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Editorial

REF2021: still time to publish your paper in Evidence Based Midwifery

Key words: REF2021, evidence-based-midwifery, systematic literature review, deadlines for REF 2021 submission, writing a good abstract

The UK Research Excellence Framework (REF2021) national assessment of research, deadline, for institutional submission is approaching rapidly. However, it is still possible to have your research paper published in Evidence Based Midwifery (EBM) before the final deadline as the cutoff date for acceptance of publications is 31 December 2020. Other important deadlines for us to remember are the 31 July, 27 November (2020) and 29 January 2021. The July deadline is for submission of census data for identification of research active staff, impact, research environment, PhD completions and details of our research income (must be money spent, not new awards). The institutional submission must be completed by the closing date of 27 November 2020 and we still have some leeway until 31 December 2020 for research outputs (publications and outputs related to our impact case studies). The final deadline for producing data on intended publications accepted and pending is 29 January 2021 and this deadline includes updates on impact case studies and additional evidence. Throughout 2021, the submissions will be assessed and we will have the outcome in late December 2021. This will be a major Christmas event for all of us involved in research.

So what can we still publish? We can publish research papers that will support our impact case studies and these need to score 2 on the assessment scale and this is important if you want to provide important evidence about the impact of your research. You can publish any of your research outputs from joint doctoral research and any of your funded research projects. The value of systematic literature reviews cannot be under-estimated. You can enhance their value by providing well-structured and clearly defined research questions with a solid rationale and a robust search strategy and framework for the approach.

You need to include your PRISMA flow chart and robust data extraction tables and assure the audience of your attention to rigor in seeking confirmation of the data extraction, analysis and synthesis. For example, this can be undertaken blindly, and randomly by demonstrating that perhaps you organized sampling of the papers for inclusion/exclusion at key points in the review journey and or perhaps you had an independent population of the data extraction tables and engaged in a process for seeking consensus with co-authors. You may wish to state how many people viewed and reviewed the abstracts and full papers. It is possible to score 2 or more and maybe even -3 with a carefully presented review. These type of outputs are worth focusing on and there is still time to do high quality reviews with clear rationales. You can ensure your review is of global value by writing a focused introduction with a good discussion targeting the clinical and academic significance of your review, relevant to the academic and clinical community. Above all, you must write a succinct abstract as this is essential in any paper. Unfortunately many of us neglect this aspect of our papers and leave writing the abstract to the last minute and rush it without taking the necessary time to include sufficient detail in a structured format. The abstract needs a sufficient background statement followed by a naturally evolving and clear rationale, aim and objectives or hypothesis. This needs to be followed by an appropriate method with sufficient detail on the approach, sample, data analysis and ethical approval (if it is a research study but this is not required if it is a systematic literature review paper). I would advise you to try to include, where the word count permits, a statement on the actions taken by the research team to enhance rigour in the data extraction process, data analysis and synthesis (if appropriate). The final section is your opportunity

to tell the reader how important your findings are at national/international level and their applicability to clinical practice, policy or guidelines. There you have it in a prescriptive format and I really hope you will find this information valuable when you are putting your papers together. A smaller point of reference is to make sure that you choose key words that are impactful and relevant to your midwifery research profession and the subject you have researched. It is still hard to believe that many databases do not have 'midwifery research' as a key term and we need to keep stating the words midwifery research to enable change to take place.

Some useful resources can help you if you are considering submitting a systematic literature review to EBM and I am suggesting a few that might be helpful. For example, if you are doing a narrative synthesis you can use a reporting framework for your literature review as this provides a logical and easy to follow structure and you can use something like the PRISMA-ScR checklist for writing it up (preferred reporting items for systematic reviews and meta analysis extension for Scoping Reviews (Tricco et al 2018). The Joanna Briggs Institute (JBI 2017) produces excellent data on how to undertake a review and a good example of a scoping review is Richards et al (2019) in the BMJ open and a narrative synthesis example would be O'Donnovan et al (2019).

