it to midwifery, like how would that impact on me in midwifery? And how relevant is it? So, one of the group assignments that we did was on cardiovascular

disease and looking at that from a midwifery perspective, it's learning about how prevalent it is in society. Whereas if you're looking at it from a health promotion point of view or something, you're probably looking at how you can prevent it. With that assignment we had to say which health care professionals would be involved in the treatment and preventative measures of people with cardiovascular disease. So therefore definitely the people from the different disciplines would have different things they bring into that. But [it was difficult to collaborate with them], I hated group assignments.

Oh, look I think not necessarily to do with each professional thing but all of the people that I worked with in group assignments were young, pretty much fresh out of school, and I had a lot riding on it because I needed to attain at least 80 course loaded average to move into midwifery, whereas they all just seemed to want to pass. And so I did find that really difficult and really challenging and kind of felt like I carried people a lot because I needed to get a better mark, so I didn't enjoy that. But that was probably more to do with age than discipline.

In life I'm not coming from a family that's really wealthy, so I've got one chance at this study and if this doesn't work, I have to work. So it's not like I can then whimsically decide I'm going to go onto something else. I need to try and make this work. Now that I'm in the midwifery course there are not very many young girls straight out of school. I think there were 33 when we first started and maybe five of them were 18 or under. Most are mums and most in general were an older bunch. So I think you are right, but I think the demographic of the people that are in our course are definitely more driven to succeed.

You know I don't think that [working interprofessionally] mattered because the courses that I did, like one of the units was evidence-based health care. So that will apply to everybody and you can relate that back, every discipline, can relate that back to how it will affect them in the future. Everybody needs to be able to provide evidence-based processes. So therefore I don't think it matters what profession you were going onto, that was definitely valid and another one was health and health behaviour. So anyone working in health needs to understand how people, or the different ways that people view health and understanding all of that. So I think definitely the content of the course was

valid to everybody in health and I think for all of the interprofessional units that we did, I was actually thinking about this on the way to uni this morning, it was such a good base to start off and there's none of the units I would choose to skip if I had to go back. Particularly one that I thought, going into it, was indigenous cultures and health. I thought this is going to be a bit politically correct and one of the ones that everyone just has to do and that's the one that affected me the most. It completely changed my perspective and just opened my eyes [to] things that you hadn't considered before or things that you hear all the time, so you just start believing them and actually you're confronted with questioning why you think that and you're thinking how stupid those thoughts really are. But thinking behind why you're thinking something.

[I found working with students from these other disciplines] interesting. I think there are definitely egos associated with some disciplines but I found that across all of my classes, physio students seemed to think that the light shone out of their bums. I don't know why, but that was just a generalisation. But I found it really interesting because I actually didn't know a lot. My work up until I started studying was in hotels, so it's completely out of everything I know, and so I worked quite a lot with or in a close group with paramedics, or a person studying paramedicine, and occupational therapy, and actually there were two occupational therapists, and I'd obviously heard of an OT but I hadn't really understood what they did and so if I hadn't worked with those people in the group I probably still wouldn't know. At some stage I'm sure I'd find out, but I definitely got a decent understanding of what the discipline actually involves, and why people choose to go into those professions. So it made me more open to other health professionals. I found it useful to know a little bit more about each of those disciplines, definitely. If I was doing just midwifery, I probably wouldn't know that until I came across someone who needed it or who was using an OT.

[Professional identity is] I guess how you personally view a midwife, and how you will view yourself as the midwife. Can you ask me the question again? I think, and this is probably a lot to do with my placement at the moment as well, but very focused on the woman, and focused on the holistic health of the woman, so not just the pregnancy, but looking after her as a whole. And probably trying to not bring too much biomedicine into it, if that makes any

sense, like trying to reduce intervention and empower the woman to know that it's a natural process and whatever, and obviously if things don't go exactly according to plan that's when biomedicine steps in. I think really, women focused on women supporting them, helping them, empowering them. Yeah, that would be my [view].

Professional identity [has impacted on my sense of what a midwife is], it definitely has. I guess I haven't really thought about how, but I guess seeing where midwifery fits within health and within all the different vocations within health and probably also understanding a little bit about the biomedicine versus folk or whatever before that. It is [about] understanding that there are a lot of other health professions that are really engrossed in biomedicine, and midwifery is probably a little bit more holistic, or going for a more holistic approach. So it's like sitting on the fence. And so understanding what other disciplines or what other professionals you would use for women depending on the circumstances that they're in, and depending on their views as well. So if they're wanting no intervention, then perhaps working with the other more folk medicines, like we're referring a lady who's overdue to an acupuncturist, as opposed to going for an induction. [My view of professional identity has changed over time] definitely. I think the change was probably from before being pregnant and experiencing midwives and then starting to study it. Why would I think that? I think it's because my experience of having children was in hospital and it was very, very biomedically based, very sterile and everything like that. But now my experience of midwifery in the course is that it's much more of a natural process and things should happen naturally and my placement for first semester is in a birth centre, like a family birth centre and the second semester is community-based midwifery which some of the other students, half do it this semester, half do it next semester. So we're hearing [about] all their experiences as well, and so that is done deliberately to give us the basis that it is a natural process and that it doesn't need all the medical intervention and that sort of thing. So even things like having acupuncture and aromatherapy and go for walks and have a hot curry and these sorts of things to get you into labour, it doesn't have to be an injection of Syntometrine or something to induce labour, it's other things that can happen. So I think it's really influenced by biomedicine but it's also a natural process so probably doesn't need as much intervention as is given.

I think I've done about 60 hours [of clinical]. It actually varies even within our course, but I am allocated to a midwife. The passion of the women that we're following, like the passion of my midwife, and also seeing how they interact with other people within the hospital [impacts on professional identity]. We're at a birth centre, but it's attached to a hospital, so we've been into the hospital quite a few times, and seeing how they [midwives] interact with the women. It scares me a little bit. I guess actually being in the workforce, following this woman in the workforce, it's making me realise, actually it's like life or death situations that I will be in charge of, so that's a little bit frightening but the midwives are empowered. They're empowering the women, they all support each other, within clinical the midwives support each other so beautifully, so it's been empowering and frightening and [at the same time]. I feel like at the end of it, it will all be okay, but at the moment, I know I did the units last year but essentially, I haven't studied anything [with] midwifery and now I'm actually with women at antenatal appointments, postnatal appointments. Some of the girls have been at a birth, I haven't. It's great to be in those situations, but it's also frightening to not be able to actually help if something goes pear-shaped.

Well I guess with uni this year I'm the only midwife, and I don't know if that continues for the next two years, I don't know if our other classes from next year onwards are with other disciplines or if it's only in the class with the midwives, so I guess that would be a barrier to working interprofessionally study-wise.

I guess there's definitely an element of that [preferring to be with student midwives] because, for me studying last year and not coming across any other midwives, it actually would have been nice to have one or two people who also wanted to study that. Apart from the fact that it's also a really competitive course to get into, so if I did meet them, I would have been racing them really. Do you know? Honestly, though, you have to get over 80 and they were saying they only take two or three course transfers so I literally would have been challenging them, but it would have been nice to have other people who were striving towards the same thing, and obviously with the same interests and that sort of thing. Most of the people in my course, two thirds of us, are mums, whereas I was in classes with kids last year, fresh out of school, there were

hardly any other mature-aged people. That's not an interprofessional thing, that's just a standard thing. It would have been nice to have people with the same sort of views, but I think it was really interesting having people coming from a different viewpoint and with different understandings of things. Some of the assignments that we did were on an illness, so I guess in different disciplines we can all come across people suffering from different illnesses and ours was cardiovascular disease, so everybody coming into the assignment from a different discipline had a different take on it because it would be affecting them professionally in a different way. So that was really positive.

Even within the classes, when you apply for the units and you pick one, in the first year there's 1800 students doing all the interprofessional units, people doing health. You're choosing from five classes a day which one you want to go into. Then for the assignments within those classes they divide you into your discipline, they choose one from each discipline and put you together in a group. So you can't stick with your own type, they actually make sure that you're working with other students, other disciplines. It's a good thing.

[In the clinical area] in the staff meetings, they talk about each member of staff. Although they're all midwives, each has a different role of working with different departments within the hospital on different wards, so they would definitely be involved collaboratively. The midwives are referring the women all the time to different people as well, so they need to be fairly up-to-date on what's required like pathology, even the acupuncture and all the different disciplines within the hospital, if they're referring for inductions and Caesars and blood tests and scans. I'm just trying to think how they know to do that. There's got to be collaboration there. The other day we had the paediatrician come down to check the babies in the birth centre before they were sent home, and my midwife said "go with the paediatrician, and see what they do, and see how they check the baby and take notes on it" and that sort of thing, so I guess that is interprofessional working.

I don't think it [interprofessional collaboration] really has affected [individual practice] it as yet, because I feel like we're a little bit fly-on-the-wall, so we're following a midwife but we're not really getting involved so it's not like we're actively referring women to other people, but I think you definitely understand and see how interwoven all the fields are, and how important it is to

maintain good relations and communication, and even attitudes towards each other. I just feel if the midwives really didn't like the obstetricians then they're planting seeds of doubt within the women, then if something goes wrong and they're in a situation where they have to have an induction or a Caesar, you can see that it's going to be a bad outcome for the woman. So I think it's really [about] understanding that everyone stays positive and happy and supportive of each other and you never know when you're going to need someone's help, so just keep it positive and all work together. It really does seem like that sort of environment, where I am anyway [in a birthing unit attached to the large metropolitan hospital (LMH)]. It is a stand-alone [unit], but it's got the runways to [LMH] if something goes wrong. So lucky [to have LMH as a first placement] that's right, and I think they really do try and do that, because the other people in my class aren't at the birthing centre, [they] are at community midwifery or that sort of thing when the ladies choose to have their babies at home. I think it's really trying to keep it natural to start with.

Now if you had asked me that I would have said yes. But I wonder if that's because of more experience with clinical placements and actually being involved with people doing radiography and obstetricians and midwives and all of that sort of thing and seeing it in action. Definitely, it has.

I'll be doing the course full time next year. I have only picked up three [Continuity of Care Experiences], and one of them I met through my midwife, so I've only seen her once. My first meeting with another lady is actually at a scan, so I guess you're going to meet them with all different health professionals, so it's going to emphasise how important it is really, because none of us can treat them individually. Absolutely, a collaborative effort, yeah. Even the women who birth at the centre and who birth on community midwifery practice, they can't have gestational diabetes, and they have to have had their dating scan so they know when they're due. So already you've got pathology and radiology that they have to see, and you have to get the results. Absolutely [it is really about this concerted working together]. One [Continuity of Care Experience] is not through my midwife. With her I've been to scans and she's going to a hospital-based clinic at a different hospital, not LMH. So that's a different way, procedures, of doing things and time restraints and that sort of thing. But it's definitely been really good because the placement at the family birth centre is

quite sheltered in that all of the midwives are really amazing, beautiful women and I haven't had the same experience at a different hospital. The other hospital has been good, to show me difference. Radiography, I didn't make the obstetrician appointment. But I've been to a physio with one. The aqua aerobics was with physiotherapy from the hospital though. I think that's the point of the CCE though, to expose you to different professions. And that has been a positive experience, yeah, I think so. I do feel like they're almost friends. So therefore, I think it must be a positive experience for both yeah.

5.1.6 Sonya's story

I just hope I've got enough to talk to you about, given that I'm just starting. I am forty-one and I was one of those people who went straight from school to university, and tried about three different degrees and never finished them, and then worked in admin area for barristers for years and loved it, enjoyed it, but always had that kind of urge to do a degree, not any particular degree, and we lived in Sydney. So we've lived in Perth for four and a half years now. I'm married with two children, my children are six and eight, and the kind of work I did in Town A doesn't really exist in Town B. I've been doing just part-time admin work which is very enjoyable but just not really fulfilling, so it's nearly two years, and because my children are now at school, so one's in year 1 and one in year three for five days a week and in a good routine, I thought this would be a good year for me to go back to studies. And, I also only realised last year that I didn't have to do nursing to do midwifery.

So my mum was a nurse, she was a midwife; she's been a Child Health Nurse, a Lactation Consultant. She worked for a mother and baby unit where you would go for a day and you could do a day stay, but most people will stay for four or five nights. She was a fabulous resource for me when I was pregnant and having my children and having young children and I was always interested in the maternity side of the health care, so the midwifery side, just never in general nursing. So once I found out that I could do it as a standalone degree that it became of interest. Then it's also being forty-one, time is very precious, so the fact that it is a three-year degree with a known outcome at the end is very relevant for me. Jobs are very secure; people always need midwives. I live in Perth now but I may not for the rest of my life and I know it's

something that's transportable and I see having a longevity in this career, although it's very physical and that might become harder as I get older. I've other things that you can move into as you get older, education and lactation and all those sorts of things that aren't so taxing on the body. So that was sort of the very practical reasons for wanting to do it.

It's going to be a big upheaval for our family, already is, with doing full-time study and doing prac work, but we'll find a way to make that work because the end result will be worthwhile. I am really excited. I love the fact that it's a job that's different every single day. And that [it's] mostly happy. I don't expect it to always be but mostly a good outcome, mostly good experience.

I'm a first year [and] my midwife is actually on holidays. She comes back on Monday so I have not done any clinical practice yet. Not done anything. So all the other girls do have fabulous stories that they could tell you about births and all those sorts of things but I've got that coming next week.

My view of interprofessional education, right, so the subjects I'm doing at the moment, I've got the one midwifery subject and then my nursing subject is called "Imagining Health in a Social Context", and that's more about theories of social constructs of the health care system. The other interprofessional one is Human Structure and Function, Anatomy and Physiology and the other is Foundations, I'm reading my labels on my folders. Foundations of Professional Health Practice is mostly going to be how to write an academic essay or an academic article and doing academic research.

So I guess from a mature-age first-year student's point of view I understand the value in these other subjects but I find it frustrating because I just really want to get stuck into the mid and theory's a bit by the way for me. Foundations I've just finished this morning and that subject was mostly about using the APA referencing system. Writing in an academic style, so writing properly and a small amount on the Australian health care system. That has been the subject that most people have found to be a waste of time, I think, because it's a whole semester's unit and it is like the inter-professional unit that everyone has to do and the material could be taught in a much smaller amount of time. That was sort of the third part of the semester and then in the second half it's been bits on the Australian health care system in a very ad hoc manner. It certainly didn't increase my knowledge about the Australian health care

system. They talked about the Gibb's reflective cycle, [and] write some reflections that are being assessed at the moment. Individually we were given a subject we had to research and write, so really the marking was about the writing and the academic research and referencing I think. Then in inter-disciplinary groups, they specifically separated us into groups of students from different disciplines, we had to do a presentation. And I do have to say, it didn't increase my understanding of what other people are studying. Yes, we had to do some group work and I guess coordinate a little bit to do our presentation, but I can't say I got much out of it. And my group got its marks this morning and we got 100% for our presentation so we did a good job. We did a good job but you know, I really don't feel I got a lot out of it. [I don't think that having worked on that particular topic, I didn't develop a greater understanding of the role of each one of those other disciplines] no, because what were they doing? One was doing nutrition and another girl's doing public health and the other one was doing exercise physiology but really, we weren't speaking to each other about what we were studying; it was just, "How are we going to put this together and present it to get the maximum amount of marks out of the blue group?" The requirements for the assignment were very specific and what we had to say, it really didn't matter about each other's perspective. It was diabetes, its impact on the interprofessional team that would be looking after someone with diabetes and nothing that you wouldn't find by jumping on the internet and looking up a few academic journals and throwing it into the presentation.

It's a bit dry, absolutely, but I do understand the benefits and I do like that at my university, they're mixed in with all the other health care students. So three other subjects you are doing with nursing and physio and lab technicians, paramedics, speech therapists, occupational therapists. So I do like the intermingling amongst all the students. There hasn't been a lot of it [intermingling] at the moment; we're only in week three. The Foundations of Professional Health Practice, that's the one that's mainly going to be about academic research and writing. They very purposely separated us out of our schools [disciplines] and got us into little groups, one student from each different school. And we'll work with that group throughout this semester doing an essay together and a group presentation.

Actually, next semester all the midwifery students are doing all their subjects together so there hasn't been a lot of intermingling this semester. We've had two subjects so far and they're human structure and function which is the anatomy and physiology class and then for Foundations, the inter-professional unit. Those two subjects we were in with all the other health science students. And, speaking for myself, I sat with other midwives in the anatomy class and then in Foundations, where I was split into my separate group, was the only one where I really was in a different spot.

Next semester, we have been told that all of our classes will be together as a cohort of midwifery students although in some the other streams are doing, there'll be a few other students in there but they will be the minority. We've been told which ones we have to be in. Nice group, thirty-two students. All right, I'm just making some notes as we go along and I've given myself a little note here – there was an expectation when you were working with your inter-professional group that you met outside of class to do the research and to do the group presentation, get it organised, etc. I've only met these people twice now, but I think it will be interesting to hear what other people are doing. I also think, just not for myself, but for a first-year student coming out and listening to other people's experiences, they may find that they're in the wrong course and should be doing something else. They can get a better understanding by speaking to other students from that course.

Then in the anatomy class, we do some group work together and this is bringing strengths and understanding, so a lot of people knew that they were coming from school into doing these health subjects and they've done a lot of biology and chemistry. [They] have a lot of knowledge that I don't have or didn't retain from high school and it's interesting to get other people's perspectives. Then our nursing unit, we actually just do as the midwife group together. So there's not any intermingling because being week three, we've just been delegated to our different assignment topics.

The expectation is that we will meet outside of class to do these, to do the research and to do the group presentation, get it set up. So just meeting in class, you're very focussed on getting the work done in class. They're not all sticking together because we've been put into these separate groups. At the beginning of this semester in that particular subject we all went and stood in the

room with other people from our discipline and then we had to make groups where there was no-one else from your discipline in that group. That's right, not two nutritionists, not two bio-medicine scientists, so then we had a midwife, a nutritionist, another one doing health promotion and the exercise physiologist. So, each group that we were standing with, there wasn't [a] double of anything, and then those groups got broken up into groups of four and that's how we got our group. So, there is no doubling up. In my group I've got Occupational Therapy, Exercise Rehab., Health Promotion and Nutrition. That was one together, health promotion and nutrition. And then Social Work, that's my group.

We will work together on the assignment that we're doing, we individually write an essay and the topic we've been given is diabetes and then we'll be doing a group presentation about the topic of diabetes. There must be parameters around it. In the team we have to make a poster in which we describe a health condition and describe the interprofessional team that will be involved in the care of the person, and the type of services they'll provide and reflect on the impact this condition has on the community e.g. financial cost, public health campaign. Diabetes will work in well for all of us.

The term, professional identity, what I'm hoping it will mean to me is that I, as a midwife, [I] will feel skilled and able in the scope of my work. I think that's what I'm hoping I will feel so that I'm competent within the scope of my training and education to carry out my role.

Then with other people's professional identities, [it means] knowing who to interact with to get the best result for a client. In the short time that I've been here, this interprofessional aspect to education, I don't think it's had a massive impact as yet. I'm very open to [it] having a bigger impact but I think being forty-one, having had small children, a mother in the health care system, father who's a barrister in the Worker's Comp[12] Personal Injuries system, I'm just interested in all those areas anyway. So I would want to interact with all of those different realms of the health care system already and I don't believe in just one sector having complete ownership of treating someone. I think it should be more holistic.

[12] Comp. refers to the term "compensation."

I think my own view of professional identity will evolve massively over the next three years. I had both of my children in the private health care system in Sydney; I had an obstetrician and my mum always worked in the public health system, but totally supported my choice to be in the private sector. She always encouraged me to have an open view about the great care that's available in the public system. That will be really interesting to me and to see midwifery where the midwives really do take ownership of a patient, and really try hard for a natural birth and a really good birthing experience. But I think my views will change. I am at the moment totally anti homebirth; I hate the idea of that risk and I think that my views could change about that a lot as well because people [have] already talked about homebirths that they've been through that have been really beautiful, and how wonderful it's been for the woman and family and how relaxing and, so, no, I think a lot of change will happen for me in the next few years. It will be interesting and I don't necessarily believe that I'll come out for a homebirth. I might still be too risk averse to be that sort of midwife but I'm open to the idea, I'm open to change.

I think it is fear [about homebirth]. I don't like risk and I think that probably the view comes from a father who, because of his work, his personal injury and worker's comp work for disaster everywhere; that trickled down to me and I just think that's a risk that I wouldn't have accepted for my births, and I wouldn't like to be involved in a homebirth and take on that risk, but really do believe that that can change and I think, when I start going to births, and I'll be going to homebirths as well, and I see what they're like and as long as the people are able to get to hospital, able to get treatment, my views could change.

I think that's an interesting question about barriers to working with colleagues in this interprofessional way. I think there are hierarchies in the workplace. I'm very interested to see what the politics of a hospital are like, having never worked in one, and I imagine that there are some barriers, just cultural barriers in workplaces. What do I mean? I think I mean that some people or some professionals will want ownership of the particular problems, and probably not want to consult outside their professional area to see the bigger picture. Does that make sense? For example, seeing a dietician about Gestational Diabetes and them not wanting to call in a social worker, someone who's not doing their treatment or their diet properly. It's hard to imagine

because I haven't been in those scenarios. [Protecting one's turf], I think people do that. And it's not for the benefit of the client. I haven't seen it because the birth centre model is the midwifery-led care and a woman is allocated to a midwife and sees that same midwife. And because I'm working with one midwife, I'm seeing what she sees and then they birth with that midwife. But I think sometimes in general conversation you'll hear that, so sometimes the midwives in the birth centre won't be happy with what happens to their patients when they're transferred to the labour ward. They might disagree with interventions or how they're managed on being transferred, but I just haven't seen that with my midwife or any woman I've been following.

[Mixing with other student professionals has not impacted my idea of professional identity], not yet. I think my attitude would always be looking after a client from a holistic point of view. Probably not yet, maybe that will be expanded, I'll probably know more about other resources that are available, but I was lucky in Sydney to have a fabulous obstetrician who employed a midwife in his practice and referred to physiotherapists and dieticians and would make sure people had access to whatever they needed, not just him. I really loved that type of care and that's the kind of care that I would want for women, probably not people who are low risk and don't need it, but anyone who had any complications; I think that's where that type of care is really important.

I haven't learnt a lot more about the other student professionals and it hasn't impacted my idea of my professional identity, no. I'm trying to think. No. One of the reflections we had to write was about what sort of professional we wanted to become, because of this interprofessional unit. I was really trying to write it to please the marker. To be honest, and I was thinking quite clinically, it's not really relevant to me. There is an interprofessional model with collaboration and communication and what makes a good team person and team leader and those sorts of qualities. So we were asked to then write about what we thought, what kind of health professional we were hoping to become and reflect on the skills, personal qualities and values that you believe most important. I did write it to their rubric which was to talk about having clear communication, working in a team, consolidating information, collaborating with other professionals, using a framework and I can see it will be useful at some point, but it's just not yet. I find this a really weird subject in that it's almost

doing it, looking ahead, but it almost needed to be done later on in your degree when you are actually looking for your workplace and putting together a resume. When you have some skills and some knowledge, have an idea of what my scope of practice might be like, I just know where I might want to be specialising, what areas I'm interested in.

All this theory in interprofessional education, I can't see it being a hindrance in my role. I think the broader your education is and based, it can only be of benefit, and to have an understanding of what professions do, to have mingled with them, studied with them, worked with them, to have a peer group coming through that's not just the thirty-one midwives, because we are a small group. I think that will make a difference and we will end up in the same workplaces and be working together and I think it will mean there's less formality, more consultation between the professions, just more sort of general chitchat about how we can help each other, not that turf protection hopefully.

The only other thing, in my last anatomy class this morning, they handed out the questionnaire about inter-professional education and whether we found it helpful, inconvenient, whether being with other students was a hindrance or a benefit, that's interesting. Vera's going to ask me about this this afternoon. I don't know. Look, I like working with other students and I like being mixed in with the other health science students but I can't say that it's a massive benefit. It's definitely not a hindrance and maybe it's different being forty-one and doing it and not eighteen and just not really having any idea about what other people do. I think the unit I've just done, I would have been happy to do it online and then things where you actually can collaborate more will be like your student-led clinic, workshops where you're interacting the whole time. We weren't really interacting in class time.

5.1.7 Thalia's story

I'm fairly new in the clinical teacher role within our university. I work as a practice support midwife [clinical teacher] for the university. I was doing it temporarily last year for about nine months and then at the beginning of this year, I started doing it permanently. So, I work three days a week as a practice support midwife, and I'm based at the LMH, which is the tertiary hospital in our state.

My role there is to support the students in the clinical areas, the birth suite, antenatal clinic and the postnatal clinic [postnatal ward], and also in the community clinic doing antenatal visits with the third-year students. I work across the board. I have a little bit to do with the first year Bachelor of Midwifery students, not a great deal, but quite a lot with the second and the third years. So, the second years do rostered shifts and I usually work one-on-one with them during that time, and the third years doing the continuity model. So, I go with them to a lot of their visits with their continuity women. We usually just work one-on-one with the students but there are probably about thirty students per year that we have the opportunity to come in touch with, so probably about ninety all up, there's about thirty in each year group. Some of them are on rostered practice so there can be students [who] spend all of their second year doing rostered practice. I do some set shifts with them and then the other time [it] is the third-year students, they follow through [their] continuity women and they will sometimes let us know when they've got an appointment or a labour, and we will join them for that appointment or for that labour. So that's a little bit different to the rostered practice and the set shifts. They usually have three days a week for the majority of the year. There's only a few of us that do this, so we don't work all the time with them but when we're not there they would buddy up with another midwife and just work with her for the shift. We usually just do the morning shift and so those on an evening or a night shift will just be buddied up with another midwife from the hospital. My role when attending with the students is to supervise their work and just be a resource and their support, to assist and fill in any gaps in anything that they haven't thought of, or just adding to what they're doing if they've missed something. I see all their clinical skills and teaching as we go along, depending on what the scenarios are, and how familiar they are with those.

I have been a midwife since 1999. I didn't have a great desire ever to do midwifery; I wasn't one of those people that just wanted to be a midwife. I was a nurse first in my 20s and I was going off travelling the world, so I just thought it would be a good skill to have, a good qualification to have to add to my portfolio, as such. So, I did my Graduate Diploma of Midwifery through the university here, and then I didn't go travelling; I ended up staying in midwifery and I've never left. I just grew to love it straight away, which was a bit of a

surprise to me, it wasn't my intended plan just to do midwifery, but that's just what's happened. I've mainly stayed within the LMH and in the birth suite, where I've mainly done most of my work. I'm an experienced birth suite midwife. I did a twelve-month graduate diploma and I work with the university here three days a week, and practice as a midwife one day a week, at the moment on the floor as a Level 2 midwife in the birth suite. As part of my practice support midwife job, we were highly recommended to do our masters, and I've nearly finished and I'll hopefully just continue on with this job and see what it brings. It's been good but it's been quite challenging.

My knowledge of the stuff that the students learn at uni is a little bit limited because I don't often go and be a participant in that part of it. Occasionally, the practice support midwives – there are four of us who work at the University, will go into some workshop and just assist them sometimes. But most of the time, we don't do the lecturing or the teaching at the university as such. So, I know that they've got weekly course outlines and things like that that they cover at uni. We gauge what they're up to and until they've practiced that at uni, then they can't put that into practice in the clinical setting.

I get my interprofessional education from the hospital as well as the university. The university offers courses that I've done that they support, like the ALSO course, which is supported by both. We participate in all the external courses and the internal courses within the hospital, all the education sessions that are mandatory training. I know that the students have [to be] a part of that as well before they're allowed to come onto the clinical setting; they have to do the mandatory training as well in the hospitals. Mainly, it's pretty much just midwifery staff; there is a fortnightly session at the hospital that is a multidisciplinary education session. That's on a Thursday and everyone is invited to that session, which is a really useful tool and it's open to students and doctors and residents, and everybody within the maternity unit. It's usually a fairly generic topic that is relevant to everybody. So that's where everyone has a chance to come together. Different speakers each week, sometimes it may be doctors, sometimes it's a midwife, sometimes it's someone from outside of midwifery, from pathology or from the nutrition department. I think it's a useful thing. I have got a lot out of those sessions so I think it should be an important part of our education because it just gives you a different perspective. I think

it’s really worthwhile, and it’s getting a lot of positive feedback and it’s well attended.

I have not participated in other interprofessional education a great deal that comes to mind. Sometimes we will go to a child protection workshop which has not just midwives in it, there were other professionals there. I've also done some clinical supervision training that had a lot of varied health professionals that came together. That was run by the health department for clinical supervision for all areas in health. So, I've participated in that. When we do midwifery education, it is very much focused on midwifery so [that] it’s just solely midwives and student midwives that come to that. Because there was quite a close link between the two, we didn't do a lot of external professional development there.

Professional identity is the public perception of what midwives are, and also our perception [of midwives] within the health system, so that we come across as a professional body or a group of professionals, comparing us to nurses, doctors, physios, nutritionists. Midwives, I think, have their own identity within the health system. It's really about what we do, what makes up our core business, that's where identity is; I think it's how we reach into the community. You know, we impact on not only the women, but their families, and I think more recently that role that the midwife plays is getting a lot of good press in the community. I think we're getting stronger as an identity. So I think that has improved, and it's a really important part of our professional identity. I think within the health system, midwives, I think we're probably getting better at being our own identity. People often would clump nurses and midwives together and say 'You're a nurse but you're a midwife,' and I think it's getting stronger. I think [with] the Bachelor of Midwifery, midwives are actually getting a stronger identity than what they've had in the past.

With women on social media, talking about midwives, making midwives a little bit more prominent in the public eye. I think that’s one example when they’ll be talking about midwives, which is a bit different to what it’s been like in the past. That’s probably one example. I know in my city it’s very much word of mouth like, “Who’s your midwife?” [It is] very positively sought after to be on a continuity midwife program, so I think that is stronger since the Bachelor of Midwifery has come out. And because, as well, the Bachelor of Midwifery

students are linked up to pregnant women through their course, I think that's helping their perception as well of what midwives do/are. So that's probably one of the driving forces, that the students are out there a lot more than what we were as nurses doing our midwifery.

Midwifery was just another skill that a nurse had, being a midwife, when we did ours. Whereas now, the way the Bachelor of Midwifery is set up has really nothing to do with nursing at all, so it's its own profession. And because a lot of the model is continuity of care, that message is getting out to the wider community that midwives are their own individual profession. So, I think that's a positive step for our identity. I think midwives and nurses seemed to, before the Bachelor of Midwifery, come under the same umbrella. A lot of the public think the same. You'll still get called, 'The nurse did this, the nurse did that' in midwifery, so I think a lot of people still think that we are nurses. Some of us are but some of us certainly aren't. It's slowly getting better because now our workforce is made up with a lot of midwives who are Bachelor of Midwifery graduates. So, it's still there but I think it's probably changing as the years go on. I think it's certainly still there as well in my city, particularly from the older generation and particularly from the nurses who don't really understand what the Bachelor of Midwifery is all about.

My view of interprofessional education [is that] I think we're getting better at that as well. I think it's certainly changing. I think we're getting better at evidence-based practice, which, from when I did my nursing in particular, it wasn't highlighted very much. And from memory, even when I did my midwifery it wasn't as strong as what it is now, it's a driving force for that education to be put out there and for evidence-based practice to be referred to a lot more by the Bachelor of Midwifery. I think that there is some input and I think that they are a little bit aware. But I think maybe being just a discipline of their own at the moment, I think they [student midwives] don't have the knowledge of say, nurses, who probably tapped into those other disciplines more. I think that some of them are a little unaware of all the other disciplines that are around and what resources you could tap into. Which I guess, just being in the health system for a little while you get more exposed to that, so I think maybe just because they're new to the health system, that's probably just an awareness that once they get to the hospital, they have a range of services that are made

available to them [and] that they can access them. Within their course they do involve other disciplines as well. I know that they have different speakers coming in from different disciplines, so they probably do get exposed to it. But I think it's probably not until you're out into the clinical areas that you can get a really good grasp of what resources are out there.

[With regard to] impacts on my own professional identity I guess being a midwife you are the specialist in midwifery, so you do have that identity when you're interacting with others, so the endocrine team might come over and, as you've certainly got your scope [of practice], they'll ask you about [something] and vice versa. So, I think it's highlighted there, when you are making referrals outside from a midwifery aspect. So that's respected and highlighted, I think. It does vary a little bit depending on who you're speaking to, but some people really will, I think it depends on their experiences with midwifery, value the midwife's input and others may not, necessarily. So, it does vary a little bit. I've recently just had a little bit of interaction with the nutritionist, just in doing my own studies, and that I've found has been a really positive interaction because they value my input, being a midwife, and they're looking at pregnant women and their nutrition, so that felt quite equal there and quite valued.

My own view of my professional identity has changed over time. As I said, when I first went to become a midwife, I didn't really understand the identity of a midwife; I went into it fairly green. I think by working in midwifery for fifteen years, I think now I've got a really good appreciation of the impact midwives have, and so it's certainly strengthened the impact midwives have and the importance of being a midwife. I think just by practicing at it, you get to see the importance and you get to see all those differences that we make which strengthens your identity as a midwife. I see it as more than just providing a service; you're providing information that can really alter someone's experience so you can give that information to facilitate decisions [for the woman] that will potentially make big differences.

We often collaborate with the physiotherapists and the nutrition department. At the moment we've set up a new clinic for women with high BMI, so the nutrition department is having input, the anaesthetics, they come under the doctor umbrella. Child protection, we come in contact with them quite a bit. The Maternal and Child Health nurses as well. The anaesthetics would be in

the capacity of, if a woman needs an epidural. And sometimes some referral antenatally if they've got some issues, they can sometimes have an anaesthetic consult antenatally.

Factors that impact [on my] sense of professional identity, I think sometimes midwives aren't seen as [being] on a level [playing] field as the other professionals, so I think that potentially, depending on who you're dealing with. Sometimes the level of respect is not equal across the board and so that impacts on your professional identity. Other times it's probably the opposite, sometimes it's negative, and sometimes it's positive.

Negativity, probably the anaesthetic department, the anaesthetic teams. I think they downplay the role that we have a little bit. I think they [anaesthetic staff members] see us as just like aide[s] to the doctors, like a nurse's aide to the doctors because when we go into their theatres, the doctors have taken over their care and we basically do jobs to help the process. So I think that's mainly how they see us. I think unless they've had a positive experience with a midwife, that's the impression that I would think they have about midwifery. The younger ones that have potentially had babies or their wives have had babies, then they have a very different view but it's more those that potentially haven't been in touch with a midwife and seen what midwives do, when they're not in theatre chasing the doctors around.

The positives come from some of the medical team, the obstetric team we're dealing with, some of them really value the midwifery input. I think most of them would appreciate the role that we have and I think after working with them, you get a level of trust build up that when you do go to them, [it's because] you're out of your comfort zone and you call them for assistance. So I think a lot of them will be very positive about midwives and what they do.

The child protection people value our input as well and what we do. We actually work quite closely with them and collaborate with them quite a bit. Usually we work closely with the social workers and child protection, I guess it's a bit of a triangle, I forgot about the social workers. But they certainly really value what we do. There's never anything negative that comes from social work team. They're always fairly appreciative of the care that we give. Maybe they're just really caring, nice people, but they seem to be a lot more

appreciative than say a physiotherapist or an endocrine person that might just come in. They might get a little bit more insight into what we do.

I think the barriers to working in an interprofessional way would be just about lack of awareness of our role and what we do from other disciplines. I think just educate them as to the relationships that midwives have with their women, they're often on a really personal level and particularly with continuity [of care] they're really thorough. Whereas, it's not just a quick referral or a quick meet and greet on the day. Often there's a lot of work that has gone into that relationship. So, the midwife is really pivotal in that, in being her primary carer. And you see, the differences are quite dramatic. The student midwives have developed such a relationship with the women, have a great relationship, it's a really nice partnership, and very valued and very strong. And certainly more than what we had.

The university is quite open to any sort of interprofessional education. On Wednesday I was encouraged to go to a workshop about having challenging conversations. It was run by the HR department and it involved everyone from the university from different faculties, so it wasn't really directed at health or midwives at all. So that was the university being really supportive of education and not necessarily just midwifery. The hospital not so much. I guess that just comes more down to resources and time off and access to study leave. So that is more of a barrier. They have education calendars but you don't always have the support to have leave to go to those [sessions]. Whereas the university, the work is different, so you can book it in, and block yourself out for the morning. Whereas if you're on a shift at the hospital, it's just not going to happen and I think it's probably fairly similar across the hospital systems. You have to book something in months in advance to actually get something and then possibly you might have to come in on your time to do it. We can't get people off the floor, supporting everyone to go off and have a great education.

We don’t really have a workshop [for the practice support midwives] run by the university. We have ‘get togethers’ with each other. The practice support midwives will meet every six weeks and discuss what’s happening and then we are encouraged to, if there’s an education session that we’re interested in, or if we want to go and do a course, then that’s the time that it can be discussed. Not actually a workshop as such where we all go and get education

or share ideas. There are generic things [notices] that get sent out and they're open to all staff so more from the HR side of things.

Interprofessional collaboration, it's really useful. It's great to get some background or some education as to why we're doing things or the focus that other people are coming from because sometimes you're not aware. So it's really useful to get some inside knowledge from the other teams, I think. It just makes you able to then understand the process that's relevant to your work and to pass that onto the students and to the women. For example, we had the GPs get together and they have a meeting about maternity care. We got some feedback from the GPs in regard to thyroxin levels in pregnancy, so their input really highlighted what I didn't know, which was really useful coming from the GP and how they managed a woman's thyroxin levels. That was really useful and appreciated by us.

I think the students are getting a fairly broad range of interprofessional education at uni. I think they're probably covering it quite well. It just gets better with time and more experience tapping into those things once you are out in the clinical setting. But they're certainly getting exposure to it in their theory. They have an inter-disciplinary meeting, I think it's really well attended and I think people are really getting a lot from that, so that's really positive, it's good for collaboration and teams as well, working together. It's just a nice way to bring everyone together, rather than split everyone up into disciplines. That's within the hospital, actually. They're free to go and lunch is provided, so that's another bonus. So it's good, everyone tends to come, and the students feel really comfortable in coming as well, they're encouraged to come. And their participation is active.

5.1.8 Valerie's story

I am a graduate of the Bachelor of Science/Midwifery from University X. This is my third year out from university. I am working at LMH. When I fell pregnant the first time, which was about 27 years ago, I didn't even really know what a midwife was. As I started reading about pregnancy and birth and that postnatal period, I just thought, 'Oh, I'd really love to be the woman that's with the women,' and so it wasn't until I had my first child that—I actually lost that first pregnancy and then I had my first child I had a student midwife at the birth,

and so I knew what a midwife was/did, and then had two other children, had a midwife with the second birth, no doctor or anything. From that time, I just had an amazing interest in the whole process, and always just thought, 'that would be fantastic.' So in 2000, I had been a hairdresser years before, and then because my husband was in the military I didn't work while we had small children because he was always away and anyway, as the girls got a bit older we were living in Sydney I decided that I'd apply to do nursing because you had to do nursing and post grad mid, and that was in 2000, and then a friend of mine who was a nurse midwife actually said to me over dinner one night—her husband did the same job as my husband—and she said, 'Look, what are you thinking?' 'I think you really need to think about this because you've got prac and ...' you know. So, we lived on acreage and didn't have any support and so I did think about it for a year and then thought, 'no I can't be.' Personally, I couldn't be the mother that I wanted to be and study full time as well with the children at their ages. So I was fortunate enough to have that choice I suppose, that I didn't have to work.

Then we moved to Town A in 2002 and it was not long after that that I read somewhere, like a clip in a paper somewhere I think about this new degree, and I just thought, 'Look, I'm going to give it [a] burl and see what happens,' because I didn't want to get to the end of my life and just think, 'Far out, I didn't even try.' So a bit of a long story, sorry. So I'd actually sat the STAT near State A but because I hadn't needed to sit the written portion of that here I had to resit the STAT so I went and did that, then didn't get the marks to get into the course at first; their mark was much higher than I thought I'd ever actually be able to reach, so I did first-year nursing and they took two switches, there were a couple of us who did nursing first, they looked at all of our marks and references and things and then allowed us to, or invited or offered us to try the midwifery stream, and that's how I got into it. I loved it; I loved every minute of it. Look there were definitely times where I felt, 'God what have I done? Like, 'I could be just sitting at home going to the gym and having lunch every day,' but I thought, especially I'd never experienced university at all. The lecturers at University X were hugely supportive because I didn't even really know the last time I visited a library, [this] was when the catalogue system was the old drawer that you pulled out.

So, it'd been years since I'd done anything, and [I was] very, very well supported. The course itself I loved, I was like a sponge, and I just absolutely loved it. So our course is three years. I actually did it over four [years] because I did nursing first, so I did some of the common units to nursing and both degrees, I did that in first year, and so I was fortunate enough that there were semesters where I only had to do three units instead of four. So that was nice. So, a lot of the units are common to both degrees, to nursing and midwifery, and we also had to do the normal, we had to get 100 postnatal cares, 100 antenatal cares, complex care, there were certain criteria that we had to tick off as you normally would. We also had to look after thirty women during the antenatal period to birth, or hopefully to birth and the postnatal period. I tended to gravitate towards socially complex women, which surprised me really; I didn't think I would be super interested in that. So that's it basically I can't really think of anything else that would be significantly different to anyone else I don't think.

Most of the units that we did were nursing units so they were the nursing students, but there were also psych[13] units and social [sociology] units, we had other students, health students, in that class as well. I think at the time that we tended to sort of splinter off a little bit, so I think those students tended to sit with their friends that were also doing the same core study, and we tended to as well, and because we were such a small cohort, I think there were twenty of us in the intake, and I think thirteen of us ended up graduating, that we tended to have quite a solid, our group was quite connected and quite supportive of each other, so we tended to sort of stick together, that was my experience at least. I didn't do any that were with paramedics or I certainly did them with nursing students but I can't remember doing joint assignments, that's not to say the other girls didn't, but I didn't.