In conclusion, there is still time to publish a paper in EBM that could be included in the REF2021 and

it is important to remember that your paper has the potential to be read by almost 40,000 midwives in the UK. All papers published in EBM are fully open access after 3 months and every paper is subject to double-blind peer review. The REF2021 team are tasked with reading the paper for quality and reach and significance and they are not looking at the journal impact factor. Best wishes for good news from your institutional REF2021 submission.

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Breastfeeding, motivation and culture: an exploration of maternal influences within midwife-led instruction in an Asian setting

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ORIGINAL

Background: Breastfeeding is a normal physiological behaviour influenced by layers of internal and external factors. Motivational and cultural influences play an important role in maternal decision making and behaviour, impacting both the initiation and duration of breastfeeding.

Aim: The aim of this study was to identify and analyse cultural and motivational links within midwife-led instruction in an Asian setting.

Method: Framed within a motivational instructional model and a cultural framework, an observational analysis of all routine breastfeeding instruction was completed (n=204). Systematic, theoretically based thematic and content analysis was completed. Breastfeeding motivational measurements were made, to gain a motivational profile of all breastfeeding mothers (n=183).

Results: Cultural and motivational components embedded into routine instruction included congruent goal structures combined with maternally and culturally relevant breastfeeding instruction. Breastfeeding champions, a high organisational value and supportive policies and practices provided consistent maternal care. The motivational maternal profile suggested a higher than normal value for breastfeeding and midwife support.

Conclusion: Maternal motivation lies at the heart of women's decisions and experiences. Motivationally consistent and culturally relevant instruction is critical to the initiation and sustainment of breastfeeding. Identifying the underpinning positive and negative cultural values and influences will empower midwives to facilitate optimal breastfeeding achievement in mothers.

Background

Breastfeeding is a normal physiological behaviour for most mothers. However, it is impacted by multiple layers of internal and external factors as evidenced in the wide variation of global statistics and low patterns of uptake in certain settings. Global breastfeeding rates show that, while increasing breastfeeding could prevent 832,000 annual deaths in children under five and 20,000 maternal deaths from breast cancer, only 43% of newborn infants are breastfed within one hour of birth and 41% of infants aged 0–6 months are exclusively breastfed (World Health Organization (WHO) 2014, WHO 2019).

In Ireland the introduction of the Breastfeeding Action Plan 2016–2021 aimed to increase current breastfeeding rates (43.6%) through the support

and enablement of mothers' breastfeeding choices during the initiation and continuation of breastfeeding (Hourigan et al 2016). The current breastfeeding rate in England is 47.9% but a position statement by the Royal College of Paediatrics and Child Health (RCPCH) highlighted that the United Kingdom (UK) has had one of the lowest rates of breastfeeding in Europe with even lower rates in disadvantaged areas, increasing the risk of health inequalities (Public Health England 2019, RCPCH 2019). A recent spotlight on infant feeding in England highlighted that cuts in maternity services have made conversations and support during the antenatal and perinatal periods, often a key time for maternal breastfeeding decision making, more challenging due to less staff time and fewer resources (Radzimirski & Callister 2016, UNICEF 2018). The Royal College

of Midwives (RCM) emphasises the challenges facing many women today including a lack of support and appropriately trained and skilled staff, and economic and social pressures on women to return to work (RCM 2018). This creates a less than optimal environment for mothers considering breastfeeding, especially for the first time.