What my professional identity means to me; I suppose it means the way I view myself and the way other people view me. I suppose you'd have to ask them what they think; my professional identity, I would like to think I'm more professional and probably medical than what the general population probably would consider a midwife to be, in that I get the feeling that some people feel that midwives are just all bean bags and infants, and I feel that my professional

[13] Psych refers to the term 'psychology."

identity is more educated than that. I like looking after women with more complex social needs as opposed to purely medically complex, so women who are prisoners, women who attend the drug and alcohol clinic. I like both but I would prefer the complex social needs [women]. Well a couple of us have actually said that until somebody is involved with birth at a complex level that most people I feel would say – you know if you say you're a midwife they think that you are there to support the woman, rub her back and all that sort of thing; they don't realise that actually the breadth of knowledge that you end up having and how scientific really it is, or could be. I think on a personal level I would like to think that I'm an educator as well, of the women, students and other midwives. So for me, when I'm at work, or even when I'm not, I'm trying to learn off my colleagues, whether they're another profession, or some are midwives, as well as learning off women; but for me I really love the idea of actually educating women and new families, but to educate students, so I've probably been drawn to that [students] more than I expected that I would be. I mean I always knew that I'd like to educate women, but I probably have gravitated and I feel like I'm going down that path of learning to educate students in a more effective manner than I might have in the past.

In practice since I've been out, I have participated in an inter-professional way by, I suppose, I've been drawn to women who are socially complex. So I've had interactions with social workers and psychs, and the drug and alcohol team, so I had to go and do learning [about] detox facilities and the people that take, or that work in those facilities.

There were a few of us that went to two detox facilities for two days basically just to observe and to get a better understanding of what the clients go through in the different programs. And the programs were very, very different. One was a government approved program and one wasn't. So it was more as an observer just to see how they sort of work and observe what the clients might have to go through in the detox process.

So social workers predominantly, and psychologists and the psych team and LMH; there's a psychiatric team there. So probably social workers and a psych team I'd say, predominantly. But there are also the physios, I mean every day they're on the wards, there are numerous different disciplines that come in and review and we have to discuss a patient and a plan, they may

change the plan, every day you're exposed to different professions and different disciplines really.

My personal view of inter-professional education is that it's hugely important. So LMH, I don't know if other hospitals do, I'm assuming they do, but LMH has in-service, it's not a set study day that we have to take part in as ongoing learning, but they have in-service a few times a week where different disciplines will come onto the ward or wherever, in different locations, and they'll go over, it's just a short hour-long, forty-five minutes, an hour, so that we extend our knowledge base regarding other disciplines. Sometimes it's midwifery, it's a topic that's midwifery focused, but it might be the pharmacist will come up and will talk about a new drug or it might be St John Ambulance that will come and do a talk, just so we have a better understanding of their paperwork so things can go more smoothly. So, in that respect it's fantastic because we get to just have a better understanding and that impacts on the ways things are done for people, the plan. It's really important and interesting.

Interprofessional education has impacted on my own professional identity because I feel more confident after having those learning opportunities, and not just confident but competent, so I suppose my identity, my professional identity, has changed since I first started because I have a much better knowledge base and a better understanding about those other disciplines and how my work impacts on them and their work impacts on me, the woman, her family, so in that respect, it's made me feel more confident and I suppose I view myself as more of a professional with more to give and more to teach. If I hadn't had those other learning opportunities then my knowledge base wouldn't have been pressed, my understanding wouldn't have been as good, and so for me personally I wouldn't have felt, when I first graduated I didn't feel as comfortable passing on information because my understanding wasn't as thorough on as it possibly is now. So all of those disciplines impact on each other and for me, now I have a better awareness of that, so that's improved my image of my professional self I suppose. I would agree with the definition of inter-professional education as working with each other or learning with each other, from each other and about each other. I've said this to some students recently at a forum, that you imagine what your path is going to be and depending on your experiences and your own further education you have to be

open to going down different paths. And just being exposed to those different disciplines then you may end up actually not being on the path that you imagined yourself on. But that's life isn't it really.

My professional colleagues could be a factor in the workplace that could have an impact on the view of professional identity. I suppose the learning opportunities, just those multidisciplinary learning opportunities have impacted on it, because without them then I would be limited as to how other things impact on my practice. And also, on my care of women and their families, because if you don't have a decent, or any understanding, of how physio for example, can impact on a care plan or you don't understand mental health issues for instance. If I hadn't learnt from those different disciplines then my care of people, how do I try and say this? My care would have been different perhaps, or I actually think I wouldn't be able to care for people as well as what I think I do. Intercollegial working has actually enhanced my practice, that's exactly what I'm saying.

I think there are some barriers in the workplace to working in that inter-professional way and I think you get this in every area of your life really, but I suppose people's own personal, my colleagues' own personal, and my personal background, that impact on how they might relate or how we relate to each other; we're all humans after all and there are some people that you can work really collaboratively with and other people that are just, it's nothing professional, it's just a personal, preference for some people's style at work or the way they practice. I think possibly, how much time we have at work impacts on it. Because there are times that you're just too busy, especially on the ward I find that you're just too busy to actually discuss something in depth with somebody who's working within another discipline. So, a time-shortage, restricted time that impacts on it.

Sometimes it's the person's personal background that might impact. Well I know we all bring something to work, whether everything's gone smoothly at home or not, whatever we've all got sort of, I hate saying it, but baggage, that's from our own personal histories that impact on how we do things in our lives, and I suppose that there might be somebody that doesn't like working with a particular nationality for instance. Well regardless of how their personal preferences come into it, they either enhance or really destroy the opportunities

you might have to learn from that person or just the fact that somebody might be ill or it's all those human factors that come into how we interact at work.

My workplace actually supports or promotes inter-professional collaboration with the in-service learning opportunities; that would be a major one I think, for me at least because they're really, really regular, so LMH giving two paid study days a year and then you have to do the other in your own time, but there are always new online learning packages, and then there's the in service, which is different all the time, and I suppose the powers that be must look at the unit's or the ward's performance and if there's an area that they feel that there's an issue that needs to be addressed, well then they actually get it organised. So what else do they do? Every ward has clinical development midwives, so they put out different learning opportunities and they touch base on each handover, and you know, they're always there so that you can go if you're having an issue or if there's something you don't clearly understand, they're always there. I think night shift you don't have them on that shift, but there's always senior people you can go to, so even if it's not a formal study day or in service, there's always the opportunity; they really do promote junior people that come to seeing the people and just to learn off each other, and if it's a quiet, not on the ward, it's never quiet, if you're on a rotation where it is quiet, you know there's always the online bits and pieces that you can go and look at and guidelines that you can go and go over. The in-service days, I'm not sure about the other disciplines, but for midwives it's all disciplines that will come and actually do in service with us.

At LMH I'm on the rotating midwifery roster at the moment, and so I rotate through lots of clinics, the ward, labour and birth suite, visiting midwives. I've just been accepted into labour and birth suite so I'm core staff there now. [With regard to the visiting midwives] I think some of them [the women] want a live-in midwife and actually, interestingly, just as a side note, I looked after a woman who had come from, I won't say [an African country], but anyway she'd come over, she had five children, no family here, [a] refugee, and she expected me to come home with her for a month because that's what happens in her country. So it was devastating for her and for me really to have to tell her that no, we're not coming home with you. Once you're discharged, and once the visiting midwives have finished looking after you at home for those few days,

you're on your own, so that was quite an interesting change of cultural expectations I think.

I am a graduate of University X and at LMH; LMH takes students from other universities as well and I work with some of these students. I haven't noticed any difference in the students in terms of how they care for women from the perspective of this inter-professional background. I think the only difference; the real difference that I notice is between whether they're a post grad student or an undergrad student. I don't notice it necessarily between University Y and University X, you know? To me at least the University X students aren't noticeably stronger in regards to, collaborating with others, knowing who to go to, that's right.

5.2 Conclusion

Each participant came from a different background at the time of their introduction to the study and practice of midwifery as listed in the table below. However, there were commonalities in their experiences of interprofessional education in the midwifery context, and their own location and perceptions of themselves within that context. The following chapter presents the themes derived from thematic analysis of participants' stories.

Table 5.1: List of Participants

1	Holly	Academic
2	Lorraine	Academic
3	Sonya	Student
4	Fanita	Student
5	Jenny	Student
6	Arizona	Student
7	Lina	Student
8	Penelope	Student
9	Jordan	Student
10	Valerie	Registered midwife
11	Alicia	Registered midwife

12	Phoebe	Student
13	Derya	Registered midwife
14	Thalia	Clinical teacher
15	Georgina	Academic

CHAPTER SIX
THEMATIC ANALYSIS

6.1 Introduction

Interprofessional education (IPE) has been a component of several undergraduate tertiary-based midwifery programs and health care providers in Australia, albeit somewhat later than the overseas counterparts. Midwifery educators, graduates and students of these programs shared their teaching/learning with students of several other health disciplines. Likewise, midwives employed within maternity services worked alongside students and graduates of these programs with IPE as part of their core studies.

The previous chapter presented the narratives about IPE in the context of participants' teaching, midwifery education and practice. In Chapter Four, section 4.4, the analytical and interpretive processes used in this study were discussed in detail. What follows here is a thematic analysis of participants' narratives from each of these groups. Five themes are presented and each theme's nomenclature has been attributed by the researcher based on the meanings drawn from the narratives. Whilst participants expressed divergent views of their experiences and understandings of IPE, they valued it on a continuum, thus there was not a dichotomy of 'good' or 'bad' experiences. Represented in the following analysis is an exploration of these views and experiences along the continuum of the IPE experience. The five themes are 'shared misconceptions,' 'shared understandings,' 'shared misdirection,' 'shared professional values' and 'shared misgivings.' Each theme is supported with the words of the participants (*Arial font and italics*), and they are identified with the acronyms 'RM' for registered midwife and 'ST' for student midwife. A table (Table 6.1) showing the thematic schemata is presented below.

Table 6.1: Thematic schemata

Theme	Sub- themes
Shared misconceptions	Defining and understanding IPE Worth of IPE Other aspects around IPE
Shared understandings	Engaging with IPE / IPC / CP Perceived barriers to IPE / IPC / CP IPE / IPC and the clinical environment
Shared misdirections	Alternative dimensions of IPE / IPC / CP Oddities
Shared professional values	Qualifications, knowledge and skills, expertise Scope of practice (what a midwife does), role identity Factors impacting professional identity: working as a midwife Factors impacting professional identity: learning to be a midwife Factors impacting professional identity: IPE between and betwixt
Shared misgivings	IPE in the classroom and beyond: attitudes and outcomes Barriers to working and learning together

6.2 Theme 1: Shared misconceptions

There are many interpretations of the term 'IPE' in the literature and this was no exception in the participants' narratives. The definition used in this study is discussed in Chapter Two, section 2.2. The term misconception in this study refers to the variety of meanings and views of IPE and experiences attributed to/of IPE by the participants. Interprofessional education for many participants ranged from sharing units of study/subjects, including group work, with other university health professional students through to knowledge acquisition and learning from others in practice. It is important to note that participants variously used the term 'interprofessional education' synonymously/interchangeably with 'interprofessional collaboration' and 'multidisciplinary,' particularly if they related their experiences when in the clinical environment.

6.2.1 Defining and understanding IPE

A commonly-held view by several participants was that IPE revolved around the sharing of common units of study with a variety of health professional students. Valerie explained how this was achieved in her experience: "*Most of the units that we did were nursing units so they were the nursing students, but there were also psych units and social units, we had other students, health students, in that class as well."* (Valerie, RM)

Jayne viewed IPE as the acquisition of knowledge in the course of her midwifery studies and enhanced with learning from others in clinical practice. She was also of the view that it was necessary for health professionals. She said:

> *So for me it's being able to learn the theory but then go into the workplace and work with people who are already in the industry to understand and learn more from them. With regard to interprofessional education, I think it is brilliant and needed in these kind of industries. I think without it then you won't be able to perform the job as well as you should be able to …* (Jayne, ST)

For other participants IPE was very much about teamwork, being able to relate to each team member from each of the disciplines represented in the course. This was viewed as useful by the participants. Fanita explained: *"So we just try to* [get to] *know each other and* [get] *ideas and talk with each other, what's your major, so try to know them. Then we have the teamwork, it's quite good."* (Fanita, ST)

Another perspective was that the experience of IPE helped locate oneself within the health care system and its workings. Jordan stated: "*… it makes you realise your place in the order of things more like what each profession is all about. The structure of it; probably more the structure of the health system and how it all fits like that."* (Jordan, ST)

Penny's view of IPE was more closely aligned with that of the CAIPE (2002) definition. Whilst her initial view of IPE was similar to other participants in that it was the sharing of subjects at university, she was also of the belief that IPE was about understanding where each and every health professional was coming

from, in other words, their roles and associated practice. She saw this as integral to understanding the diverse viewpoints regarding health care provision. In addition to this, her learning experience was enhanced by the differing viewpoints brought to the table by the other health professional students. Furthermore, she believed that IPE was valuable for all health professionals to work together for the benefit of the client.

> *I would say that, especially for the first year, interprofessional education is understanding that for all the people studying health there's so much common ground, and it's about understanding that we're all coming from the same sort of basis. And then we branch off into specialities, in essence, we're all after the same thing for the clients, we're after looking after them, and it probably involves a bit of everything to keep someone well and healthy, and you're just a small part of that. And understanding that you need to work with everybody, and understand where everybody's coming from in order to achieve the best outcomes I guess.* (Penny, ST)

These sentiments were echoed by Lina: "*…but in future that we work together because obviously we've got problems to solve and if we know how to work together then it makes life so much easier."* (Lina, ST)

For Georgina, IPE in the classroom was about discussing the contribution of each discipline and sharing formal learning experiences. Sonya attested to the worth of this approach, as she felt that formal learning experiences in the form of group work assisted her with having diverse understandings and strengths of the other disciplines. Sonya recounted: "*…in the anatomy class, we do some group work together and this is bringing strengths and understanding,…they have a lot of knowledge… and it's interesting to get other people's perspectives."* (Sonya, ST)

Alicia was of the opinion that IPE allowed her to develop awareness of other disciplines and found studying alongside the other health professional students as especially useful, as in her view they had a good mix of disciplines. She also felt that it was a pragmatic approach to teaching delivery in the course given the small midwifery cohort.

> *I think that being aware of that multidisciplinary approach or that holistic health aspect is really important. I just think it's not feasible to teach midwifery to, I think it was thirteen students in our second and third year. One supervisor or one tutor to thirteen students is not*

> *economically viable… having the combination's really good. I don't mind sitting and having a lecture on psychology with 200 students because it's not going to be any different if it was to 13 thirteen students …That was lots of talking, lots of interaction, lots of feedback. You couldn't do that if it wasn't just midwifery*
>
> *It would have been good for other students to have us there and it was good for us to have the other students there because it makes you aware of what others were doing.* (Alicia, RM)

This thinking was reiterated by Penny with particular reference to the fact that IPE allowed her to understand the roles and practice of the other disciplines, she said: "*I'd obviously heard of an OT*[14] *but I hadn't really understood what they did and so if I hadn't worked with those people in the group I probably still wouldn't know."* (Penny, ST)

This view was supported by other participants who concurred that IPE leads to broader thinking and a view of other perspectives outside of one's scope of practice and broadened one's own understanding of the content at hand. In their words:

> *… it makes you think a little bit more broadly, it makes you think outside of your own scope, your own training, your own view, I suppose. I think that it brings another perspective, especially probably their experiences that they might have in the other disciplines …* (Derya, RM)
>
> *It was really good to see something that you wouldn't normally think about. Yeah, a line of thought that wouldn't really cross your mind but it's been brought up by someone else; it really broadens your views.* (Phoebe, ST)

Whilst Jenny shared the view that IPE was about studying with other students from different discipline backgrounds generally, she expressed the opinion that at university level there existed a dissonance between the ideology of IPE and its actual implementation at the operational level.

> *And the tutors were trying to even when I went into this nurses' thing for bioscience, she's like, "There is a midwifery class, you know, don't you?" "Well, you do know that the other one's more midwifery centred?" And I said, "Yeah, but we're all doing the same exam, we're all doing the same eTest." And she said, "Well, yeah." And I thought, "Well, what's the point?" They're slated to be offered, it's a common unit across all the disciplines and ideally we should be able to be mixed in together, definitely. I've tried to stay in the mixed class, I*

[14] OT refers to an occupational therapist.

> *can't see why not as it's the same content and assessment.* (Jenny, ST)

For some participants IPE was seen as enabling one to enlist other health professionals to address the clients' concerns rather than the definition of IPE used in this study. Phoebe's interpretation is expressed by the following:

> *My understanding* [of interprofessional education] *is that from a midwifery perspective is …so if a patient or someone presents with a range of issues then they can be referred to other people and then the other professional would talk to the original professional to get a better scope on how to help that person.* (Phoebe, ST)

Derya saw IPE as the professional development of oneself and also learning from other professionals in the clinical environment. She also felt that IPE assisted her to work as a midwife.

> *My view of interprofessional education, [I think] it's important. I've gone off and done a couple of courses within my role now on XXX* [specific label given] *Disorder and then I'm going to do another one about counselling and cultural diversity. So there's a lot of input from professional people that you've got to link in with…* (Derya, RM)

Derya had found IPE in her course to be empowering as a student and expressed the view that IPE was necessary for collaboration with other health professionals in the clinical environment and for affirmation of her decisions/thinking by the other health professionals as seen in the following:

> *I really saw the relevance of interprofessional education when I was at uni. I [was] really empowered [by] that … I think it is important to have that education together so you can relate it to your practice later … it's good to be able to go to her to get that confirmation you're on the right track.* (Derya, RM)

6.2.2 Worth of IPE

Quite apart from the meanings attributed to the term 'IPE' by the participants, there were other views and opinions expressed about IPE. The spectrum of these views and opinions was expansive, ranging from the perceived usefulness of IPE both in the classroom and on clinical practice, the difficulties experienced as a student of a course with IPE, through to the barriers of working interprofessionally with other health disciplines in the course. Most participants were in agreement that having IPE was a positive and valuable

experience. However, some like Sonya questioned how beneficial it was for them at their particular stage of the course:

> *Look, I like working with other students and I like being mixed in with the other health science students but I can't say that it's a massive benefit. It's definitely not a hindrance and maybe it's different being X-years old and doing it and not X-years old and just not really having any idea about what other people do.* (Sonya, ST)

Sonya found that overall, being involved in IPE at that point in the course did not, however, increase her knowledge of what the other health disciplines were about:

> *… in inter-disciplinary groups, they specifically separated us into groups of students from different disciplines, we had to do a presentation. And I do have to say, it didn't increase my understanding of what other people are studying… I really don't feel I got a lot out of it. I didn't develop a greater understanding of the role of each one of those other disciplines … we weren't speaking to each other about what we were studying; it was just, how are we going to put this together and present it to get the maximum amount of marks* (Sonya, ST)

However, Sonya still perceived IPE as valuable in the long term as it allowed a broader perspective of health. She expressed this as follows:

> *I think the broader your education is and based, it can only be of benefit, and to have an understanding of what professions do, to have mingled with them, studied with them, worked with them, to have a peer group coming through that's not just the midwives …. I think that will make a difference and we will end up in the same workplaces and be working together and I think it will mean there's less formality, more consultation between the professions…* (Sonya, ST)

On a more positive note Jordan felt that IPE was valuable as a pre-cursor to working with other health professionals on clinical settings and to learn about the other health professionals.

> *…it was nice getting to hear about what they have to do as part of their degree. I think interprofessional education is definitely a good thing and it'll help us all out in the future. I think if we'll have to work together in hospitals or health care settings in the future anyway. So I guess the earlier we can get it started with interprofessional work, the better.* (Jordan, ST)

Jenny also found that learning about the different disciplines was both useful and interesting:

> *Learning alongside them, it was good. It just broke up the group. Hearing a bit about their experiences as well, because you just hear about our clinical midwifery stuff, and just hearing a bit about what they do and where they're at.* (Jenny, ST)

In addition to IPE assisting in educating about the knowledge base of other health professionals, some participants explained that having been exposed to IPE during her education, she found that it impacted her own practice and in turn this benefitted her clients. She relayed this as: "*… we extend our knowledge base regarding other disciplines. So in that respect it's fantastic because we get to just have a better understanding and that impacts on the ways things are done for people, the plan."* (Valerie, RM)

For Lina the concept of IPE was questioned in terms of the worth of the content they were presented with in the shared units of study: "*Well, this doesn't really relate to us because we're midwives. We're not nurses, so why are you forcing us to do something that really is not within our scope and not something that we'll ever come across?"* (Lina, ST)

Lina was also of the opinion that more opportunities for IPE in the course was necessary to avoid becoming isolated from meeting other health professional students and thus decreasing opportunity for interaction with them: "*I think I personally would like to see more interprofessional working together in the course … we become very isolated and very reliant on each other rather than meeting different people."* (Lina, ST)

Sonya questioned the timing of some of the units of study with IPE and associated assessments. It was felt that placing this unit of study later in the course would have been more beneficial:

> *I did write it to their rubric … it's almost doing it looking ahead, but it almost needed to be done later on in your degree when you are actually looking for your workplace and putting together a resume.* (Sonya, ST)

Lorraine's view of the worth of IPE was more in keeping with the definition of IPE in this study. She explained that for her IPE opened up other health

professionals' viewpoints and perspectives in the provision of health care and education:

> *… as a consequence of the interprofessional education, I can see the value of involving other people so that you don't have such a narrow view and become focused, become inwardly focused. But you're more likely to step outside of the box and have more of a helicopter view and see things from other perspectives and be able to appreciate other people's viewpoints.* (Lorraine, RM)

She also was of the belief that IPE raises awareness that health care provision is multifaceted and that graduates of courses with IPE embedded in them are more broadminded in their practice:

> *I think interprofessional education is a fantastic thing. I think it's really worthwhile to demonstrate to everyone that it takes a whole group of professionals; it's not just dependent on one person. I think it's a good idea. We have already graduated students from this course. In terms of how they practice I would say they're definitely more broadminded…* (Lorraine, RM)

The view that health care is multifaceted was also reiterated by Penny who believed that midwives are one member of the health care team as evidenced by the following: "*… none of us can treat them individually. Absolutely, a collaborative effort, yeah."* (Penny, ST)

6.2.3 Other aspects around IPE

Participants described difficulties in their ability to work interprofessionally in the classroom due to timetabling restraints, clinical practice requirements, difficulties related to group work, and a perceived inequity around syllabus delivery systems which, in their view, favoured other disciplines. An emergent thread was the rationale behind the course structure and IPE.

> *All the group assignments that we did were based on just general health as opposed to midwifery… But it was difficult to collaborate with them, I hated group assignments. … all of the people that I worked with in group assignments were young, pretty much fresh out of school, and I had a lot riding on it because I needed to attain at least eighty course loaded average to move into midwifery, whereas they all just seemed to want to pass. And so, I did find that really difficult and really challenging and kind of felt like I carried people a lot because I needed to get a better mark, so I didn't enjoy that.* (Penny, ST)

Lina proffered that whilst IPE was a central focus of the course, the timetabling system precluded any real intermingling with the other health professional students. She expressed this as:

> *In the course, I suppose apart from when we do units where we have to do group presentations, I would say interprofessional collaboration is pretty much not promoted. … in the university setting you pick which day you want to do what unit on or what day suits you;* [as midwives] *we're not given that opportunity. We basically get our timetable given to us: they have certain days that they block out completely for the practical element … That in itself alienates us as an interprofessional team*
>
> *… they keep ramming down our throat interprofessional relationships and then in the next instance they're making it almost impossible for us to have interprofessional relationships.* (Lina, ST)

Apart from the sharing of common units of study, one participant felt that there was little encouragement for further episodes or opportunity for IPE with other disciplines as evidenced by the following: "*… apart from when we do units where we have to do group presentations, I would say interprofessional collaboration is pretty much not promoted."* (Lina, ST)

Financial consideration of course delivery was an issue verbalised by some of the participants in that whilst the Bachelor of Midwifery course was supported institution-wide, it was to be cost-effective. Including IPE was a measure to ensure this.

> *…the university would not agree to have a midwifery course, because it was too expensive and the only way they would agree to it is if there were lots and lots of shared units.* (Lorraine, RM)
>
> *If you're running midwifery units and two of them are interprofessional then the school only needs to do one lecture and however many tutorials and so it makes it much cheaper.* (Lorraine, RM)

6.3 Theme 2: Shared understandings

The word 'understanding' has several meanings and this was evident in the narratives of the participants. When discussing IPE, participants both students and midwives, invariably used the terms 'professional development,' 'multidisciplinary,' 'in-service,' 'collaborative practice' and 'interprofessional collaboration' in the telling of their story concerning IPE and their own experiences. Thus, this theme addresses the common experiences shared and

understood by the participants to be interprofessional education, both in the tertiary and clinical setting. Alternative views of IPE / IPC / CP are also discussed as these were often used interchangeably with the more commonly accepted definitions or explanations of the terms.

6.3.1 Engaging with interprofessional education (IPE)/interprofessional collaboration (IPC)/collaborative practice (CP)

An aspect of IPC was that it broadened knowledge of client care provided by other health professionals, not just from the midwifery perspective as seen in the following excerpt:

> *Interprofessional collaboration might have affected my own individual practice if I were to be in practice or in relationships with clinical partners by having an awareness after the referral has been made, of what happens next rather than just thinking, okay this woman needs to see, and then just handing it on to the next person. So it cuts both more in overall involvement rather than compartmentalising for different professions' input.* (Lorraine, RM)

For Thalia, IPE was seen as getting further education opportunities within her workplaces. Some of these opportunities were shared with others from diverse disciplines:

> *I get my interprofessional education from the hospital as well as the university. …there is a fortnightly session at the hospital that is a multidisciplinary education session. …everyone is invited to that session, which is a really a useful tool. So that's where everyone has a chance to come together. I think it's a useful thing. I have got a lot out of those sessions so I think it should be an important part of our education because it just gives you a different perspective.* (Thalia, RM)

For Valerie undertaking interprofessional education meant doing a course which supported her work in caring for her clients and participating in the in-service/professional development opportunities provided. She undertook this further education both internal and external to her workplace.

> *In practice … I have participated in an inter-professional way by… I had to go and do learning [about] detox facilities and the people that take, or that work in those facilities.' '…inter-professional education is … hugely important. So Large Metropolitan Hospital (LMH), I don't know if other hospitals do, I'm assuming they do, but LMH has in-service, it's not a set study day that we have to take part in as ongoing learning, but they have in-service a few times a week where different disciplines will come onto the ward…* (Valerie, RM)

Alicia's viewpoint was that it was important to have an overall understanding of health and that this was afforded by the multidisciplinary approach: "*Interprofessional education. … we did a lot of our course with the other health-based professions… …I think that being aware of that multidisciplinary approach or that holistic health aspect is really important."* (Alicia, RM)

For Georgina participating in IPE was synonymous with multidisciplinary education and in-service where the sessions were open to all health professionals. Her experience of this was related to the researcher in the following way: "*I would have … in education or practice … in an interprofessional way. … a lot of ward-based education, multidisciplinary. … we run an in-service at the hospital and everybody comes…"* (Georgina, RM)

A shared view of IPE being synonymous with both 'interprofessional collaboration' (IPC) and 'collaborative practice' (CP) was common-place amongst the participants with particular reference being made whilst in the clinical environment. Working alongside and sharing of information amongst other health professionals as well as referring patients/clients to them was viewed as a positive means of enhancing care provision whilst at the same time engaging in interprofessional collaboration. This was evidenced by Jayne and Penny:

> *…clinical environment supports interprofessional collaboration by the information sharing. … they shared the information to try and work together to get a positive outcome. … and it is about that sharing of information and working together that is the real crux I think of interprofessional collaboration.*
> *Interprofessional collaboration will make me more aware of looking out for areas where I may not be able to help and where there is another professional that may be able to help and then sharing that information with that other professional. So I think it's just made me more aware of looking out at who else could possibly be involved in the care.* (Jayne, ST)

> *…in the staff meetings, they talk about each member of staff. Although they're all midwives, each has a different role of working with different departments within the hospital on different wards, so they would definitely be involved collaboratively. The midwives are referring the women all the time to different people as well … There's got to be collaboration there. The other day we had the paediatrician come down to check the babies in the birth centre before they were sent home, and my midwife said go with the paediatrician, and see*

what they do, and see how they check the baby and take notes on it and that sort of thing, so I guess that is interprofessional working. (Penny, ST)

6.3.2 Perceived barriers to IPE / IPC / CP

Two recurrent patterns in the stories of the participants were that of firstly, lack of clarity about the midwives' role on the part of other health professionals which created a barrier for interprofessional collaboration/working and secondly, the hierarchical structures evident in the clinical environment particularly emanating from, but not confined to, the medical profession. Derya referred to it as 'treading on toes'. Nevertheless, participants could observe successful episodes of interprofessional collaboration with particular health professionals better than others.

Participants expressed views that in order to be able to participate in a truly interprofessional manner, both in the classroom and clinical environment, it was important that clarity exists around the role of the midwife as well as other health professionals' roles. This lack of knowledge around the role of the midwife subsequently undermined their worth as a professional in their view. The education of other health professionals about the role of the midwife would address this issue in their opinion:

I suppose you start treading on each other's toes in a way. I suppose that's where we really need to understand what I was saying before, understand where that line is where the physio[15] *does take over.* (Derya, RM)

… the barriers to working in an interprofessional way would be just about lack of awareness of our role and what we do from other disciplines. I think just educate them as to the relationships that midwives have with their women, they're often on a really personal level and particularly with continuity [of care] *they're really thorough. Whereas, it's not just a quick referral or a quick meet and greet on the day.* (Thalia, RM)

When recalling their experiences in the classroom and the clinical environment, a common thread was that of hierarchical structures in place which participants who felt mitigated against true interprofessional education and/or collaboration. Furthermore, an entrenched hierarchical structure had, in the eyes of the

[15] Physio refers to a physiotherapist.

participants, the ability to dictate clinical work practices. The following passages demonstrate the participants' views around this issue:

> *I suppose there is that hierarchy with communicating with doctors that you're always aware of … … people out there that think midwives are a bit lower down on the pecking order and just ignore what you say.* (Alicia, RM)

> *… once the social worker has spoken to the woman and then the information comes back to the midwife, the midwife gets a better understanding of really where they're at mentally but also how to help that in terms of their pregnancy. I think it is good. I didn't see any of that between the doctors and the midwives but I definitely did see it between the psych*[16] *liaison, and the social workers and the midwives.* (Phoebe, ST)

> *… they just can't see that something is better done a different way because we default to that old way all the time. It is hierarchical, and it makes people feel safer at the top I think.* (Georgina, RM)

However, in the telling of their stories, some participants felt that issues such as those expressed above could be partly addressed through interprofessional teaching (education) at the tertiary level, as this would have the capacity to break down barriers between medical and midwifery students (in one participant's view) and also have the flow-on effect of decreasing the opportunities for socialisation to so-called 'bad' practices in the clinical environment. Effectively the IPE at university would allow new graduates to keep an open mind regarding practice and interactions with other professionals. This is what they relayed.

> *A lot of the med*[17] *students haven't, they're just at the beginning of their obstetric[s] rotation. It is really powerful, I think, to see the dynamic, because the midwifery students end up teaching the medical students, and it, I think it breaks down a lot of barriers at a very early stage, yeah.* (Holly, RM)

> *I'd like to think that with these midwives that we're educating in this particular model, that they wouldn't then go on to espouse these particular views of being easily socialised to some bad practices once they go out or once they graduate. I'd like to think that we'd given them more [of a] broad base and more of an open mind. Speaking to past students in the clinical area, it does seem to be that that is the case, they do seem to be more open minded and prepared to involve other people and prepared to just be more open generally really. I think that the fact that they're exposed to more interprofessional*

[16] The term 'psych' refers to the word 'psychiatric.'
[17] The term 'med' refers to the word 'medical.'

education means that they have it from the horse's mouth. (Lorraine, RM)

6.3.3 IPE / IPC and the clinical environment

According to the participants, for IPE / IPC to be effective, it was imperative that certain conditions/elements existed in the teaching and clinical environments. These were good communication, respect for each member of the health care team, and trust, especially in smaller health agencies.

> *So the more you work together on that collaborative care everyone's happy. With it working, everyone's happy. But there're just so many communication systems in play and when it all works, it's great. When the communication doesn't work then everything falls in a heap.* (Alicia, RM)

> *I do think the best outcomes come from a strong interprofessional team where there's respect for each person's, knowledge and abilities, and it's clear who does what, and there's good communication amongst that team. So that's the ideal, and sometimes it works really well and sometimes, there's a strong hierarchy which means that people's knowledge isn't respected necessarily.* (Holly, RM)

> *… it was a small place, you knew people, people knew each other well and there was a trust there that in the larger place there isn't, because people don't know each other as much.* (Holly, RM)

For some participants IPE during their course assisted them with IPC in practice and found it to be valuable to some extent but in most cases, it was not overly evident in the clinical environment. Phoebe explained it thus:

> *… at uni it did support inter-professional collaboration because all of those base units were with other disciplines in health. But on my clinical prac, not really. It doesn't strictly fit, that promotion of inter-professional collaboration …* (Phoebe, ST)

However, participants were supportive of IPE / IPC as they believed that interprofessional education enhanced the education of midwives and ultimately clinical practice. In their opinion, collaborative practice was seen as fundamental to midwifery practice. According to Thalia:

> *Interprofessional collaboration, it's really useful. It's great to get some background or some education as to why we're doing things or the focus that other people are coming in from because sometimes you're not aware. It just makes you be able to then understand the process that's relevant to your work, and to pass that onto the students and to the women.* (Thalia, RM)

Participants also explained that in their view, interprofessional collaboration would improve health care delivery in the clinical environment as health care professionals worked together towards the same goal.

> *This mix of IPE and midwifery for the midwifery students … … it's great to have some mixing with other professionals right from the beginning, so that they're aware that in the clinical environment you'll be working with all of these different professions anyway. So it's a good idea to start off right from the beginning, understanding the different professions. And understand the kinds of people who are working within these professions, and more importantly the fact that so much of what we use in our day-to-day practice is overlapping with other professions.* (Lorraine, RM)

In some instances, IPE / IPC was a strategy for further learning which also benefitted the client. Alicia explained it thus:

> *I find that, especially when there's been an emergency situation and I was involved with an outcome for a scenario just recently, they were really supportive and we sat down and had a bit of a chat about how we could have handled things, whether if we could do it differently. I said, "oh what about this, and why did we do that, and why would that work and what was happening then", and they've been really, really good. This interprofessional collaboration is great. I learn heaps, constantly learning, and it supports the patient.* (Alicia, RM)

6.4 Theme 3: Shared misdirections

The term 'misdirection' has various meanings depending on the context within which it is used. In this theme, the term reflects the various orientations or inclinations attributed to IPE when telling their stories that do not, strictly speaking, adhere to the accepted definition of IPE as used in this study.

6.4.1 Alternative dimensions of IPE / IPC / CP

For the most part participants spoke of IPE, IPC and CP in the more commonly accepted definition of the terms. However, interspersed throughout their respective stories was the tendency to describe or refer to these terms in a different manner to that traditionally accepted by health professionals. IPE, IPC and working interprofessionally was variously referred to as: midwives and doctors discussing, planning and agreeing on the care of a patient/client; midwives coordinating and talking with doctors; meeting with, chatting with and interacting with other health professionals from different disciplines; 'doing'

handovers, and passing instruments to doctors; familiarising themselves with the role of other health professionals for the benefit of the client; continuing to learn from other health professionals in the clinical environment; the sharing of in-service sessions in the hospital; and physically being on a ward with other health professionals. Some examples follow:

> *Just becoming familiar with their role and working together as much as possible to benefit the patient.* (Alicia, RM)

> *I didn't do a lot of working interprofessionally … but I saw my midwife coordinating with the doctors and obstetricians, everything like that. I'm on the labour and birth suite and that's probably the most I've ever worked interprofessionally, but just still with the RMO doctors and doing handovers to them. I've had to do an instrumental birth, just passing them the instruments, unwrap it and then pass it to them …* (Jordan, ST)

For one participant, Lina, IPE was viewed as important; however, in her opinion working collaboratively with other health professionals was necessary as she did not view midwifery as a profession. She expressed the view that it was important to commence IPE early in the course to ensure that new graduates develop the ability to work with other health professionals without too much difficulty in order to 'get things done.' Other participants felt that IPC allowed for best care provision and also as an adjunct to the provision of midwifery care. This was demonstrated in the following excerpt by Alicia:

> *I believe interprofessional education it's quite important. We're not a profession on our own; we work collaboratively with lots of different areas … … and that we don't feel uncomfortable having to go to other health professionals in order to get things done and sorted I suppose.* (Lina, ST)

> *This interprofessional collaboration is great. I learn heaps, constantly learning, and it supports the patient. I couldn't provide what everybody provides for that one patient. So it lightens my load…* (Alicia, RM)

6.4.2 Oddities

Some participants discussed the reality of IPE in both the classroom setting and the clinical environment, and the issues surrounding the implementation of IPE in general. It was felt that true IPE was a difficult concept to 'do well.' It required a commitment from other health disciplines which was not always forthcoming and thus difficulties arose. According to Georgina:

> *My view of interprofessional education, I think it's hard to do well. …we'll run some days together. So we did that with obstetrics as that profession and those particular people they were invested[in] at the time. They did no prep, they did no work, they came unprepared to the day.* (Georgina, RM)

This had the flow-on effect of an end to IPE sessions with one particular discipline. There was also a perception of inequality existing within the IPE sessions possibly related to gender and class differences. Whilst overall these sessions could be conducted, the hierarchical structures made it difficult for true IPE sessions.

> *One of the hospitals that our students go to frequently has interprofessional learning … …But it's very, very hard. Apart from the whole gender thing, and class [that] complicates midwifery and obstetrics, there is also the whole issue around numbers. So if you run an in-service, at handover, at changeover time, you get a whole lot of midwives and just a couple of registrars, and that skews [it]… … interprofessional learning, they were very big on it, … and we tried quite hard to collaborate, in a small way, with obstetrics … … but the practice around it was quite hierarchical…*(Georgina, RM)

Another viewpoint was that IPE in the form of sharing of common units of study presented difficulties when it came to discipline content. It was felt that lectures could be "IPE-specific" but discipline specific content was best managed and delivered by single-discipline tutorials. This was supported by another participant, who was also of the view that generic tutorials were a barrier to true IPE in class and thus the format was changed to common lectures for all disciplines, but content-specific tutorials. This led to better student engagement with the discipline content. Lorraine relayed the following:

> *So, it started off completely interprofessional and it just didn't work out because they were using examples that had nothing to do* [with midwifery]*,… We decided then, yes although it was an interprofessional unit and they'd still go to the same lectures, when it came to the tutorials it was better to quarantine the midwives into their own group. So we'll have midwifery specific tutorials because it makes more sense and they get more out of it, they're going to be more engaged. Whereas [with] some of the absolutely interprofessional units, they don't engage quite so well because they think it's all a bit vague and not midwifery specific enough for them.* (Lorraine, RM)

For one participant there was a suspicion that perhaps the direct-entry midwifery course fostered IPE or learning as it was referred to, between

midwifery students and the obstetricians. According to the participant there was a greater willingness on the part of the registrars to assist student midwives in undertaking certain skills than had been observed with non-direct entry student midwives in the past. This was exemplified by Georgina who recounted:

> *What we saw happening when the BMids came in was that sometimes, especially the registrars, but sometimes the residents as well, sometimes the consultants too, spent time describing their work to the BMids and including them as well.* (Georgina, RM)

Interprofessional education extended beyond the classroom and ward practice to handovers and informal discussions at the ward desk. This 'vicarious IPE' was considered to provide good learning opportunities for students. Providing education to other health disciplines was also a form of IPE. According to Georgina: "*Interprofessional education with the other disciplines was with obstetrics and actually nursing too of course. We used to teach in the paramedic course."* (Georgina, RM)

Despite the fact that all participants were aware of the definition of IPE, they continually interchanged the terms outlined (see the beginning of section 6.4).

6.5 Theme 4: Shared professional values

'Professional values' is a canvas that paints a picture of the meanings that participants attributed to terms such as professional identity, role identity and to a lesser extent, scope of practice. A profession in the everyday sense of the word generally refers to a paid occupation having its own specific body of knowledge. Its members will possess the required expertise after undergoing training and gaining a formal qualification (Scott & Marshall, 2009; Soanes et al., 2008). Identity is a term that denotes who or what a particular person is, and role refers to a person's function in a particular situation (Soanes et al., 2008). It is according to these definitions that the following theme addresses the meanings of the terms 'professional identity,' 'role identity' and 'scope of practice' in the narratives of the participants.

6.5.1 Qualifications, knowledge and skills, expertise

A common thread for many participants was that professional identity was associated with possessing the appropriate qualifications required for a midwife, thus having the requisite body of knowledge and having expertise, competence, and confidence in midwifery practice. For these participants, professional identity also entailed sharing their knowledge and advocating for the women in their care. Jayne viewed her professional identity as follows:

> *…professional identity … means how others would perceive me and how I conduct myself in my professional role. So how much knowledge I have and how I'm sharing that with the people and then how they feel about me sharing that.* (Jayne, ST)

For other participants such as Valerie, professional identity was very much a three-pronged concept which entailed level of knowledge possessed, what a midwife does, and the multiple roles they undertake as a professional. She described it in the following manner:

> *…my professional identity means … the way I view myself and the way other people view me. …the breadth of knowledge that you end up having and how scientific really it is. …I'm an educator as well, of the women, students and other midwives.* (Valerie, RM)

Another view of professional identity according to several participants related to public perceptions and expectations of who a midwife is and what she/he does, coupled with one's perception of oneself as a midwife and where the midwife is situated within the health care system. Thalia spoke of her professional identity as:

> *Professional identity is the public perception of what[sic] midwives are, and also our perception [of midwives] within the health system, so that we come across as a professional body or a group of professionals, comparing us to nurses, doctors, physios, nutritionists. Midwives, I think, have their own identity within the health system. It's really about what we do, what makes up our core business, that's where identity is … (Thalia, RM)*

Thalia (RM) went on to say that professional identity was a broader concept than scope of practice as "*practicing it* [midwifery] *strengthens your identity as a midwife"* but for other participants professional identity was similar to role identity in that it related to what midwives "*do in their job"* (Fanita, ST). There

was no point of difference between professional and role identity for other participants.

Whilst the participants described the forging of one's professional identity in various ways, there were commonalities evident in the narratives. The words 'expertise', 'equality' as a professional and 'being valued', as a professional were used by many participants to describe their view of professional identity. According to them, professional identity encompasses collaboration as equals and this is based on equal power and respect for each other. This is evidenced in the following excerpt:

> *…my professional identity in [that] I think it's made me a stronger midwife actually. …you need to be very sure and clear of your own position and then you can collaborate as equals. …it's that collaboration between equals. It works best when the power's equal and that it's based on respect.* (Georgina, RM)

There was a general perception of inequality of power between the midwifery profession, and its clinicians, compared to other health professions such as medicine, obstetrics in particular, but also nursing. It was felt that this was due to the lack of knowledge of the nature of midwifery practice and the requisite body of knowledge its clinicians need. In Lina's words:

> *…Other professions or other disciplines seem to think that the midwives aren't as well educated; I think some of it comes from how it's interpreted, I suppose. "Oh midwifery students, you know, we know what you're all about", and sort of scoffed at you a little bit because he said, "Oh you'll soon get used to what you need to learn and what you need to do and none of this mambie pambie stuff."*
>
> *I've had a couple of run-ins with anaesthetists and obstetricians, they almost treat you as if you're a non-entity, you're not there, you're not a person, you're not a professional…* (Lina, ST)

Lina also expressed feelings of being de-valued as midwifery students compared to their nursing counterparts:

> *…everything in that course is set up for nurses, not set up for midwives. So they've got the labs; we can't get the labs at university because the nursing students are using them …* (Lina, ST)

Holly described the existence of unequal power relations between medical health professionals, other health professionals and also amongst midwifery colleagues. She was of the opinion that if one was valued as a professional

and respected for one's level of experience and knowledge, then this would lead to more effective interprofessional collaboration.

> *Midwives as a group are probably an oppressed group. I mean by that that perhaps they're not comfortable, the system has oppressed them. Ultimately a medical person will be in charge, even if the midwife has a lot more experience, understanding, education and knowledge. …even though you'll say "Well, actually normally we don't do that because of blah, blah, blah, blah, blah", ultimate, so, but having that conversation, I haven't been comfortable to actually even have that conversation, I think a lot of midwives aren't. They don't want to step up and because I suppose experience has told them that when they do step up they often get torn down.* (Holly, RM)

The inequality of the funding model for the clinical education of midwives also promoted inequality in the clinical environment. The view was held that an increase in the funding of midwifery education would foster an increased level of IPE which would flow on to more robust interprofessional collaboration in the clinical environment. Georgina explained:

> *…we need to do something really serious about midwifery funding from the Commonwealth in order to get us some more paid time so then we could do inter-collaborative interprofessional learning better.* (Georgina, RM)

6.5.2 Scope of practice (what a midwife does), role identity

Perceptions of a midwife were developed by several participants after experiencing midwife care. Participants spoke highly of 'what the midwife did' for them, in other words, their 'scope of practice.'[18]

> *As I started reading about pregnancy and birth and that postnatal period, I just thought, 'Oh, I'd really love to be the woman that's with the women,' and so it wasn't until I had my first child that … …that I had a student midwife at the birth, and so I knew what a midwife was …From that time I just had an amazing interest in the whole process, and always just thought, 'that would be fantastic.'* (Valerie, RM)

Participants reported that it was important to have an awareness or knowledge of one's scope of practice as this clarified one's role, and thus enabled the midwife to make appropriate referrals. It was also clear that scope of practice entailed more than a set of specific skills.

> *…scope of practice… what it is we do, and what it is we don't do, and what's reasonable that we should be expected to be able to do. I think it helps establish a certain area of expertise that midwives*

[18] ICM definition of a midwife.

> *should claim and hold on to and be proud of, and it also helps to establish some barriers, some boundaries around that, that actually, once you become that, a number of things are outside of our area of expertise, and we should be referring or collaborating. So that is an issue too, isn't it? So yes, I think it's quite a powerful way to help to draw those lines in a practical sense.* (Holly, RM)

Role identity took many forms for participants and varied greatly. For some it was embedded in the process of becoming qualified as a midwife, or 'learning the craft'. For others it reflected being exposed to midwifery experiences, entailed one's scope of practice and was also considered to be an important component of professional identity. However, overwhelmingly, most participants referred to their role identity as to "what they did", for women in their care and the expectations of other health professionals to a lesser extent. Jayne's interpretation of role identity is expressed by the following:

> *…role' a lot of it is to do with more care of the woman, I guess it's more of, I mean I know there's a lot of the delivering the baby et cetera, but I think it's a lot about making the couple feel at ease and the woman feel at ease and helping her through the time so that she feels relaxed enough in the situation to be able to follow the advice you're giving her and to trust that you'll be doing what's best for her. I think a lot of it is about the human side of it, the interaction.* (Jayne, ST)

Phoebe's view was similar to that of Jayne's; however, she was of the view that there was a distinct difference between role and professional identity.

> *Role, role in terms of midwifery, conjures up supportive, advice, education, empowerment for women, women's rights, women's equality, screaming women in labour. Qualities that make up a midwife are compassion, empathy and strength. You know to use a good sense of your own intuition. I think role identity and professional identity are different.* (Phoebe, ST)

For Jordan there was an added dimension to role identity compared to Jayne and Phoebe. She expressed that in addition to 'what you do,' role identity also includes the demeanour of the midwife in practice. She said: "*The midwifery role refers to the things that you have to do and the way you act as a midwife."* (Jordan, ST)

The constructs of role identity, professional identity and scope of practice were not clear-cut as such, with many instances of overlap for many of the participants. At times the terms were used interchangeably.

6.5.3 Factors impacting professional identity: working as a midwife

In recounting their experiences/stories about professional identity, there were several factors that had an effect, to varying degrees, on their professional identity as they described it at the time. The most significant of these were clinical midwifery experiences, practice, education, knowledge and IPE.

Participants told of the enhanced sense of professional identity through their various clinical experiences. They spoke of these clinical experiences as increasing their feelings of competence as midwives and being valued as a team member. This in turn led to a heightened sense of professional identity. Alicia recalled the following:

> *…professional identity… where I'm at the moment, …I'm feeling a little bit more competent [and a] valued member of the team… I think I'm feeling more confident and competent… … I think that I'm ready to learn probably in a more accelerated range. I've got a bit more of a professional role and I'm a bit more competent so that I can now build on stuff.* (Alicia, RM)

These sentiments were echoed by Thalia who found that actually undertaking midwifery practice replaced earlier ideas about professional identity.

> *My own view of my professional identity has changed over time. As I said, when I first went to become a midwife, I didn't really understand the identity of a midwife; I went into it fairly green. I think by working in midwifery for fifteen years, I think now I've got a really good appreciation of the impact midwives have, and so it's certainly strengthened the impact midwives have and the importance of being a midwife. I think just by practising at it [midwifery], you get to see the importance and … all those differences that we make which strengthens your identity as a midwife. I see it as more than just providing a service; you're providing information that can really alter someone's experience so you can give that information to facilitate decisions* [for the woman] *that will potentially make big differences.* (Thalia, RM)

Undertaking clinical practice altered participants' perceptions of professional identity. This certainly was the case for Jayne whose clinical experience demonstrated that the midwife role was far more extensive than her early perceptions of professional identity.

> *My view of professional identity has changed. I used to think a midwife was the person who just looked after the baby. So it's certainly changed a lot from that because I know that it's more of a*

> *whole, it's more about the woman than the baby I think, the majority part, but before I used to think it was just about the baby.* (Jayne, ST)

The actual clinical environment and in some cases, the underlying philosophy, had the propensity to impact participants' sense of professional identity. For some, professional identity was affected by their role which in turn, they believed, was determined by their scope of practice.

> *There are factors in the workplace and clinically or even in academia that have impacted how I identify as a midwife. Clinically a lot of it is about the woman, you could often do a shift, walk out with your hair all scrunched up, you haven't had anything to eat for eight hours, you're absolutely exhausted, but the woman and often her partner might be the ones that say "Thanks, you made a difference", and even though no one you work with notices or the system doesn't acknowledge you, midwives, clinical midwives don't get a lot of pats on the back … The woman says "You made a difference for me", and so that helps me say "Yeah, I'm a midwife, this is what I do and it matters".* (Holly, RM)

Georgina's experiences of midwifery practice with a strong philosophy of 'normality of birth' contributed to her sense of professional identity.

> *I don't think my view of professional identity has changed over time. I got taught by a bunch of midwives who were very proud to be midwives and even though they were all nurses they really, really had a strong midwifery sense. … They were very clear about when you came to mid*[19]*. you sat on your hands until you had to get off them, that was the flavour I grew up with. That was from young midwives and older midwives. … There was a philosophy of that* [non-intervention] *in the* [midwifery] *unit, even though the unit I did my mid in was quite interventionist. So the leadership in that unit was [that] you couldn't always see that philosophy, but from some leaders you could.* (Georgina, RM)

Exposure to multidisciplinary learning opportunities were seen as having the ability to impact one's view of professional identity for some participants as it enhanced one's own practice. An exemplar of this follows:

> *…those multidisciplinary learning opportunities have impacted on it, because without them then I would be limited as to how other things impact on my practice… If I hadn't learnt from those different disciplines then my care of people, ...I actually think I wouldn't be able to care for people as well as what I think I do. Intercollegial working has actually enhanced my practice, that's exactly what I'm saying.* (Valerie, ST)

[19] The word "mid" is an abbreviation of "midwifery."

6.5.4 Factors impacting professional identity: learning to be a midwife

The acquisition of knowledge through their education as midwives was another aspect described by participants as impacting their sense of professional identity. For some the newly acquired knowledge, coupled with clinical practice, changed what their earlier perception of professional identity prior to commencing the Bachelor of Midwifery. This was particularly so for Lina who also described that through education and then clinical practice, she found that her sense of professional identity changed. She believed this to be related to the acquisition of knowledge which she found to be empowering, leading to a change in her professional identity.

> *I think I had an idea of what my professional identity as a student midwife and future midwife was before we did any interprofessional education. My view of professional identity or role has changed over time since I've been studying and have been exposed to clinical. …I had an idea of what I thought a midwife did and that's changed that quite a bit. I suppose I've changed a lot of my views around midwifery just because of the new experiences I've had rather than the experience I had in childbirth. So that's changed my view, and who I'd like to be as a midwife, that has changed quite dramatically from my personal experience to now, having my midwifery experience within the university and in prac[20]. That has changed.*
>
> *So I suppose I'm more of an advocate for knowledge now, and being told, being given that information, and having choices and them being informed choices rather than just, "This is what we're doing."* (Lina, ST)

Jordan was firmly of the view that the level of knowledge possessed by an individual has the capacity to affect one's sense of professional identity. She said:

> *I think that the education has contributed to the change in my idea of professional identity definitely; in first semester, I just don't think I even looked into midwifery and I didn't realise the kind of ideals about normal childbirth and the history, I've never seen anything either. I just had no idea. I think because when I started, I didn't realise all the different places you could work as a midwife or how different they could be really.* (Jordan, ST)

Whilst there were absolutes regarding the effect of knowledge and education on professional identity, for some participants there was ambivalence. Sonya expected her midwifery education and practice to influence the development of

[20] "Prac" refers to "practice."

her professional identity in addition to challenging her currently held views of midwifery practice.

> *I think my own view of professional identity will evolve massively over the next three years. I think my views will change. I am at the moment totally anti homebirth; I hate the idea of that risk and I think that my views could change about that a lot… I think a lot of change will happen for me in the next few years. It will be interesting and I don't necessarily believe that I'll come out for a homebirth. I might still be too risk averse to be that sort of midwife but I'm open to the idea, I'm open to change.* (Sonya, ST)

For other participants, impacts on sense of professional identity were multifactorial. They described power plays in the work environment, differing personalities of colleagues, models of education, clinical practices, workplace politics and personal study as having impacted one's sense of personal identity as seen in the following exemplar:

> *Definitely [there've been factors in the workplace that have had an impact on my view of professional identity]. … I did land in a place that even though it wasn't perfect, it was quite an obstetric[s] unit strangely run by midwives. …things have happened and that I've seen and people I've worked with have had an effect, definitely. I think it's certainly true that the path I've chosen, an academic path, affects my idea of identity but my idea of midwifery identity affected the path I chose as well. …I thought that you could make a difference if you set up a course, …that taught the kind of midwifery that we wanted to have. … the power plays of obstetrics… So definitely people first. There've been highlight-able people in my workplace both at the hospitals and at the universities that I've worked at that definitely affected my view of my professional identity. …I think my studies made a really big difference. Then I've looked carefully around at practices too. I looked carefully at models of education…* (Georgina, RM)

6.5.5 Factors impacting professional identity: IPE between and betwixt

Participants vacillated equally between IPE positively and definitely impacting their sense of professional identity and not being certain if this was the case in their experience. For some participants, professional identity was heightened as a result of IPE increasing their self-confidence and competence. This led to an increase in their knowledge base, a better understanding of other health disciplines and how they impact midwifery care. Valerie explained IPE in the following manner:

> *Interprofessional education has impacted on my own professional identity because I feel more confident after having those learning opportunities, and not just confident but competent, so I suppose my*

> *identity, my professional identity, has changed since I first started because I have a much better knowledge base and a better understanding about those other disciplines and how my work impacts on them and their work impacts on me, …it's made me feel more confident and I suppose I view myself as more of a professional … If I hadn't had those other learning opportunities then my knowledge base wouldn't have been pressed, my understanding wouldn't have been as good, … I wouldn't have felt, …as comfortable passing on information …so that's improved my image of my professional self…* (Valerie, RM)

Other viewpoints held included the notion that IPE highlighted one's own view of professional identity which was limited in their opinion. It broadened one's thinking and to see the need to connect with other health professionals. Others concurred with this thinking including Derya.

> [Interprofessional education or collaboration] *has impacted on my own* [professional identity], *I suppose it makes you think a little bit more broadly, it makes you think outside of your own scope, your own training, your own view, … it affected my view of my identity; it makes you realise how little you know probably. I think it makes you realise how much you all have to interlink…* (Derya, RM)

> *…interprofessional education has impacted on my particular view of professional identity. It has certainly kind of made me more broadminded…* (Lorraine, RM)

According to Holly, IPE facilitated the development of professional identity at the novice midwife student level by engaging students early in discussion about what constitutes a midwife. It also affected one's own sense of professional identity as it clarified the importance of the midwife's scope of practice.

> *In my view, it* [IPE] *should start, you need an opportunity to establish some professional identity within your group early on… … give them an opportunity to say "Well, what is it that makes you a midwife here, rather than a nurse?" …IPE probably has impacted on my view of professional identity. It has changed over time to now that perhaps I've done research in the area and implemented IPE in an academic situation. …I have high regard for nurses and midwives… …over the years my sense of professional identity has made me more proud I suppose, more overtly proud to say "I'm a midwife, this is what I do, and what I do matters; I make a big difference to people.* (Holly, RM)

There were participants who felt that their sense of professional identity had not been impacted at this stage of their careers. Sonya attributed this to not having sufficient knowledge of other disciplines thus not changing her own viewpoint of professional identity. She explained it as follows: "*I haven't learnt a lot more*

about the other student professionals and it hasn't impacted my idea of my professional identity…" (Sonya, ST)

For several participants, professional identity was already established before they commenced midwifery education or practice and IPE was not a change agent. In Phoebe's words: "*Inter-professional education has not really impacted my view of professional identity. It hasn't changed my view of midwifery. Clinical would not impact on my view of professional identity, not really because I would still identify totally as a midwife…"* (Phoebe, ST)

6.5.6 **Factors impacting professional identity**: working and learning **together**

In the telling of their stories about professional identity, participants referred to impacts on role identity. There was less evidence of this in their narratives compared to the impacts spoken of in relation to professional identity. Impacts on role identity were most evident in relation to collaboration in the clinical environment and IPE as an influence on role identity or the perception thereof. Lesser mentioned impacts were those related to communication, socialisation in the clinical environment, level of one's knowledge of other health professionals' roles, level of competence in midwifery, and the hierarchical structure in the clinical environment.

Participants were of the opinion that working collaboratively in the clinical environment was a positive influence or contributor to the development of their professional identity. Underlying this observation was the need for positive communication.

> *I've had generally a really positive experience with the collaborative care and communication aspect and it has probably enhanced my sense of role identity.* (Alicia, RM)

> *But "What's the difference in your role as a midwife" so I suppose you need a little bit of time and exposure and to have conversations around that for the first year or so. …team work is the way health care it's the reality of the world they're going to enter. …they have to work collaboratively. So to understand, and it is scope practice, but it's also about power dynamics and conflict management and all those things. It's really important to have some sense of conflict management.* (Holly, RM)

Participants also valued interprofessional collaboration in the clinical environment as it was viewed as a vehicle for both positive and negative role modelling. Lina proffered the following insights into this:

> *Interprofessional collaboration affects my individual practice as a student midwife because we're learning; I suppose you pick up lots of different [things from different] people and some of it you take away, some of it you don't. And there have been occasions where I've thought, "Yeah, I don't want to be like you," and there's other times when I've thought, "Yeah, you know, I'll really take that bit of your practice away and use that."* (Lina, ST)

Interprofessional education was seen to highlight in a positive manner the scope of practice and role definition of the midwife for some participants. As a result, participants' sense of role identity was clarified.

> *That scope of practice is really about what you see in clinical practice, you see it, see it, certainly, so you don't have to just try and explain it, they can experience it. For many midwives IPE helps establish a certain area of expertise. This IPE in the course tends to highlight who they might be as midwives, or what they might do as midwives versus not having it. IPE helps to clarify boundaries and really reinforce the role of the midwife, especially where the norm is involved. So it has changed, since I've been exposed to IPE, I've spent more time reflecting on what it is to be a midwife and also instilling that type of positive view of midwifery in my students.* (Holly, RM)

For Lina the acquisition of knowledge as part of her studies coupled with IPE directly impacted her view of her role identity as a midwife. She explained it as: "*…having done midwifery and even some of the interprofessional education with nurses, it has impacted what I think of the midwife's role."* (Lina, ST)

6.6 Theme 5: Shared misgivings

'Misgivings' is a term that can have several meanings. In the context of this theme it is used in the sense of one having reservations or apprehension with regard to a certain situation or concept (Soanes et al., 2008). The previous four themes addressed IPE, professional identity and role identity emanating from the participants' narratives. However, the narratives also highlighted areas in which participants had mixed reservations or were apprehensive with regard to IPE and interprofessional collaboration in particular. The terms IPC, IPW/WIP,

IPL and IPE were, in many instances, used interchangeably. Thus, this theme highlights the reservations participants voiced which cannot be disregarded.

6.6.1 IPE in the classroom and beyond: attitudes and outcomes

As discussed in section 6.1, participants expressed divergent views of IPE and valued it on a continuum from 'highly regarded' to 'not so sure'. Participants relayed that having a high content of IPE in the course was not appealing to students initially, and resulted in resistance of students to mixing and working with other health professional students in the classroom. Whilst this was a barrier early in the course, students developed an appreciation for IPE as they progressed through the course, and it was considered to be structurally and pedagogically sound from an academic perspective.

> *This mix of IPE and midwifery for the midwifery students, midwifery is their chosen subject so they would prefer to have more midwifery units rather than three quarters of it being mixed. So from their perspective they're a bit upset about it. But from our perspective it's great to have some mixing with other professionals right from the beginning so that they're aware that in the clinical environment you'll be working with all of these different professions anyway. …the students do complain that they don't have enough midwifery… They would like it to be 100% midwifery content and all focused around the midwife and midwifery examples and everything else. But having said that they do appreciate having the knowledge around other systems as well and they're going to use that in their clinical practice.* (Lorraine, RM)

In addition to resistance to IPE from students, participants also relayed that there were differing viewpoints from other academic colleagues.

> *There's mixed feelings* [about IPE], *really. There are some people who think it's a fantastic idea and others who say, well, the students don't mix anyway. They all sit in their own groups and they don't really have a great deal to do with each other.* (Lorraine, RM)

However, resistance to IPE in the course was remedied by the passage of time and resulted in acceptance of this type of course structure.

> *…people that did not buy into it* [IPE] *and were resistant to this type of education at the beginning of the course, but I think it's such a standard situation now that everyone just takes it for granted, this is the way it is.* (Lorraine, RM)

Other participants expressed the view that they were more comfortable not working with other disciplines and in fact, tended to avoid studying with other

health professional students. There was also a resistance to non-midwifery-specific content during IPE classes shared with other health professional students. Lina explained it thus with regard to a common assessment task: "*Well, is there any chance we could get something that's a little bit more midwifery-orientated, that's more relevant to us and to our course?"* (Lina, ST)

With regard to working collaboratively in the clinical environment, there was a preference to work with midwives rather than medical staff. Jordan said: *"I feel more comfortable at the moment with the midwives rather than the doctors."* (Jordan, ST)

The view that there did not seem to be any obvious difference in clinical practice between students exposed to IPE as opposed to those without that exposure or experience was noted by participants. According to Valerie: "*I haven't noticed any difference in the students in terms of how they care for women from the perspective of this inter-professional background".* (Valerie, RM)

Participants described that interprofessional collaboration required self-confidence and that you needed to 'arm yourself' to work interprofessionally and that this was an aspect that one should be able to learn in the university setting.

> *I really think it's about really knowing what you're doing and having as much prac[21] experience as you can while you're a student to really experience a whole range of things before you go out. I also think it's about personal self-confidence. … Having that correct knowledge available to you or you should be able to develop that whilst you are studying…* (Phoebe, ST)

For some participants there was no issue with interprofessional collaboration; however, it was dependent on several factors such as individual personalities, timetabling and a preparedness to engage with other health professionals. Jenny described it as:

> *…working in an inter-professional way, no barriers. …it might depend on the person's personality and if they're approachable, or you're aggressive. Also, timetabling probably would be a big thing, because I've noticed that we're all over the place. For me personally I'm in a class at the moment where I'm sure it's all nurses and I'm the only midwife there and I don't have an issue with it at all. I don't find there's*

[21] The term "prac" refers to the word "practical."

a barrier and you've got to make the effort, and they seem quite welcoming. (Jenny, ST)

Jenny also relayed that whilst her experience of IPC was positive but dependent on other factors, IPC had not influenced her own practice up to this point in time. She enjoyed the interactions with other health professionals and understood the need to learn about them in the clinical environment. She also vocalised that IPC impacts care provision of the women she cared for and it was useful to have differing viewpoints of the patient's care and perspectives of other health care professionals' roles.

Inter-professional collaboration at the moment hasn't had a massive impact on my individual practice when I'm on clinical [practice]. *I like being in a room with other professions and having an experience and seeing how they work… It needs to happen. I like being in a room with different professionals and learning about them. …it definitely impacts care because we've got our scope of practice, and then you're seeing other professionals coming in and they've got their role to do. … it just gives you a different aspect to the care for the patient.* (Jenny, ST)

6.6.2 Barriers to working and learning together

Participants mentioned several factors that had a bearing on their abilities to collaborate effectively in the classroom and the clinical environment. The most significant were the existence of hierarchical structures in the clinical environment, the clinical environment itself and clinical placements. Effective interprofessional collaboration was affected by hierarchical structures related to perceptions of discipline knowledge possession and cultural behaviours in the clinical environment as if to protect one's territory. Some participants felt that it was entrenched behaviour.

…maybe people thinking that they're better; they know more than the other discipline. It's a bit like turf wars… … territorial, like nurses, the labour ward, the nurses on the wards, the nurses in theatre, it's funny to watch. It's about the culture. (Jenny, ST)

I think there are hierarchies in the workplace. …some people or some professionals will want ownership of the particular problems, and probably not want to consult outside their professional area to see the bigger picture. (Sonya, ST)

What might stop me from working in an inter-professional way would be judgement from doctors or obstetricians. I know it is entrenched in the system. It is male dominated; you know the hierarchy is definitely entrenched. (Phoebe, ST)

Lina, on the other hand, felt that any difficulty in working in an interprofessional manner was related to the fact that she was a student. "*There are barriers to working in an interprofessional way in practice, not so much from a midwifery point of view but from a student point of view. … you're not a person, you're not a professional…"* (Lina, ST)

Holly felt that effective collaborative practice was important for midwifery practice and hierarchical structures had the potential to impede this:

> *…there's a strong hierarchy which means that people's knowledge isn't respected necessarily. Its teamwork, I can't ever imagine working as a midwife without working with other health professionals. So to me it's fundamental in terms of IP or interprofessional education…* (Holly, RM)

Participants shared concerns regarding the type of clinical environment they were allocated with regard to IPE. Interprofessional collaboration (IPC) was limited, depending on the model of care within particular maternity units such as a birthing centre. Jordan voiced her concern that the opportunity for IPC was limited in her first clinical allocation as the birthing centre was purely staffed by midwives and thus did not promote IPC or IPE. These concerns were also reiterated by Phoebe. Jordan said:

> *In first term, because it was all midwives in the birth centre on clinical prac I didn't do a lot of working interprofessionally… (Jordan, ST)*
>
> *I am in the birth centre currently and I am not participating in an interprofessional way, no, not at all, because we're not really in contact with obstetricians or nurses, it's just midwives.* (Phoebe, ST)

Another viewpoint regarding the clinical environment and its impact on IPC was that expressed by Jenny who recounted that IPC was impacted by the actual type of work environment. It related to the busy-ness of the particular maternity unit, the personal traits of the individual staff, and the differences between the various maternity units within the health care agency.

> *In the clinical sense working in an inter-professional way all the environments are different. Like LMH, I can find it quite difficult there. They are really all flat out, they're busy; they don't want to get into a conversation about what's going on. And now at Clinic A, everybody's been really welcoming, all the registrars are happy to sit and have a chat. …the barriers come from personal traits. And then there's also the midwives, I've seen it even transferring, the midwives on the labour ward when they're handing over women to theatre,*

> *even* [then] *there's a bit of tension between the different areas. And then obstetricians come in and the midwives are all funny because the obstetrician's there…* (Jenny, ST)

6.7 Conclusion

This chapter has presented a thematic analysis of the participants' experiences of interprofessional education and interprofessional collaboration. Both were valued by participants on a continuum of being perceived as necessary through to having doubts in relation to the ideology versus the practicality. However, views and experiences of the participants highlighted by the themes of 'shared misconceptions', shared understandings', 'shared misdirection', 'shared professional values' and 'shared misgivings' were dependent on three factors. These were: the point in time along the career trajectory at which experiences were happening or views were formed, that is, during the early phase of their education or as experienced midwives; the location within which they were occurring, that is, within the university or the clinical environment; and with whom participants were interacting. It is these factors that the following chapter addresses using Clandinin et al.'s (2000a) narrative inquiry approach.

CHAPTER SEVEN

INTERPRETATION AND DISCUSSION

We do not see things as they are; we see things as we are.
The Talmud (Record of rabbinic discussions pertaining to Jewish law, ethics, customs and history)

7.1 Introduction

This chapter discusses how midwives developed their professional identity. This was done by using Clandinin and Connelly's three-dimensional narrative inquiry space (NIS), which was originally underscored by the defining works of Dewey, an educational theorist (Clandinin & Murphy, 2009, pp. 598-599). By exploring further how the themes identified in Chapter Six were related to the three elements of Clandinin et al.'s (2000a, pp. 54-62) NIS, namely interaction, situation, and continuity (see Chapter Three), a theoretical position of professional identity development in midwives was explicated. However, a brief discussion was necessary to explain the alternate use of terms such as 'relational', 'temporality' and 'spatial' rather than those elements described by Clandinin et al. (2000a) and Clandinin (2013).

7.2 The elements defined

The three elements of the NIS, namely 'interaction,' 'continuity,' and 'situation' (ICS) have been used interchangeably by authors (Clandinin et al., 2009; Haydon, Browne, & van der Riet, 2018; Wang & Geale, 2015) of narrative research with the terms 'relational,' 'temporality' and 'spatial,' (RTS) either wholly or in part. In this study the researcher has chosen the latter nomenclature of the elements of the NIS for the reasons outlined as follows.

7.2.1 Element: relational or interaction

The element 'interaction' is defined as a "reciprocal action or influence" by Soanes et a'. (2008, p. 739). To the researcher this suggests a somewhat two-dimensional linear relationship between two persons. On the other hand, the term 'relational' presents a more fluid and potentially more expansive situation between two persons as its definition is the "way in which two or more people or

things are connected or related" (Soanes et al., 2008, p. 1214) which allows for a more expansive viewpoint for this research.

7.2.2 Element: temporality or continuity

According to Soanes and et al. (2008, p. 309), 'continuity' refers to the "unbroken and consistent existence/operation" whereas 'temporality' is defined by the same authors as "the state of existing within or having some relationship with time" (p. 1483). Once again, the researcher prefers the latter term as it implies the potential for change as time changes, or even as participants recall the events from the past in the story-telling at the current time (Haydon et al., 2018, p. 127). This process of recall may have a subliminal effect on the participant's subconsciousness, however unintended, and it is not confined to an 'unbroken' or 'consistent' application of meaning-making.

7.2.3 Element: spatial or situation

Finally, the element 'situation' is defined by Soanes et al. (2008, p. 1348) as "a set of circumstances in which one finds oneself" which again for the researcher is limiting. 'Situation' is well aligned with a sense of continuity and possibly contained interactions, which is not the way participants shared their stories. Alternatively, the term 'spatial,' defined by Merriam-Webster (2003) as "relating to, occupying, or having the character of space", has a broader dimension of application in this researcher's opinion and sits well with how participants' drew meaning from their narratives.

For the reasons outlined above, the researcher has used the elements of relational, temporality and spatial (RTS) in the theoretical application of Clandinin et al's (2000a) NIS to the findings of this study. Where an original element from the NIS is used, an explanation is provided.

7.3 Relational

The way in which two or more people or things are connected or related.[22]

7.3.1 Interprofessional education

The analysis of the participants' narratives presented multiple and diverse facets of interprofessional education (IPE). The most simplistic of these was that IPE was concerned with the sharing of common subjects in health courses which provided health education students with shared formal learning experiences. Through this mechanism, and through the teamwork this enabled, participants stated they acquired knowledge and thus learnt from the other health professionals. These views were exemplified as follows:

> *Most of the units that we did were nursing units so they were the nursing students, but there were also psych[23] units and socia[24]l units, we had other students, health students in that class as well.* (Valerie, RM)

> *So for me it's being able to learn the theory but then go into the workplace and work with people who are already in the industry to understand and learn more from them.* (Jayne, ST)

> *With regard to interprofessional education, I think it is brilliant and needed in these kinds of industries. I think without it then you won't be able to perform the job as well as you should be able to …* (Jayne, ST)

From a provision point of view, IPE was a cost-effective approach to teaching delivery in the tertiary setting. The need to meet external course requirements and work alongside institutional logistics was not an isolated phenomenon as reported in the study by Craddock et al. (2013) and also Parker, Gottlieb, Dominguez, Sanchez-Diaz, and Jones (2015).

The teamwork that IPE facilitated also afforded participants opportunities to understand and develop awareness about the other health professionals in the clinical environment. This included learning about their respective roles and practice and to be exposed to the diversity of views and particular strengths of the other health professionals. This was viewed as an avenue to providing

[22] Soanes & Stevenson, 2008, p. 1214.
[23] The term "psych" refers to the word "psychology."
[24] The word "social" refers to the subject "sociology."

improved client/patient care through collaboration and the ability to enlist the assistance of other health professionals when required. These views are in keeping with research by Hammick (2000) and Rodger et al. (2010) and participants in this study. "*I'd obviously heard of an OT but I hadn't really understood what they did and so if I hadn't worked with those people in the group I probably still wouldn't know".* (Penny, ST).

Another facet of IPE were the personal benefits that participants derived from being able to relate to other members of the health care team from diverse disciplines in a familiar/safe setting. This allowed broader thinking in general, but specifically about the content being discussed, plus understanding others' perspectives in the health care setting. Sonya expressed her views thus: "*…in the anatomy class, we do some group work together and this is bringing strengths and understanding,…they have a lot of knowledge… and it's interesting to get other people's perspectives".* (Sonya, ST).

The net effect that the engagement with IPE in the clinical environment was that participants were able to relate to other members of the health care team from diverse disciplines, as well as to locate themselves within the health care system and its workings. Support for these study participants' experiences can be seen in research undertaken by Pollard (2009), MacDonald et al. (2010) and Murray-Davis et al. (2011), whose findings recognised the importance of health professionals being cognizant of each other's respective roles in the clinical setting. Added to this was that IPE was viewed as an agency of empowerment, a vehicle through which there existed the validation of their thinking by other health professionals, and the ability to further develop professionally. Derya proffered the following insights:

> *I really saw the relevance of interprofessional education when I was at uni. I [was] really empowered [by] that … I think it is important to have that education together so you can relate it to your practice later … it's good to be able to go to her* [the physiotherapist] *to get that confirmation you're on the right track.* (Derya, RM)

7.3.2 Professional identity and interprofessional education

Views of professional identity associated with IPE differed. For some participants their professional identity was associated with possessing the appropriate qualifications necessary for a midwife. This afforded them knowledge, the ability to develop their expertise as midwives, thus becoming competent clinicians with the associated confidence that comes with expert practice. Others equated the level of knowledge possessed by midwives, what a midwife actually does, and their role as contributing components of professional identity. Holly's experience personified these views:

> *I suppose I mean by 'professional identity' the role, the expectations, the legal and ethical boundaries all around with being a registered midwife in Australia. So what are the expectations of a midwife who works in Australia, and how do they fit in that, so it's not necessarily their personal views, because of course some of their personal views might be a bit different. But it's the expectation of that role within the context, so for us it's in Australia, and it's national now and it would be different in different countries.* (Holly, RM)

Some participants were of the view that professional identity was about sharing their knowledge with, and advocating for, women in their care. For others being part of the normality of birth also strongly contributed to, and influenced, their professional identity. Commonalities existed with regard to professional identity being associated with possessing expertise in their discipline, being valued as a professional member of the health care team, collaborating as equals, and being afforded equal power and respect in the clinical environment. Andrew (2012) makes the case that how a particular profession is viewed by another profession, can in fact influence a particular member of that profession in terms of their professional identity. These views were particularly the case with qualified midwives.

> *…my professional identity in [that] I think it's made me a stronger midwife actually. …you need to be very sure and clear of your own position and then you can collaborate as equals. …it's that collaboration between equals. It works best when the power's equal and that it's based on respect.* (Georgina, RM)

However, some participants, in particular student midwives, did not share these views based on the premise that there existed unequal power/power relations in the clinical environment and thus they did not feel valued as professionals-in-

waiting. This situation did not contribute positively to their sense of professional identity as evidenced in the following: *"…and because I wasn't a nurse previously, they were of the opinion, 'oh you don't seem as if you know what you're doing' that kind of thing. I found that quite a few of the doctors were like that as well, very, I wouldn't say standoffish…"* (Lina, ST)

A pervasive point of view regarding inequalities in the clinical environment was expressed and attributed to the fact that other health professionals were not as cognisant of midwifery practice and midwives' roles. This contributed to feelings of not being valued in the health care team on an equal footing such as medicine. For example: *"I've never liked the power plays of obstetrics. I've never liked the idea that they just own the high moral ground, I think that ground is for sharing".* (Georgina, RM)

The need for health professionals to be cognisant of others' roles in order to foster successful interprofessional collaboration features prominently in the literature. Studies such as Fernandes, Palombella, Salfi, and Wainman (2015), Tucker et al. (2003), and in particular MacDonald et al. (2010), all support this notion. This has the added benefit of strengthening others' professional identity. The equality argument also applied to the clinical education of student midwives as participants believed that the government funding model for clinical education led to inequality of opportunity in the clinical environment.

Interprofessional education was seen to positively impact participants' sense of professional identity as it increased their self-confidence and competence. IPE broadened their thinking, allowed them to better define their role within the health care setting and thus strengthened their professional and/or role identity. For others, participation in IPE sessions clarified/defined their role identity through acquisition of knowledge. For some, engaging in *multidisciplinary* learning enhanced their practice and thus contributed to their sense and view of professional identity.

> *…those multidisciplinary learning opportunities have impacted on it [professional identity], because without them then I would be limited as to how other things impact on my practice… If I hadn't learnt from those different disciplines then my care of people, ...I actually think I wouldn't be able to care for people as well as what I think I*

> *do. Intercollegial working has actually enhanced my practice, that's exactly what I'm saying.* (Valerie, ST)

Valerie's experience and that of others like her is certainly supported by research undertaken by Levett-Jones et al. (2018), whereby a multi-country study of IPE initiatives returned findings of an enhanced sense of professional identity, understanding others' roles, and application of their knowledge for enhanced collegial practice amongst others.

7.3.3 Interprofessional education: perceptions of its worth

Participants expressed that IPE raised awareness of health care as a multifaceted entity and thus the need for a collaborative effort in the clinical environment. It impacted their own practice positively which was seen as a positive outcome for women/patients in their care.

> *I think the broader your education is and based, it can only be of benefit, and to have an understanding of what professions do, to have mingled with them, studied with them, worked with them, to have a peer group coming through that's not just the midwives …. I think that will make a difference and we will end up in the same workplaces and be working together and I think it will mean there's less formality, more consultation between the professions…* (Sonya, ST)

Whilst IPE provided positive and valuable experiences in the tertiary setting, it was not without difficulties. Some of these were the existence of barriers in working interprofessionally with other health disciplines, the value of IPE at particular points in courses, and the need for IPE to be located prior to clinical placements for students. Sonya explained her experience as follows:

> *… in inter-disciplinary groups, they specifically separated us into groups of students from different disciplines, we had to do a presentation. … it didn't increase my understanding of what other people were studying… I really don't feel I got a lot out of it. I didn't develop a greater understanding of the role of each one of those other disciplines … we weren't speaking to each other about what we were studying; …* (Sonya, ST)

Sonya's experience may, in part, be explained by a potential lack of preparation for interprofessional teamwork, whether that be in the classroom or the clinical setting. Research by Orchard (2010, p. 250) found that most nursing education programs did not adequately prepare its students for interprofessional

teamwork. This could, by extension, apply equally to midwifery programs. Jordan expressed a different viewpoint.

> *…it was nice getting to hear about what they have to do as part of their degree. I think interprofessional education is definitely a good thing and it'll help us all out in the future. I think if we'll have to work together in hospitals … in the future anyway. … the earlier we can get started with interprofessional work, the better.* (Jordan, ST)

For some participants, IPE/IPC/CP was viewed as the physical 'doing' of activities with other health care professionals rather than the intended meaning derived from the CAIPE (2002) definition of IPE. For other participants it meant being physically present on a ward with other health professionals. However, there was agreement amongst participants that it requires a commitment by all health professionals for it to be successful. This reflection of their understanding has been widely reported in the research literature such as Fernandes et al. (2015). Unfortunately, for some participants, what was actually scheduled in an interprofessional session was not the reality.

Perceptions of inequalities in IPE sessions were reported and this was attributed by the participants as a result of gender and class differences. Research by Tucker et al. (2003) supports the need for equality amongst students undertaking IPE for it to be successful. Overall, existing hierarchical structures in the health sector contributed to the less than satisfactory IPE sessions for some participants. This was particularly evidenced by Georgina in the following excerpt:

> *But it's very, very hard. Apart from the whole gender thing, and class* [that] *complicates midwifery and obstetrics, there is also the whole issue around numbers. So if you run an in-service, at handover, at changeover time, you get a whole lot of midwives and just a couple of registrars, and that skews* [it]*… … interprofessional learning, they were very big on it, … and we tried quite hard to collaborate, in a small way, with obstetrics … … but the practice around it was quite hierarchical …*(Georgina, RM)

7.4 Temporality

The state of existing within or having some relationship with time.[25]

[25] Soanes & Stevenson, 2008, p. 1483.

7.4.1 Professional identity and IPE: transitioning towards it

The concept of 'temporality' evokes an image of a transaction/activity that cannot be hurried and which does not necessarily occur in a linear fashion, that is, through a set progression of activities and/or time, but rather as an evolutionary event, that is to say, growing and evolving with the passage of time. In this researcher's opinion, this view of temporality resonates deeply with Benner's (1984) framework, when she postulates the importance of time in the development of a nurse from a novice, and culminating in the expert nurse. Clearly the point is, that becoming an expert nurse takes time and repeated exposures to differing experiences in diverse contexts. Thus, it is conjectured that this framework can equally be applied to midwifery students, both in becoming an expert midwife and also in developing a professional identity and becoming professionally socialised (Khalili et al., 2013).

In addition, Benner's (1984) framework can be applied to other situations in health care and health care delivery such as engaging with IPE and IPC, and with the development of both role and professional identity. The student midwife may come to the commencement of a midwifery course with either an already established sense of role and/or professional identity or without any idea at all. This was the case with most of the participants in this study. Through shared learning experiences both intra- and interprofessionally, at the university and/or on clinical placement, a sense of both who a midwife is, and what a midwife does, begins to form. This early formation of professional identity can wax and wane as the student midwife, even the registered midwife, move(s) between different maternity units within the same health agency, for example, from the postnatal unit to the birthing suite or even the special care nursery where the student midwife/midwife is exposed to new learning experiences and caregiving (Benner, 1984). This process may take time, that is, until the end of the university course or even after the graduate year of practice and beyond to establish itself within the new midwife.

There is no pre-determined set point in time that one's sense of role/professional identity is 'switched-on'. It cannot be timetabled. This was demonstrated in the research by Smith et al. (2012, p. 65) and further supported

by Khalili et al. (2013), who found that developing one's identity and/or professional identity is not linear in fashion, but very much shaped by the context and their relationship and interactions with peers, colleagues and other health care professionals over time. This certainly was Thalia's experience:

> *My own view of my professional identity has changed over time. As I said, when I first went to become a midwife, I didn't really understand the identity of a midwife; I went into it fairly green. I think by working in midwifery for fifteen years, I think now I've got a really good appreciation of the impact midwives have, and so it's certainly strengthened ... I think just by practising at it* [midwifery]*, you get to see the importance and you get to see all those differences that we make which strengthens your identity as a midwife…* (Thalia, RM)

Furthermore, Williams and Ritter (2010, p. 90) demonstrate that as a participant/person transitions through a program of study, their original view of identity, whilst it undergoes change, and through repeated interactions with other health care team members, is not discarded but reconstructed. This is certainly in keeping with Gergen's (1985) constructivist philosophy which acknowledges that people, through interactions, give meaning to the result of those interactions. Research by Ibarra et al. (2010) adds weight to the potential for identity to change or evolve as the context changes.