Globally there are wide variations in breastfeeding practices between high, middle and low-income countries with one in five infants in high-income countries never breastfed, in comparison to one in 25 in low and middle-income countries (Arts et al 2018). Evidence suggests that in high-income countries it is low-income mothers who are less likely to breastfeed, in contrast to low-income countries where it is more often wealthy mothers who do not breastfeed (Arts et al 2018). Factors contributing to this include caregiver and societal beliefs which favour mixed feeding, a lack of skilled staff and breastfeeding champions and a lack of knowledge and support in effective breastfeeding techniques (WHO & UNICEF 2014). The authors believe these factors contribute to the complexity of breastfeeding behaviour and demonstrate a range of cultural, family and economic influences which are also impacting breastfeeding behaviour. In Thailand for example only 40% of babies are breastfed within one hour of birth and 23% are fed exclusively up to six months, although the Ministry of Health have now set a target of 50% by 2025 in line with global targets (National Statistical Office & UNICEF 2016, WHO 2019).

The emphasis on the value and benefits of breastfeeding has fuelled global research into the identification of breastfeeding influences. These have now been identified as education, self-esteem and social factors (Chopel et al 2019, Parry et al 2019, Tang et al 2019). Evidence suggests that when professional support is offered to women the duration and exclusivity of breastfeeding behaviour is increased but the timing and form of support remains debateable. A Cochrane review of 24 studies (n=10,056) purported that there was little difference in the initiation and duration of breastfeeding behaviour between targeted antenatal programmes and routine care (Lumbignon et al 2016). In clinical contexts, where financial and human resources are becoming increasingly limited, it is critical to understand the range of determinants which impact breastfeeding behaviour in order to support mothers in their decision making (McFadden et al 2017). This includes influences that impact both maternal decision-making and motivation.

Motivation

Research into motivation has become a focus in breastfeeding behaviour and education within the last 20 years and suggests a range of influences which include value, self-efficacy, satisfaction, family

dynamics, socialisation as well as transient factors (Stockdale et al 2008b, Avery et al 2009, Pinto et al 2016, Tuthill et al 2016). Motivation has been defined as that which both energises and guides a behaviour towards achieving an identified goal (Harackiewicz & Sansone 2000). With the wide breadth of motivational theories and influences now discussed within research it may be a challenge for midwives and health professionals to explore and understand motivation. However, one key theoretical paradigm has been the selection of behavioural cognitive theories which include expectancy value theory, social motivation, attributional theories and competency theories which are as interlinked as maternal behaviours (Dornan 2015). Stockdale et al (2011) propose that rather than considering motivation as a single construct it would be better viewed as a diamond which can only be fully appreciated when explored from multiple perspectives. Indeed, examining and analysing motivation from multiple angles provides midwives with an opportunity to deepen their knowledge, reflect on practice and increase the effectiveness of their interventions. Understanding human motivation and mothers' intrinsic and extrinsic goals and their need for feedback to sustain and persevere in their breastfeeding behaviour are key factors in achieving optimal outcomes (Stockdale et al 2011, Dornan 2015).

Culture

A critical factor in understanding breastfeeding behaviour in different countries and contexts is the recognition of cultural impact. Elliot (2010) suggests that the term culture has different associations depending on whether we have in mind the development of the individual, group or society but argues that each of these is inextricably linked. Culture is frequently manifested at different levels of depth and affects both behaviour and interpretations of the visible and invisible world. In fact, culture lies at the heart of both identity and behaviour. One seminal concept was the recognition that individuals and groups may have strikingly different concepts of themselves and others through their cultural value systems which can affect how they perceive their experiences including cognition, education and motivation, which in turn may impact achievement of aspired goals (Markus & Kitayama 1991, Oettingen et al 2008, Dornan 2015). Breastfeeding as a maternal behaviour occurs across cultures but while there is recognition of the implications of culture, less is known of the cultural values which transcend or immobilise behaviour. A literature review exploring breastfeeding and culture suggested that cultural norms related to the concept of breastfeeding, attachment and maternal obligation seemed to bring together an ideology of value, tradition, meaning and practice which may create a powerful motivational influence (Dornan 2015). Significant differences exist

between cultures, especially between those identified as Western individualistic cultures and the 'collective' or community cultures of Asia as defined by Schwartz (1990) and Hofstede (2001) who were crucial early contributors to the exploration of culture. However, within these differences and similarities there may be valuable lessons and resources which, when explored, could influence and change national and global midwifery practice, particularly within the person-centred approach now evident within nursing and midwifery in the UK (McCormack & McCance 2017). This study analysed the influence of motivation and culture on breastfeeding behaviours and potential application to practice within a global context.