Just as important is the ability to engage with other health professionals within the university course and to be comfortable with this engagement. Obstacles such as timetabling had the potential to railroad set IPE sessions but over time these were overcome. These logistical issues were not isolated to the current study but also discussed in studies by Morison et al. (2003), Hammick et al. (2007), and Parker et al. (2015). Less easy to overcome was the reluctance of student midwives to engage with, at times, both the IPE content and the other health professionals within the session. Over time, and with exposure to and within the clinical environment, these difficulties were not only overcome, but came to be appreciated by the participants as their relevance to practice manifested in most cases. This was reported as early as 2000 in a discussion paper by Ross and Southgate (2000, pp. 739-743). The common denominator in these scenarios is the passage of time. This was exemplified by one participant:

> *… in inter-disciplinary groups, they specifically separated us into groups of students from different disciplines, we had to do a presentation. And I do have to say, it didn't increase my understanding of what other people are studying… I really don't feel I got a lot out of it. I didn't develop a greater understanding of the role of each one of those other disciplines … we weren't speaking to each other about what we were studying; it was just, how are we going to put this together and present it to get the maximum amount of marks.* (Sonya, ST)

However, with further probing this participant was able to view IPE through the lens of the passage of time (i.e. the long-term aspect of practice and time). She stated:

> *I think the broader your education is and based, it can only be of benefit, and to have an understanding of what professions do, to have mingled with them, studied with them, worked with them, to have a peer group coming through that's not just the midwives …. I think that will make a difference and we will end up in the same workplaces and be working together and I think it will mean there's less formality, more consultation between the professions…* (Sonya, ST)

7.4.2 Role identity and scope of practice

Interestingly participants associated the development of role identity with the passage of time, and associated processes, to become qualified as a midwife.

> *As I started reading about pregnancy and birth and that postnatal period, I just thought, 'Oh, I'd really love to be the woman that's with the women,' and so it wasn't until I had my first child that … …that I had a student midwife at the birth, and so I knew what a midwife was …From that time I just had an amazing interest in the whole process, and always just thought, 'that would be fantastic'.* (Valerie, RM)

For others this encompassed what they actually did in their roles and the midwifery experiences they were exposed to, also seen as part of their scope of practice. Collectively these views were seen as a component of professional identity. This viewpoint is supported in part by Stets (2010) with regard to knowledge, skills and meanings the midwife associates with particular behaviours she/he exhibits as a midwife. Another dimension of role identity was espoused as the demeanour of the midwife in practice, a view observed over time in the clinical environment. However, the difference between role and professional identity was expressed by Phoebe, but was not able to be elaborated further.

> *Role, role in terms of midwifery, conjures up supportive, advice, education, empowerment for women, women's rights, women's*

> *equality, screaming women in labour. Qualities that make up a midwife are compassion, empathy and strength. You know to use a good sense of your own intuition. I think role identity and professional identity are different.* (Phoebe, ST)

7.4.3 The interprofessional[26] and the clinical environment

Effective IPE and IPC was attributed to a work environment in which the appropriate conditions existed namely, good communication, respect for, and trust in all members of the health care team. This was a position advocated by Engum et al. (2012), whose recommendation included the use of simulation in IPE to foster collegial working. These were also issues identified by Murray-Davis et al. (2011), with consideration of the lack of appropriate conditions to foster effective IPE and IPC. With regard to the current study, it was also believed that not only did effective IPE and/or IPC directly affect their current practice, it had the potential to influence the future education of midwives as well as future clinical practice. Ultimately it was seen as a vehicle through which health care delivery would be enhanced alongside serving as a strategy for further learning. This was exemplified by the following statement: "*This interprofessional collaboration is great. I learn heaps, constantly learning, and it supports the patient."* (Alicia, RM)

By working alongside other health professionals post initial registration, participants were able to further broaden their knowledge of client care provided by other health professionals rather than just terminating the midwife-client/patient interaction at the end of the care episode. For other midwives further education opportunities were an added benefit of working interprofessionally both in the clinical environment and attending interprofessional sessions at the university. Undertaking interprofessional education courses post-registration was found to be supportive of their practice in caring for women and also provided them with a better understanding of health care. According to Lorraine:

> *Interprofessional collaboration might have affected my own individual practice if I were to be in practice or in relationships with clinical partners by having an awareness after the referral has been made,*

[26] 'The interprofessional' refers to the environment of interprofessional education (IPE), interprofessional collaboration (IPC), and interprofessional practice (IPP).

> *of what happens next rather than just thinking, okay this woman needs to see, and then just handing it on to the next person. So it cuts both more in overall involvement rather than compartmentalising for different professions' input.* (Lorraine, RM)

The insights proffered by Lorraine were reflected/underscored in/by Benner's (2012) writings regarding the need for all health care professionals' obligation to be working from the same page in terms of IPE and health care delivery.

7.4.4 Barriers to the interprofessional

According to participants, working interprofessionally was hindered as timetabling restraints precluded the intermingling with other health professional students, particularly in the classroom setting. Clinical practice requirements of the midwifery syllabus further added to the difficulties. There were perceived inequities in teaching and syllabus delivery which was seen to favour other disciplines and this further mitigated effective interprofessional group work. These findings resonate with those of Tucker et al. (2003, p. 635) who strongly recommended equity amongst groups undertaking IPE. As one participant recalled:

> *We basically get our timetable given to us: they have certain days that they block out completely for the practical element … That in itself alienates us as an interprofessional team*
>
> *… they keep ramming* [it] *down our throats* [about] *interprofessional relationships and then in the next instance they're making it almost impossible for us to have interprofessional relationships.* (Lina, ST)

In recalling their experiences in both the classroom and clinical environment, midwives stated that hierarchy dictated their work practices and thus impeded effective IPE and collaboration. One participant expressed her experience as: "*I suppose there is that hierarchy with communicating with doctors that you're always aware of … … people out there that think midwives are a bit lower down on the pecking order and just ignore what you say".* (Alicia, RM)

Alicia's view was not an isolated one. The literature demonstrates that hierarchical structures have the potential to impact health professionals' likelihood to engage with each other (Burford et al., 2013; Johnson, 2012; Stevens et al., 2012).

7.5 Spatial

Relating to, occupying, or having the character of space.[27]

7.5.1 Professional identity: a multifaceted concept

Professional identity is associated with how the midwife and her/his role is perceived by the public coupled with their own perception and where in the health care sector the midwife is situated.

> *What my professional identity means to me I suppose, it means the way I view myself and the way other people view me.* (Valerie, RM)

> *[Professional identity is] I guess how you personally view a midwife, and how you will view yourself as the midwife.* (Penny, ST)

> *What I think professional identity means,…is that people in society know what a midwife is and respect midwifery as a useful thing to society. …we have a legislated profession and the society thinks that it's important enough to legislate around midwifery… professional identity is all tied up in that idea of usefulness and value to society and therefore it comes with responsibility and that comes with identity.* (Georgina, RM)

Khalili et al. (2013) argue that it is socialisation within and relation to the work context featuring differing health professionals that partly contributes to the development and formation of identity in the health professional. Valerie and Penny's experiences were reflected in this viewpoint as was Georgina's.

Generally speaking, there was no consensus of agreement as to what constitutes professional identity. For some it is a broader concept than scope of practice; for others it is similar to role identity, in other words, what the midwife actually does in practice, but more than a set of specific skills. This was exemplified in Thalia's comment that *'practicing it* [midwifery] *strengthens your identity as a midwife'* but for Fanita, professionalism and role identity were the same. It was what midwives *'do in their job.'* This may be explained by where they were positioned on their career trajectory, vis-à-vis, a student as opposed to an experienced midwife. However, it was apparent that those participants that viewed professional identity as a concept greater than, but inclusive of, scope of practice were more in keeping with the ICM's (2017) definition of the

[27] Merriam-Webster, 2003.

midwife. Nonetheless, it was felt that being aware of one's scope of practice was necessary in order to clarify one's role, which in turn impacts one's sense of professional identity. For Holly, scope of practice allowed for the shaping of one's role identity:

> *…scope of practice… what it is we do, and what it is we don't do, and what's reasonable that we should be expected to be able to do. I think it helps establish a certain area of expertise that midwives should claim and hold on to and be proud of, and it also helps to establish some barriers, some boundaries around that, that actually, once you become that, a number of things are outside of our area of expertise, and we should be referring or collaborating. So that is an issue too, isn't it? So yes, I think it's quite a powerful way to help to draw those lines in a practical sense.* (Holly, RM)

Clinical practice was found to alter perceptions of, and impact upon, professional identity in that it highlighted how much more extensive a midwife's role was in comparison to initial entry into midwifery education and practice. According to Jayne, exposure to the care of women had the following impact:

> *My view of professional identity has changed. I used to think a midwife was the person who just looked after the baby. So it's certainly changed a lot from that because I know that it's more of a whole, it's more about the woman than the baby I think, the majority part, but before I used to think it was just about the baby.* (Jayne, ST)

This is not uncommon in the literature. It is through the lens of the community of practice within which the midwife practices that will influence or contribute to how that person will perceive or derive their professional identity (Andrew, 2012; Larsson et al., 2009; Lave & Wenger, 1991).

7.5.2 Factors impacting role identity: working and learning together

Working collaboratively with other health professionals in the clinical environment was a positive factor in the process of development of role identity. Contributing to the developing perception of one's role identity was IPE and socialisation in the clinical environment. Knowledge of other health professionals' roles, one's level of competence in midwifery, and good communication were also considered as contributors to development of role identity. A hierarchical structure in the clinical environment that allowed for effective collaboration was also viewed as positively impacting role identity, but to a lesser degree. Effective and positive communication in the clinical

environment was seen as a factor in the development/perception of role identity as IPC was valued, and could be both a positive and negative factor for role modelling as demonstrated by Alicia:

> *I've had generally a really positive experience with the collaborative care and communication aspect and it has probably enhanced my sense of role identity.* (Alicia, RM)

> *Interprofessional collaboration affects my individual practice as a student midwife because we're learning; I suppose you pick up lots of different* [things from different] *people and some of it you take away, some of it you don't. And there have been occasions where I've thought, "Yeah, I don't want to be like you," and there's other times when I've thought, "Yeah, you know, I'll really take that bit of your practice away and use that".* (Lina, ST)

7.5.3 The interprofessional and the clinical environment

The clinical environment featured prominently and positively with participants as the means through which each member of the interprofessional health care team was able to work meaningfully with each other. The sharing of information and referral of clients amongst the diverse disciplines when necessary, was commonplace and viewed positively as it was seen to enhance care provision of their mutual clients. This was demonstrated by Jayne and Penny in their respective experiences:

> *…clinical environment supports interprofessional collaboration by the information sharing. … they shared the information to try and work together to get a positive outcome. … that sharing of information and working together that is the real crux I think of interprofessional collaboration. Interprofessional collaboration will make me more aware … and where there is another professional that may be able to help and then sharing that information with that other professional. … made me more aware of looking at who else could possibly be involved in the care.* (Jayne, ST)

> *…in the staff meetings, they talk about each member of staff. Although they're all midwives, each has a different role of working with different departments within the hospital on different wards, so they would definitely be involved collaboratively. The midwives are referring the women all the time to different people as well … … so I guess that is interprofessional working.* (Penny, ST)

The positive experiences of both Jayne and Penny was in keeping with research by Xyrichis et al. (2008), whose review highlighted that the existence of team structures and processes enabled health professionals, midwives

amongst them, to better work together to provide a higher level of health care to their clients.

7.5.4 Barriers to working and learning together

The type of clinical environment, even within the same hospital/health agency presented as barriers to effective IPE and CP. Added to this was the work environment, that is, how busy the unit was and the differing traits of staff had the potential to be a barrier to CP. In some instances, IPC was very much dependent on the model of care underlying care provision.

> *…the barriers come from personal traits. And then there's also that whole professions the midwives, I've seen it even transferring, the midwives on the labour ward when they're handing over women to theatre, even there's a bit of tension between the different areas. And then obstetricians come in and the midwives are all funny because the obstetrician's there…* (Jenny, ST)

Once again, the literature supports some of the negative experiences expressed by Jenny. These barriers had the potential to foster negative attitudes towards IPE and IPC in participants, and were reported by researchers including Felstead (2013) and Pollard et al. (2006).

The preceding discussion used Clandinin et al.'s (2000a) three-dimensional narrative inquiry space (NIS) to present an interpretation and discussion of the themes identified in Chapter Six. However, not all the themes could be discussed within the framework, as themes move beyond discussion using the NIS. Knowledge generated as a result of the findings and thematic analysis from Chapters Five and Six respectively, have been expanded upon with Clandinin et al. (2000a) and Clandinin's (2013) work. It is to this which the discussion now turns.

7.6 The borderlands[28] of becoming a professional

According to Soanes et al. (2008, p. 161), the term 'borderland' refers to "a district near the border between two countries or areas." In this study, this term represents the space occupied between the discussion generated by the

[28] See Clandinin's (2007), *Handbook of Narrative Inquiry* for the use of this term.

application of Clandinin et al.'s (2000a) NIS elements to the data and the 'new knowledge' generated by this study. This new knowledge for the most part adds to the discussion resulting from the use of the NIS, but at times ebbs and flows in relation to the three NIS elements.

Whilst the NIS is bounded by its elements according to Clandinin et al. (2000a), this study revealed that the environments of both IPE and midwifery practice are fluid, and thus the NIS is not able to capture ebb and flow adequately. The tensions that exist between interprofessional and midwifery exchanges (given that the midwifery context is an everchanging social environment) and importantly, the impact upon professional identity development, are reflected aptly, by the term 'borderlands'.

7.6.1 Factors impacting professional identity: learning as a midwife

Whilst the acquisition of knowledge coupled with clinical practice was empowering at one level, there was also ambivalence with regard to some participants who expected that to be the case when it was not. Impacts upon professional identity were multifactorial. These included power plays in the work environment, differing personalities of colleagues, the models of education underpinning learning, workplace politics, and one's own professional development and clinical practices.

Research by Smith et al. (2012) and Phillips and Hayes (2006, p. 231) which found that socialisation in the workplace was a significant factor to professional identity development, reflects and supports the experiences of participants in this study. All contributed to or impacted professional identity.

> *… I had an idea of what my professional identity as a student midwife and future midwife was before we did any interprofessional education. My view of professional identity or role has changed over time since I've been studying and have been exposed to clinical* [practice]*. …I had an idea of what I thought a midwife did and that's changed that quite a bit. I suppose I've changed a lot of my views around midwifery just because of the new experiences … who I'd like to be as a midwife, that has changed quite dramatically from my personal experience to now, having my midwifery experience within the university and in prac…* (Lina, ST)

Interprofessional education provides midwifery students with early opportunities in discussions about what a midwife does; this clarifies very early on the importance of the midwives' scope of practice and influences their sense of professional identity. An interesting feature in this study is the notion that IPE in the early part of a midwifery course does not affect one's sense of professional identity, due to the fact that little is known about the other disciplines. In other cases, IPE was not seen as a change agent in terms of professional identity development, it was already established prior to the course commencement. The concept of an already-established professional identity prior to entry to a program of study, is supported in part, by Johnson et al. (2012), and the following participants:

> *In my view, it* [IPE] *should start, you need an opportunity to establish some professional identity within your group early on… … give them an opportunity to say "Well, what is it that makes you a midwife here, rather than a nurse?"* (Holly, RM)

> *Inter-professional education has not really impacted my view of professional identity. It hasn't changed my view of midwifery. Clinical would not impact on my view of professional identity, not really because I would still identify totally as a midwife…* (Phoebe, ST)

7.6.2 Factors impacting professional identity: practicing as a midwife

Clinical experiences were contributors to participants' heightened sense of professional identity. This was as a result of increasing competence and being valued as a member of the health care team. This notion of being valued and respected is supported by the work of Thomson, Outram, Gilligan, and Levett-Jones (2015, p. 638), in particular where clinical experiences include interprofessional collaborative practice, which highlighted the importance of the role and contribution of other health professionals. Interestingly, the concept of interprofessional collaboration is described by Mivšek, Pahor, Hlebec, and Hundley (2015) as a 'new' characteristic needed, in order to lay claim to the status of being a profession. This aspect of professionalisation can, by extension, contribute to professional identity development.

Midwifery practice was the change agent of earlier perceptions of professional identity. The journey through midwifery education and the acquisition of knowledge was empowering and led to changed views of professional identity.

> *Has my view of professional identity changed over time? I've always thought that doing that study, we had the different disciplines, we did the social cultures a fair bit and* [it] *made me realise probably while I was studying what was involved. I think the reality of it becomes apparent when you start working…*
> (Derya, RM)

This acquisition of knowledge, coupled with the relevant disciplinary clinical experiences, has been reported by Reid et al. (2008) who describe the formation of one's professional identity as the nexus between the learning and the practice contexts. The study by Arreciado Marañón and Pilar (2015) also reinforces the importance of the clinical practicum as a contributor to professional identity development. The researcher believes that these factors, coupled with the opportunity to practice intercollaboratively as described by Mivšek et al. (2015), can only serve to enhance the sense of professional identity for the midwife, and is supported also by Trede et al. (2012).

7.6.3 Factors impacting professional identity: knowing as a midwife

For some participants, the practice of midwifery refined and strengthened their sense of professional identity. This was based on their perception of the value that midwives bring to midwifery care that positively impacted the woman's decision making. However, another factor surfaced, that is, knowledge acquired through practice was not always due to the prevailing paradigm of knowledge generation based on science and technology that arises from it as discussed by Davis (1995), who describes multiple ways of knowing as does Cheney-Morris (2012). The participants' description of the value of their midwifery care is reflective of both "aesthetics" (in this case, the art of midwifery) and "ethics" domains described by Carper (1995) in her seminal writings on the various ways of knowing in nursing, and which can equally be applied to midwifery. This is particularly so in continuity of care models as it allows the midwife to truly be 'with woman.' Thalia described her experience thus:

> *I think just by practicing at it, you get to see the importance and you get to see all those differences that we make. … you're providing information that can really alter someone's experience so you can give that information to facilitate decisions* [for the woman*] that will potentially make big differences.* (Thalia, RM)

A similar sentiment was expressed by Valerie who said, "*As I started reading about pregnancy and birth and that postnatal period, I just thought, 'Oh, I'd really love to be the woman that's with the women…"* (Valerie, RM)

According to Davis (1995, pp. 30-32), these other ways of knowing are also used in midwifery care that, whilst they are not as widely acknowledged as the scientific tradition, are equally valuable for midwives to use in their care provision.

Lina put forth the opinion that practising interprofessionally enabled her to select aspects of best practice (emulated by qualified midwives she worked with) and incorporate these into her practice, as well as those aspects she thought were not indicative of good midwifery care provision to ensure she did not model those behaviours. This is in keeping with Carper's (1995) domain of "personal knowledge" which, in addition to knowing one's strengths and weaknesses, develops both in order to improve one's practice (Cheney-Morris, 2012, p. 48).

> *I suppose you pick up lots of different [things from different] people and some of it you take away, some of it you don't. There have been particular aspects that I've seen, where I shudder and think, "That's not how I would do it," well not just from a different discipline, from the midwives as well, there's lots. There's lots of looking down the nose and the health professionals, "You're just a woman. This is what's happening. This is what we're doing." No information, no collaboration, and you've just got to sit there and cringe and go, "Oh my God, I can't believe you just said that." So definitely.* (Lina, ST)

7.6.4 The interprofessional context in the classroom and beyond: attitudes, concerns and barriers

Engagement with IPE was seen as studying with other students from diverse disciplines. However, dissonance existed between the ideology of IPE and the actual implementation of IPE sessions at the operational level. The concept of IPE was questioned in terms of its worth to midwifery practice or the value of the content presented. This viewpoint is in keeping with the old model of

uniprofessional education which contributed to the creation of “professional silos’’ (Angelini, 2011, p. 175), which of course does not foster interprofessional collaboration in the workplace effectively. On another level the dichotomy was presented that more opportunities for IPE were needed in order to avoid isolation from other health professional students. However, there was some consensus as to where in the course of study IPE should be located, namely later in the course, a notion not widely supported, particularly by Williams et al. (2012), Bainbridge et al. (2012), and Reeves et al. (2012). Participants offered the following views:

> *…what my university has done, we’ve got our mid unit and we had one a semester last year, we’ve two this year. But then our other units, they have separated us. They’re like, “midwifery students, when you’re doing applied bioscience, lock into this class”, or when we were doing Indigenous, all the midwives were in the same* [tutorial group]*, and I just did not understand. They’re slated to be offered, it’s a common unit across all the disciplines and ideally we should be able to be mixed in together, definitely.* (Jenny, ST)

> *… it’s almost doing it looking ahead, but it almost needed to be done later on in your degree when you are actually looking for your workplace and putting together a resume.* (Sonya, ST)

Interprofessional education was not appealing initially as it was felt there was too much IPE content at the expense of midwifery/nursing content. Midwifery students resisted mixing with other health professional students and also resisted engaging with non-midwifery course content. This resistance to “buying-in” is acknowledged as a barrier to effective IPE and is not uncommon in the literature (Angelini, 2011). However, the passage of time remedied this view and an appreciation of IPE developed as the course progressed. This behaviour was repeated in the clinical environment as midwifery students preferred working with other midwives and not the medical staff.

> *This mix of IPE and midwifery, for the midwifery students; midwifery is their chosen subject so they would prefer to have more midwifery units rather than three quarters of it being mixed. So from their perspective they’re a bit upset about it. But from our perspective it’s great to have some mixing with other professionals right from the beginning so that they’re aware that in the clinical environment you’ll be working with all of these different professions anyway.* (Lorraine, RM)

> *I feel more comfortable at the moment with the midwives rather than the doctors.* (Jordan, ST)

Interprofessional collaboration was seen as requiring self-confidence, a viewpoint acknowledged by Angelini (2011). IPC positively impacted the care of women and was useful for gaining differing viewpoints and perspectives of other health professional students. This was however viewed as challenging for some. For others IPC was very much dependent on other factors such as individual personalities, timetabling and the preparedness to engage with other health professionals.

> *I really think it's about really knowing what you're doing and having as much prac experience as you can while you're a student to really experience a whole range of things before you go out. I also think it's about personal self-confidence. …* (Phoebe, ST)

> *…working in an inter-professional way, …it might depend on the person's personality and if they're approachable, or* [whether] *you're aggressive. Also, timetabling probably would be a big thing, because I've noticed that we're all over the place. For me personally I'm in a class at the moment where I'm sure it's all nurses and I'm the only midwife there and I don't have an issue with it at all. I don't find there's a barrier and you've got to make the effort, and they seem quite welcoming.* (Jenny, ST)

Jenny's views were echoed by findings in research by Robben et al. (2012) and Miller et al. (2013) which found that allowing students from mixed professions to learn together about each other and each other's viewpoints did not create barriers, but actually improved interprofessional attitudes as well as collaboration with each other. In fact, the research found that the educational content was as important as what the students' learnt about each other.

Outside of formal sessions for IPE there was little encouragement for additional IPE opportunities. Clear concerns were expressed about the fact that IPE was initially instituted around the concept of financial considerations of course delivery. According to Lorraine [the university]: "*… would not agree to have a midwifery course, because it was too expensive and the only way they would agree to it is if there were lots and lots of shared units."* (Lorraine, RM)

This pragmatic approach to IPE is counterproductive to that intentioned by the WHO (2010) as appropriate resourcing and providing a coordinated and collaborative approach for the provision of IPE in both the educational and clinical context, have been identified in studies by Hammick (2000) and Reeves

et al. (2012). These are viewed by proponents of IPE as critical elements towards educating a health care workforce capable of delivering the required sustainable health care of the twenty-first century.

As midwifery was perceived as not being a profession by one particular participant, it was necessary to work collaboratively with other health professionals. This was not able to be elaborated upon. The IPC enabled the best care provision and was viewed as an adjunct to the provision of midwifery care. Whilst this viewpoint is not widespread in the literature examined, nor in this current study, it was a particular finding in the study by Mivšek et al. (2015, p. 1198), partly impacted upon by the educational level of their participants according to the authors. This may be due to the trajectory on which midwifery in that country is located with regard to professionalisation.

> *I believe interprofessional education it's quite important. We're not a profession on our own; we work collaboratively with lots of different areas … … and that we don't feel uncomfortable having to go to other health professionals in order to get things done and sorted I suppose.* (Lina, ST)

In the tertiary setting, IPE presented difficulties for the delivery of discipline-specific content, which is not necessarily the specified goal. Interestingly, IPE was viewed as favouring direct-entry Bachelor of Midwifery students, particularly by obstetricians and their registrars who appeared to be more willing to engage with them. This is presented and supported in the literature as a possible threat to professional identity due to the unequal treatment of, and by, professional groups according to McNeil et al. (2013, p. 291). Interestingly, in general IPE extended beyond the classroom and the immediate clinical environment in that 'handovers' and 'informal discussions at the ward desk' provided excellent learning opportunities. The value of these informal learning opportunities has been expounded by Phillips et al. (2006) with particular reference to the clinical context and clinicians' contribution to professional identity formation.

> *What we saw happening when the BMids came in was that sometimes especially the registrars, but sometimes the residents as well, sometimes the consultants too, spent time describing their work to the BMids and including them as well.* (Georgina, RM)

Significant factors that mitigated effective collaboration in both the classroom and clinical environment were the existence of hierarchical structures in the clinical environment, particularly with regard to obstetricians, and the perceptions of discipline knowledge possessed. These factors were also identified in a study by Thomson et al. (2015). A lack of knowledge about the midwife's role by other health professionals and vice-versa, was seen as undermining the worth of a midwife as a professional. The clinical environment in terms of entrenched cultural behaviours, such as turf protection, were also identified by Angelini (2011), compounded the situation. Another contributing factor was the type of clinical placement the participant/student was located within.

> *…maybe people thinking that they're better; they know more than the other discipline. It's a bit like turf wars… … territorial, like nurses, the labour ward, the nurses on the wards, the nurses in theatre, it's funny to watch. It's about the culture.* (Jenny, ST)

> *What might stop me from working in an inter-professional way would be judgement from doctors or obstetricians. I know it is entrenched in the system. It is male dominated; you know the hierarchy is definitely entrenched.* (Phoebe, ST)

> *I suppose you start treading on each other's toes in a way. I suppose that's where we really need to understand what I was saying before, understand where that line is where the physio does take over.* (Derya, RM)

Phoebe's views were also highlighted in research undertaken by Sollami, Caricati and Mancini (2018) who found that if nursing students believed that hierarchical structures were justified, then they were less likely to engage positively in both IPE and IPP. There was hesitancy in challenging the perceived existent hierarchical structures.

7.7 Fluidity: the fourth element

The quality of being likely to change repeatedly and unexpectedly.[29]

The term 'fluidity' refers to the ability of a substance to flow easily and to be able to change and flow in any direction at any given point in time. In this study, the fluidity is used to signify 'ebb and flow' of a given concept/situation, that is, not a fixed or static position/occurrence, as it is impacted by other situations or

[29] *Cambridge Dictionary Online*, Cambridge University Press (2008)

circumstances occurring at the time. Thus, put simply, it is a shifting situation according to the clinical or educational environment and the synergies between the various health professionals within that environment. The following discussion turns to the nascent[30] nature of professional identity which arose from the previous discussion.[31]

The interpretation of the narratives of the participants in this study yielded that the concept of professional identity was multifaceted. It was not confined to a point in time (temporality), it was not bound to a particular situation (spatial), nor was it solely dependent on particular persons or organisations (relational). The interplays were various but all contributed to the development of professional identity, some more than others, at any given time. That is, there was fluidity in the effect of the factors involved, on professional identity development. In keeping with this view, Trede et al. (2012, pp. 378-379) describe the fluidity of professional identity development as a dynamic and fluid concept.
Unless midwives perceive that they are valued, that they have respect, that they are empowered to practice in their area of expertise, and do so with competence, then their professional identity is precarious, compromised or diminished and therefore their projection of their professional identity becomes weaker. However, when the four influencers (i.e. empowerment, competence, value and respect), come into play at the forefront of practising, knowing and learning, unfurling that fourth element of fluidity, then projection of professional identity is at its strongest.

7.7.1 The emerging professional

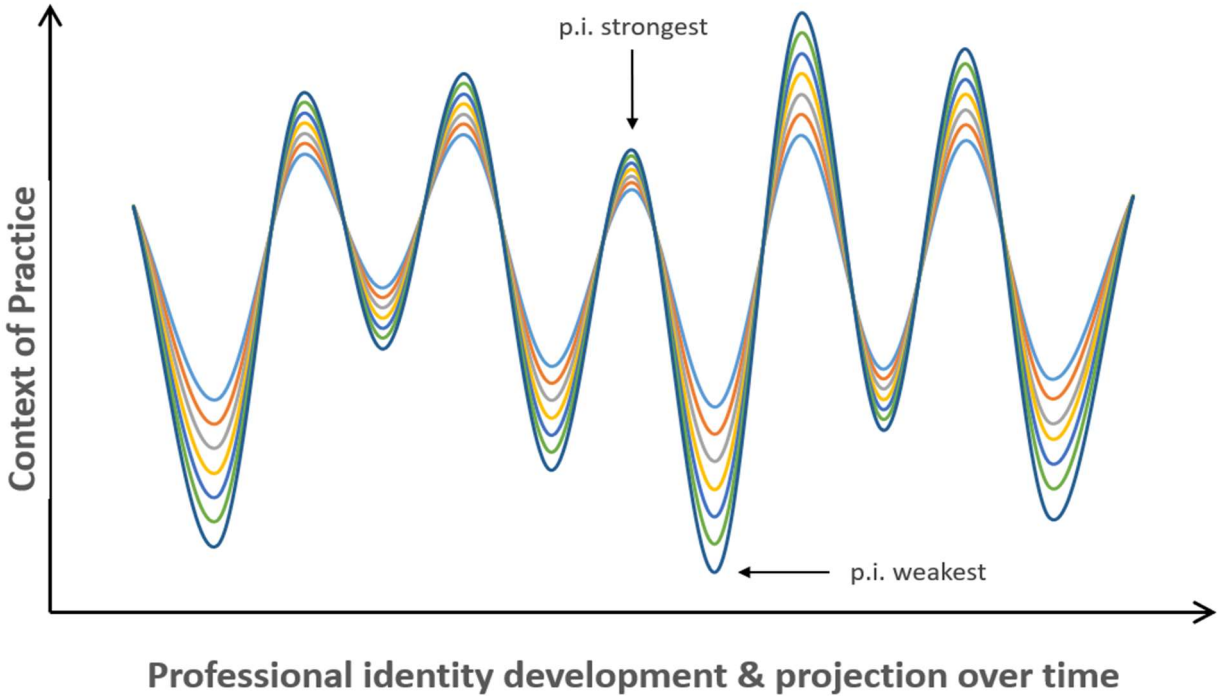
The development of professional identity in the midwife is, in part, a result of feeling empowered both in the classroom and in the clinical environment (Derya). This empowerment was enabled through the acquisition of discipline-specific knowledge and the opportunities to apply this knowledge to their practice in the clinical environment. According to Connolly, Jacobs, and Scott (2018), empowerment of the individual is enabled in the presence of a

[30] Nascent: (especially of a process or organization) just coming into existence and beginning to display signs of future potential (Soanes & Stevenson, 2008).
[31] Refer Section 7.6.5

supported environment, clearly the case for some of the study participants. However, their sense and level of professional identity was affected by extraneous factors such as those discussed in section 7.6.1 (Lina). Thus, one's sense of professional identity would strengthen in the presence of positive influencing factors and take 'a beating'/become diminished when confronted with adverse influencers. The notion that professional identity is not a static state is supported by Larson, Brady, Engelmann, Perkins, and Shultz (2013) who posit that professional identity development is a continual and evolving process throughout the person's career. This was evident in the participants' experiences of professional identity development with particular reference to the four influencers and their sense of competency. Indeed, there is an inter-relational dimension between practising, knowing and learning and the four influencers.

Professional identity is reflected in Figure 7.1 where the lines of the sinewaves are close together. In contrast, when the midwife's sense of professional identity was impacted or diminished in her view (all the participants were female in this study), in the presence of negative influencers, the lines of the sinewave are shown as moving further apart. This was not a static situation and indeed, the lines would come together when professional identity was at a high, and then at times, depending on the environment, those lines would sometimes separate, further in some situations, and less so in others. This representation of professional identity as a fluid element/concept, is in stark contrast to Clandinin et al.'s (2000a) NIS framework with its defined boundaries.

Figure 7.1: The projection of professional identity development



The concepts of professional competence, value of the self, and respect afforded to the student midwife/qualified midwife, are the other contributing influencers to the development of professional identity of the midwife. Interestingly, the concepts of respect and values were identified by Begley (2009); Gum et al. (2013) and Ward et al. (2017) as being necessary in the preparation of students for interprofessional practice (pp. 2, 6). In this study, these concepts were more profoundly felt in the clinical environment as a result of the individuals' clinical experiences. Thus, professional identity may/may not be conceived in the interprofessional classroom, but it is nurtured and gestated in the midwifery clinical environment. However, underlying these three concepts was the participants' valuing of the knowledge and skills gained through interprofessional participation, magnified in the midwifery clinical environment, and perceived in the context of other disciplines' professional identity (Ward et al., 2017, p. 7). According to the authors, being cognisant of who one is, that is, one's professional identity, through their clinical practice, contributes to enhanced patient care, and by extrapolation, improved midwifery care. Indeed, the authors make the case for the development of "self" (professional identity) in IPE curricula (Ward et al., 2017, p. 8).

The affordance of these three influencers for the study participants was also a fluid situation depending on which type of midwifery clinical environment the participant/midwife found herself. Thus, her sense of professional identity was very much in a fluid state and very much influenced by surrounding colleagues, both interprofessional and single-disciplinary.

7.7.2 The projection of the midwifery professional identity

The preceding discussion gives rise to the notion that professional identity development cannot purely be explained and understood comprehensively by the NIS, put forth by Clandinin et al. (2000a), due to its closed structure. Thus, the additional element of fluidity impacts the development and projection of professional identity by midwife; whether they be student, clinician, or educator. This notion of a fourth element added to Clandinin et al.'s (2000a) NIS of relational, temporality, and spatial elements, more revealingly illuminates the influencing factors on the ability of a midwife, whether student or registered, to project their professional identity. Such influencing factors may well be viewed as empowerment, competence, respect, and value which were all concepts that the participants themselves identified. Thus, as a consequence, it is my strongly held view that the concepts of 'empowerment,' 'professional competence,' 'value,' and 'respect' are the influencers from which the midwifery professional identity emanates and together comprise the fourth element 'fluidity.'

The changing and fluid dynamics of each of the influencers determines the strength of that professional identity at any given point in time on the midwifery clinical practice trajectory. Thus, 'fluidity' is a useful and powerful lens through which to explain and interpret the narratives of the participants with regard to how they developed their own professional identity.

The aim of this study was to illuminate how midwives establish, maintain and extend their professional identity and roles within the context of interprofessional education. Through the use of narrative inquiry and underpinned by social constructionist philosophy, the research has achieved

this aim through a fourth element, that of fluidity (advancing Clandinin and Connolly's NIS framework), encompassing the influencers described above.

7.8 Conclusion

In this chapter, the narratives of the participants have been interpreted using Clandinin et al.'s (2000a) NIS. From this analysis a further lens was developed to more adequately present the interpretation of the participants' narratives which could not be accommodated with the NIS. This resulted in the fourth element of 'fluidity', comprised of the influencers of 'empowerment,' 'competence,' 'value,' and 'respect.' It is through this element that the nascent nature of professional identity of the midwife in interprofessional education has been explored and presented.

The following chapter presents the strengths and limitations of the study, implications for midwifery education and practice in addition to a summary of conclusions and recommendations. The implications for future midwifery research are also discussed.

CHAPTER EIGHT
CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This is the final chapter of this study which sought to identify how midwives developed their professional identity in the context of interprofessional education. The research employed narrative inquiry and was underpinned by social constructionism as its guiding theoretical framework. As the final chapter, the following areas of discussion are presented: the strengths and limitations of the study; the implications of the study findings for midwifery education and practice; and the implications for further research of both of these in the interprofessional context. Additionally, recommendations are included. Finally, a concluding statement is presented.

8.2 Strengths of the study

It is the researcher's opinion that the conduct of the study has illuminated four particular strengths. The first of these is the identification of how midwives derive their professional identity in the context of IPE, an area in which there is a paucity of research and literature to date. Therefore, this has significantly contributed to the existing body of knowledge. Using qualitative methodology was a deliberate strategy as it provides deep and meaningful data which can be explored in depth. Thus, the second strength was the expansion of Clandinin et al.'s (2000a) narrative inquiry (NIS) approach through a fourth element, that of fluidity. This expansion arose directly from, and contributed to, a rich understanding of the participants' stories.

At the commencement of the study the researcher found that most of the literature related to professional identity was not situated in the midwifery context. The plethora of literature related to professional identity was to be found predominantly in the medical, nursing, and allied health arenas. Previous researchers in IPE such as Reeves et al. (2012) and Trede et al. (2012), identified the need for further research in professional identity development both from a theoretical perspective and contextualised within practice. This study

identified four key influencers that were involved in the development of professional identity of midwives: empowerment, respect, value, and professional competence. Coupled with the identification of these four influencers through interpretation of the data, was the distillation of these influencers from multiple perspectives, that is, learning, practice, and knowing. Thus, these findings and the perspectives from which they are drawn, allow the midwifery community a more keenly developed sense of how the professional identity of midwives comes into being. This significantly adds to the extant literature on professional identity development of health professionals, but most importantly midwives, both student and registered, within the interprofessional context of practice and education, and especially in the Australian context at the present time. This in the researcher's opinion, has implications for the education and preparation of midwives for practice, and is the third strength.

The greater of the four identified strengths of the study is, in the researcher's opinion, the expansion of Clandinin et al.'s (2000a) three-dimensional NIS into a fourth element, fluidity. This additional lens enables interpretation of participants' narratives in contextual situations that are not static, but rather ebb-and-flow according to the dynamics of the environment, the individuals, and the discombobulation that can emanate from these.

Parallel to this strength is the use of social constructionism which takes into account individuals who are constantly interacting with each other, such as in the clinical environment, thereby producing a fluidity in their daily interactions (Gergen, 1985). In addition, narrative inquiry allows the participant to tell their story as they live their professional life. What this means is that participants recounted the social and personal aspects of their professional selves, particularly how they were in the present time, how they were in the past, and what they expected to be in the future, bearing in mind an acknowledgement of the importance of context in which these were located. Thus, the fourth strength illuminates the congruency between the tenets of social constructionism and the central concepts of Clandinin et al.'s (2000a) narrative inquiry methodology.

The use of this particular approach, whilst a methodological issue, has implications for midwives and their care practices with childbearing women and their babies in the clinical environment. How midwives, as a result of IPE in the classroom and IPC in the clinical environment, perceived themselves as having a professional identity, however fledgling, and a specific role, illuminated how they subsequently modelled themselves and provided care to women based on their perception of themselves as a professional and how they fulfilled their role on this basis. Being aware of this personal knowledge would assist midwives in being effective members of an interprofessional collaborative health care team which would allow them to advocate for women and their babies in terms of best health-care provision.

8.3 Limitations of the study

Just as there are strengths in the study, so too there are limitations. They are: the paradigm used, the number of participants, and the geography from which the participants were drawn.

Given the qualitative nature of this study, it cannot be replicated, nor was it intended to. However, credibility has been established through a member-check process, the presentation of the participants' narratives in their entirety in this thesis, thus providing an audit trail from data collection, analysis and interpretation. Given the richness of the stories and their analyses, this study can be used as a springboard for further research into the professional identity development of midwives in a broader context.

Notwithstanding the voluminous data obtained through qualitative data collection methods, such as interviews and their richness of detail as described above, the second perceived limitation refers to the sample size. Some might argue that a total of fifteen participants is limiting in its scope. However, given the depth of detail that the narratives provided, is, indeed, a strength of qualitative research and this study is no exception. The size of the 'sample' or participant numbers in qualitative research, this study being no exception, represents the classical trade-off that exists between qualitative and quantitative

research. That is to say, where quantitative research has large sample numbers in order to be representative of the population/phenomenon being investigated, qualitative research has smaller participant numbers in order that the unique nuances of the participants' stories are not lost and thus one achieves the depth of exploration that provides the richness of the data.

Finally, the sample was drawn from three states within Australia. The researcher would have preferred to have participants from each state and territory; however, this was not a realistic expectation as there are time constraints associated with the conduct of doctoral studies. However, the breadth of participants encompassed both student and registered midwives, both in the educational and practice contexts. Future research could be aimed at increasing the number of participating institutions, thus gaining a wider viewpoint and perspectives. This represents the third limitation.

To engage a broader section of practising midwives from more diverse education and practice contexts could enable a deeper understanding of professional identity development in midwives. Such a consideration could include midwives educated overseas where IPE is well-established, community midwifery practice such as that practiced in the United Kingdom, and midwives with a wealth of experiences, both with provision of care, and exposure to interprofessional health care teams.

Of concern to the researcher at times, was the imbalance of power between the student cohort of participants and the researcher. Given the nature of the researcher's employment, that of an academic, there was the possibility that student midwife participants may have felt uncomfortable. Several asked questions such as "is this correct?" The researcher was able to reassure them that there was no correct answer; in fact, only their experiences within their story mattered. This was at the forefront of the researcher's consciousness when interviewing student midwife participants in particular. Whilst the approach is not viewed as a limitation, it is offered up here, as an insight into the unique sensitivities within the study and was addressed in Chapter Four, section 4.6.4.

8.4 Implications of the study findings

The implications of the study findings of professional identity development of midwives relate to firstly, the educational preparation of midwives in the tertiary sector. As such this has implications for midwifery course content. Secondly, there are implications for the midwifery practice context. Lastly, there are implications for further research of both of these in the interprofessional context.