Aim

The aim of this study was to identify and analyse cultural and motivational links within midwife-led instruction in an Asian setting.

The objectives were to:

- Report the findings from a range of studies of breastfeeding instruction within a university hospital in Thailand.
- Identify key motivational components with breastfeeding instruction.
- Explore the motivational profile of mothers initiating breastfeeding.
- Examine the impact of culture on education and maternal value for breastfeeding.

Method

This study was framed within the macro-theoretical ARCS model of motivation, adapted into breastfeeding (Stockdale et al 2008b, Stockdale et al 2014). ARCS stands for Attention: that which catches a person's attention, Relevance: the information on a topic which is relevant to the person, Confidence: the instruction and content which builds a person's confidence and Satisfaction: that which allows the person a sense of achievement upon reaching a desired goal.

Designed to identify motivational strengths and weaknesses within educational instruction, ARCS offered a systematic process in the identification and analysis of motivational influences in breastfeeding through a process of gathering information on antenatal and postpartum education and motivational profiles of breastfeeding mothers. As the experiences of learning and breastfeeding are common to all cultures it was considered that this theoretical framework would allow for the analysis of education. However, to allow for the additional focus on culture a further model was adapted into the framework to analyse the influences of national, organisational and individual cultures (Gardenswartz et al 2003, Dornan et al 2017). Data collection was completed in a three-phased approach including national and

corporate policy analysis, observational analysis of all breastfeeding instruction and a motivational analysis of breastfeeding mothers. This paper will report the results of the observational and motivational analysis with reference to the influence of policies and practice.

Ethics

Ethical approval was obtained from Ulster University and Chiang Mai University ethics committees prior to commencement of the study. Due to the potential vulnerability of the women and staff in this study, likely ethical issues including cultural expectations, language barriers and social consent were considered and addressed. Permission was also granted by the Faculty of Medicine and Head of Nursing Staff.

Setting and data collection

Data collection took place in a maternity unit within a university hospital in northern Thailand. The unit is a regional referral centre for women and supports an approximate birth rate of 2000 per annum. Data collection and analysis took place between 2014–2015. Midwife-led observations were completed in pre and postnatal contexts where routine breastfeeding instruction occurred through a convenience sampling approach. Prior to each observation, midwives and women were given information explaining the purpose of the research and invited to participate. Consent forms were then offered. A total of 62 midwives and nurses and 204 women participated in the observation study. Seventy-five hours of observation of breastfeeding instruction were completed in one-to-one and group sessions in eight pre and postnatal environments. Breastfeeding instruction was offered in each setting to both primigravida and multigravida women. Breastfeeding motivational surveys were collected in the postnatal unit of the hospital to women who had initiated breastfeeding within the unit. The Thai Breastfeeding Motivational Measurement Survey (TBMMS) was adapted and translated as per WHO (2014) guidelines with forward and back translation, review by an expert panel and pilot testing (n=37). Feedback included cultural preferences of positive responses to the Likert scale and responses to negative questions as a concern that offence may be caused or the perception of 'trick' questions. To address these concerns additional explanations of the purpose of the survey and confidentiality were added and adjustments made to the wording of the questions while maintaining the reliability of the scale (Dornan et al 2014, Dornan 2015). A prospective cohort of 200 women, calculated with a 10% attrition rate based on previous studies, was calculated by a priori power analysis and recruited by the team within the maternity unit. A total of 183 women completed the TBMMS.

Data analysis

Data for the observational analysis was collected by and included observation notes and a field diary to gather cultural, contextual and motivational content. Due to potential cultural and language barriers a second observer was included in some sessions to improve inter-observer reliability. All information was documented, transcribed and analysed immediately after each observation. The data was then mapped to a semi-structured observation schedule for analysis of motivational content. Identified data were also mapped to the Gardenswartz et al (2003) model of national, organisational and personal culture. Thematic and content analyses were completed through the implementation of Braun & Clarke's (2006) qualitative thematic framework and a motivational goal framework (Harackiewicz & Sansone 2000). This goal framework included purpose goals: reasons to breastfeed; target goals: how to breastfeed successfully; and performance feedback indicators: how to know that you are breastfeeding successfully. These goals are related to the underlying motivational value and relevance components within motivation and form the guidelines in supporting women to achieve their goals. Results were examined by a second researcher with expertise in motivational research for validity. Cultural content and advice were carefully considered and integrated by the international research team. All results and changes were discussed and agreed by the research team.

The TBMMS was designed and tested to examine value and expectancy for success among breastfeeding women receiving best practice education with motivational constructs of value for breastfeeding, expectation for success and midwife support (Stockdale et al 2008a, Dornan et al 2014, Stockdale et al 2014). Data was entered into SPSS V21, checked and verified and data cleaning completed. Statistical analysis comprised of item and factor analysis.

Results

Context

Thailand is an upper middle-income country in South East Asia. Known for its welcoming culture it holds an influential role within the region and is a fascinating combination of tradition, respect and status. The Thai worldview of social harmony and hierarchy is firmly anchored in tradition and included respect for King Bhumibol Adulyadej (who was monarch at the time of data collection) and those in positions of authority (Dornan 2015). Family, Buddhism and attributes of knowledge, patience and virtue are central to the cultural value system. Analysis of national and organisational policies showed a clear support for breastfeeding which is also valued within the culture. Integration of international and national policies into the organisational

policies and culture demonstrated a high value of breastfeeding across the multidisciplinary teams which was implemented throughout the unit (Dornan 2015, Dornan et al 2017). These policies were evident in practice and included skin-to-skin, early initiation of breastfeeding and twice daily midwife-led group teaching sessions on the ward which demonstrated strategies to overcome early breastfeeding challenges such as blocked ducts, cracked nipples and breast care. Breastfeeding and maternal health classes were offered to all women within both antenatal and postnatal settings in the hospital. Daily antenatal classes were held with additional individual and group instruction within the antenatal clinic, labour ward, postnatal ward, lactation clinic and nursery settings. Additional classes including a self-efficacy class to build women's confidence to breastfeed and a postnatal discharge class were held regularly on the main postnatal ward. Although all midwives participated in the breastfeeding instruction there was also a designated breastfeeding champion who took the lead in teaching and promoting breastfeeding in each context. This resulted in what appeared to be a sense of ownership among the nurses and midwives across the unit.

The Thai Breastfeeding Motivational Measurement Survey

The TBMMS consisted of 19 items designed to measure motivation through the constructs of value for breastfeeding, midwife support and expectation for success. Following descriptive, item and factor analysis the results were collated and reported. The overall initiation rate within the unit was over 90%, combined with a continuation rate of 68%. The mean age of mothers was 27 years. Mothers under the age of 20 accounted for 10%. Over 60% were employed and 40% had completed secondary school. Analysis for validity and consistency showed a Cronbach Alpha score of 0.923 with a high mean within items ranging from 6.91–4.74. However, the results showed a high level of skewness and kurtosis across the items. This level of high skewness demonstrated a high ceiling effect which, due to the non-normality of distribution, left little difference between the scores. The Mann Whitney test was completed and showed a wide variance between the items but led to a risk of poor factor structure. Due to this and the high level of skewness and kurtosis full factor analysis could not be reliably completed. The positive responses and high ceiling effect suggested a high maternal value for breastfeeding and midwife support, but further testing of the survey should be completed to test for reliability and validity in motivational profiling of breastfeeding mothers in a different setting.