8.4.1 Implications of the study findings for midwifery education

The implications of the study findings for midwifery education relate to how best to prepare students with a strongly held view of their own professional identity for interprofessional practice and collaboration in the face of diminishing financial resources. The educational preparation of midwifery students would, based on the study findings first and foremost, benefit from continued involvement in IPE. **Thus, I recommend that interprofessional education continue to be a requisite component of all midwifery undergraduate programs.**

Furthermore, early exposure to IPE so as to foster meaningful discussion of the disciplinary nature of professional identity in midwifery is crucial. Coupled with this, should be a concerted effort within tertiary health educational programs, such as midwifery, medicine, nursing, physiotherapy and the like, to promote the understanding of each other's discipline when undertaking IPE (Trede et al., 2012). It is the researcher's opinion that this will lead to the respective 'valuing' of other disciplines and affordance of 'respect' to each other, firstly in the educational setting, but also when in the practice environment (Stevens et al., 2012). **Therefore, I recommend the following: the introduction of a core module related to the nature of the midwifery discipline and the professional identity of the midwife and; a core component to promote education and discussion about the nature of other health disciplines with whom midwives collaborate.**

An association between professional competence and empowerment was also found in research by Lukasse and Pajalic (2016). An important consideration

for midwifery education and the researcher's study finding of empowerment (as an influencer) is that reported by Hildingsson et al. (2016) in a study of midwives from Australia, New Zealand and Sweden (n=2585) with regard to their professional identity and empowerment. Alarmingly, whilst there are several factors that contribute to midwifery workforce shortages according to the authors, midwives' sense of their own professional identity and empowerment are significant factors contributing to midwifery workforce attrition, particularly for Australia. This has implications of course for the care of women during the childbearing period. As such, concepts such as what it means to be a professional and how to work collaboratively, should be considered when developing midwifery education programs in this researcher's view. Interprofessional education can contribute to this aspect of the program. **Therefore, I recommend the inclusion of a core module on interprofessional education and collaboration as a component of midwives' ongoing professional education.**

The structure of midwifery education courses, especially those with embedded IPE, should enable students to experience early exposure to clinical practica. As the study findings and discussion suggest that knowledge acquisition coupled with interprofessional practice opportunities, to be the nexus to professional identity development, facilitation of this as early as possible in the midwife's education trajectory would be advantageous. This, participants stated, was 'empowering'. Being professionally competent is a contributor to feeling empowered and an important factor for interprofessional collaboration according to Friend and Sieloff (2018). Research undertaken by Sidebotham, Baird, Walters, and Gamble (2018) supports the notion of student midwives' acknowledgment of a beginning sense of professional identity development as they undertook continuity of care experiences with women. For these student midwives, this culminated in a strengthened sense of professional identity towards the end of the study program facilitated through a capstone assessment task. The capstone task drew on the students' practice and knowledge and facilitated the "strengthening of professional identity and competency" (p. 84). Whilst this was an academic requirement, what shone through was how education and practice are inherently dependent on each

other and thus, in this researcher's opinion, clinical practice should not be delayed. **Therefore, I recommend that midwives experience clinical placement early in the program of study in order to facilitate professional identity formation based on knowledge and the application of that knowledge in the clinical environment to embed and cement their professional identity.**

8.4.2 Implications of study findings for midwifery practice

In order to reinforce and foster midwives' professional identity, a supportive clinical environment for the midwives' level of education is tantamount. It would be incumbent upon tertiary midwifery clinical coordinators to ensure that maternity units are not 'political beasts that swallow its young'.[32] **Therefore, I conclude that it is essential that tertiary institutions offering midwifery education work closely with midwifery clinical partners to ensure that clinical placements are conducive and supportive of students and indeed all midwives.**

The discussion reveals the worth of clinical environments which include opportunities for IPC as providing midwives with a sense of being valued, which in turn increases their sense of professional competence. Parallel to this, ensuring that midwives, especially students, are able to participate in informal interprofessional collaborations, such as interprofessional handovers as a valuable learning opportunity, would contribute to their professional identity formation (Phillips et al., 2006). **Thus, I conclude that maternity units would benefit from providing opportunities for midwives, registered or student, to regularly participate in interprofessional debriefing sessions/handovers as part of maternity unit practice.**

Participants highlighted the use of reflective practice, whether intentionally or otherwise, as a tool to determine which practices/skills they wished to add to

[32] An expression long-used amongst nurses/midwives that refers to the sometimes-entrenched behaviours akin to intimidation, bullying or harassment of other nurse/midwife colleagues especially those less experienced. https://well.blogs.nytimes.com/2010/02/11/when-the-nurse-is-a-bully/

their repertoire or to emulate, both from their own discipline and those of the other disciplines they interacted with. This raises the willingness of midwives, student or registered, being actively engaged with interprofessional practice which may not happen if solely focused on single-disciplinary practice. **Thus, I conclude that reflective journaling be reinforced as an ongoing practice in midwifery education programs and as part of interprofessional practice in the clinical environment.**

8.4.3 Summary of conclusions and recommendations

The following conclusions and recommendations are drawn directly from the study findings and may be useful for consideration by midwifery education providers and midwifery industry partners alike.

I recommend that interprofessional education continue to be a requisite component of all midwifery undergraduate programs.

I recommend the following: the introduction of a core module related to the nature of the midwifery discipline and the professional identity of the midwife and; a core component to promote education and discussion about the nature of other health disciplines with whom midwives collaborate.

I recommend the inclusion of a core module on interprofessional education and collaboration as a component of ongoing professional education.

I recommend that midwives experience clinical placement early in the program of study in order to facilitate professional identity formation based on knowledge and the application of that knowledge in the clinical environment to embed and cement their professional identity.

I conclude that it is essential that tertiary institutions offering midwifery education work closely with midwifery clinical partners to ensure that clinical placements are conducive and supportive of students and indeed all midwives.

I conclude that maternity units would benefit from providing opportunities for midwives, registered or student, to regularly participate in interprofessional debriefing sessions/handovers as part of maternity unit practice.

Thus, I conclude that mandatory reflective journaling be included in midwifery education programs and as part of interprofessional practice in the clinical environment.

8.5.4 Implications of study findings for midwifery research

This study has illuminated how midwives develop, maintain and extend their professional identity within the scope of a doctoral research program. As such the time constraints associated with such a program necessarily limit the scope of the study. The possibilities for further research emanating from this study and the associated paucity of literature related to IPE and professional identity development in midwives are as follows:

- An extension of this study in terms of number of participants to include a nation-wide study.
- Further research into professional identity development from the perspectives of practice, learning, and knowing, using the extension of Clandinin et al.'s (2000a) NIS and fluidity as the lens.
- Research into professional identity of midwives who have completed a direct-entry Bachelor of Midwifery education as compared to those who complete a dual degree in nursing and midwifery or post-graduate RN entry programs.
- Research into the culture of maternity units where IPC is not encouraged and the effect on midwives' professional identity.

This is recommended for the following reasons. 'Knowing' in midwifery is different from 'learning', which again is different from the 'doing/practice.' However, along the education and practice trajectory/continuum, both pre- and post-registration, the three are braided together to form a 'professional' and in so doing, the professional identity of that midwife/person. Importantly to note is

that they are not developed at the same time, nor in the same way; they are developed and refined uniquely over time, and is individual-dependent. Thus, whilst an individual might progress effortlessly ahead on the 'learning,' they may lag on the 'doing/practice' component. Traditionally, midwifery education programs focus on the 'learning', with some associated 'doing/practice,' acknowledging that the 'knowing' comes with the passage of time (Benner, 1984).

The nexus between the three elements of Clandinin et al.'s (2000a) NIS and the practice, learning, and knowing components distilled in this study in terms of professional identity development, is the fourth element, fluidity. It is involved in the development of each stage in the researcher's opinion. Thus, the areas of practice, learning, and knowing are the specific areas that if explored more in detail, using fluidity as a lens, would enrich midwifery, and other health disciplines in their understanding of how professional identity develops and extends in the clinician.

Rather than having a myopic approach to professional identity development, further research with the aim of explicating clearly how the fluid movement functions between the aspects of practice, learning, and knowing would have a two-fold purpose: firstly, a clearer understanding would ensue of how to strengthen the professional identity development in the individual clinician and secondly: that professional identity can be built within the context of the midwifery discipline, and indeed, other health disciplines. That is to say, there is a nested approach to professional identity development. Furthermore, having a keen sense of one's professional identity was reported as a significant factor in building resilience in one's self according to Hunter et al. (2014). This has implications for midwives when dealing with workplace difficulties.

There are several important issues to consider in the pursuit of further research into professional identity development mentioned above. Firstly, it is important to note that an individual midwife (student or registered in the case of this study), must have their own professional identity established before a linkage to another health professional(s) in the same discipline, that is, midwifery, or other

health disciplines can occur. Secondly, of equal importance to note is that each individual midwife will develop their professional identity at a different pace and in a different manner.

A third issue to consider is that the strength/intensity of professional identity of an individual will differ as it is contextually-based in practice. Thus, their professional identity will change if a transfer occurs from one area of practice, such as the postnatal ward, to the neonatal intensive care unit, until such a time that the passage of time and experience will strengthen that professional identity once again. Professional identity does not 'accumulate' on a constant basis per se; it shapes and reforms, in other words, it ebbs-and-flows; it is fluid. It is dependent on where the midwife is at in their career trajectory, the length of their experience, the context of practice, and the different influences on their practice, learning, and knowing.

8.5 Concluding statement

The researcher's interest in the nature of this study arose as a result of her employer instituting and embedding an interprofessional education program into ten of the health disciplines within the institution. After discussion with the principal supervisor, the topic of interest was refined to the point that it became the aim of the study.

The process of undertaking the study was, for the most part, exhilarating, as it became clear that other institutions around the country were also involved in this activity and, in fact, well immersed in it. Some of the most interesting aspects of the study, apart from what was emerging, were the so-called 'light-bulb' moments that would arise for the researcher. One such moment was when the researcher, reading to decide on the methodology and theoretical framework that might be appropriate for the study, suddenly realised the congruency between narrative inquiry and social constructionism as a way to address the research question/aim. There were many of these moments that remain in the researcher's consciousness. What remains clear to the

researcher is the growth that has occurred in the time that it has taken to undertake this study.

To realise that there may be the opportunity to influence midwifery education and its graduates, and by extension, midwifery care, from the perspective of professional identity formation in subjects such as undergraduate professional midwifery studies, presents interesting opportunities. These may be in the form of further research into professional identity formation as discussed earlier in the Chapter, and midwifery program design with the foci being a midwife with a clearly delineated sense of professional identity that empowers her/him to advocate for best-practice midwifery care of women and their babies.

REFERENCES

Australian Department of Health (2013). *Nursing and midwifery education*. Retrieved from https://www1.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-7-nursing-midwifery-workforce%E2%80%93education-retention-sustainability~chapter-7-nursing-midwifery-education

Abu-Rish, E., Kim, S., Choe, L., Varpio, L., Malik, E., White, A. A., . . . Zierler, B. (2012). Current trends in interprofessional education of health sciences students: A literature review. *J Interprof Care, 26*(6), 444-451. doi:10.3109/13561820.2012.715604

Andrew, N. (2012). Professional identity in nursing: Are we there yet? *Nurse Education Today, 32*, 846-849.

Andrews, M. (2012). What is social constructionism? *The Grounded Theory Review, 11*(1), 39-46. doi: 10.1016/j.nedt.2012.03.014

Andrews, M., Squire, C., & Tamboukou, M. (2008). *Doing narrative research*. London: SAGE Publications.

Angelini, D. J. (2011). Interdisciplinary and interprofessional education. What are the key issues and considerations for the future? *The Journal of Perinatal & Neonatal Nursing, 25*(2), 175-179. doi: 10.1097/JPN.0b013e318212ee7a

Arreciado Marañón, A., & Pilar, I. P., M. (2015). Theory and practice in the construction of professional identity in nursing students: A qualitative study. *Nurse Education Today, 35*(7), 859-863. doi:https://doi.org/10.1016/j.nedt.2015.03.014

Aune, I., & Olufsen, V. (2014). 'From fragmented to interdisciplinary understanding of integrated antenatal and postnatal care'—An interprofessional project between public health nursing students and midwifery students. *Midwifery, 30*(3), 353-358. doi:http://dx.doi.org/10.1016/j.midw.2013.03.007

Australian Government. (2007). *Australian Code For the Responsible Conduct of Research*. (1864964324). Canberra, ACT.: Author. doi: 10.5694/mja16.00550

Australian Institute of Health and Welfare. (2018a). *Australia's health 2018. Australia's health series no. 16. AUS 221*. Canberra: Australian Institute of Health and Welfare. Retrieved from https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2018b). *Australia's mothers and babies 2016—in brief. Perinatal statistics series no. 34. Cat. no. PER 97.* Canberra, ACT: AIHW. Retrieved from www.aihw.gov.au/reports/mothers-babies/perinatal-data-visualisations.

Australian Nursing & Midwifery Accreditation Council. (2013). Review of the midwifery accreditation standards. First Consultation Paper. Canberra: Author.

Australian Nursing & Midwifery Accreditation Council. (2018). Midwife Accreditation Standards 2014. Retrieved from https://www.anmac.org.au/

Bainbridge, L., & Wood, V. I. (2012). The power of prepositions: learning with, from and about others in the context of interprofessional education. *J Interprof Care, 26*(6), 452-458. doi:10.3109/13561820.2012.715605

Baker, L., Egan-Lee, E., Leslie, K., Silver, I., & Reeves, S. (2010). Exploring an IPE faculty development program using the 3-P model. *J Interprof Care, 24*(5), 597-600. doi:10.3109/13561820.2010.481336

Barr, H. (2010). The WHO Framework for Action. *J Interprof Care, 24*(5), 475-478. doi:10.3109/13561820.2010.504134

Barr, H. (2013a). Enigma variations: Unravelling interprofessional education in time and place. *Journal of Interprofessional Care, 27*(S2), 9-13.

Barr, H. (2013b). Toward a theoretical framework for interprofessional education. *J Interprof Care, 27*(1), 4-9. doi:10.3109/13561820.2012.698328

Barr, H., Koppel, I., Reeves, S., Hammick, M., & Freeth, D. (2008a). Frontmatter. In *Effective Interprofessional Education* (pp. i-xxiv). Oxford: Blackwell Publishing Ltd.

Barr, H., Koppel, I., Reeves, S., Hammick, M., & Freeth, D. (2008b). Capturing interprofessional education in essence. In *Effective Interprofessional Education* (pp. 29-39). Oxford: Blackwell Publishing Ltd.

Begley, C. M. (2009). Developing inter-professional learning: Tactics, teamwork and talk. *Nurse Education Today, 29*(3), 276-283. doi:https://doi.org/10.1016/j.nedt.2008.09.006

Benner, P. (1984). *From novice to expert*. California: Addison-Wesley Publishing Company.

Benner, P. (2012). Urgently needed, a radical transformation of professional collaboration and teamwork. *EducatingNurses.com*, n.p.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality. A treatise in the sociology of knowledge.* London: Penguin Books.

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge.* London: Penguin Books.

Best, J. (2008). Historical development and defining issues of constructionist inquiry. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of constructionist research* (pp. 41-64). New York: The Guildford Press.

Bharj, K. K., Luyben, A., Avery, M. D., Johnson, P. G., O'Connell, R., Barger, M. K., & Bick, D. (2016). An agenda for midwifery education: Advancing the state of the world's midwifery. *Midwifery, 33*, 3-6. doi:https://doi.org/10.1016/j.midw.2016.01.004

Blackburn, S. (Ed.) (2005) Oxford dictionary of philosophy (2nd ed.). Oxford: Oxford University Press.

Blanchard, M. H., & Kriebs, J. M. (2012). A successful model of collaborative practice in a university-based maternity care setting. *Obstet Gynecol Clin N Am, 39*(3), 367-372. http://dx.doi.org/10.1016/j.ogc.2012.05.005

Bluteau, P., & Jackson, A. (2009). *Interprofessional education. Making it happen.* London, U.K.: Palgrave, Macmillan.

Burford, B., Morrow, G., Morrison, J., Baldauf, B., Spencer, J., Johnson, N., . . . Illing, J. (2013). Newly qualified doctors' perceptions of informal learning from nurses: Implications for interprofessional education and practice. *J Interprof Care, 27*(5), 394-400. doi:10.3109/13561820.2013.783558

Burr, V. (2003). *Social constructionism*. New York: Routledge.

CAIPE. (2002). Centre for the Advancement of Interprofessional Education. Retrieved from http://caipe.org.uk/about-us/the-definition-and-principles-of-interprofessional-education/

Cambridge University Press. (Ed.) (2008) Cambridge Dictionary Online. Open Educational Resources (OER) Portal. Retrieded from https://dictionary.cambridge.org/dictionary/english/fluidity?topic=changing-frequently

Carper, B. (1995). Fundamental patterns of knowing in nursing. *ANS: Advances in Nursing Science, 1*(1), 13-23.

Chase, S. E. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 651-679). London: SAGE.

Cheney-Morris, S. (2012). Empirics: one way of knowing. *Essentially MIDIRS, 3*(6), 47-49.

Christians, G. (2011). Ethics and politics in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 61-95). London, U.K.: SAGE.

Clandinin, D. J. (2006). Narrative inquiry: A methodology for studying lived experience. *Research Studies in Music Education, 27*(1), 44-54. doi:10.1177/1321103x060270010301

Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Walnut Creek, CA: Left Coast Press.

Clandinin, D. J., & Connelly, F. M. (2000a). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.

Clandinin, D. J., & Connelly, M. F. (2000b). *Narrative Inquiry: Experience and story in qualitative research*. San Fransisco, USA.: Jossey-Bass.

Clandinin, D. J., & Murphy, M. S. (2009). Relational ontological commitments in narrative research. *Educational Researcher, 38*(8), 598-602. doi: 10.3102/0013189X09353940

Clandinin, D. J., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 35-75). London: SAGE Publications.

Clark, P. G. (2013). Toward a transtheoretical model of interprofessional education: Stages, processes and forces supporting institutional change. *J Interprof Care, 27*(1), 43-49. doi:10.3109/13561820.2012.730074

Clark, P. G., Cott, C., & Drinka, T. J. (2007). Theory and practice in interprofessional ethics: A framework for understanding ethical issues in health care teams. *J Interprof Care, 21*(6), 591-603. doi:10.1080/13561820701653227

Commonwealth of Australia. (2010). *National Maternity Services Plan 2010*. Canberra, ACT: Australian Health Minister's Conference. Retrieved from www.ahmac.gov.au.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational Researcher, 19*(5), 2-14. doi: 10.3102/0013189X019005002

Connolly, M., Jacobs, S., & Scott, K. (2018). Clinical leadership, structural empowerment and psychological empowerment of registered nurses working in an emergency department. *Journal of Nursing Management, 26*(7), 881-887. doi:10.1111/jonm.12619

Conway, J. F., Little, P., McMillan, M., & Fitzgerald, M. (2011). Determining frameworks for interprofessional education and core competencies through collaborative consultancy: The CARE experience. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 38*(1-2), 160-170.

Cook, T. H., Gilmer, M. J., & Bess, C. J. (2003). Beginning students' definitions of nursing: An inductive framework of professional identity. *Journal of Nursing Education, 42*(7), 311-317.

Coster, S., Norman, I., Murrells, T., Kitchen, S., Meerabeau, E., Sooboodoo, E., & d'Avray, L. (2008). Interprofessional attitudes amongst undergraduate students in the health professions: a longitudinal questionnaire survey. *Int J Nurs Stud, 45*(11), 1667-1681. doi:10.1016/j.ijnurstu.2008.02.008

Craddock, D., O'Halloran, C., McPherson, K., Hean, S., & Hammick, M. (2013). A top-down approach impedes the use of theory? Interprofessional educational leaders' approaches to curriculum development and the use of learning theory. *J Interprof Care, 27*(1), 65-72. doi:10.3109/13561820.2012.736888

Creswell, J., W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches* (3rd ed.). London: SAGE.

Creswell, J., W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). London: SAGE

Crotty, M. (1998). Constructionism: The making of meaning. In M. Crotty (Ed.), *The foundations of social research. Meaning and perspective in the research process.* Crows Nest, N.S.W.: Allen & Unwin.

Davis, D. (1995). Ways of knowing in midwifery. *Australian College of Midwives Incorporated Journal, 8*(3), 30-32. doi:10.1016/S1031-170X(05)80022-4

Denzin, N. K., & Lincoln, Y. S. (2008). Glossary. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed., pp. 557-568). Thousand Oaks, CA: SAGE Publications.

Denzin, N. K., & Lincoln, Y. S. (2011a). *The SAGE handbook of qualitative research* (4th ed.). London: SAGE.

Denzin, N. K., & Lincoln, Y. S. (2011b). Introduction. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 1-19). Thousand Oaks, CA: SAGE.

Dragon, N. (2010). Raising the bar: Nursing & midwifery education. *Australian Nursing Journal, 17*(7), 22-25.

Earland, J., Gilchrist, M., McFarland, L., & Harrison, K. (2011). Dietetics students' perceptions and experiences of interprofessional education. *J Hum Nutr Diet, 24*(2), 135-143. doi:10.1111/j.1365-277X.2010.01141.x

Ebert, L., Tierney, O., & Jones, D. (2016). Learning to be a midwife in the clinical environment: Tasks, clinical practicum hours or midwifery relationships. *Nurse Education In Practice, 16*(1), 294-297. doi:https://doi.org/10.1016/j.nepr.2015.08.003

Ellingson, L. L. (2011). Analysis and representation across the continuum. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 595-610). Thousand Oaks, CA: SAGE.

Engum, S. A., & Jeffries, P. R. (2012). Interdisciplinary collisions: Bringing healthcare professionals together. *Collegian, 19*(3), 145-151. doi:10.1016/j.colegn.2012.05.005

Ericson, D. L. (1991). Guest editorial: territorialism in the health care professions. *International Journal of Childbirth Education, 6(3):30-31.* Retrieved from https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=c8h&AN=107479773&site=eds-live&custid=s1145751

Ezzy, D. (2002). *Qualitative ananlysis: practice and innovation.* Crow's Nest, N.S.W.: Allen & Unwin.

Fagermoen, M. (1997). Professional identity: Values embedded in meaningful nursing practice. *Journal of Advanced Nursing, 25*, 434-441. doi: 10.1046/j.1365-2648.1997.1997025434.x

Felstead, I. (2013). Role modelling and students' professional development. *British Journal of Nursing, 22*(4), 223-227.

Fernandes, A. R., Palombella, A., Salfi, J., & Wainman, B. (2015). Dissecting through barriers: A mixed-methods study on the effect of interprofessional education in a dissection course with healthcare professional students. *Anatomical Sciences Education, 8*(4), 305-316. doi:10.1002/ase.1517

Flick, U. (2006a). Qualitative research: Why and how to do it. In *An introduction to qualitative research*. Thousand Oaks, CA: SAGE Publications.

Flick, U. (2006b). Theoretical positions underlying qualitative research. In *An introduction to qualitative research.* Thousand Oaks, CA: SAGE Publications.

Friend, M. L., & Sieloff, C. L. (2018). Empowerment in nursing literature: An update and look to the future. *Nurs Sci Q, 3*(14), 355-361. doi: 10.1177/0894318418792887

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266-275. doi: 10.1037/0003-066X.40.3.266

Gergen, K. J. (1999). *An invitation to social constructionism.* Thousand Oaks, CA: SAGE Publications.

Gergen, K. J., & Gergen, M. M. (2003a). *Social construction. A reader*. Thousand Oaks, CA: SAGE Publications.

Gergen, M. M., & Gergen, K. J. (2003b). Qualitative inquiry: Tensions and transformations. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (2nd ed., pp. 575-610). Thousand Oaks, CA: SAGE Publications.

Gibbs, G. R. (2007). *Analyzing qualitative data*. London: SAGE.

Gilbert, J. H. (2010). The global emergence of IPE and collaborative care. *J Interprof Care, 24*(5), 473-474. doi:10.3109/13561820.2010.487723

Gordon, F. (2009). Interprofessional capability as an aim of student learning. In P. Bluteau & A. Jackson (Eds.), *Interprofessional education: Making it happen* (pp. 59-79). United Kingdom: Palgrave Macmillan.

Grbich, C. (2013). *Qualitative data analysis. An introduction.* (2nd ed.). London: SAGE.

Green, C. (2013). Relative distancing: A grounded theory of how learners negotiate the interprofessional. *J Interprof Care, 27*(1), 34-42. doi:10.3109/13561820.2012.720313

Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. Thousand Oaks, CA: SAGE Publications.

Guba, E. G., & Lincoln, Y. S. (1998). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 195-220). Thousand Oaks: SAGE Publications, Inc.

Guilliland, K. (2016). Feminism is the framework that we should use when we look at how to provide care. *Midwives, 19*, 21-23.

Gum, L. F., Lloyd, A., Lawn, S., Richards, J. N., Lindemann, I., Sweet, L., . . . Bramwell, D. (2013). Developing an interprofessional capability framework for teaching healthcare students in a primary healthcare setting. *Journal of Interprofessional Care, 27*(6), 454-460. doi:10.3109/13561820.2013.807777

Hammick, M. (2000). Interprofessional education: Evidence from the past to guide the future. *Med Teach, 22*(5), 461-467. doi: 10.1080/01421590050110713

Hammick, M., Freeth, D., Koppel, I., Reeves, S., & Barr, H. (2007). A best evidence systematic review of interprofessional education: BEME Guide no. 9. *Med Teach, 29*(8), 735-751. doi:10.1080/01421590701682576

Hartz, D. L., Foureur, M., & Tracy, S. K. (2012). Australian caseload midwifery: The exception or the rule. *Women and Birth, 25*(1), 39-46. doi:10.1016/j.wombi.2011.01.001

Harvie, K., Sidebotham, M., & Fenwick, J. (2019). Australian midwives' intentions to leave the profession and the reasons why. *Women and Birth*. doi:https://doi.org/10.1016/j.wombi.2019.01.001

Haydon, G., Browne, G., & van der Riet, P. (2018). Narrative inquiry as a research methodoogy exploring person centred care in nursing. *Collegian, 25*, 125-129. doi: 10.1016/j.colegn.2017.03.001

Headrick, L. A., & Khaleel, N. I. (2008). Getting it right: Educating professionals to work together in improving health and health care. *J Interprof Care, 22*(4), 364-374. doi:10.1080/13561820802227871

Hean, S., O'Halloran, C., Craddock, D., Hammick, M., & Pitt, R. (2013). Testing theory in interprofessional education: Social capital as a case study. *J Interprof Care, 27*(1), 10-17. doi:10.3109/13561820.2012.737381

Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. London: SAGE.

Hildingsson, I., Gamble, J., Sidebotham, M., Creedy, D. K., Guilliland, K., Dixon, L., . . . Fenwick, J. (2016). Midwifery empowerment: National surveys of

midwives from Australia, New Zealand and Sweden. *Midwifery, 40*, 62-69. doi:10.1016/j.midw.2016.06.008

Hind, M., Norman, I., Cooper, S., Gill, E., Hilton, R., Judd, P., & Jones, S. (2003). Interprofessional perceptions of health care students. *Journal of Interprofessional Care, 17*(1), 21-34. doi:10.1080/1356182021000044120

Hogg, M. A. (2010). Social idenity theory. In R. L. Jackson (Ed.), *Encyclopedia of identity* (Vol. 2, pp. 749-753). Thousand Oaks, CA: SAGE Publications, Inc.

Holloway, I. (2008). *A-Z of qualitative research in healthcare* (2nd ed.). U.K.: Blackwell Publishing.

Holloway, I., & Freshwater, D. (2007a). *Narrative research in nursing*. Oxford: Blackwell Publishing.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Oxford: Wiley-Blackwell.

Homer, C. S. E., Griffiths, M., Brodie, P. M., Kildea, S., Curtin, A. M., & Ellwood, D. A. (2012). Developing a core competency model and educational framework for primary maternity services: A national consensus approach. *Women and Birth, 25*(3), 122-127. doi:https://doi.org/10.1016/j.wombi.2011.07.149

Hunter, B., & Warren, L. (2014). Midwives' experiences of workplace resilience. *Midwifery, 30*, 926-934. doi: 10.1016/j.midw.2014.03.010

Ibarra, H. (1999). Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly, 44*, 764-791. doi:10.2307/2667055

Ibarra, H., & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review, 35*(1), 135-154. doi: 10.5465/AMR.2010.45577925

International Confederation of Midwives. (2017, 9 August 2018). ICM International Definition of the Midwife. Retrieved from https://internationalmidwives.org/what-we-do/global-standards-competencies-and-tools.html

Johnson, M. (2012). How much interprofessional education did I receive in my medical training? *Quality in Primary Care, 20*, 207-209.

Johnson, M., Cowin, L. S., Wilson, I., & Young, H. (2012). Professional identity and nursing: Contemporary theoretical developments and future research challenges. *International Nursing Review, 59*(4), 562-569. doi: 10.1111/j.1466-7657.2012.01013.x

Kear, T. M. (2012). The use of narrative analysis to study transformative learning in associate degree nursing students: A focus on the methodology. *Teaching and Learning in Nursing, 7*(1), 32-35. doi:10.1016/j.teln.2011.07.003

Khalili, H., Orchard, C., Laschinger, H. K., & Farah, R. (2013). An interprofessional socialization framework for developing an interprofessional identity among health professions students. *J Interprof Care*. doi:10.3109/13561820.2013.804042

Kvale, S., & Brinkmann, S. (2009). *Interviews. Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA: SAGE.

Larson, J., Brady, M., Engelmann, L., Perkins, B. I., & Shultz, C. (2013). The formation of professional identity in nursing. *Nursing Education Perspectives, 34*(2), 138-138. doi: 10.5480/1536-5026-34.2.138

Larsson, M., Aldegarmann, U., & Aarts, C. (2009). Professional role and identity in a changing society: Three paradoxes in Swedish midwives' experiences. *Midwifery, 25*(4), 373-381. doi:10.1016/j.midw.2007.07.009

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.

Lawn, S., Lloyd, A. King, A., Sweet, L. and Gum, L. (2014). Integration of primary health services: being put together does not mean they will work together. BMC Research Notes, 7 (66): 2-10. doi: 10.1186/1756-0500-7-66

Leap, N., Brodie, P., & Tracy, S. K. (2017). Collective action for the development of national standards for midwifery education in Australia. *Women and Birth, 30*(3), 169-176. doi:https://doi.org/10.1016/j.wombi.2017.02.013

Levett-Jones, T., Burdett, T., Chow, Y. L., Jönsson, L., Lasater, K., Mathews, L. R., . . . Wihlborg, J. (2018). Case studies of interprofessional education initiatives from five countries. *Journal of Nursing Scholarship, 50*(3), 324-332. doi:10.1111/jnu.12384

Liamputtong, P. (2013). *Qualitative research methods* (4th ed.). Victoria, Australia: Oxford University Press.

Lincoln, Y. S., & Denzin, N. K. (1998). The fifth moment. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 407-429). Thousand Oaks, CA: SAGE Publications.

Lincoln, Y. S., & Denzin, N. K. (2003). The seventh moment. Out of the past. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (2nd ed., pp. 611-640). Thousand Oaks, CA: SAGE Publications.

Lincoln, Y. S., & Denzin, N. K. (2008). The eighth and ninth moments - qualitative research in/and the fractured future. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed., pp. 539-554). Thousand Oaks, CA: SAGE Publications.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4th ed., pp. 97-128). Thousand Oaks, CA: SAGE.

Lukasse, M., & Pajalic, Z. (2016). Norwegian midwives' perceptions of empowerment. *Sexual & Reproductive Healthcare, 7*, 58-64. doi:https://doi.org/10.1016/j.srhc.2015.11.010

Luyben, A., Barger, M., K., Avery, M., D., Bharj, K. K., O'Connell, R., Fleming, V., . . . Sherratt, D. (2017). Exploring global recognition of quality midwifery education: Vision or fiction? *Women and Birth, 30*(3), 184-192. doi:https://doi.org/10.1016/j.wombi.2017.03.001

Luyben, A., Barger, M. K., Avery, M. D., & Bick, D. (2018). What is next? Midwifery education building partnerships for tomorrow's maternal and neonatal health care. *Midwifery, 64*, 132-135. doi:https://doi.org/10.1016/j.midw.2018.06.014

MacDonald, M. B., Bally, J. M., Ferguson, L. M., Lee Murray, B., Fowler-Kerry, S. E., & Anonson, J. M. S. (2010). Knowledge of the professional role of others: A key interprofessional competency. *Nurse Education In Practice, 10*(4), 238-242. doi:https://doi.org/10.1016/j.nepr.2009.11.012

Macrina, F. L. (2005). *Scientific integrity* (3rd ed.). Washington: ASM Press.

McConville, F. (2018). Midwifery education from perspective of the WHO. *Midwifery, 65*, 83. doi:https://doi.org/10.1016/j.midw.2018.07.004

McKendree, A. G. (2010). Personal identity versus self-identity. In R. L. Jackson (Ed.), *Encyclopedia of identity*. Thousand Oaks, CA: SAGE Publications, Inc.

McNeil, K. A., Mitchell, R. J., & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review: The Journal of the Health Section of the Australian Sociological Association,*(3), 291. doi: 10.5172/hesr.2013.22.3.291

McNeil, K. M., & Silvey, S. R. (2018). Training the global midwifery workforce. *Midwifery, 65*, 87-88. doi:https://doi.org/10.1016/j.midw.2018.06.004

Meads, G., Jones, I., Harrison, R., Forman, D., & Turner, W. (2009). How to sustain interprofessional learning and practice: Messages for higher education and health and social care management. *Journal of Education and Work, 22*(1), 67-79. doi:10.1080/13639080802709646

Merrick, E., Duffield, C., Baldwin, R., & Fry, M. (2011). Nursing in general practice: Organizational possibilities for decision latitude, created skill, social support and identity derived from role. *J Adv Nurs, 68*(3), 614-624. doi:10.1111/j.1365-2648.2011.05769.x

Miller, A., Morton, S., Sloan, P., & Hashim, Z. (2013). Can a single brief intervention improve participants' readiness for interprofessional learning? *J Interprof Care, Early Online*, 1-2. doi:10.3109/13561820.2013.805736

Mills, J. E., Francis, K., Birks, M., Coyle, M., Henderson, S., & Jones, J. (2010). Registered nurses as members of interprofessional primary health care teams in remote or isolated areas of Queensland: Collaboration, communication and partnerships in practice. *J Interprof Care, 24*(5), 587-596. doi:10.3109/13561821003624630

Milton, C. L. (2012). Ethical implications and interprofessional education. *Nurs Sci Q, 25*(4), 313-315. doi:10.1177/0894318412457066

Missen, K., Jacob, E. R., Barnett, T., Walker, L., & Cross, M. (2012). Interprofessional clinical education: Clinicians' views on the importance of leadership. *Collegian, 19*(4), 189-195. doi:10.1016/j.colegn.2011.10.002

Mivšek, P., Pahor, M., Hlebec, V., & Hundley, V. (2015). How do midwives in Slovenia view their professional status? *Midwifery, 31*(12), 1193-1201. doi:https://doi.org/10.1016/j.midw.2015.08.008

Morison, S., Boohan, M., Jenkins, J., & Moutray, M. (2003). Facilitating undergraduate interprofessional learning in healthcare: Comparing classroom and clinical learning for nursing and medical students. *Learning in Health & Social Care, 2*(2), 92-104.

Munhall, P. L. (2012). Ethical considerations in qualitative research. In *Nursing research. A qualitative perspective* (5th ed., pp. 491-502). Sudbury, MA: Jones & Bartlett Learning. doi: 10.1177/019394598801000204

Murray-Davis, B., Marshall, M., & Gordon, F. (2011). What do midwives think about interprofessional working and learning? *Midwifery, 27*(3), 376-381. doi:10.1016/j.midw.2011.03.011

Murray-Davis, B., Marshall, M., & Gordon, F. (2012). From school to work: Promoting the application of pre-qualification interprofessional education in the clinical workplace. *Nurse Educ Pract, 12*(5), 289-296. doi:10.1016/j.nepr.2011.10.009

National Health Workforce Taskforce. (2009). *Core competencies for primary maternity services. Part 1*. Retrieved from https://www.uts.edu.au/sites/default/files/core-competencies-pt1.pdf

Neary, S. (2014a). Professional identity: What I call myself defines who I am. *Career Matters, 2*(3), n.p.

Neary, S. (2014b). Reclaiming professional identity through postgraduate professional development: careers practitioners reclaiming their professional selves. *British Journal of Guidance & Counselling, 42*(2), 199-210. doi:10.1080/03069885.2013.869790

NMBA. (2018). *Nursing and Midwifery Board of Australia annual report summary 2017-2018*. Melbourne, Australia: AHPRA. Retrieved from https://www.ahpra.gov.au/Publications/Annual-reports.aspx.

Nursing and Midwifery Board of Australia. (2018). Midwife standards for practice. Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx

O'Neill, N. B. (2010). Social constructionist approach to personal identity. In R. L. Jackson (Ed.), *Encyclopaedia of identity* (pp. 739-742). Thousand Oaks, CA: SAGE Publications, Inc.

Ohlen, J., & Segesten, K. (1998). The professional identity of the nurse: Concept analysis and development. *Journal of Advanced Nursing, 28*(4), 720-727. doi: 10.1046/j.1365-2648.1998.00704.x

Oliver, P. (2010). *The student's guide to research ethics* (2nd ed.). Berkshire, England: Open University Press.

Orchard, C. A. (2010). Persistent isolationist or collaborator? The nurse's role in interprofessional collaborative practice. *Journal of Nursing Management, 18*(3), 248-257. doi:10.1111/j.1365-2834.2010.01072.x

Padgett, D. K. (2012a). Ethical issues in qualitative research. In *Qualitative and mixed methods in public health*. Thousand Oaks, CA: SAGE Publications, Inc.

Padgett, D. K. (2012b). Strategies for rigor. In *Qualitative and mixed methods in public health*. Thousand Oaks, CA: SAGE Publications, Inc.

Paradis, E., & Reeves, S. (2013). Key trends in interprofessional research: A macrosociological analysis from 1970 to 2010. *J Interprof Care, 27*(2), 113-122. doi:10.3109/13561820.2012.719943

Parker, R. A., Gottlieb, H., Dominguez, D. G., Sanchez-Diaz, P. C., & Jones, M. E. (2015). Integrating an interprofessional education model at a private university. *International Journal of Higher Education, 4*(3), 112-118.

Patton, M. Q. (2002a). Variety in qualitative inquiry. In *Qualitative research and evaluation methods* (3rd ed., pp. 131-135). Thousand Oaks, CA: SAGE Publications.

Patton, M. Q. (2002b). Variety in qualitative research. In *Qualitative research and evaluation methods* (3rd ed., pp. 114-119). Thousand Oaks, CA: SAGE Publications.

Perriman, N., Davis, D. L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery, 62*, 220-229. doi:https://doi.org/10.1016/j.midw.2018.04.011

Phillips, D. J., & Hayes, B. (2006). Moving towards a model of professional identity formation in midwifery through conversations and positioning theory. *Australian Journal of Adult Learning, 46*(2), 224-242.

Pinnegar, S., & Daynes, J. G. (2007). Locating narrative inquiry historically: Thematics in the turn to narrative. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry. Mapping a methodology* (pp. 3-34). Thousand Oaks, CA: SAGE Publications.

Pollard, K. C. (2009). Student engagement in interprofessional working in practice placement settings. *J Clin Nurs, 18*(20), 2846-2856. doi:10.1111/j.1365-2702.2008.02608.x

Pollard, K. C., & Miers, M. E. (2008). From students to professionals: Results of a longitudinal study of attitudes to pre-qualifying collaborative learning

and working in health and social care in the United Kingdom. *J Interprof Care, 22*(4), 399-416. doi:10.1080/13561820802190483

Pollard, K. C., Miers, M. E., Gilchrist, M., & Sayers, A. (2006). A comparison of interprofessional perceptions and working relationships among health and social care students: The results of a 3-year intervention. *Health Soc Care Community, 14*(6), 541-552. doi:10.1111/j.1365-2524.2006.00642.x

Pollard, K. C., Miers, M. E., & Rickaby, C. (2012). "Oh why didn't I take more notice?" Professionals' views and perceptions of pre-qualifying preparation for interprofessional working in practice. *J Interprof Care, 26*(5), 355-361. doi:10.3109/13561820.2012.689785

Pope, C., & Mays, N. (2008). *Qualitative research in health care* (4th ed.). Oxford: Wiley-Blackwell.

Ramsey, E. R. (2010). Philosophical history of identity. In R. L. Jackson (Ed.), *Encyclopedia of identity* (pp. 556-560). Thousand Oaks, CA: SAGE Publications, Inc.

Reeves, S., & Hean, S. (2013). Why we need theory to help us better understand the nature of interprofessional education, practice and care. *J Interprof Care, 27*(1), 1-3. doi:10.3109/13561820.2013.751293

Reeves, S., Perrier, L., Goldman, J., Freeth, D., & Zwarenstein, M. (2013). Interprofessional education: Effects on professional practice and healthcare outcomes (update) (Review). *The Cochrane Library*(3), 1-46. doi: 10.1002/14651858.CD002213.pub3

Reeves, S., Tassone, M., Parker, K., Wagner, S., J., & Simmons, B. (2012). Interprofessional education: An overview of key developments in the past three decades. *Work, 41*, 233-245. doi:10.3233/WOR-2012-1298

Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Koppel, I., & Hammick, M. (2010). The effectiveness of interprofessional education: Key findings from a new systematic review. *Journal of Interprofessional Care, 24*(3), 230-241. doi: 10.3109/13561820903163405

Reid, A., Dahlgren, L. O., Petocz, P., & Dahlgren, M. A. (2008). Identity and engagement for professional formation. *Studies in Higher Education, 33*(6), 729-742. doi:10.1080/03075070802457108

Reissman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: SAGE Publications.

Robben, S., Perry, M., van Nieuwenhuijzen, L., van Achterberg, T., Rikkert, M. O., Schers, H., . . . Melis, R. (2012). Impact of interprofessional

education on collaboration attitudes, skills, and behavior among primary care professionals. *J Contin Educ Health Prof, 32*(3), 196-204. doi:10.1002/chp.21145

Roberts, K., & Taylor, B. (2002a). *Nursing research processes: An Australian perspective* (2nd ed.). South Melbourne, Australia: Nelson.

Roberts, K., & Taylor, B. (2002b). Qualitative data analysis. In K. Roberts & B. Taylor (Eds.), *Nursing research processes: An Australian perspective* (2nd ed., pp. 423-448). South Melbourne, Australia: Nelson.

Rodger, S., & Hoffman, S. J. (2010). Where in the world is interprofessional education? A global environmental scan. *J Interprof Care, 24*(5), 479-491. doi:10.3109/13561821003721329

Rosenfield, D., Oandasan, I., & Reeves, S. (2011). Perceptions versus reality: A qualitative study of students' expectations and experiences of interprofessional education. *Med Educ, 45*(5), 471-477. doi:10.1111/j.1365-2923.2010.03883.x

Ross, S. J., & Southgate, L. (2000). Learning together in medical and nursing training: Aspirations and activity. *Medical Education, 34*, 739-743. doi: 10.1046/j.1365-2923.2000.00626.x

Savin-Baden, M., & Niekerk, L. V. (2007). Narrative inquiry: Theory and practice. *Journal of Geography in Higher Education, 31*(3), 459-472. doi:10.1080/03098260601071324

Schmitt, M. H., Gilbert, J. H. V., Brandt, B. F., & Weinstein, R. S. (2013). The coming of age for interprofessional education and practice. *American Journal of Medicine, 126*(4), 284-288.

Schwandt, T. A. (1998). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research. Theories and issues* (pp. 221-259). Thousand Oaks, CA: SAGE Publications.

Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (2nd ed., pp. 292-331). Thousand Oaks, CA: SAGE Publications.

Schwandt, T. A. (2007). *The SAGE dictionary of qualitative inquiry*. Thousand Oaks, CA: SAGE Publications, Inc.

Scott, J., & Marshall, G. (Eds.). (2009) A dictionary of sociology (3rd ed.). Oxford: Oxford University Press.

Sidebotham, M., Baird, K., Walters, C., & Gamble, J. (2018). Midwifery education in practice: Preparing student midwives for professional practice: Evaluation of a student e-portfolio assessment item. *Nurse Education In Practice, 32*, 84-89. doi:10.1016/j.nepr.2018.07.008

Smith, C., & Boyd, P. (2012). Becoming an academic: The reconstruction of identity by recently appointed lecturers in nursing, midwifery and the allied health professions. *Innovations in Education and Teaching International, 49*(1), 63-72. doi:10.1080/14703297.2012.647784

Soanes, C., & Stevenson, A. (2008). *Concise Oxford English dictionary*. Oxford: Oxford University Press.

Sollami, A., Caricati, L. and Mancini, T. (2018). Does the readiness for interprofessional education reflect students' dominance orientation and professional commitment? Evidence from a sample of nursing students. *Nurse Education Today, 68,* 141-145. doi: 10.1016/j.nedt.2018.06.009

Soltani, H., & Sandall, J. (2012). Organisation of maternity care and choices of mode of birth: A worldwide view. *Midwifery, 28*, 146-149. doi: 10.1016/j.midw.2012.01.009

Spatial. (2003). *Merriam-Webster's Dictionary*. https://www.merriam-webster.com/dictionary/spatial

Steel, A., & Adams, J. (2012). Developing midwifery and complementary medicine collaboration: The potential of interprofessional education? *Complementary Therapies in Clinical Practice, 18*(4), 261-264. doi: 10.1016/j.ctcp.2012.06.009

Stets, J. E. (2010). Role identity. In R. L. Jackson (Ed.), *Encyclopedia of identity* (Vol. 2, pp. 648-650). Thousand Oaks, CA: SAGE Publications, Inc.

Stevens, J. R., Witmer, T. L., Grant, R. L., & Cammarano, D. J. (2012). Description of a successful collaborative birth center practice among midwives and an obstetrician. *Obstet Gynecol Clin N Am, 39*(3), 347-357.

Streubert, H. J., & Carpenter, D. R. (2011). Ethical considerations in qualitative research. In H. J. Streubert & D. R. Carpenter (Eds.), *Qualitative research in nursing* (5th ed., pp. 56-71). Sydney, Australia: Lippincot Williams & Wilkins.

Tappen, R. M. (2011). Research ethics. In R. M. Tappen (Ed.), *Advanced nursing research. From theory to practice* (pp. 171-190). Sudbury, MA.: Jones & Bartlett Learning.

Thistlethwaite, J. (2012). Interprofessional education: A review of context, learning and the research agenda. *Med Educ, 46*(1), 58-70. doi:10.1111/j.1365-2923.2011.04143.x

Thomson, K., Outram, S., Gilligan, C., & Levett-Jones, T. (2015). Interprofessional experiences of recent healthcare graduates: A social psychology perspective on the barriers to effective communication, teamwork, and patient-centred care. *Journal of Interprofessional Care, 29*(6), 634-640. doi:10.3109/13561820.2015.1040873

Tierney, O., Sweet, L., Houston, D., & Ebert, L. (2018). A historical account of the governance of midwifery education in Australia and the evolution of the Continuity of Care Experience. *Women and Birth, 31*(3), e210-e215. doi:https://doi.org/10.1016/j.wombi.2017.09.009

Trede, F., Macklin, R., & Bridges, D. (2012). Professional identity development: A review of the higher education literature. *Studies in Higher Education, 37*(3), 365-384. doi:10.1080/03075079.2010.521237

Tucker, K., Wakefield, A., Boggis, C., Lawson, M., Roberts, T., & Gooch, J. (2003). Learning together: Clinical skills teaching for medical and nursing students. *Medical Education, 37*(7), 630-637. doi: 10.1046/j.1365-2923.2003.01558.x

van Manen. (1990). *Researching lived experience. Human science for an action sensitive pedagogy*. Ontario: The Althouse Press.

Victoria University. (2012). Victoria University application for ethical review of research involving human participants. In. Melbourne, Australia: Author.

Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies. *JAMAR, 10*(1), 69-80.

Wakely, L., Brown, L., & Burrows, J. (2013). Evaluating interprofessional learning modules: Health students' attitudes to interprofessional practice. *Journal of Interprofessional Care., 27*(5), 424-425. doi:10.3109/13561820.2013.78473010.1002/

Wang, C. C., & Geale, S. K. (2015). The power of story: Narrative inquiry as a methodology in nursing research. *International Journal of Nursing Sciences, 2*(2), 195-198. doi:https://doi.org/10.1016/j.ijnss.2015.04.014

Ward, H., Gum, L., Attrill, S., Bramwell, D., Lindemann, I., Lawn, S., & Sweet, L. (2017). Educating for interprofessional practice: Moving from knowing to being, is it the final piece of the puzzle? *Day Surgery Australia, 17*(1), 10-17. doi:10.1186/s12909-016-0844-5

Webster, L., & Mertova, P. (2007). *Using narrative inquiry as a research method*. London: Routledge.

Whitehead, D. (2013). An overview of research theory and process. In Z. Schneider, D. Whitehead, G. LoBiondo-Wood, & J. Haber (Eds.), *Nursing and midwifery research. Methods and appraisal for evidence-based practice* (4th ed., pp. 20-34). Sydney, Australia: Elsevier.

Williams, B., McCook, F., Brown, T., Palmero, C., McKenna, L., Boyle, M., . . . McCall, L. (2012). Are undergraduate health care students 'ready' for interprofessional learning? A cross-sectional attitudinal study. *The Internet Journal of Allied Health Sciences and Practice., 10*(3), 1-11. Retrieved from https://nsuworks.nova.edu/ijahsp/vol10/iss3/4/

Williams, J., & Ritter, J. (2010). Constructing new professional identities through self-study: From teacher to teacher educator. *Professional Development in Education, 36*(1-2), 77-92. doi:10.1080/19415250903454833

Woods, M., & Schneider, Z. (2013). Ethical and legal issues in research. In Z. Schneider, G. LoBiondo-Wood, & J. Haber (Eds.), *Nursing and midwifery research. Methods and appraisal for evidence-based practice* (4th ed., pp. 77-99). Sydney: Mosby.

World Health Organization. (2010). Framework for Action on Interprofessional Education & Collaborative Practice. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf

Xyrichis, A., & Lowton, K. (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *Int J Nurs Stud, 45*(1), 140-153. doi:10.1016/j.ijnurstu.2007.01.015

Yazdannik, A., Yekta, Z. P., & Soltani, A. (2012). Nursing professional identity: An infant or one with Alzheimer. *Iranian Journal of Nursing & Midwifery Research, 17*, S178-S186.

Young, R. A., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behavior, 64*(3), 373-388. doi:10.1016/j.jvb.2003.12.005

APPENDICES

APPENDIX A: NARRATIVES

AF.1 Fanita's story

I am a first-year, first semester student midwife. What led me to want to be a student midwife was because I had a good experience during my labour in the hospital. But during that time, as English is their second language, I found that it is still a struggle for pregnant women. I have had a labour in an Australian hospital. I came from Country A. I have been in Australia around 5 years. I was an international student and came here. I kept studying but during the pregnancy, I found it hard, sometimes even the appointment would be a struggle to talk with them. I couldn't understand what the information was about.

I found I was quite interested in the labouring [delivery suite] staff, the midwives and midwifery. So, I thought it was a good idea to study and help lots of women who are migrants or came from Country A. I could help them, provide suggestions for them. I am hoping to assist other women who are of similar background to me, to make their labouring experience not as difficult as perhaps mine might have been because of English. It's one of the reasons [for doing midwifery].

Before I studied [midwifery], I started nursing, so I thought I would quite like [midwifery] because I know about the pregnant woman, the labour and after the labour, how they look after the baby. I was quite interested in this area so I wanted to know information and how I can help pregnant ladies [women].

I got lots of exemptions, maybe 14 units for the nursing course so I just need to do the [parts of the] course that is related to midwifery. For instance, I did the Foundations of Midwifery and next semester is about childbearing theory and practice. Then next year it's on baby's health and mother's health and mental health. Actually, my course is three years but I got credits so the next two years is a part time course. I think all of the units left relate to the midwifery [course]. I checked the other courses Indigenous Health, or Professional Practice, all that was exempted.

Interprofessional is [about] how you look at the whole picture. It's not like the Anatomy or Physiology, you need to look at the whole picture, because it's

quite different with nursing. Midwifery, your client, is the healthy pregnant lady [woman]. You might know that the lady is from a different country, they have a different culture. They may have support, or they may not, so it's quite different. So, we have different classes, beliefs about their social background and their culture. And also, we need to know how to check the pregnant lady [such as for] postnatal depression. So, as I understand it, it's like trying to learn the whole picture of midwifery not just the physical parts.

In terms of interprofessional education learning with other students from other backgrounds or other disciplines, I think I had one lecture in Human Function, Physiology. All my classmates came from different majors like dentistry, pharmacy, nursing or physiology. But for that course that we shared, we stayed together. So, we just learn the basic things. Because it's the first semester we just started from the basic human body's name and function. It's actually the first time [for me]. In our country it is quite a different system. We're all in the same class have the same lecturer. But here it is different. [It is] the better thing, because we can talk, we can know different things and we can share different things, and because different majors have different opinions, they have different objectives. So consequently, we can talk with each other. I only had one class like that. And then because I had a nursing degree, they gave me some credits, so that particular course was exempted. So, I only had one [interprofessional] class. I finished the nursing degree 2 years ago. I have not practised as a nurse. During that time, I was an international student. I needed to do the English test but I didn't pass that one. And then I was pregnant and had my daughter, so I just stopped everything. And now I'm here.

My personal view of these interprofessional subjects, actually I don't know how to tell you because like you mentioned about interprofessional, I only had a one class with other major students. The midwives are together for a lot of [the] experience, like this is why they need to do more practice from a different culture, different area, just to try to provide the best service for them, for the women.

Professional identity. What does identity mean? I think it's about how the midwife goes about their job. They are usually very patient and should try to understand the pregnant ladies, put themselves in their shoes and try to understand especially when the ladies are from a different culture. I met my

midwife during my clinical practice. She works in the migrant and refugee centre. She tried to understand them, but sometimes it was still hard because of the different culture. She couldn't understand some Asian ladies after their labour. Their culture told them that they need to stay in bed for 1 month. No showering and they [the midwives] don't understand why. They think it's not hygienic you know? But this is our culture, so I think the person [the midwife] should just try to understand that. They try to give enough support, not only about the childbirth education, but also if they get support from family, maybe try to help with social work or something. Just try to help them. Especially for the first-time mum, give all of the information they need because they don't know, they have no idea what it will be like during the labour, maybe they're scared. And so, if they're scared, they are stressed and this also can influence the baby. So, what I think during these two weeks of prac [is that], I think the midwife should give more education.

It will make a difference to how I see my professional identity as a midwife. We look to see that the mums and children are healthy and give them education about the labour. For the physio, they help the lady from a different view. They tell them to do more exercises, I think. Actually, I didn't talk to them but that is what I think [they do]. Because different majors they have different objectives. This is what they provide for the baby.

I've only had one class with the other students and everyone is in the class but the teacher separated us into a different group, because the group work is actually quite effective. So, we just try to [get to] know each other and [get] ideas and talk with each other, 'what's your major,' so try to know them. Then we have the teamwork, it's quite good. Because everyone was just working together and then finish, you try to finish that teamwork.

Other barriers that might stop me or have an impact on how I work in an interprofessional way, I don't know. Because I had my first baby in hospital, I also had a male obstetrician. So, I was lucky to have a female midwife help me to have [my] baby. One of my friends said she had a male obstetrician; she was a little bit embarrassed and she just felt a little bit uncomfortable. I don't know, maybe in your country, all of the obstetricians are ladies, female, so maybe few feel embarrassed if they have the male obstetrician.

I have only had two weeks of clinical practice. One was in the medical centre and the other one in the migrant and refugee centre. I thought they are quite interprofessional. So, the refugee [centre] is for women who came from another country, they may speak a little bit of English but they still have different cultural experiences so they looked uncomfortable and not confident. The midwife uses the interpreter and gives them more information such as how the Australian hospital runs and how long you need to wait for labour and when you need to call the hospital and things like that.

In the medical centre it was my first place on prac[tice] as a midwifery student. So, what I do normally is I just watch and listen, help the midwife communicate with talking with the women and just help them to deal [with] the issues they have. And also tell them what the process should be like. Like [at] how many weeks you need to have the blood test and the ultrasound and at how many weeks you need to go to the hospital. Just try to help them to get more information and also enquire about their birth plan, what they plan for labour and how they will feed the baby after the labour and any kind of pain relief they will receive. It's a consultation at the medical centre.

They [the midwives] help the lady with their issues and concerns such as morning sickness but they also give them information on feeding when she sees the pregnant lady. She always checks if they are comfortable and they will give her a score. I forgot about the name but one of the ladies, her score was very high. So, the midwife waited for her [the woman] to see the GP and tried to do the education to just try and help. Not only just for [her current pregnancy] but also for other things like mental health issues. I just realised for some women from Asian countries they are more worried about having a baby boy, it depends on the culture because a baby boy can make their husband happy. So, if the husband is happy the family is happy. It's quite common in the Indian family or Chinese family; this is a thing I have noticed. I also found that the women do lots of housework during their pregnancy and they also look after their husband. If they have a baby boy maybe they feel better because they get support from the mother in law. It depends on the culture. Do you understand what I'm talking about? It revolves around the cultural practices.

The [staff on prac in the medical centre] do promote interprofessional collaboration with the students; she just told me and also showed me that

situation and what she would do. During the few weeks of prac I think it's encouraged because the midwife tells them, like the part of the birth journal and they also send the lady to see their own GP if they feel something is not right. So, the GP will select an obstetrician or their patient's own GP will do another part of the check with the woman. Also, if they [the women] need antenatal education they will send the ladies to the antenatal education [classes] to teach the women about the labour and labour process or just full-scale antenatal education. Just like different people they play a different role and their job is like that.

Interprofessional collaboration affects my own practice. It helps and it hinders my practice. Actually, for both of my pracs I did not come into the centre [university]. For both they give a very positive example for students. So, I think that I'm very appreciative, I work hard, just want to be like them one day when I graduate. Because it depends on what their major is and also, they love to ask a question and help you to help you answer. It's very good experience.

My personal view of these interprofessional subjects, actually I don't know how to tell you because I only had one class with students from other majors. The midwifery students are together for a lot of their experience; this is why they need to do more practice from different cultures and different areas, just to try to provide the best service for the woman.

Actually, all my prac is in the medical centre or education [university] centre. There are midwives, nurses, obstetricians and physiotherapists. It's more like a grad team. So, they work with the others, it's a lot like that but all my prac is in a different place. Just from my studies not like the public hospital, I quite understand how they work. But the last time I followed my CCE [Continuity of Care Experience woman], when she went into labour, I saw how they worked as a team because she had a C-section [Caesarean section]. So, I saw the anaesthetist meet her first and check her medical history and also to make sure her blood tests and everything are normal so he can give her the exact dosage for the anaesthetic. Then before the C-section she went to see the midwife. So, the midwife checked her vital signs and also confirmed with her that she was happy, not nervous and told her everything would be fine and then she went to the theatre. Two surgeons took the baby out. Before the surgeons did that two nurses, I think [there were] two nurses, put the IDC [in-

dwelling catheter] in, and also made sure she was anaesthetised, that she couldn't feel any pain or anything in her belly. So the surgeon took the baby out and after the baby was out another midwife took the baby and checked the baby, the muscle [tone] and the motor [response] and everything and measured baby's weight, baby's head [circumference] and this is what she did and then I think it was the other theatre nurses' job to check [that] all the equipment is back in the trolley and the actual number. This process is why I think they look like a great team; they work together to make sure the patient gets good service.

I think I need to recheck it [IPE], because interprofessional in our culture I don't understand what's it means. I will do some research.

AF.2 Jayne's story

For me, I had studied sports science and some counselling degrees. I did those and found it very hard to get into the industry and I then went through fertility treatment to have my own daughter and during that time I really got to admire the midwives and how caring they were and how much help and support they were. And so, when I'd been through all of that I decided you know what, I want to be like these ladies [midwives] to be able to help other people who are in my situation. And so that's kind of how I decided that's what I wanted to do and that's why I applied to do this course. I am a civil celebrant, indeed, yes. I'm [in] Year 1 [of the course].

I am enjoying the course. I'm finding it very full on but I'm enjoying it. With regard to interprofessional education, I think it is brilliant and needed in these kind of industries. I think without it then you won't be able to perform the job as well as you should be able to because of the nature of the work you really need to be able to see it and then put into practice what you're learning. So, for me it's being able to learn the theory but then go into the workplace and work with people who are already in the industry to understand and learn more from them.

Okay so with that then being the definition of interprofessional education, well I don't really mix with them so you know I still find that everyone gets to know each other in the units where, through our Foundations of Midwifery unit, we get to meet everyone in there and we get to build a relationship with them so

I don't really think that we interact with the other students so much. When we're going into a class where there are other people from other disciplines, we will sit with the people that we already know. So, I don't think that there's really, I guess that much to be gained from it. I am still waiting to find out about the presentations. I'm not sure yet. But I presume it will be other students from other disciplines.

Personally, I actually haven't been out on clinical, I've been waiting for mine to start because I've got a special thing going this semester so I'm doing the breast-feeding clinic with Aboriginal women. So, I'm actually not starting for another two weeks. So, I've been out on my CCE, so my ladies, yeah. So, I've been out with those, but not actual any clinical placement as yet. So, in practice I'm seeing how the midwife there actually interacts and answers the questions of the couple and makes them feel at ease and provides information about certain testing that can be provided to bub when they're in the hospital, so I see all that. I also then get to see and also be hands on with, I guess, the abdominal palpations and the blood pressure and all of those kinds of things there, so I'm able to see those. So that's all I've been seeing so far. It's purely the midwives, that's all I've seen so far.

I've not collaborated with other health professionals or other disciplines. The term professional identity, oh gosh to me I guess it means how others would perceive me and how I conduct myself in my professional role. So how much knowledge I have and how I'm sharing that with the people and then how they feel about me sharing that. I guess it's about how others perceive how I am in my role as well as how I feel I'm doing and how successful I would be in it.

I think with the term 'role' a lot of it is to do with more care of the woman, I guess it's more of, I mean I know there's a lot of the delivering the baby et cetera, but I think it's a lot about making the couple feel at ease and the woman feel at ease and helping her through the time so that she feels relaxed enough in the situation to be able to follow the advice you're giving her and to trust that you'll be doing what's best for her. I think a lot of it is about the human side of it, the interaction.

The clinical, I know a lot of it will be doing obviously all the checks, so the respirations and the blood pressure and all that kind of stuff, doing that and

checking how the bub's doing, where the bub's lying, doing, helping with the delivery depending on what the situation is, whether or not it's just going to be straight forward or whether there's a complication, so whether you'll be doing it alone or whether you'll need to call medical intervention from the doctor. Doing things such as discussing all the episiotomies and epidurals and all that kind of stuff with them as well and then helping in those situations and administering medication as required and as directed.

Well I'd say that 'professional role' and 'professional identity' would be very close to each other but because there's the doing the actual role and how you perceive yourself in that role could be different. You may be someone who thinks that, like I said for me, I think it's more of the personal side of it and then the clinical stuff is just all the stuff that comes along with it, so for me I would think more about it as making sure everyone's comfortable and that kind of thing. So, I think it could slightly differ based on how you perceive yourself and what you feel's most important in the role.

My view of professional identity has changed. I used to think a midwife was the person who just looked after the baby. So, it's certainly changed a lot from that because I know that it's more of a whole, it's more about the woman than the baby I think, the majority part, but before I used to think it was just about the baby.

I think that factors in the clinical environment might have had an impact on my professional identity. I think because the midwife I saw was really aiming at making sure that the couple were comfortable and they really understood everything, so I think that really, I guess emphasised to me how important it was to actually make sure the knowledge is shared with the couple. So, I think that really did influence me a bit. Before this I didn't realise how much information and knowledge was shared by the actual midwife, I thought most of it was by the doctor so.

I think there will be barriers to working in an inter-professional way on clinical when say another person, or in their profession, they think that their role is more important, that could be a problem, instead of everyone realising that everyone's role is important. So, if you do have someone who sits there and goes 'oh well I'm more important than you' then that could cause some barriers. Oh gosh, I don't know what profession it would be. Maybe perhaps I think a

general nurse. Mainly because when I tell people that I'm doing this course they're like 'oh were you a nurse beforehand?' and I'm like, 'no I wasn't,' and they're like, 'oh well how can you do that job then?' So perhaps they may perceive their role as more important. I don't know, I haven't seen it, but it could be a possibility.

From what I've seen so far from my continuity of care experiences that the clinical environment supports interprofessional collaboration by the information sharing. So, I think that kind of is what promotes it. So, if there's something that they feel someone in another profession may need to know then they will share that information with them. So, say a physio, say someone was having a lot of difficulty with her lower back pain they would share that information with the physio who could then come up with some suggestions as how to work with that and manage it a bit better. So, I think that's the biggest thing I've seen was that they shared the information to try and work together to get a positive outcome. Which is really important and it is about that sharing of information and working together that is the real crux I think, of interprofessional collaboration.

Interprofessional collaboration will make me more aware of looking out for areas where I may not be able to help and where there is another professional that may be able to help and then sharing that information with that other professional or finding someone that the woman could chat to if there was no-one available in the area I was in. So, I think it's just made me more aware of looking out at who else could possibly be involved in the care.

That's a hard question about whether interprofessional education will impact my idea of professional identity, I'd say it would do. I mean everything that you do and every situation you're involved in would affect that in some way. How, at this stage, I have no idea but I'm sure that it will in some way affect my professional identity.

The way I've participated in education in an interprofessional way is primarily through sharing of a subject, but not specifically being intermingled with all the different disciplines to date. I definitely think that will change. I think that once I head out into a bigger environment, so at the hospitals et cetera, there'll be a lot more interaction with all the different disciplines and so that will definitely change. As I said at the moment, because I've been just going to

women's clinic, I've found that it's just the exposure isn't there, but bigger environments will lead to that, I think. And then I'll learn, and then I'll need to learn a little bit more about it.

Previously I participated in education in an interprofessional way particularly in the undergraduate degree. In the graduate diploma I didn't so much, but in the undergraduate [degree] I did yes. I think it's good to have some exposure to other disciplines. I mean there are certain areas where that is not appropriate. So, when you're just learning about that particular area that you're working in but for the general areas such as anatomy et cetera it's interesting to see how they think about it when they're thinking about applying it to their role. Before I did a lot of study with people who were training to be teachers et cetera, they were more seeing it as about how they could teach it to somebody else, than as about how it actually works in practice. And in my courses, mine was Social Science and I did Sports Science and Criminology together, mine was more about looking at how the actual body parts would work in the role that I was doing. So, it was slightly different. It was just interesting to see how people went about that kind of thing.

AF.3 Jenny's story

I'm thirty-eight. So, I was in the mining industry for about thirteen, fourteen years, and then had kids and I knew I wanted to change careers. I didn't know what I wanted to do at uni, and had the kids and had a great experience and loved the midwives, and that was it.

Well, the course has been full-on. I think just studying, my boys are four and six, full-time and I was working up until probably September last year, I just found it very intense. As far as the course goes, I love it, but I think because it's the direct entry midwifery and it's quite new in State B, you go into clinics and in environment and you get a bit of "You're not even a nurse yet", you know what I mean? Like I feel like we're on a bit of the back foot. We're chucked out into clinical settings and we have absolutely no background [in midwifery]. So, I don't think we're that, I mean this year's better already, but last year was quite full-on.

I was offered a spot back in 2007; I'm not sure, actually. It might have been later than that, 2008? What we're experiencing in clinical, do you think it

will change? And I think because I'm a bit older it doesn't, I just go, "Yeah, whatever". I think it's a bit harder for the younger ones. We've actually got quite a few young ones in our group this year.

My particular view of what interprofessional education is like, the scenario in the clinic is. As in education, I don't know. I'm not sure. The communication and working alongside people from different backgrounds, we've got paramedic students and we've got nursing students and working, a lot of our units we are studying with those students, so we're doing presentations at the moment and I think they're trying to make them more degree-specific, but I've actually chosen to go into a nurses' tute for one, which is different. I quite like it, actually. What am I liking? This sounds terrible. I've come from a male-dominated industry and I've struggled a little bit with all the female, and sometimes, the midwifery students can get just a bit, I don't know, everybody feeds off everybody. It's just nice to be able to go into a class or a tute with people that, we're just sitting there, we're doing the unit, do you know what I mean? It's like a bit of a breather.

Midwifery is a bit intense; it can be. I think everyone, it could just be our group, but I just find everybody just gets carried away and if someone starts panicking about an assessment or, something happens in the clinical setting, everybody just feeds of it. So, I actually have to sometimes just detach a bit and get some space. They can get a bit crazy.

That whole philosophy of midwives thinking that they know best about the women exclusively, I see that a lot, definitely. The ones that sort of fuel, and they're beautiful people, don't get me wrong, but it does seem to be those ones that are all about the woman, "We don't need obstetricians blah blah blah blah blah," that they sort of create this, it's just so intense sometimes. I had my own personal issues going on last year, but I was talking to a couple of the girls yesterday or the day before and just said, "I actually have to detach." And I've missed quite a few tutes and stuff because I can't be bothered, I can't be bothered listening to it. And I mean, I can access everything online anyway, so it's not like I'm missing out. And I think a lot of the younger ones, you can just see them sitting there going, "Oh my God, like, shut up and let's just get on with it."

I've joined the nursing group, or a group with predominantly nurses in it. It's only this semester that I've done it and it's just this one particular unit and it's fine. Everyone just seems to sit there and, again, the majority are nurses and the majority are quite young, but it just seems to be more tutor-led. A little bit of discussion, but everyone just gets on with it. Last year there was paramedicine, OTs [occupational therapists]. I'm not sure if they do physio at University X. They do, yeah. It was mainly paramedicine, midwives, nurses and OTs.

Learning alongside them, it was good. It just broke up the group. We had a really hard unit last year and that was totally mixed with all those different disciplines, we just broke it up a bit and it just seemed like everyone was a bit more focused on the topic and not getting crazy. Hearing a bit about their experiences as well, because you just hear about our clinical midwifery stuff, and just hearing a bit about what they do and where they're at. And I think as well, I find that the midwives think everything's related back to midwifery, where in those other units it was a bit more generalised and relating it to different disciplines, not just hearing about midwife stuff.

I am doing placement now. Last year was a bit awkward because you're a student; it's the first time I've been in an environment like that as a professional, not a patient. I suppose I was bit on the back foot last year a bit, but just professional but approachable. And I'm really keen to learn, so I ask a lot of questions, which probably annoys people. I don't know if that's the right answer.

My first placement was the Family Birth Centre, which is the low-risk sort of home environment that's attached to Hospital X, so I was there for first semester. So, I had a bit of interaction with paed[iatrician]s, not a lot else because, unless they were transferred to the hospital, we didn't really see anyone else. A psych[iatrist], I think I came into contact with a psych for a couple of the women and it's that assessments for them. And then last semester was the CMP, the Community Midwifery Practice, so again, all the contact last year that I had with obstetricians and anaesthetists and stuff was my CCE girls, so it's when they were birthing in hospital. The Continuity of Care Experiences, we need twenty of them over the three years. So, I had more interaction with them. I feel that a lot of the midwives are all like, "Oh

obstetricians, oh anaesthetists, blah blah blah", but I've just found them just, you know, they've obviously got a role to do as well, and it's interesting to see how they work.

With regard to my role or my identity in that clinical setting, obviously there are different professionals in that setting, but that's sort of my identity, my role in that clinical setting is to support the woman and her family, husband, to care for and document antenatally, postnatally and care for the baby. In general, a midwife's role is broader than that. I think that the midwife's role is to be with the woman and to help her through, or keeping track of the pregnancy, being there for her in labour, caring for her and the baby during labour and delivery.

I don't think that the interprofessional education experience has impacted on my view of my professional identity. My view of my role as a midwife and being in those other education side of things with other disciplines, I don't think that how I see myself has changed at all. I came in with a particular idea of what my role was or what it would be as a student midwife and then at the end of it as a midwife. And that type of education hasn't changed that idea at all at this point in time.

I think maybe when I wanted to do it, I saw the midwife from a patient's point of view. And then when I went into it, I started hearing this "midwives can do anything" and "it's all about the women blah blah blah." But then I've been in some traumatic births and I know that, well, for me anyway, there's definitely a place for people higher up than us and we don't know everything and it concerns me a bit that some of the midwives at the arrogance or the confidence that they've got in what they do and you see it all the time. There'll be a registrar, "we've got to get this baby out" and they're like, "no, just leave us, leave, leave us." And then, there's no change in practice or viewpoint on the part of the other midwives. I feel I'm there for the woman, I'm there to care, but I also know my limitations and I would have no hesitation standing back to get help from people higher up than me with more expertise such as doctors and registrars et cetera.

When we talk about limitations we're really talking about scope of practice, and that is part of our role. Where we should stop and when to call for

help, then really, we might be practising outside our scope of practice or potentially. And I do think a lot of them do do that, from what I've seen.

With regard to any barriers to working in an interprofessional way, no barriers. I suppose if it's a personal thing, it might depend on the person's personality and if they're approachable, or you're aggressive. Also, timetabling probably would be a big thing, because I've noticed that we're all over the place. For me personally I'm in a class at the moment where I'm sure it's all nurses and I'm the only midwife there and I don't have an issue with it at all. I don't find there's a barrier and you've got to make the effort, and they seem quite welcoming.

In the clinical sense working in an inter-professional way all the environments are different. Like LMH, I can find it quite difficult there. They are really all flat out, they're busy; they don't want to get into a conversation about what's going on. And now at Community Hospital A, everybody's been really welcoming, all the registrars are happy to sit and have a chat. I think the barriers come from personal traits.

And then there's also that whole professions, the midwives, I've seen it even transferring, the midwives on the labour ward when they're handing over women to theatre, even there's a bit of tension between the different areas. And then obstetricians come in and the midwives are all funny because the obstetrician's there; if that's what you mean by barriers.

They feel that way I'd say because it's their own personal experience, and they've probably, say obstetricians have had to come in and deal with stuff that they thought maybe should never have got to that point, or maybe people thinking that they're better; they know more than the other discipline. It's a bit like turf wars. And I've never really seen it before in my work life. I was in the male-dominated industry and I was in the corporate sector so it was middle-aged men and I was just working with them, and they all thought they were great but I didn't really see a lot of what was happening underneath. And not territorial, like nurses, the labour ward, the nurses on the wards, the nurses in theatre, it's funny to watch. Because I'm still a student and I'm quite observing, I just go, "Oh my, seriously?" I can't see it ever really changing. It's about the culture.

I found that what my university has done, we've got our mid[wifery] unit and we had one a semester last year, we've two this year. But then our other units, they have separated us. They're like, "midwifery students, when you're doing applied bioscience, lock into this class", or when we were doing Indigenous, all the midwives were in the same, and I just did not understand. And the tutors were trying to even when I went into this nurses' thing for bioscience, she's like, "There is a midwifery class, you know, don't you?" And I said, "Yeah, but for me, time-wise with the kids, it finishes at six, it doesn't work for me." And she's like, "Well, you do know that the other one's more midwifery centred?" And I said, "Yeah, but we're all doing the same exam, we're all doing the same eTest." And she said, "Well, yeah." And I thought, "Well, what's the point?" They're slated to be offered, it's a common unit across all the disciplines and ideally, we should be able to be mixed in together, definitely. I've tried to stay in the mixed class, I can't see why not as it's the same content and assessment.

The university at the moment promotes interprofessional education. Well, I do recall a couple of units last year with there being a big discussion on interprofessional communication and interaction. But I mean, in saying that, we were in units where we were all midwives. And I've always wondered why they did that, because we all get graded and do the same assessments, so it's weird.

Interprofessional collaboration at the moment hasn't had a massive impact on my individual practice when I'm on clinical. But I think that's because I don't have all the full skills, I'm not doing everything, but I like it, I like being in a room with other professions and having an experience and seeing how they work and it's got to be done, doesn't it? It needs to happen. The communication needs to be there, and nothing's going to work if it's not there. I like being in a room with different professionals and learning about them. Apart from being in there physically and you're learning some things, it definitely impacts care because we've got our scope of practice, and then you're seeing other professionals coming in and they've got their role to do. I suppose again, it just gives you a different aspect to the care for the patient.

I still feel like the way it's being taught, and then also, like on the CMP and the Family Birth Centre where it's that whole low-risk, it horrifies me some of the stuff that these women are listening to, everything the midwife's saying,

they've got so much trust in them, and I just feel like some of the practices and the way that they do things because they think the midwife can do anything, and don't intervene and it really frightens me a bit. It's not like I'm going to go into a setting and I'm going to feel like I'm nervous about giving the care in my scope of practice. But if there's an issue, I'm not going to ignore it and just keep on pursuing with it because I think that we can do everything and we don't need anyone else to assist. With regard to whether there's a mismatch between how we learn midwifery and how it's actually practised out there in the real world, I don't know. That's a hard one, probably not. I think because I've been in more of the low-risk settings, I haven't seen enough of it. In saying that, I've seen some traumatic births, so I don't know. I don't really know how to answer given that it is still an issue. It's difficult for students as we are trying to do skills and procedures the right way and the staff can still be disgruntled.

AF.4 Jordan's story

I am a second-year student. I went to uni straight out of high school but I started in an arts degree at a different university and I realised I really didn't know what I wanted to do after school and I realised it wasn't for me. So, then I thought about what I'd like to do a bit more and other people and a manager I had at my part-time job were talking about midwifery and I'd never thought about it and I started looking into it and I transferred into it last year. I enjoy it definitely. It feels very like I'm doing something productive and worthwhile.

We had one unit last year that was focussed on interprofessional education. We had a group assignment that we all had to be from different degrees so I was with a nursing student, an occupational therapy student and I think it was a pharmacology student and we did an assignment on arthritis and we just all had to be from different fields, it was nice getting to hear about what they have to do as part of their degree. I guess since it was first year, first semester, we were all doing quite similar things. The occupational therapy I didn't know much about, so it was interesting to hear about that. I don't think we will be working interprofessionally again at uni this semester, not as far as I know because we've just got a midwifery unit and then we have one other like Pathophysiology in it but that's just all, they keep us altogether. So, it's all midwives at the minute in my class for that. I think interprofessional education

is definitely a good thing and it'll help us all out in the future. I think if we'll have to work together in hospitals or health care settings in the future anyway. So, I guess the earlier we can get it started with interprofessional work, the better.

I have done some clinical, so far, I've had three placements. We started week one of first semester, though, so I've been doing it for a while. I was at a birth centre on the Group Practice program and you just get allocated to a midwife and they tell you their days and then I go in as well. So, first semester was a bit like thrown in the deep end but it was good, looking back that we got to start that early and weren't waiting around. In first term, because it was all midwives in the birth centre on clinical prac I didn't do a lot of working interprofessionally unless we went up to the hospital, twice maybe. The birth centre's more for healthy women, so if there was a complication then we'd go up to the hospital to go to a doctor, or get a scan done if they had a complication. I wouldn't say I really worked interprofessionally but I saw my midwife coordinating with the doctors and obstetricians, everything like that. Then second semester I was at the same birth centre but it was team midwifery.

I don't know how many women they saw, maybe forty or something in a month. There were, I think, six to eight midwives in the team, and they'd all see these different forty women and they'd try and introduce them to the whole team of midwives, and say "oh, this will be one of the midwives that will be with you during your birth." They'd try to all see them at least [for] one appointment. The group practice is different to just the one midwife for the one lady through the whole pregnancy. So that was actually similar, it was mostly midwives. Then I got my placement for this semester, I'm on the labour and birth suite and that's probably the most I've ever worked interprofessionally, but just still with the RMO doctors and doing handovers to them. I've had to do an instrumental birth, just passing them the instruments, unwrap it and then pass it to them, we have to watch birth suturing. I've done that a few times and they've been telling you what they're doing and trying to explain the type of stitch and the type of material they use to stitch and stuff like that. When the lady had to go up to the hospital for an obstetrician's appointment, the midwife who'd been looking after her the whole time, they discussed it together and made a plan, because she was postdates, of what they were going to do. So, they did that together. I

suppose it happens in the labour and birth suite when the midwives can talk with the doctors, they come to an agreement together.

Professional identity would be different to private identity, I guess. In the workplace your identity and what your role is there. For a midwife the identity you take on is advocating for the woman and what she wants out of the experience, but also taking care if complications arise and knowing what to do or who to transfer it onto and as a midwife, you would be able to make those decisions. So, in terms of professional identity it is your role as a midwife to do those things.

Professional identity is the identity you take on when you're at work, you think different and act different because of the situations you're in at work, that wouldn't be situations like your private life. Similar, but you have to be a bit more professional about things [at work]. The midwifery role refers to the things that you have to do and the way you act as a midwife. Like all of the antenatal, labour and birth and postnatal care and doing it in a way that supports it. When I first heard people talk about midwifery, I thought it was only the birth. I didn't even take into account antenatal and postnatal care really. I thought it was more medical than I found it to be so far as our whole first year focuses on normal, uncomplicated pregnancies and I'd always thought of it to be a complex thing, but I've seen that it's not always. Going out on prac and seeing it, seeing what they do first hand gives you more than you can read about what midwives do or anything like that. It gives you a better impression of role or professional identity so I'd say that's been helpful.

I think that the education has contributed to the change in my idea of professional identity definitely; in first semester, I just don't think I even looked into midwifery and I didn't realise the kind of ideals about normal childbirth and the history I've never seen anything either. I just had no idea. I think because when I started, I didn't realise all the different places you could work as a midwife or how different they could be really. I thought it was just hospital, and I didn't even realise the difference between public and private, and how much you had to do in each hospital, so it was good to see there were more options than I had thought there were originally. We had a few speakers come into our uni. All classes had either midwives or had something to do with midwifery; they did presentations on what it was like. We had one from a private hospital,

one from a public hospital, one from a community midwifery place and then a Child Health Nurse as well. Probably, just hearing it as well was helpful.

The first time I ever, because I was used to the birth centre last year, went up to the labour ward, I went up with a lady who had to be transferred up and it was seeing the doctors step in with what they were doing, it was a bit different to what I was used to. We had to go upstairs, the doctors just had more input and I wasn't used to that sort of thing, why are they telling us what to do and we've been with this, my midwife had been with this woman her whole pregnancy and then I see it from both sides, they have got medical background so it had an impact on professional identity. Everything was normal [with the woman] anyway, even when we went up to labour ward, I think. The doctors just came into the birth, and that was the first birth I had been part of, I think. My midwife wasn't very happy with it either; it just made you feel like the doctors got the priority for the birth. A student doctor as well came in. I was a bit annoyed that they thought they knew best, maybe they did but I don't know. In my opinion, did they know best? No, because they'd only just met her and they just came in and did it and they would have got a handover but they didn't. It's not the same as following through the same woman through the whole pregnancy and everything I don't think.

They knew I was a student and so I think they thought I was more advanced than I was and I'd never done a delivery myself before and they [said] "oh so are you?" I know they meant well, they didn't know, and then they just stepped in to do it. And they let me, we both did hands on hands but that was meant to be my midwife and I doing that, not the doctor so it was different to what I expected. It was a student doctor as well and he just had no idea how because he only came in the room for the delivery part, and he had no idea how I was, or how much I'd done, and it was just sort of "oh so are you going to do it, or am I?" And then I didn't know what to do because I'd never done a birth before. We sort of did it together so it was okay in the end.

I guess there are barriers to working interprofessionally like the difference in, and you obviously have to be educated in different things, but I guess the medical view and then the normal midwifery view are quite worlds

apart, and then you have to merge them sometimes in the labour and birth suite and get to an equal, well get to a common ground to operate alongside.
I have been to postnatal, I've been on the Visiting Midwifery Service, home visits and they came into the birth centre and the postnatal ward as well. The different areas of midwifery that are more likely to promote working in an interprofessional way I suppose would be on the ward because at the birth centre and on the home visits it was only midwives doing that again.
On the ward, before women can be discharged, they might need to be checked by an obstetrician or the baby checked by the paediatrician or anaesthetist or whatever comes around. So, I guess there's more interprofessional management of them on the ward.

That particular unit [ward] promotes interprofessional collaboration just like on the labour ward and now they have the nurses' station, the central kind of open office where everyone can see all the CTGs [cardiotocographs] on the screens and the midwives and doctors, whoever's around like anaesthetists or whatever. It's not really a working interprofessionally, it's more really a physical coming together rather than a promotion of interprofessional collaboration.
They also did handovers there. The manager midwife or coordinating midwife and the doctors would speak about a particular woman and what they were going do next. So, I guess there was a bit more inter-professional work than I thought originally. I think if we didn't have that nurses' station there would be a bit more interprofessional collaboration. I haven't seen the one for the doctors but there's a midwives' staffroom and I'm sure there's one for the doctors, but just in the nurses' station, more [of] everyone together. So, I guess if there wasn't that, everybody would stick to their own staffroom. In terms of the care for the woman, the planning, I suppose they'd have to make a meeting point together and do it somewhere else. I'm not sure if I'm answering this question right, but I think I feel more comfortable at the moment with the midwives rather than the doctors. I guess that's just my personal feelings of comfort. Probably because I'm going to be a midwife, not a doctor so that's why I feel I'll get more out of it being with the midwives rather than with the doctors. I think just because that's what I've been most exposed to so far. I'm still getting used to the whole, after a year of all such normal stuff and [then] getting used to the fact that the doctors are needed.

[Another clinical placement] was a hospital, and I rotated between postnatal and [the] assessment unit, and I did one antenatal day and then four shifts on labour and birth suite. It was good but we didn't cover any sort of, on the antenatal day especially, we'd refer, like we wouldn't see the other … we'd hand over to the other professionals occasionally but then they'd go off into their room and talk to the lady separately. It was a time thing, we didn't have enough, we had so many women to see and there wasn't enough time for us to stay. There was a social worker, a dietician/nutritionist, and there were also doctors, and I think there might have been a physio.

How does interprofessional learning impact on my professional identity? I guess it makes you realise your place in the order of things more like what each profession is all about. The structure of it; probably more the structure of the health system and how it all fits like that. In classes we have been exposed mostly to midwives, because they keep us altogether because we don't have a block of prac, we have [prac] throughout the whole year every week, one or two days. So, they give us all the same timetable to facilitate that, so they work out the clinical placements and what days you can do. We're always together as a group for the midwives and then every so often there will be a couple of people from a different degree. That unit, Enquiries for Evidence-based Practice, an interprofessional one, was quite a big class so that's where there's been the most differences. I've just done it actually; I've just finished it. It was mixed with all different people from I think nursing and midwifery and health sciences. But because it was not only part of it that was really working with others, like a group assignment, we got to, like, choose our own groups, so I just went with some other midwifery students, it was just easier. I know people who didn't though, and because it's all online, they had trouble contacting the other people in their group and getting responses and things like that, so it was nice that I was just with everyone I knew, and we knew we were all going to do the work and everything.

I think I'm doing one of the interprofessional units, I'm doing it externally so that's maybe why I haven't got it this semester. I think the Pathophysiology hasn't turned out that way that we've got anyone else, any other professions in our class. Normally we do. The Pathophysiology unit, I guess it's more important for nursing than it is, and they probably do other units, whereas we

had one unit on Pathophysiology and it's not based on pregnant women, it's just based on normal. I was interested in it, and it's easy to just get by in the unit, not doing a whole lot of work. I would have liked to have done more work in it, and learned more about it, and also not many people would like more assessments on it to actually check that you're learning properly about it because we just did group assignments and essays, I could have learnt more in a test or something. It was just with the midwives.

AF.5 Lina's story

It's a bit of a long story. I'm in my forties so I'm a bit older than most I suppose. I wanted to be a midwife when I was younger and around the age of eighteen, but that time I lived in the UK and you could only become a midwife by being a nurse. So, I went and did nursing for a couple of years and absolutely hated it, it wasn't me at all, and they were the days when nursing was done on the wards; you didn't do it in a classroom environment. We had a couple of days in the classroom and the rest of the time on practical. I was pretty much put onto geriatric and mentally ill wards, and just hated it; it wasn't for me, it wasn't what I wanted to do, so I put up with it as I said, for about eighteen months or so, and then decided that I couldn't do it so I ended up leaving and did lots of other jobs; joined the police force and was a police officer for a while in the UK, then I had my own children and was off work for a while and then started to think that I really needed to get back into the workforce and what was I going to do, and midwifery came up again as something that I was interested in. But at the time it was just not feasible financially and with having young children.

And then in 2008 we moved to Australia and I actually joined the prison service then, became a prison officer for the last five years, and then I had an injury at work which just made me realise I didn't want to be in that industry anymore and I really needed to be looking at something else. So, I sort of relooked at my options and obviously midwifery came up again, and it was just something that I thought I would want to do this for a good few years and now the direct entry was available so I looked into that and thought, "Yeah, okay. I'll give this a go," and pretty much that was it. I applied a couple of years ago, did my STAT test because obviously I'm from England so my qualification didn't

count as such, did the test and got accepted last year, so I did my first year starting last March. So that's why I'm here and I'm in my second year which is a miracle, but there you go.

In first year, a lot of our units were interprofessional so we had lots of different areas, so we were with nurses and potential physiotherapists and all sorts of different health care professions. In each unit we were expected to do group presentations or group work where we worked together to solve problems and that sort of stuff. So, I suppose we had to work quite closely with lots of different people just in order to get through the course pretty much. So that's the main way, I would say, how I participated in interprofessional education.

I believe interprofessional education it's quite important. I think certainly from a midwife's point of view that midwives are pretty much, not ostracised, but we're treated differently than nursing staff and people seem to think that we're not as educated as a nurse because we're not a nurse. Even postgrads think that they're above us because they're nurses first of all and then midwives. So, I believe that it's really important certainly, not just from the learning point of view, but in future that we work together because obviously we've got problems to solve and if we know how to work together then it makes life so much easier. We're not a profession on our own; we work collaboratively with lots of different areas and I think, if as students, we can get that close working relationship started then I think when we get out into the workforce it's probably something that'll come naturally and it won't be difficult or it won't be forced; it'll just be something that we'll know that we can do and that we're happy to do, and that we don't feel uncomfortable having to go to other health professionals in order to get things done and sorted I suppose. I think it's important. Other professions or other disciplines seem to think that the midwives aren't as well educated; I think some of it comes from how it's interpreted, I suppose.

All the pracs that we've done have been in maternity settings so it's been difficult to say that we've been treated differently. I've done a lot of prac with our local Birth Centre which is attached to the main hospital but is a separate entity. When I moved from there and went up into the main maternity setting, the more hospital environment, that's when I came across it a bit more because people sort of scoffed at me, I suppose, because I'd been in the Birth Centre

where you haven't done an awful lot in there because it's very unfussed and because I wasn't a nurse previously they were of the opinion, "oh you don't seem as if you know what you're doing", that kind of thing. I found that quite a few of the doctors were a bit like that as well, very, I wouldn't say standoffish, they were quite open with it, but I did have a couple that sort of laughed and went, "oh midwifery students, you know, we know what you're all about", and sort of scoffed at you a little bit because he said, "oh you'll soon get used to what you need to learn and what you need to do and none of this mambie pambie stuff". So, I suppose that's where I found it personally coming from. I think mine was because I wasn't previously a nurse, a lot of people expect that if you go into midwifery that you'd previously been a qualified nurse and a lot of people have said to me, "so how can you be a midwife if you're not a nurse?" And even some of the midwives who were nurses and are midwives went, "oh how did that work, how can you do midwifery if you haven't done nursing previously?" So, yeah, there's a little bit of that.

But certainly, even the way the course is run, for instance, this year we're doing applied bioscience, and everything in that course is set up for nurses, not set up for midwives. So, we go in and we go, "Well, this doesn't really relate to us because we're midwives. We're not nurses, so why are you forcing us to do something that really is not within our scope and not something that we'll ever come across?" I've just done an assignment on a 73-year-old man with pneumonia. It's not something that we're ever going to come across, and it seems as if we're not as important; that's certainly not just from me but a lot of the girls that are on my course, that's how we feel as if we're not as important as they are. So, they've got the labs; we can't get the labs at university because the nursing students are using them, just little things like that that, not so much in a professional setting outside of university, but certainly within the university. And I suppose from a personal point of view from doing the nursing aspect many years ago the nurses were always the ones that, as you couldn't do midwifery unless you were a nurse, were more important. And I think that sort of mentality stuck with a lot of people. So eventually when you go out into prac and the midwives, the nurses first and midwives second, still say, "Oh, you're a direct entry?" You know, it's almost as if they look down on you, down their nose at you as if you're not going to be as good. "Oh, you're no good.

You can't check my drugs because you're not a qualified nurse." You know just little things. Essentially, we're not allowed to check any drugs. We're not allowed to do Schedule 8s and we're not allowed to be the counter signature on. So, I'm assuming you have the same schedule and you have to have two midwives who check it together and countersign it. So, we can't be the second midwife for that. We can be involved in it and be like the third wheel almost, but very often we seemed to get pushed out because it seems a bit pointless, I mean, three people doing the same thing. Schedule 4s we can, and I only found this out the other day because we had a bit of a worry about it because I'd been given a Hep B to give to a neonate and we were like, "oh I'm not sure I should be doing that [be]cause I don't know whether it comes under the policy", but apparently if it's a Schedule 4 medication we can actually check it and administer it as long as we've got a registered nurse or midwife to check it as well. So that's sort of where we stand here but we've always got to have a counter signature, so even paracetamol or Panadol, we still have to have a midwife to sign our signature afterwards to counter sign. I suppose we do get it [about direct entry midwifery] when you're out in the hospital but for me personally I found it more to be at uni with everything that's going on there at the moment.

Doing the assignment on a seventy-three-year-old male with pneumonia, we did actually question this as midwives. We're lucky enough that our class for this particular module has actually been done as midwives together, so all the midwives do the class together. And we did actually ask the tutor and say, "Well, is there any chance we could get something that's a little bit more midwifery-orientated, that's more relevant to us and to our course?" and actually to take it back to the unit coordinator who said, "No, this is the assignment. It's part of your overall grade, and in order to mark it everybody has to do the same." So that's what we've been given, that's what we've got to do. So we did actually question the fact that it seems a bit silly for us, and I suppose the only answer we got was, "Well, you might come across somebody with pneumonia," which we might, and it's very interesting to do, don't get me wrong, it is, but when we're doing midwifery we're never, ever going to come across a seventy-three year-old, ever, and very rarely do we come across men, as far as I'm aware unless there's something exciting happening in medicine recently.

So, we're just told, "This is what you have to do," and that's what we do. But it seems a shame that they didn't use it the other way around because nurses will very often come across a pregnant woman. But we'll never come across a seventy-three year-old man with pneumonia who's had a hip replacement. So surely, we should be thinking outside the box and saying, "Well okay, if we make it more midwifery-based then everybody gets a better understanding." But that was just what we were told, we just had to do it.

The university actually tells us which classes we have to enrol in because of our prac. So right from week one we go on prac, we do two days a week, so in order that they've got the availability to give to the hospitals to say when we're available, we have to do certain classes so that we can fit all our classes into two days, so that the other three/four days are available for prac. So, it gives the hospital more [flexibility]. We've done that with a lot of them, a couple of our nursing ones for next semester are the same, we've had to book in for specific classes and we did it last year with all of our classes, all the midwives were together, so much so that one of the ladies this last term couldn't make one of the classes, had to actually ask permission to change class into a nursing one because they block them out completely for midwives. We don't get as much interprofessional working together because we're never put together, we're put separately and people are tested differently because of that I feel.

Whereas the nurses here do set blocks, they do so many weeks at uni and then so many weeks on prac. We start our prac from day one and every week we have to do a minimum of two days. So, in order to fit that in around the stipulation we have to do the actual uni contact time within certain times. No, we don't have any choice, we're told. I've already got my timetable for next semester and I know what days and what times my classes are and I don't get to choose. Most of them you go in and you can plan your timetable and choose and fit around your lifestyle. We can't actually do that now.

With regard to the term "professional identity" I don't know whether I've actually thought about that. I've honestly really not ever thought about that as such. I suppose I try and attack it from more of a general medical perspective and for me I'd like to think that I fit in wherever, if that makes sense. I don't really know if I am making sense. I don't really know how to answer that one to

be honest. I suppose obviously the midwife role is to be with a woman during pregnancy, birth and postnatally, to be a support as well as a medical professional, to be there to give her information and help her through everything that is involved in, well not just pregnancy, through conception, pregnancy, birth, postnatally, to do with her health, the health of her baby, family and partner, family members, I suppose like a support person as well as a medical professional. So, I suppose that's how I'd think of it.

Interprofessional education has not impacted on my professional identity or my role. It has not made a difference. I think, as much as I hate to say that midwives are a little bit different, I think they are a breed upon themselves to a point. And I think being a midwife is something completely different than being a nurse. My view of the interprofessional relationship, there's more to do with how we can help that woman get the best care by being able to go to different areas [types] of medical professionals. So no, I don't think so. I think I had an idea of what my professional identity as a student midwife and future midwife was before we did any interprofessional education. My view of professional identity or role has changed over time since I've been studying and have been exposed to clinical. I suppose being an older woman I've got children of my own and going through the whole pregnancy and birth, I had an idea of what I thought a midwife did and that's changed that quite a bit. I suppose I've changed a lot of my views around midwifery just because of the new experiences I've had rather than the experience I had in childbirth. So that's changed my view, and who I'd like to be as a midwife, that has changed quite dramatically from my personal experience to now, having my midwifery experience within the university and in prac. That has changed. I've done quite a bit of clinical.

I suppose I've attacked it differently because I had a completely different experience of pregnancy and childbirth. Mine were all very negative personal experiences. So, I've had the opportunity now to go into the industry and see it from a different point of view and I've seen how positive it can be and how nice and natural it can be, which obviously was something that I did not have the opportunity to see [before]. So for me, that's where I come from, it's from the other end, I've gone in thinking that everything's medical and that everybody should have an epidural and everybody should be able to just lie on the bed and

have things done to you and not worry and Caesareans are fine to actually this is the most natural thing in the world, and we're built and made to do this and this is what we should do and this is how it should be. I feel as if, certainly, with my ladies that I follow through, I tried to be quite positive with them around natural childbirth, even the ones that are quite scared of childbirth, which most new mothers are, it's a terrifying experience, you don't know what's going to happen. But rather than go along the lines of some people pushing, "oh don't worry you can have an epidural, and oh don't worry, it won't hurt if you do this, or there's always this and there's always that", I try and do it more from a natural point of view and just say, "look this is the most natural thing in the world, yeah, it's going to hurt, and it's going to hurt a lot but you'll forget about it, you know, you won't remember that in a couple of years' time, you'll just remember this wonderful experience that you had." I try and be more positive about the natural experience of childbirth without being over the top I think, because I've been in both situations now, which not many people can say, and I've seen both sides of the argument almost. So, I think, for me, that's made me more passionate as a midwife wanting woman-centred care because that's really important to me, and I'd like to think that I show that when I get out and give it to my ladies as well.

There were factors or situations in the clinical practice setting that might have had an impact on my view of my professional identity. I did most of my prac within a family birth centre this last year in Year One. So, I was completely away from the hospital environment. I had both my children in a hospital environment; both of them were intervention pregnancies and births due to illness, and I suppose that's what I always thought. I went into midwifery thinking that I was going to be a nurse, but as a midwife, the medical intervention, being there, lying on the bed, you're on your back, your feet up in the stirrups, or you're a Caesarean or it's suction [vacuum extraction/ventouse], I suppose I went into it thinking that that's who I wanted to be, that's where I wanted to be.

My idea was, because I'd had a Caesarean section and I'd had quite traumatic births, that I wanted to be a support person and be there for somebody that went through the same as me, but would be able to say, "You do come out the other end and everything is fine, and things work out." So, I

suppose I looked at it more along the medical side of things. I then spent a year in a really low risk, hands-off environment where it's been all natural childbirth and totally hands-off, no intervention whatsoever, and I suppose for me personally that's made a massive difference because I can see that natural childbirth without any drugs or without any help is actually achievable, it's do-able, and it's really quite beautiful. So, I suppose for me I was never personally given any choices. Nothing was ever explained to me or told what was happening; it was just, "This is what we're doing." So, for me personally I am now very much an advocate that I want to give that information to women. It's okay if you want to go down the route to a Caesarean or you want to get induced, that's fine; but you need to be able to understand what you're doing, what that means, and where that will lead you, rather than just saying, "That's what I want." So, I suppose I'm more of an advocate for knowledge now, and being told, being given that information, and having choices and them being informed choices rather than just, "This is what we're doing." And I find even in the few times that I've been up into the hospital with ladies that eventually, things have happened and we've had to intervene, I've gone up and said to them, the midwives, "she doesn't want to be on a CTG lying on the bed immobile. She wants to be mobile; she wants to be in the shower, she wants to be able to walk around, she wants to be able to give birth on all fours, or she doesn't want to be lying on the bed." And I've felt that I'm able to do that and say that, whereas before I went into midwifery, I honestly believed that everybody should be on the bed, that hasn't changed. I still believe that you've got choices and if you want epidurals and you want Caesareans that's fine, but I'm a little more along the natural childbirth path now.

Maybe, I suppose if I really reach into it there would have to be some point where, having done midwifery and even some of the interprofessional education with nurses, it has impacted what I think of the midwife's role. I think everything that you do has some impact. I suppose it's to what degree. Obviously, all education has an impact. We've been given a lot of knowledge that I didn't have previously, so I suppose it does. You know, if I think about it, of course it impacts; it's got to because you're given so much more knowledge than you had previously, so that's what's changed your views. It's not just what you see and do outside; it's what you learn about as well.

I don't personally think there any barriers to working in an interprofessional way amongst colleagues or within the course. I think myself and most of the girls that are on my course are very open to working with others. I suppose the biggest thing for us if you are looking at barriers from the course perspective, is the amount of contact time we have at university and the workload, and the practical amount that we have has been the biggest barrier in working interprofessionally because the nurses are on their courses, they do their practical in two or three weeks in a stint and they do a whole week, whereas we have to do our practical every week that we're at uni throughout the semester. So, we have two full days at uni and then two full days on prac, so we're very limited to being able to get together with other groups in order to work well with them. So, on the few occasions that we've had group work to do and we've had people that are not midwives, we've got different timetables, it's been very, very difficult to find the time to get together to actually do the work that we need to do. And very limited, because as the other members are saying, "Oh yeah, let's get together on Wednesday," we're saying, "Yeah, we can't do any because we're at uni all day and we've got lectures back to back, and then can't do Thursday because I'm on prac, and can't do Friday because I'm on prac," and they're saying, "Oh, well I can't do Saturday and Sunday because I've got a part-time job and I work." And so, I suppose that's the biggest barrier, the amount of workload that we as midwifery students have got is very limiting when it comes to really doing anything. I suppose if I'm totally honest that's been probably the biggest barrier in any sense because we don't really like doing group work with other people apart from the midwifery students that we work with because it's too difficult, and then you end up doing more work that somebody else because they're not as bothered, I suppose. Their pass marks aren't as high as ours, so that's difficult because a lot of students in our course are older and mature women who've had a job and done stuff, whereas you go into the nurses and they're all eighteen-year olds, they're doing their share I'm sure they're committed but their most important thing is who we're going out with on Friday and Saturday night, and where are they going, not "Oh my God, I've got four assignments to be done by Monday, and I'm on prac as well." There are different priorities and I suppose the midwifery course that we're doing is so full-on, so jam packed full with what we have to learn and

the grades that we have to achieve, as well as everything else, certainly first year, it's not as bad this year, but I mean last semester we had five units to do plus practical two days a week, plus five CCEs which was absolutely manic, I worked out one week that I'd done more hours in one week than I ever did when I worked full-time. You sit back and you go, "I'm not even being paid for this. I must be crazy." I'm haemorrhaging money just on petrol and everything that I need to purchase, and it is a really tough course to do, I think. So, I suppose that's difficult. We've got a mixture [of students] but when it comes to group work, unless we're allocated, we tend to sheer off and go into those sorts of groups that we're friendly with because we live in similar areas, we've got similar time restraints such as families and things like that. So that's why I end up being with being more mature people, although I have worked with some of the younger girls in the groups.

We're on clinical two days a week, every week, and the nurses, they get block. I have no idea, that's just how it works. I don't know why we do that here. We just get given it. From what I can gather it's to do with the actual number of students they've got here in our state and the number of placements that they've got, so they spread it out throughout the year. We've all said on our course, "Wouldn't it be so much easier if you just spread it throughout the whole year instead of just a semester? Could we only do prac during the semester weeks?" So, for fourteen weeks we do prac, and then when we're on holidays we don't do anything which seems a bit silly because you go from one extreme to the other; you go from being manic, running around like some sort of crazed maniac for fourteen weeks to doing nothing. We don't get holidays in all honesty. We get holidays but we don't do prac but we still just had three months off so we've had December, January, February off, and after those three months I've only actually had five full days when I haven't been doing something, and that's because I've had follow-throughs. But they're all pretty much ready to birth so you're seeing them every week and I've had three or four of them. Then you've got the birth and then you've got the postnatal. We've just been told this year, "Don't make any plans for January, February this year going on holiday because you're probably going to do prac because they [the hospitals] haven't got enough prac hours." And we're sitting there going, "Well, why don't you just tell us at the beginning of the course that from "January to

December you've got prac during this time," because the number of hours we've got to do over three years is a lot to be rammed into six months a year which to me doesn't make any sense I suppose.

I didn't personally do prac during those times but I'd taken on quite a few CCEs, the women I follow in order to try and take the pressure off when I went back to uni during exam time. So, what I did was I had something like five or six of my women who were all due to birth over that three-month period. Because they were all due to birth, they were all having antenatal appointments weekly and two weekly, two at that period which meant that I never really got a full break because of having to go and see them and trying to get all the hours included in them and then every one of them birthed and then you've got your postnatal and everything as well afterwards. So I think before [the] five days I got, we were supposed to be going away and then one of my ladies went into labour early because after seven days, she went into labour early and I ended up going in on the Friday night and saw her on the Saturday and the Sunday postnatally and then I have the five days off before I had another appointment. Even then, that was because I said to all my ladies, "look I'm really sorry but this week I'm off, my husband was off on holiday and my kids were off school", so I just felt I needed that break, and the same thing probably will happen this time. I've got two ladies that are due in this break and another lady that I'm following through, so obviously I'll be seeing them but I've only got three this time which isn't too bad and then for December to March again, I'll probably try and do the same sort of thing so that for my final year I'm not worrying about trying to do CCE hours because it's getting more and more difficult because we're getting more and more prac. So that's quite hard doing twenty follow-throughs, we haven't had ours changed.

They [the university] basically said that they don't think it's worth petitioning for [a reduction in CCE numbers] because if we don't do the twenty CCEs we've got to find another seventy plus hours prac that we have to do which I think is a bit ridiculous because it's easy to get your prac hours, seventy hours isn't too difficult to do on prac, whereas, CCEs are really difficult. The CCE hours are really difficult, certainly now in our second and third year because of the way our prac is organised. So, we're not allowed to go on CCE

appointments if we're rostered on prac, but we don't know what days we're rostered on prac until probably a week before you're due to go in sometimes. So, then it's impossible to make appointments with your women when you see them a month apart because you don't know what you're working. Then this next year it's going to be the same and then third year we do three days prac so it'll probably be even more difficult but it seems a bit silly but they don't seem to want to change it and if they do, I don't think it'll be for when we're here. I think we just carry on and do the twenty. I've got fourteen so I've got three still ongoing and the rest have all birthed and I've finished with. So, I've got three at the minute still ongoing. So, I'll have fourteen by the time I go back next semester, I'll have thirteen birthed and one still on the go. It's getting harder to pick them up as well which is a bit of a problem. Because you're not working in an area where you see antenatal women very often because you're in the hospitals, it's harder to pick up CCEs. Then because you're not there available when they want you, they don't want you to follow them. They'll take a first year because it's easier for them, that they can be more available than us. That seems a bit unfair. We've just been told this last week that we've got one of our units for next semester, one of the nursing units, for which we have to do three weeks nursing prac. Why do we need to do nursing prac? What use is that to us as a midwife, really? I can't remember what it's called, I think it's integrated something or other. I haven't got it on me at the moment, integrated, I know it's a nursing unit but what happens is the nurses do their three weeks prac during semester. So, they go off and do three weeks prac, and that's them covered, but because we've already done prac for our mid, we can't do that. So we've got to do it during our semester break in December, so we finish uni, have a study week, a week or two weeks of our exams and then we go back full-time five days a week to do nursing prac which of all the girls that have already done it, have said, "well it was a complete waste of time". You couldn't do anything because you're not a registered nurse, so even though you do catheters and injections in mid]wifery], they won't let you do it in a nursing environment. That [nursing prac] used to be two weeks apparently and we just found out last week that they've changed it to three weeks, and when I rang them and questioned that and said, "why do we have to change", they said, "because we've got to be brought in line with the nurses" but they won't bring the mid students in line with

other mid students throughout the country. They're only doing ten CCEs now, so it's chaos at the moment.

There are barriers to working in an interprofessional way in practice, not so much from a midwifery point of view but from a student point of view. It seems again that as you're a student, this is the situation that you're in. I've had a couple of run-ins with anaesthetists and obstetricians, they almost treat you as if you're a non-entity, you're not there, you're not a person, you're not a professional; they talk to you like rubbish and a few of us have had instances where we've had to step back and go, "Whoa, hang on a second." I mean to me personally that's difficult coming from the industry that I come from, having to then take a step back and not be the sort of person that says, "Hang on a second. Who do you think you're talking to?" So, I think it's more of a student thing rather than a midwifery thing, I think. Personally, I haven't come across anybody that's been anything other than professional as far as the midwifery bit goes, but from a student's point of view I've come across instances where the interprofessional relationship just doesn't exist because you're a student.

Personally, I'm the kind of person that I'll talk to anybody. You know, I'm happy to include anybody, and in my old profession when we had anybody new, more than happy to take somebody under your wing because you just think, "Well, I was there once." It was scary and now you just don't know anything and how scary that is, so for me I've always been somebody that's encompassed that and said, "Oh, come here, I'll show you." Or if somebody's made a mistake, "Don't worry about it. We all did that. This is what you should have done. This is how you do it." And I've had a lot of times when we're just ripped into basically and just gone, "What are you doing?" or, "You're no use to me, move." You're a student and it's like, "Oh my God," but I wouldn't say from a midwifery point of view but more a student's perspective.

In the clinical practice area, the way they support or promote interprofessional collaboration, the bits I've seen work quite well, most of them have got their own areas to a degree, so I've worked in the big maternity hospital, so they've already got their ultrasonographers and the obstetricians and the different things. I've had a couple where we've had babies that have had to be transferred to the children's hospital, and that worked really smoothly, really well. And I think that's been built up over a good few years. There are

people and they say, “Oh, this is what we’ll do. This is how we do it.” And it’s quite a smooth flow. I suppose a couple of the hospitals that I’ve been to with my follow-through ladies have been slightly different, and I know I’ve had a couple of friends who have dealt with private practice and that’s been totally different altogether. But my personal experience is that it’s run really well in big maternity hospitals and I’ve personally never seen anything that’s made me step back and think, “Wow.” Everybody’s friendly, everybody’s helpful, everybody’s supportive, so if you need something doing it’s, “Oh, we’ll send it.” And very often, if it’s an outside agency we tend to send them to the same people that they’ve dealt with previously because they know it’s going to go smoothly, or they know things. I’ve not come across anything yet that doesn’t work very well.

The example about the baby who had a tracheoesophageal fistula having to be transferred out to the children’s hospital that worked really smoothly. The ambulance service was involved, the actual hospital itself was involved, there were surgeons involved, paediatrics was involved. I think that particular one there was the ENT specialist involved as they actually knew before the baby was born that there were issues and that it would have to be transferred. There were counsellors and psychiatrists involved, it was quite a wide net to be honest, because there was everybody for the baby and everybody for the mother and father as well, and the medical team for the mother as well. She obviously wanted to go with baby and because of what she was having done she couldn’t follow straight away. And so, there were counsellors and psychiatrists and lots and lots of different people from the basics of just things like the operation.

Everybody worked really well together and everybody did their section of whatever it was they were doing without taking over and not taking responsibility of the whole thing because obviously one person had to take responsibility. Everybody worked really well together as a team, there was no one individual that stood out because everybody worked together well and that showed quite clearly. I still remember the case now, it was a very smooth transition and the parents were not happy because obviously there was something wrong with the baby, but they were well informed by everybody and everybody worked so well together as a team that the pressure and the extra

stress of worrying about that was taken away from them so they only had to really worry about the baby and that was it. They didn't have any other worries about how it was going to happen or when it was going to happen or who would be there and who wouldn't be there and everything was explained well in advance before it actually came about which was lovely.

Of course the midwives that had been looking after her were all involved in her side of things as well, that's how I got involved because I was actually doing my placement down at the breastfeeding centre and she came in before she was due to go in for her Caesarean to come in to see whether she could eventually breastfeed and how she would go about continuing to get her milk to come in while baby was in the hospital. So, there were lots of patient consultants, midwives, and all sorts. That particular case was surprisingly lovely to be around because nobody really took over anything in particular, all took responsibility for their part of it without taking over and everybody gave advice for their part and then if needed said "But this isn't my remit you need to speak to…" And then they came in and she got appointments at different times, and some sticking to her, she was really happy with what happened before I was involved and I saw her again after the baby was born and she was very happy with how things had gone during the whole transition and then afterwards as well. So, I didn't get any of that sense of "I know best and you need to do this" type of thing at all. You do sometimes, even [something] as simple as breastfeeding; on the wards you've got midwives, especially the older midwives, they're saying, "Oh, we need to do this, this and this and this," and then there are lactation consultants who come in and say, "That's rubbish. You don't do that, you need to do *x, y* and *z*." And that can sometimes be a bit, "Oh, I got told this, and then you told me this, and I don't know what's right and what's wrong." So, in that particular instance, no, everything seemed to run really very smoothly. Like I say, it was lovely to watch and lovely to be around from a professional, interprofessional point of view.

Lactation Consultants, we seem to get quite a bit on that. I've had that quite a bit this last semester as well, because I've been on a postnatal ward predominately. Birthing fascinates me; the whole thing around it fascinates me. I've done a few days at our Breastfeeding Centre with a really experienced Lactation Consultant and then when you go up on the ward you also try and put

that into practice, what you've been taught, and they just come along and say, "oh just do this and do it", and you're sitting there going, "oh."

I've actually had one lady who I spoke to postnatally who came back and actually said to me, that she would bottle feed her baby because she got so much conflicting advice from different midwives and from the Lactation Consultants, that she just didn't know what to do and how to do it. When things went wrong, she just said she didn't feel she could go and talk to anybody so she stopped and started bottle feeding the baby which I thought was really quite sad, but I've seen that in action, definitely. We're taught the whole hands-off technique and you're not supposed to touch; you're supposed to explain the tummy to tummy, nipple to nose and all that kind of stuff. One instance I spent hours with this one lady, who was really, really struggling to get this baby attached properly without cringing. So I kept going over it and I got dolls and the knitted boobs and everything to show her what I meant and went through it all and then one of the midwives came in, [she] was actually like a preceptor to me, she came in and I understand fully that when you're on a ward you don't have hours to spend with somebody, you've got six other patients to look after. But she came in and immediately said, "Oh what are we doing?" I said "oh just going through all the breastfeeding and trying to get this baby attached, not really attaching very well and nipples getting sore blah, blah, blah", and she just said, "oh, okay come here", and then she said, "oh you don't mind if I help you, do you? She's hands on, straight on, baby on the breast and all this and I felt like a complete fool because I'd just spent an hour talking to this lady and not touching her. And then she came and got baby on straight away within five minutes by using her hands. I'm like, "well we're taught we can't do that", and to be honest, no, she [the woman still] didn't know what to do. She can call you and get you to put the baby on the breast but she still doesn't understand how to do it. So, it's a bit frustrating and that happens a lot. That was just one example that was quite obvious to me.

Interprofessional collaboration affects my individual practice as a student midwife because we're learning; I suppose you pick up lots of different [things from different] people and some of it you take away, some of it you don't. And there have been occasions where I've thought, "Yeah, I don't want to be like

you," and there's other times when I've thought, "Yeah, you know, I'll really take that bit of your practice away and use that." And I suppose for me, that particular instance really sort of brought home that, at the end of the day it's not about us, it's professional. It's not about me as a midwife; it's about that woman, that baby, her family, and what it means to her. So, I think certainly it took a lot of weight in that particular case and obviously that was the one that I've highlighted, so it obviously made an impact on me. So yeah, I would say definitely, yeah. There are instances when you see particular practices that you think, "No, I don't want to be like that." There have been particular aspects that I've seen, where I shudder and think, "That's not how I would do it," well not just from a different discipline, from the midwives as well, there's lots. There's lots of looking down the nose from the health professionals, "You're just a woman. This is what's happening. This is what we're doing." No information, no collaboration, and you've just got to sit there and cringe and go, "Oh my God, I can't believe you just said that." So definitely.

In the course, I suppose apart from when we do units where we have to do group presentations, I would say interprofessional collaboration is pretty much not promoted. Certainly not, and I think because we're very much singled out as midwives, like the fact that our applied bioscience, we have our own special class with just midwives. I mean I totally understand that aspect of it because of the practical and all the workload, it would be difficult to go on different days. But normally in the university setting you pick which day you want to do what unit on or what day suits you; [as midwives] we're not given that opportunity. We basically get our timetable given to us: "You will be at uni from this time to this time on this day." And that's I suppose because then they have certain days that they block out completely for the practical element which is that we're available two days a week, so I suppose they get that totally booked. That in itself alienates us as an interprofessional team because we very rarely, and certainly now in second year, we very rarely are involved with any other interprofessional people so that's the bit, I understand it to some degree, but from another point of view where they keep ramming down our throat interprofessional relationships and then in the next instance they're making it almost impossible for us to have interprofessional relationships.

We've even suggested doing similar to the nurses where we do a whole week because certainly this year the university, for certain units, that's what they've done for the nurses. So again, I go back to the applied bioscience; our timetable for this bis a fourteen-week semester, but we only actually have seven classes as such because what we've done is, we have each class twice so that the nurses who go off on a week of prac don't miss. So, if they miss one, for instance, we do immune dysfunction and infection this week, so if they're on prac this week and can't make the immune dysfunction that's fine because the next time it runs, they'll be able to come. So, it's either that everything's set up for the nurses again, but not for the midwives. It makes it difficult, but I suppose everybody has different things to accomplish.

I think I personally would like to see more interprofessional working together in the course, although I totally get it, and it's nice that when we go we've got our own little group, but we become very isolated and very reliant on each other rather than meeting different people. Maybe that's because when we go out into the workforce it'll be like that anyway, because even though we do have the interprofessional relationships in the workforce, it's still very different in that most of them, because in a big maternity hospital you've got everybody that you will see working within that hospital and the agencies that you use are maternity related, even your physios, who are based in the hospital. Very rarely do we advise people to go and use physios outside of the hospital. We'll say, "Oh, go and see the hospital physio. This is the number. This is where she is. This is the time of the clinic." So, I suppose even that is interprofessional but it's a small area, whereas with nurses I suppose it's completely different.

AF.6 Phoebe's story

I have two kids and I tried to get a job and I couldn't, thinking okay, I need to really try and – I've never been quite sure about a career. I was a cook for twelve years. So I did my STAT test and I got into uni. I missed out on really wanting to get into midwifery, I missed out by five points, so I did a year of nursing last year but I made sure that all the units were the same foundation units for midwifery. And I worked my butt off and then I got in. I think it [midwifery] was sort of triggered from my own births and having two very

different experiences but I just find midwives so incredible and just the thought that they help women and I know a lot of women with children and I like babies and I quite like the medical side of things, there was always that question of am I smart enough type stuff. But no that's why. That's really why I was drawn into it and I really would like to think that when I become a midwife, I'm going to empower women to have the birth that they would want.

The STAT test originally it was eighty to get in to direct entry and my score along with my STAT test I think was between seventy and seventy-five. And then as the year progressed I tried to get in mid-semester but it wasn't going to happen and so when I finally put my application in at the end of the year I originally got a 'no, you did not get accepted' and I thought oh God, what's going on. So, I called and they had said that every applicant had scored in the nineties for the whole year and mine for the year was seventy-nine point nine. So, they said don't even sort of – even if someone drops out you won't get a place. But then two weeks later I got a 'you're accepted' letter. So, I didn't question it, I just accepted it but I'd hassled them throughout the year and I'd really made myself known. Well I thought 'well at least you know I come across as really wanting to be a midwife.'

It was pretty challenging at first. My first day at uni I spent crying on the grass out the front because I hadn't studied since 1998 (that was the end of year twelve, but I didn't do my TE and I hardly went to school) and I've got two small children and I'm not with their dad so there was a lot of 'can I do this?' But then I got into the swing of things and I found out how everything worked and I was just really enjoying the content. I did five units. I did Imagining Health in Cultural Contexts, Foundations for Professional Health Practice, Evidence Informs Practice, Indigenous cultures and Health and Health Behaviour. Well I did two units in the first semester and three in the second.

My understanding [of interprofessional education] is that from a midwifery perspective, is that what you're asking? So, if a patient or someone presents with a range of issues then they can be referred to other people and then the other professional would talk to the original professional to get a better scope on how to help that person. I've been on prac for the last seven weeks. So I was really just observing but I was at an Aboriginal antenatal clinic at the rural hospital, I learnt there were lots of issues going on there so that originally the

women would come, present to the midwife and then the midwife would start referring to LMH for the drug and alcohol unit, or to the social work, psych liaison, or even the Aboriginal grandmothers for transport and things like that. [This is] because if you're a midwife and you're chasing up a patient and they're Aboriginal and you just rock up to their house unannounced, half the time even if they're there they won't let you in or they won't acknowledge you're there, but if you have an Aboriginal person with you or an Aboriginal grandmother, usually they know the family and it's a way in. It makes the client or the woman a little more receptive to visiting midwifery services and half the time it's a way to get them to come to their appointments because you know they don't have money to catch a bus or they want a cab charge or they just can't get there even if there are eight cars out the front. I was in the room for all of it but I wouldn't say that I was actively involved, no. I wouldn't think I participated in any other type of practice in an interprofessional way. I am in the Birth Centre currently and I am not participating in an interprofessional way, no not at all because we're not really in contact with obstetricians or nurses, it's just midwives. And the paeds come down to assess the babies and I've watched that a couple of times but it wasn't like working with them.

So, in my classroom last year it was pretty general. There were lots of other students in other disciplines. Lots of OT's, psych, so I guess lots of different perspectives on the topics that we were talking about. I found it really good. It was really good to see something that you wouldn't normally think about. Yeah, a line of thought that wouldn't really cross your mind but it's been brought up by someone else; it really broadens your views. I can't think of any examples right now.

I thought it was good but I'm enjoying it much more now that I'm only in classes with midwives, or student midwives. Because we all have a common goal and even though everyone has different opinions about the different aspects of midwifery, we all want to end up in the same area and it's good to bounce those ideas off each other and know that they're in the same discipline. I prefer it much more so if I'm just working with the same group.

The actual work that I did with those students last year from those other disciplines, it was all very general health-based stuff. Like Health and Health Behaviour was really general, why do people smoke, why do people drink, why

do people put on weight and that sort of thing. So, it was class discussions on those kinds of topics and everyone gave their opinion. In the Foundations [unit] that was more of the same thing. Indigenous cultures, it was all pretty much the same thing, it was all very general, there was nothing – it was all generally health based but nothing specific. Those units were fine, quite spoon-fed. I did not find it useful, not at all because I really felt like I already understood a lot of the concepts they were talking about. I'm thirty-four, I've done a lot of travelling, I've been through the Middle East, I've got kids, you know, relationships, and so I am interested in that sort of stuff anyway, so I felt like I had either experienced it or I was aware of it. So, it was kind of going over, well not old stuff, but I felt it was like going over things that I already knew about but it was different to have to be able to put that into like essay form. But I could see that for the younger few, like the kids that were straight out of high school, all that stuff was quite new to them. I found the assessments good actually. There were only a couple of times where we had group assignments and I found that good because most of the people that I was with were really into what they were doing, they weren't there for slacking off, they were actually quite interested as well so we all sort of put in an effort. It was good and a lot of them were nurses or studying to be nurses. For Indigenous cultures I had a group assignment, and for Imagining Health in a Social and Cultural Context, we had a group assignment for that too.

Some of the other disciplines were OT's, psych's, some paramedics. I didn't really learn anything about what they were studying or what they were. I didn't get a chance to explore what each other did. No not at all. They would not have had the opportunity to learn more about what midwives do because it was all so general.

Professional identity? I guess I'd start off with the qualifications that you have and then after that I guess extra sort of life experiences. Basically, I would start off with qualifications. What I'm qualified for but then once – you know I would think about myself, once I'm qualified, I want to do a further range of things, not just be a midwife but that's the starting point for me. So, I would build on that professional identity. Role, role in terms of midwifery, conjures up supportive, advice, education, empowerment for women, women's rights, women's equality, screaming women in labour. Qualities that make up a midwife are compassion, empathy and strength. You know to use a good

sense of your own intuition. I think role identity and professional identity are different.

I would really like to become an eligible midwife, because I want to catch those women at the GP clinic before they get shoved off to an obstetrician, so that's being able to prescribe [medications]. Not that I'm an advocate of pharmaceuticals but I would like to just have a broader scope on that side of things and I would really like to be more involved in lactation consultancy because I think breast feeding is one of the best things you can do for your baby and I'd like to promote that.

Role identity from where I sit right now? I'm just learning, I really just feel like a student, I feel like I've got life – I don't know how to answer that question – I feel like I've got life experience to bring to the midwifery table but I don't really feel like I can play a role or have a role just yet.

Well aside from my own two births watching friends being pregnant and giving birth and all those family overseas and here and just those general sort of interactions with women and people that you have through your life, you sort of work out if you could have done something better or that kind of thing, a bit more of a sense of how to approach people and really I know myself now. So, it's not like I'm sort of trying to find myself and be a midwife.

Last year I didn't do any clinical practice; it was all theory-based learning at uni. I did seven weeks at the Aboriginal antenatal clinic, I did a couple of days at the Breastfeeding Clinic and now I'm at a refugee and migrant clinic. A lot of the births are normal. I haven't done any work with the women as they're labouring. Basically, I've just been in antenatal appointments. I saw one birth on Saturday, my first one. I was just a very quiet observer and she didn't have a student and they asked the labouring woman if I could just quietly come into the room and so I just stood in the corner really and just watched.

I had a pretty good idea but now I'm beginning to understanding more about the midwives' scope of practice. Well basically, especially from the antenatal side at the Aboriginal clinic, because there are so many other issues, I found it really incredible that the midwives could only focus on the pregnancy and just go from there. Well domestic violence, child abuse, sexual abuse, alcoholism, drug abuse, just general sort of dodgy life patterns. But like inter-professionally, they do refer off to psych liaisons, social workers and that sort of

thing. It was up to the woman if she accepted or not. In the beginning I thought that could be a scope of practice for the midwives as well which will be giving advice and support but really it would be a lot of emotional stuff to take on so I began to really understand why they needed to focus on the pregnancy at that time and still be supportive but not for all the emotional stuff. I think maybe a little bit of it but I think mainly it's outside the midwives' scope of practice.

Inter-professional education has not really impacted my view of professional identity. It hasn't changed my view of midwifery. Clinical would not impact on my view of professional identity, not really, because I would still identify totally as a midwife and not go into the other areas which seem to be needed if you know what I mean. Is that a good way to explain it? Well the other areas being the social work, and the sort of other support services that are there for women. No, I don't think the midwifery services that are provided for them and the midwives providing those services, I don't think that any of that might impact on my view of my professional identity.

What might stop me from working in an inter-professional way would be judgement from doctors or obstetricians. I haven't experienced it first-hand but I hear a lot of stories about sort of the political stuff that happens in hospitals and being a midwife but then still having to work underneath a doctor or an obstetrician even though you may know not better, but you may have a better scope on it if you know what I mean. So, you might not speak up as much as you should because well, they're going to be right there saying, "well actually I'm the doctor or I'm the obstetrician," especially male obstetricians. I don't like being told off but I definitely, I know it is entrenched in the system. It is male dominated; you know the hierarchy is definitely entrenched.

What is it with male obstetricians? They're men, they don't have vaginas, and how do they know better? They've never had a baby and I think for me that is going to be a little bit challenging because I would be the type of person to speak up for myself and I'd probably get into trouble. I guess just coming from a space of I really want to know more. "I'm not saying that you're doing the wrong thing but I want all the information I can get and all the knowledge from every aspect." I think I'd approach it like that so it wouldn't be like undermining them. In a sense that's interprofessional collaboration. Especially in private hospitals because over here the private sector, it's all male

obstetricians, book you in for a Caesarean because I'm going on holidays for three weeks, you know. No, I don't think it's confined to my city either but it's quite unbelievable.

I really think it's about really knowing what you're doing and having as much prac experience as you can while you're a student to really experience a whole range of things before you go out. So, you can be assured in yourself that well you have really studied and you have had all of this clinical experience, or as much as you can while studying, to be able to recognise when things should be going a different way. I also think it's about personal self-confidence. I guess on prac we're just working with midwives and then we hear all those stories about obstetricians and male doctors or doctors in general. I don't know, so maybe we could do a prac a semester with an obstetrician as their student.

Having that correct knowledge available to you or you should be able to develop that whilst you are studying, absolutely, so you don't get put into a situation where you have qualified and you've finished your degree and you go out, and I know a lot of it's on the job sort of learning, I don't doubt that, but to just think well hang on a minute, I don't agree with what you're doing, can we talk about it, is there another way we can approach this issue? I think more as a qualified midwife but as well as a student, I think we should be able to question if we're not sure. Like you said, not in an aggressive way or I know better than you sort of way, but being able to feel open enough to question what's going on. I guess maybe it would come down to your own life experience and your age you know, I don't know if that would make a difference but that's how I see it.

If we worked and if we educated all our health professionals together so that we all had a better understanding of what it is that we do, and with that respected each other for our different types of knowledge, absolutely. I think that's probably the only way you're going to be able to start changing the hierarchy of obstetricians, doctors, nurses and midwives because as far as I know midwives and nurses do all the hard yards and the doctors just come in. No-one really cares if you're a student and you've had a kid. They're already qualified, you know it's that thing of "oh here we go again, she's talking about her own experiences and that means nothing in this, right now."

In the first year at uni it [the iniversity] did support interprofessional collaboration because all of those base units were with other disciplines in health. But on my clinical prac, not really. It doesn't strictly fit that promotion of interprofessional collaboration, well there's all that doctor/midwife stuff happening and you know, "oh God I don't like that doctor, oh he didn't even…" – you know there's all sorts of "oh he didn't even check her GTT results." There's all that kind of stuff, so that kind of avoidance stuff almost because you know that they're not going to listen as a midwife or he just wants completely different things for the patient. It's about not wanting to take responsibility. You know, you just want to pass the buck because it's easier and let someone else deal with following up her results or that kind of thing. I think it happens in lots of places. The midwife who is her primary carer [would follow up], pretty much unless the GP [says] "oh maybe we should check this out," but they don't usually. They just expect [it]. Every so often you have the GP appointment, so I guess they'd expect that the midwives are on top of that and spending extra time looking up notes and results and scans. Relaying basic information and there's no real collaborative stuff happening aside from with the social workers. There's collaboration probably between the social workers and the midwives. The dieticians don't work closely with the midwives. I have not seen one dietician. I think if they come back positive for gestational diabetes then I think at their next GP appointment, I think the GPs do that.

I guess it's just sort of bringing all the information to the fore. Like from one person, from the midwife all that information is gained right then and then it's going out and then coming back, mainly with the social workers. So, I think once the social worker has spoken to the woman, and then the information comes back to the midwife, the midwife gets a better understanding of really where they're at mentally, but also how to help that in terms of their pregnancy. I think it is good. I didn't see any of that between the doctors and the midwives but I definitely did see it between the psych liaison and the social workers and the midwives. I think that interprofessional collaboration is present and yes, I can say in a way it has affected my practice, it's for the better [and] I guess it's cemented that hierarchy thing as well. Does it start now at uni or does it start when you have your grad program? I think it should start now [at uni] I don't think it does but I think it should. In second year, oh I don't know, I think there's

a couple of nursing units, like another evidence-based practice unit. [It would] be a really good thing if we educated all the health professionals together so everybody had a better understanding [of the others].

AF.7 Alicia's story

This is my second year out. I started March this time last year. I work for the State Health Department, the LMH. Okay so I'm originally a podiatrist. After I had my own children, like many women, just wanted something different, something a bit more challenging. I wanted to go back to study and I had thought about teaching in podiatry but you needed a masters and I thought if I was going to go back to study, I'd like to do something interesting rather than more feet. So as my friends say, I went from feet to fanny. I decided to stay in health because I do like that and just came across the course online actually, more than anything and decided that the B Mid direct entry was a quicker way to go than doing nursing and then doing mid as a post-grad. That in itself is probably an interesting decision that I may not have done the same way if I'd known more about it. But I probably would've, because I've got to where I wanted to, quicker. I could've done nursing, four-year nursing degree and then it would've been an eighteen months post-grad on top of that. If I did it back-to-back straight through with no breaks that would've been five and a half years down the track, compared to three. It did take four to get through the course, four years to get through the three-year degree only because I've got three children. My eldest is starting high school and I thought I would do my final year in two bites. That was a good decision as I needed my sanity at the end, just as much as getting through it. I'm hoping that in the same timeframe, five and half years, I will have picked up a lot of the nursing skills that you do need more than I realised when I first started. I've practiced as a podiatrist as well for about twenty years.

The challenges doing direct entry are that, as soon as you graduate, you're not only a new grad midwife but you're a new grad nurse. So, you don't have the basic nursing skills behind you when you're learning all the new mid stuff. So you're learning through lots of things at the same time, not that I've ever felt unsupported, and people are very understanding, it's just a massive load and if I had been a nurse and then a midwife, I suspect, as long as I've had a few years' experience being a nurse and then done mid, I think it would have

been [an] easier, less stressful pathway, not that I don't think it's hard anyway. I just think it's been a massive, massive learning curve and very stressful. I also think the fact that I worked part-time and not full-time has an impact because I'm just not getting the hours that my colleagues are getting in, although sometimes I think the level of stress would be worth [it] if I was doing more hours sometimes in the early stages. I feel better about it now because things don't stress me out nearly as much as they used to because I have eighteen months experience, so you'd expect that. But if I look at where I will be at a five-year plan, I will be further along than if I'd done a four-year nursing degree and then followed it up with an eighteen-month grad dip, and you still don't have any experience because you haven't worked as a nurse. So, I think, knowing now, I probably would still have gone down the same track but I really feel that, and I don't know whether that's because I work at a tertiary hospital and we see a lot of high-risk people, whether that's added to the level of stress and difficulty just because the clientele at LMH are really high risk. So, if it was in a more normal situation I would have coped better and learnt a lot more normal stuff and then maybe then all this high risk wouldn't have been quite so full on, but I don't know. I don't think I would have done a double degree, probably not. A three-year undergraduate degree in midwifery sounds pretty good when you look at it, especially as a mature-age person. I'm not sure I would have committed to longer timeframes.

Not necessarily, [I don't think I would have been] better equipped with a double degree, only because the prac experience that you get with our direct entry degree, we did a two week prac in second year and, because we spent the time in hospitals just being with women, the midwives teach us so much, with the CCE, especially in first year, we can basically do as many hours, I think I did fifteen CCEs in my first year. I got a Human biology exemption so I did a massive amount of just CCE work, and the midwives teach you as you go along and you learn so much. You are exposed to a whole lot more prac hours just because of that CCE program and you sort of drop back and so I did a two-week stint at a short stay recovery unit at LMH2, the other big tertiary main medical hospital over here, and the second-year nursing students, it was just chalk and cheese. We were quite competent in doing stuff the other students [nursing students] hadn't come across yet, but I think the real thing is, it's the

same with any degree, you don't really learn until you're out there on your own. So even [if] you've done a double degree nursing, unless you're out there on your own learning those nursing skills, it doesn't really count, do you know what I mean?

The nursing skills? Absolutely, pumps, a lot of it's around the drugs. Because we're a little bit limited in our prac we can't give out a lot of the drugs. So learning pumps, you can prime a pump and start a pump but when it's got a bubble in it and there's a problem with the pump and you've got to back prime and do all those sorts of things and then there's a little bit of blood in the line coming back from where the IVC [intravenous cannula] goes in, and all of that problem-solving, all that troubleshooting stuff. So, you'd have to go and find somebody else who'd say, "No, no, that's normal, that's okay, do this, do that", and it's not difficult and you learn it quite quickly. It's just time consuming and it's also sort of saying, "yeah, I don't know how to do this," it's a very basic nursing skill, even this, preparing antibiotics. It's that triple IVADs and other than the fact that you're triple checking everything, because you're terrified because you're not giving IV anything. It's not second nature so you triple check stuff and learning which ones to put first so you manage your time better. You can do a quick push and then put the pump on and then quickly go and have a tea break and come back and change it, all of those sorts of things and [we get taught how to prepare the IVs in the skills laboratories] absolutely, but I just think you might do it a couple of times but, of course, the drugs change.

You've got your little piece of paper and you sit there and get it checked off but you also have to do this at the rate of knots. It's not sit down and do this at your pace, it's do this at the rate of knots because you're usually half an hour late because you do everything so slowly. So, you put this pressure constantly on yourself and you've got to calm yourself down and make sure you concentrate and do that. And after you've done each drug a couple of times, it's no problems, but you have to have all those experiences and it's the time management aspect, and especially if you've got a baby with a high temperature that's got to be under a warmer, or you've got a mum whose condition is deteriorating maybe, and if you've got that added stress or you've got a day one [Caesarean] section coming and you're trying to get all this stuff done before your section arrives or, if it's really busy down on the ward and all

of those sorts of things, that constant background, or you're down in labour and birth suite and you're there watching a CTG because they think they're going to go to theatre for a Cat 1; so, you're trying to remember all the things you have to do before you go to theatre. A Cat 1 is when you've only got a certain timeframe, like the emergency ones. It's just an emergency section and they time from when you leave, when they call it, when there's nasty things and it's got to be left in a certain timeframe.

I'm also working with new grad midwives who have been nurses for five years or so and they might have worked in ED or with neonates or kids so they bring this background of experience. Their new stuff is the mid stuff, but on the wards, because so much of it is basic nursing, they just handle so many of those things that stress [the] direct entry [midwives]. They handle it so well because they've also in their course been handling a caseload, they might only have four patients, whereas, in our course we don't handle a caseload, we're completely supernumerary until the day we graduate and then all of a sudden, we have a caseload. I didn't have a caseload until I started on the ward.

The Bachelor of Midwifery, I think it could be improved. I think theoretically, people like me, maybe not my age but a bit younger than me, the thought of doing a nursing double degree of four years, I suspect it would put people off, that it would have amazing candidates and that's what is good about the three-year degree. But I think that they really need to be able to choose their candidates because there was over a fifty percent drop out in the course itself. Look, I'm really glad I've done it and I'm really happy that I am where I am. Trying to improve it, I just don't know how other than making it longer. And no-one wants to do that. There's no money to do that, no places.

Interprofessional education. I'm assuming what you're referring to is that we did a lot of our course with the other health-based professions. Oh, it's fine. Don't have a problem with doing the units with other students. I think with mid we tend to focus very much on midwifery all the time. That's really good, because we're just doing a three-year degree so we need to. But I think that being aware of that multidisciplinary approach or that holistic health aspect is really important. And I think at uni you need to appreciate that we're already studying together, it's not all about just midwifery all the time. I just think it's not feasible to teach midwifery to, I think it was thirteen students in our second and

third year. One supervisor or one tutor to thirteen students is not economically viable. So, a lot of it, we did and having the combination's really good. I don't mind sitting and having a lecture on Psychology with 200 students because it's not going to be any different if it was to thirteen students, so you know those core units, it's neither here nor there, whereas our specific mid stuff was just us and that was great. That was lots of talking, lots of interaction, lots of feedback. You couldn't do that if it wasn't just midwifery. It would have been good for other students to have us there and it was good for us to have other students there because it makes you aware of what [the others were doing].

A bit of both [economic and educational point of view] but I think a lot of the nursing, Physio[logy], Microbiology, a lot of that you're doubling up. It makes sense to fit them all in together. One of our units was a Psych[ology] unit and I thought they handled that really well in that they gave all the new students a specific case. It was in the assessment; it was a theory assignment. There were lots of scenarios and you could just choose one, and there were two that were available for mid students to choose if they would like and they were postnatal depression or a post- traumatic stress PTSD patient. So, it was specific to mids but still well within the whole, we're all in the same Psych unit together. I thought that was really good in that we still got to be assessed, and it was tailored to mid students rather than just [a] generic assignment. I thought that was really good because I hadn't had that in Podiatry before, where everyone just got treated equally and you did whatever the assignment was, that didn't really apply to you but you just got on and did it. Whereas, I thought that that was good the way they did that and the same with some of our tutes, we were all in the same tute, it was Pathophysiology and they just put us all together in a tutorial, so with a midwife who was able to take the tute. So, it was really good. We did quite a bit with the post-grad mid as well. So, there were a lot of medicine students, I'm assuming we did a bit with physio and OTs and those guys. Mainly nurses that we used to see, there weren't any paramedics, maybe the microbiols? It was really mainly nurses that were the majority.

Professional identity means probably my role like where I sit in the scheme of things [and] how an everyday hospital runs and then your different obstetric hospital. Being perceived as a midwife, as a competent midwife and contributing in that role probably [as] the primary carer of women. The person

on the ground. So that direct awareness of what is happening to the woman, whether she's antenatal or it's postnatal. You're that one, getting that constant contact and so to a certain extent responsible for letting everybody else know where that woman's at and what other care she needs or if her condition changes and ideally, not the go-to person, but the person that should be involved in her assessment and planning of her care as well.

I probably had a sort of very, wishy washy romantic ideal of what midwifery involved. I think the only experience I'd really had with mid was having my own children and they were a very positive, relatively average. Not average, as in not good, but a fair run of the mill experience. It was very positive. So that's really all I had to go on. Then the stuff that you read about so now I suppose it's a lot more realistic. The nitty gritty and the sheer volume of work and hard work and more work. That aspect of it was unexpected but not unwelcome or a negative. I had no idea midwives worked so hard and had so much responsibility and dealt with a lot of stress and we're so overworked and underpaid and the rest of it. So, your identity comes out of that as well. I probably admire and respect midwives and nurses so much more than when I started. I'm quite proud of the fact that I'm a midwife.

The nitty gritty, just about that basic caring for a woman having a baby or a postnatal lady, you're getting your hands dirty; there's blood, guts and gore. You're cleaning up stuff, you're reassuring women that that's normal, you are down on your hands and knees, you're trying to find something, racing to get a hot pack because you think that's got to be something that will benefit that woman but you know you should be doing something else but you try fix something else and you're always on the go and you're always actually thinking what could I be doing to help this situation or this scenario or you are running and you're getting sweaty and you're just really giving everything you've got to look after these women for the time you're there. It's not always easy or nice or pretty or don't always smell nice. It's that aspect of it that is probably an eye opener because I didn't know it was there, but I don't mind it, it's not off-putting. I think that is quite a tough thing but you become a tough person. You don't see too many princesses out there doing this, you know. The sense of responsibility, absolutely. That was what I wasn't really finding before and you are responsible, you are legally responsible, you are that, but when you actually

get out there and realise that you're giving drugs and you are responsible to make sure that you've done obs[ervations] and given the right drugs and looked after that baby and checked, double checked this. All that sort of stuff is and, I do think, that that level of responsibility does add to that professional identity.

Liaising with doctors and physios is what I do on a day to day basis. I interact with different health professionals. When I refer someone to a physio and have a quick chat about, where they're at and I have a bit of a quick chat and they'll ask for a quick rundown from my point of view, why they would need to see a physio and that sort of stuff. Sometimes I'll stick my head in and listen to what they've got to say, especially because I'm not very experienced and I haven't had a lot of the physio so it's something that I'm interested in. I'll go and actually listen to what the physio says about pelvic floors and those sorts of things. I like learning, especially about pelvic floors, the more you can learn about pelvic floors the better. I've worked with physios quite a lot before. Some conditions, musculoskeletal conditions, I've got a bit of an interest in [them] because that's what I used to do. So it's just interesting, probably, for me to hear, just about the and aches and pains and bits and pieces and assessing people and just the term, the language that they use to educate patients so that I can use the same language because, most things you can read a pamphlet, but the physios will always explain things a little better and [I] always try and improve, how I teach other patients as well. I then go and have a quick chat afterwards and follow that up and say what do I think and talk about lab diaries, all those sorts of things. Just becoming familiar with their role and working together as much as possible to benefit the patient, so that's me with physios.

[The collaboration with] mainly the obstetricians, the consultants, the RMOs, there's lots of lines as you can imagine, all those different lines of communication and how you interact at different levels. I suppose because I'm a mature-aged midwife I suppose most of the time I'm quite happy to talk to consultants, because they're probably more my age than the newer grads. So, I'm getting better, I was quite intimidated when I started but generally, I'm not intimidated enough. If I hear them talking about my patient I'll go over and introduce myself and if there are some concerns, I ask what their plan is or see if there's change in the management or, what they want me to give them, the blood results or any of those sorts of interactions with the medical team. A

tricky one, I suppose there is that hierarchy with communicating with doctors that you're always aware of but also, especially when the senior registrar, and probably because I'm reasonably inexperienced, you probably wouldn't get this feedback from a more experienced midwife, with [the] senior registrar, [and] because we're at a tertiary hospital, they're very good at explaining stuff. I find that, especially when there's been an emergency situation and I was involved with an outcome for a scenario just recently, they were really supportive and we sat down and had a bit of a chat about how we could have handled things, whether if we could do it differently. I said, "oh what about this, and why did we do that, and why would that work and what was happening then", and they've been really, really good. I find them very approachable as well, so I tend to be a little bit more respectful of them and their time because they're doctors, that whole hierarchy.

The same with ultrasound and getting downstairs to ultrasound or talking to the lab about lab results or pharmacists about drugs [that] we don't have on the ward. So just quick phone calls and you see them when they're on the ward and might have a quick chat to them then. Especially seeing as I don't know a lot about the nursing aspect of it. So, I'm always having a quick chat to [the] physio, the pharmacist about stuff, much better, face to face communication.

Collaborating interprofessionally has impacted on my sense of professional identity because it reinforces that you're a valued member of the team and that you're all working together for the good of the patient, theoretically. Realistically, I think most of the time it works. At the end of the day, if the patient goes home happy, the sooner you get them out the door, the better. So, the more you work together on that collaborative care, everyone's happy. With it working, everyone's happy. But there're just so many communication systems in play and when it all works, it's great. When the communication doesn't work then everything falls in a heap. There may be people out there that think midwives are a bit lower down on the pecking order and just ignore what you say. And they don't keep you in the loop. Not that long ago I thought we were going to theatre. They said "right we're going to theatre for delayed progress" and so I'm getting everything ready, getting all the paperwork ready, I'm saying to the other midwife "can you let me know when we're ready to go?" About 20 minutes later, I'd say "are we going?" I wander

outside, stick my head outside and I say “are we going?” “Oh no, we’re going to give it another hour.” Right, okay, thanks for letting me know. So, then I think, everybody else knew but no one’s bothered to tell the midwife in the room that is actually looking after the patient. The consultant made the decision but somewhere along the line [it] just wasn’t passed on. So, whether the registrar was meant to let me know, or whether the coordinator was meant to let me know, or someone going on a tea break was meant to let me know, I don’t know. But look when that happens you just sort of roll with it and move on a bit. Those sorts of things, when there’s four people in a chain of communication it surely doesn’t get through. I think you have to let those sorts of things wash over you but if I’m having a bad day or a bad week, it probably would bother me, but probably less, though now because I’m a little bit more confident with where I’m at but I probably just get pissed off and just probably actually say something whereas before I wouldn’t say anything.

Probably anything roundabout when I first graduated would have knocked me for six, had a bigger impact on my own sense of professional identity. My professional image was pretty well in tatters when I graduated. I missed out on a grad program and just thought that obviously I was the worst midwife to graduate from my university that ever lived and just really struggled I think, because I just got a job. I didn’t have a lot of backup, [but] I did have support, I had lots of support wherever I was. The staff around me was fantastic. But I didn’t have anyone sort of keeping an eye on me and looking after me. So, at that point I was a bit fragile and so anything would just really throw me. But like most new grads, I don’t think it would’ve been that much different if I was on a grad program. I’ve had probably a lot more time to have a bit of a think about why it threw me so much. I think going from being quite a well-respected Podiatrist and I had quite a good name and I was, not at the top of my field, but not too far off. I was very involved with the Podiatry profession and the different groups and the association and all that sort of stuff. So, I’ve left that behind and I’ve gone off to do my midwifery and I’m an A student and get on, have a really good rapport with my clinical supervisors and people at uni. I went to all the workshops on how to apply for your grad program. My mum’s an English person so she helped me [with] my application [and it] was grammatically correct. Then I got the interview and then, I’d not just assumed,

but everybody that had applied the year before had got in and they were all, because I'd taken a little bit longer to do my course, so my original cohort was from the year before, and they'd all gone through and so I applied, and I felt within my year group, that I was one of the better students, and so just not getting in just completely threw me. All my supervisors and everyone were constantly saying, "I can't believe you didn't get in and dah, dah, dah, dah." It just took me a long time to understand that, I thought that they would have looked at my grades, spoken to my supervisors, looked at my past and present career, all those sorts of things, but it took me a little while to work out that they're not actually interested in that. It's just what you say in your interview and you just have to tick the standard boxes because it's a very subjective, it's not subjective, it's just tick the boxes and if you say the right things, you get the position. I also think that maybe because I only wanted a part-time position. I've moved on from that aspect, then you go through your normal challenges and you think, oh okay, well maybe they did know something about me, maybe I thought I was better than I actually am, maybe I'm not good enough to be a midwife at LMH, maybe my ego was bigger than my abilities and I am not good at this and they knew that all along. Then having people ask you at every turn, "are you a new grad?", "no, I am a new grad but I'm not in the grad program", because that would have to be "oh, have you got a grad program", "no, I haven't got a grad program", "oh why not", "I didn't get one." So, every day this was reinforced and reinforced and reinforced, so after a while you think, I didn't get it because I'm not good enough. "Why didn't you get a grad program", "I don't know." I think you just flounder a bit more because there are other little things that constantly niggle [at] you. You go to a new section of the hospital, "we haven't got you down on the grad program," "that's because I'm not on the grad program."

I got a rotating midwife position only because they're short staffed, and they need new staff and it doesn't really change how I'm treated in the day to day work on the wards because they allocate new patients and look after you depending on your experience levels. So that didn't really worry me and the staff there were always really lovely but it's just that ground stuff going on all the time that just erodes your self-confidence and combined with dealing with being a new grad, [it] was just a lot to deal with.

I graduated in November, I think I got offered the job the 1st of January, only a month after, but I didn't start [un]til March. So, I started roughly at the same time as all my peers. The staff were great [but] I didn't get any of the education sessions because by the time I got there the whole year was booked out. So, I went through a whole year with no further education. Staff and the normal grads would get about nine sessions during the year. There wasn't anyone to say, "look this is..." I would have thought the people that did my interviews and ran the grad program knew that I was floating around on my own as well. You're so molly coddled when you're at uni.

You know you're just struggling from day to day, [the] anxiety levels and stress is really high, and you just go from one high risk obstetric emergency to the next. I think if I had, as a new grad those sorts of things, it used to bother me and they do, depending on what day I'm having. That communication issue is, thinking to the last time I felt really flat after a shift, was when I'd got through an early shift and it was nearly 1 o'clock, the afternoon staff were nearly coming on and I had a lady who was pushing, she had an epidural in so they allowed an hour for descent and the epidural pain relief had been brilliant and I thought great, we're just going to have a baby and it's all going to be good. And then it all turned to shit. Her pain relief wore off and then she needed an instrumental delivery and then I needed extra hands, and the afternoon staff wasn't on yet. So, then the afternoon staff comes in to a room that looks like a bomb. Then the registrar is firing off questions at me and my blood sugar level is in my boots. Then they defer to the afternoon midwife that's come in who's quite a lot more experienced and they just completely defer to her. Which is fine, at the time, I'm happy just to get on top of the situation but afterwards I'm thinking everything was really good and I was looking really good and then it just turned. You just feel like you're not very competent. So, your identity just plummets. I thought she was going to have a baby and she didn't have a baby and ended up having a forceps and the new midwives came on and all the beautiful fresh eyes "yep, we're going to this, this and this", and I just sort of went, "oh, why couldn't I do that". That whole not getting a grad program and not belonging anywhere added to that as well. It erodes your self-confidence, it did then, and I don't know that it does now. At the time it absolutely did. It was just another

thing; it was just constant. I just felt that you would have a couple of good days and then something else would happen and you'd think, no.

But you know, I'm a mature-aged student so I go to the midwife that did come on and say "Look, what could I have done to have made that better." And she said "You were fine. You were absolutely fine, if you'd just kept the pain relief up." At that end stage she didn't want to keep pressing her epidural. So, she said "Just don't do that, just keep that pain relief up and everything would've gone a bit smoother." So those things tend to put a dint in your sense of yourself, absolutely. But I assume that that happens, that continues to happen, that's just the profession I'm in. [if you are] more experienced and senior, you don't do stupid things as much either, so you don't have to ask for that help, defer to somebody more experienced. And you need a certain amount of professionalism. It's a situation and they're looking after the woman. It's not really about me. I mean it's like most people I suppose, you mull over the negative things and you don't really think about the positive things and the things you've done well. You always, and I think being mature-age does that as well, you don't let things go and move on. The rest of the scenario would have happened, it just would have been a bit better then. If the woman wasn't in pain it would have been dealing with a changing scenario or a change of circumstance at the end of labour, if the woman's coping better, everybody copes better. I was upset, but in hindsight other people would say, "No, you did the right thing, you shouldn't be, you anticipated that she would have a baby," everything was going really, really well, so a lot of people don't do that last top up. And she wasn't wanting to press her button and self-release either so somebody else might have done it the same way I did, but the other thing is, it's 1 o'clock and your sugar levels are rock bottom, and you're walking into a room with fresh eyes you can do that. You can say, "yep, okay, she needs more pain relief and she needs a lot now, we're not going to catch up on that, on what she's got, but just get her a top up and let's do this and that and you're all good but you can go to lunch." They're learning experiences; they're very solid learning experiences that you might have. No, I think they just reinforce how inexperienced I am and that all of these are learning experiences and I can berate myself for not knowing that and not being on top of things, but I actually

have to acknowledge at some point that you've got to learn and you learn through experiences.

I find that the clinical development midwife can impact on who you are as a midwife. They can be really good or not as good. How well they support you or less experienced staff, can really make a difference. How they approach things, or just keeping an eye on you, making sure that you're moving along and getting better. I remember when I first started, I had made a few mistakes when filling out the numerous amount of paperwork. I just hadn't seen some of the new stuff. Some of them approached it really well like "I noticed you haven't seen some of these things, I know you haven't done this before" and "it's been brought to our attention that this wasn't done and are you familiar with this, have you done this before. Do you want me to sit down and show you how we do it?" Whereas other times it's, "oh you haven't done this, this and this," you know. So, I suppose that aspect, that support that you get and how they do it. You know everyone makes mistakes and how that's approached and how that's handled can make in that first twelve months, can really make a difference as well.

The clinical development midwives were the only persons looking out for me. Because I'm a little bit unusual they didn't realise that they were the only persons looking out for me. So, there would be one on labour and birth suite and one on the ward where I was based, and so roughly [I was] doing about twelve weeks or eight weeks, and then I'd flip between the two. So, they didn't realise that they were the only backstop for me because they're used to grads being looked after by the grad program. So, they were really good because that's all I had and they were my go-to persons if I didn't quite understand something that had happened, or needed to talk through something; and they did my personal appraisal, twelve-month appraisal, and they were really good.

The new graduates were looked after by the graduate program people and the clinical development midwives. So, they had those people on the wards wherever they were, and then they had a go-to person. Just getting computer access and ID access and parking and filling in your super and getting all your compulsory education requirements and getting your education program, they had someone looking after them and showing them the ropes, how to do all that.

It would have been nice for me if the person that interviewed me, she was one of main grad supervisors so she knew that I was the only other one floating around that was a new grad, and it wouldn't have taken much to just say, "hey, how are you going, if you ever want to chat or if you've got any queries on stuff, give me a yell." But I don't know whether their roles are very defined and their time is very limited for the paperwork they have. So, I would end up asking my CDM all these questions and they'd sort of say, "don't you know how to do this, or haven't you done this before" and I'd say, "no, no, I haven't", because nobody else was in my situation. Yeah, toughest twelve months I've done I think, other than the birth of my first child.

[There are] barriers towards working in an interprofessional way with other disciplines, especially postnatally, where we are in my state [because] it is a high-risk area. The standard patient is usually a drug addicted adolescent or somebody with a high BMI or somebody who maybe has psych issues. We have a huge number of social work, psych and drug and alcohol midwives floating through constantly. So, the only barrier is just sometimes not knowing who they are because of the sheer number of them. We have two full-time Aboriginal health workers in social work as well and two or three social workers in the normal adolescent clinic and the psych clinic. We don't have a psych clinic on our ward much, but they're doing well. I forgot about them when I was talking about the physios and the mental [health] team. But we have so many of the other staff around. I think probably sometimes there's so many staff that you don't know who's who. Most people are really good at introducing themselves. If you're not in the midwifery uniform, you could be anyone. We can look at the badges but it is much easier when people introduce themselves. The pharmacy staff floats through and stocks up the cupboards and has a quick chat to people. Because it's such a massive hospital the staff are changing all the time but after you've been there for a while you know who's who, but you forget you learn all that as well as you go along. Now that I've been there for twelve months, I recognise the faces much better and I know if they've come to see my patient because I'm also more experienced and I read the file and I know. Now I will just say, "Hi, I'm Alicia, I'm a midwife, what's your role, and what's your job?" They're there for a psych review or social work review, so that's probably me getting on top of things. Before I wasn't able to look up from

what I was doing task to task, so I'm comfortable working with these other people now in that interprofessional manner. I was comfortable working with them before; I just didn't know who they were and how it all worked.

The medical team, they don't tend really to interact as much as the social work team, especially on the wards. In labour and birth suite [they] aren't too bad, but on the wards, they sort of keep to themselves. I suppose because they're a whole entourage, they've got the consultant there and the senior registrar and the registrar and the RMO, the whole lot. They're like this whole team, normally the ones that look after the women are the RMOs, the younger ones, not younger as in age, but the junior ones. Working collaboratively with them or interprofessionally with them happens, absolutely. They're approachable but they're very busy. Everyone's always in a hurry and can be a bit short especially if it's not a time to speak to them. [An example of working with them interprofessionally is] getting them on the ward, getting hold of them to do a discharge review or if their obs [the women] are a little bit out and you want them to write on the obs chart if their vitals are a little bit high or a little bit low, just to do a modification to their obs chart, you've just got to grab hold of them. They're usually pretty positive, they're okay about doing all those sorts of things as long as you approach the right person from the right team and do it appropriately, they're usually fine.

[If a] woman wasn't quite right, something was off, I usually ask a couple of different people because they constantly tell you that the RMOs are a little bit, depending on when they arrive, what their level of experience is. So, I'll also usually run something by a coordinator before, most of the time I run it by the senior midwife rather than the RMO and they will go straight over the RMO's head if they need to, straight away. I think I'm getting better at being non-confrontational, just the way I ask for things and I'd say, "I'm not sure, but do you need to do this, or is this my role or is this your role", because I'm quite new. I think my manner is not so, some of the midwives especially the more experienced ones, can be quite blunt when they're talking to some of the junior doctors. I'd like to think I don't do that; I'd like to think that I present things in a little bit more non-confrontational because we're all working together, and often I get it wrong anyway. So, I might be actually asking them to do something that is not appropriate for them or whatever, so I'm learning all the time. If it wasn't

appropriate [what was ordered] the response [has been] usually, “oh thanks” or, “yep, great, thanks, thanks for that”. It’s usually a positive thing, the junior doctors are great. It’s really hard work and I really sympathise with them and their workload and their hours that they do as well, and everyone’s working together, it’s a generally really positive team.

In my actual workplace everyone’s in working together, there’s not a problem. They all usually float through and find the midwife that’s looking after the patient. [The] medical team not so much, but the social work and psych will often make sure that they’ve spoken to the midwife, just to get a feel for where the patient’s at. They’re really good. But no so much the medical team, probably because the way the medical team’s structured with, the RMO being the sort of the groundwork person that writes your notes and things. They’re just doing ward rounds, generally, during the week. They’re just flat strapped and when the team does come, there’s the consultant, two registrars, three RMOs. They’re just this group that moves around. It’s a cast of thousands and it’s usually not long after handover and they seem to run more on their own, they’ll check obs and things, and speak to the coordinator, but they don’t necessarily have as much to do with the midwife. But then as the condition changes and you’re speaking then directly with the RMO or a registrar they will then defer back to you. So, I suppose it just depends on where they’re at. Or if they’ll come and check all those sorts of things, they’ll just get on and do it. Then if they query something, they’ll come and find you. Whereas the social work and psych tend to want more a heads up on things, so they want more insight that the notes don’t really sometimes provide especially if the patient is on the ward as well.

This interprofessional collaboration is great. I learn heaps, constantly learning, and it supports the patient. I couldn’t provide what everybody provides for that one patient. So, it lightens my load, if I have to give pelvic floor exercises and instructions on how to write a lab diary and then do a psych consult and then work out where they’re getting their food vouchers from and their next change of clothes and who’s done domestic violence on some-one else. I’d go completely crazy. But that’s probably also my stage of experience. [If] you ask somebody that’s got twenty years under their belt they probably aren’t quite so positive about junior doctors.

My role as a midwife, and what I do, it helps, yeah, because they need me as well. Everyone's valued. So, I feel like a very valued, integral member of the team, and I don't think my time is wasted. Interprofessional education generally has been a really positive experience. I know that I've only been out twelve months but I really enjoy where I'm working and generally the people I work with are very respectful and very supportive. It can't be positive all the time. You know it's not like that and people can't be nice and happy all the time either. Because we all have lives outside of work. So, I'm probably more accepting of times when that collaborative care doesn't go as well, that there are lots of other factors. It's not just me. I've had generally a really positive experience with the collaborative care and communication aspect and it has probably enhanced my sense of role identity.

My view of professional identity as a newly qualified midwife where I'm at the moment, okay not as fragile as it was, I'm feeling a little bit more competent [and a] valued member of the team is that about it? I think I'm feeling more confident and competent but, and I think I'm probably at a level where I can actually, I'm at a base level like I've crawled up to step one, I think. I'm now on a base level where I think that I'm ready to learn probably in a more accelerated range. I feel like my stress levels have come down, so I manage the stress situations a little bit better. I've got a bit more of a professional role and I'm a bit more competent so that I can now build on stuff.

Last time we spoke I said I had a bit of a wishy-washy idea of what midwifery was, a romantic notion. [Now] I've become a cynical midwife like the rest of my peers. No, I think I have a realistic view of looking after high-risk women and I think that maybe if I looked after low risk women my perceptions would be a little different. I like the LMH as an institution and I do feel that once I have, say, five years of experience under my belt, that I will be a good midwife by the end of that. I remember someone saying that, if you can shine a light wherever you are, doesn't really matter if it's having a wonderful homebirth experience in a quiet room, or whether it's holding someone's hand while waiting for an emergency section, it doesn't matter how you shine that light and support that woman, and how you make that change, it's the fact that you're doing it. So, I'm not sure whether I'll stay in high risk maternity the whole time but as long as I'm contributing in my little small way. I don't necessarily have to

be that alternative holistic midwife or the high risk one, I'm not sure where I'll be, but as long as I'm doing what I can, do the best way I can do it, I suppose. I'd like to go and do stuff in a low risk hospital or first entry type if it works with my family, but probably just a normal community hospital, just something nice and small, but I'd like to do that at some point.

APPENDIX B: PARTICIPANT RECRUITMENT FLYER

HOW DO 'MIDWIVES BECOME MIDWIVES?'

Are you a student midwife, a midwifery academic or midwifery clinical teacher or a registered midwife?

This research project will examine the impact of interprofessional collaboration on the role development and professional identity of student midwives, educators (both academic and clinical), and practitioners.

What do I have to do?

You are invited to participate in a research project which seeks to answer the question above.

I am keen to hear your views on how your role as a midwife developed through interviews at your convenience.

What do I do if I want to take part?

Please contact Vera on (03) 9919 2420 or via email on vera.brown@vu.edu.au

IPE improves communication

APPENDIX C: INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

Project title: Professional identity of midwives in interprofessional education

The purpose of using the 'interview' method of data collection is to allow the study participants to tell their individual stories. Thus, the opening question will be:

Question 1
How have you come to be a student midwife / midwifery educator / midwifery clinical teacher/ midwife?

Rationale
This question will generate rapport between the PhD candidate and the participant as well as provide the background of the participant.

Question 2
How have you participated in education / practice in an interprofessional way?
Rationale
This is the question that will elicit their individual experience and experiential knowing about IPE or collaboration with other health care professionals.

Question 3
How has IPE / collaboration impacted on your professional identity?

Rationale
This particular question directly answers the research question.

Below are probing questions that can be used if required:

- What is your view of IPE?
- What other disciplines have you collaborated with?
- What does the term 'professional identity' mean to you?
- How has IPE impacted your view of 'professional identity'?
- Has this changed over time? If 'yes,' why and how?
- What factors in your practice/workplace might have had an impact on your view of your professional identity?
- In your opinion are there any barriers to working in an interprofessional way?
- In what way does your workplace support/promote interprofessional collaboration?
- How does interprofessional collaboration affect your individual practice?

APPENDIX D: PARTICIPANT STATEMENT

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled *Professional identity of midwives in interprofessional education (IPE).*

This project is being conducted by a student researcher Vera Brown as part of a PhD study at Victoria University under the supervision of Professor Kristine Martin-McDonald from the College of Health and Biomedicine.

Project explanation

This research project will examine the interprofessional aspects of professional identity for students and qualified clinicians in midwifery. There is very little IPE literature that relates to the discipline of midwifery and little evidence on how midwives "become midwives," that is, professional identity development. This research project takes the perspective that professional identity and role refers to the midwife's view of her/himself within the context of her/his scope of practice, which includes IPE and interprofessional practice (IPP), and how she/he functions within any given situation in that context.

Thus, this research project proposes to examine the interprofessional aspects of professional identity for students and qualified clinicians in midwifery. More specifically, this research project aims to illuminate how midwives establish, maintain and extend their professional identity and roles within the context of interprofessional education and/or interprofessional practice.

What will I be asked to do?

Your participation in this study will involve three interviews. With your permission each interview will be digitally recorded. It is anticipated that the first two interviews should take no longer than one hour, with the third interview lasting half an hour at the most. The topic of the interview is about your story of how you developed your identity as a midwife / student midwife in the context of interprofessional education.

Each of the interviews will be transcribed with all identifiers, including your name, removed or altered in order to ensure your privacy and confidentiality. That is, all information is de-identified. The student researcher and her supervisors will be the only persons who will have access to the transcripts which will be converted to your story. The transcripts of your interviews will be made available to you to read, and if you desire, change until you are satisfied that the information is reflected in the way you choose to share your story. You are encouraged to read and/or make additions to your story.

What will I gain from participating?

You may not receive any benefits directly from participating in this research project, but the information you provide may contribute to the body of knowledge surrounding how midwives develop their identity in the context of interprofessional education. If you wish, a summary of the research result will be offered to you at the end of the research.

How will the information I give be used?

The information will be used towards a PhD degree but may also be used in article/s offered for publication and conference presentation/s. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. The information that you share will contribute to a better understanding of how midwives "become midwives."

What are the potential risks of participating in this project?

Although there are no perceived risks, you may at times, feel uncomfortable about sharing your story. In you become upset at any point, the interview will be stopped and you will be offered basic emotional support and counselling. You will also have the opportunity to decide whether to continue with the interview or to withdraw from the research project. If you would like additional support, you will be referred to your organisation's counselling service (for students/staff).

How will this project be conducted?

The first and second interviews will take up to 60 minutes each, with the final interview taking approximately 30 minutes. With your permission, each interview will be digitally recorded. You will be allocated a pseudonym in the transcripts and stories of the interviews and stories.

At the completion of the research study, the research data will be stored in Professor Martin-McDonald's office for 5 years after publication. All demographic data will be scanned and copied onto a DVD. Computer databases will be password protected until such time that it is destroyed in a confidential manner according to ethics protocol.

Who is conducting the study?

The project will be conducted at Victoria University by:

Principal Investigator
Professor Kristine Martin-McDonald
Executive Academic
Interprofessional Education Program (IPEP)
College of Health & Biomedicine
Phone 0438 331417
Email Kristine.Martin-McDonald@vu.edu.au

Student
Elvira (Vera) Brown
Phone 9919 2420
Email: vera.brown@vu.edu.au

Any queries about your participation in this project may be directed to the Chief Investigator listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

APPENDIX E: CONSENT FORM

CONSENT FORM FOR PARTICIPANTS

INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into the PROFESSIONAL IDENTITY OF MIDWIVES IN INTERPROFESSIONAL EDUCATION (IPE).

This research project will examine the interprofessional aspects of professional identity for students and qualified clinicians in midwifery. There is little IPE literature that relates to the discipline of midwifery and little evidence on how midwives "become midwives," that is, professional identity development. Thus, this research project proposes to examine the interprofessional aspects of professional identity for students and qualified clinicians in midwifery. More specifically, this research project aims to illuminate how midwives establish, maintain and extend their professional identity and roles within the context of interprofessional education and/or interprofessional practice. Participation involves taking part in three interviews lasting up to two and a half hours in total.

CERTIFICATION BY SUBJECT

I, …….. (Participant's name)

of

……..

(Address)

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study: PROFESSIONAL IDENTITY OF MIDWIVES IN INTERPROFESSIONAL EDUCATION being conducted at Victoria University by: Professor Kristine Martin-McDonald.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Vera Brown (PhD candidate)

and that I freely consent to participation involving the below mentioned procedures:

- A digitally recorded interview of up to 60 minutes (1st interview)
- A digitally recorded interview of up to 60 minutes (2nd interview)
- A digitally recorded interview of up to 30 minutes (3rd interview)

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.
I have been informed that the information I provide will be kept confidential.

Signed:

Date:

Any queries about your participation in this project may be directed to the researcher
Professor Kristine Martin-McDonald.
0438 331417

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email Researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.