Motivation

Identification of the motivational components was completed through the analysis and collation of

motivational goals and themes offered during each breastfeeding interaction. Following content analysis initial results were collated into a goal trajectory. A goal/learning trajectory is a researcher-based, empirically supported description of a network of constructs which forms the basis for instruction (Sztajn et al 2012). In this study the goal trajectory was mapped between the settings to identify the number and type of goals that were set by midwives in order to measure the motivational content of the instruction (Figure 1).

Motivational goals contained within the written materials included 36 purpose goals, 44 target goals and one PFI.

Following thematic analysis, it was evident that breastfeeding instructional goals were introduced routinely as ways to motivate women to breastfeed. There was one main overarching goal and a range of higher order and attainment goals which were set within both the antenatal and postnatal phases of care. These included the concept that breastfeeding was always the best option for mum, baby and for Thais. The cultural content was woven throughout the instruction and used to attract attention and

increase relevancy to breastfeeding. While the goal structure was complex the overall message communicated throughout the instruction was a positive one, with midwives promoting breastfeeding as a positive behaviour and outcome for individuals, communities and the nation. There was a range of higher order and attainment goals set within the instruction (Figure 2).

Within the higher order and attainment goals there were also multiple subthemes which reflected both the value of breastfeeding and the expectation for success that was being set within the instruction as well as the cultural influences (Figure 3).

Many of the goals emulated the high value of breastfeeding which was evidenced in the policies and practices within the unit and combined practical suggestions with evidence and support. The thematic analysis also showed clear motivational components within the instruction. For example, many of the themes within 'Breast: best option' included reasons why women would want to breastfeed and highlighted both the benefits and convenience of breastfeeding. This included the value of attachment, protection, convenience and multiple physical

benefits, especially during the antenatal period. (For codes of the data collection see Table 1).

Examples of this include: natural contraception (PNDCV), breastfeeding helps you lose weight (PNDC HN), perfect nutrients (PNDCV), and:

'Wherever you are, even if you are travelling you can still breastfeed.' (ANC 5 MW2)

There was a significant focus on building maternal confidence across the themes which was incorporated across the antenatal and postnatal instruction:

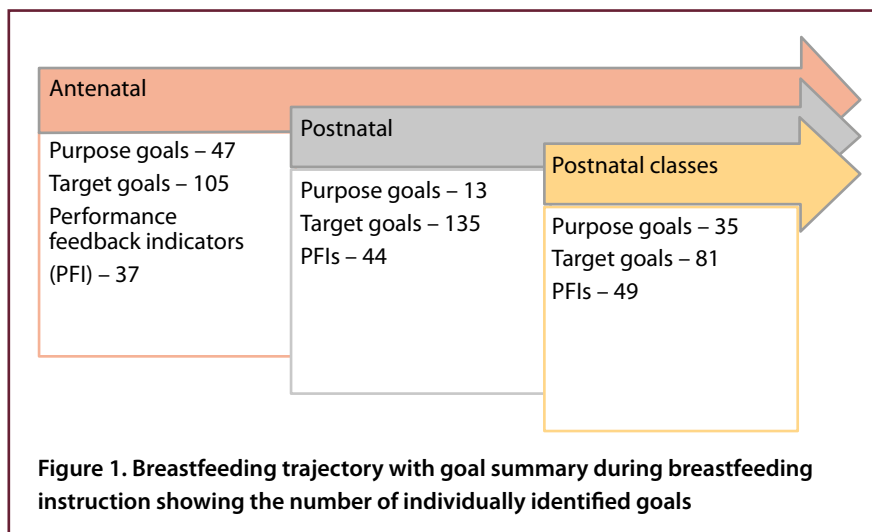


Figure 1. Breastfeeding trajectory with goal summary during breastfeeding instruction showing the number of individually identified goals

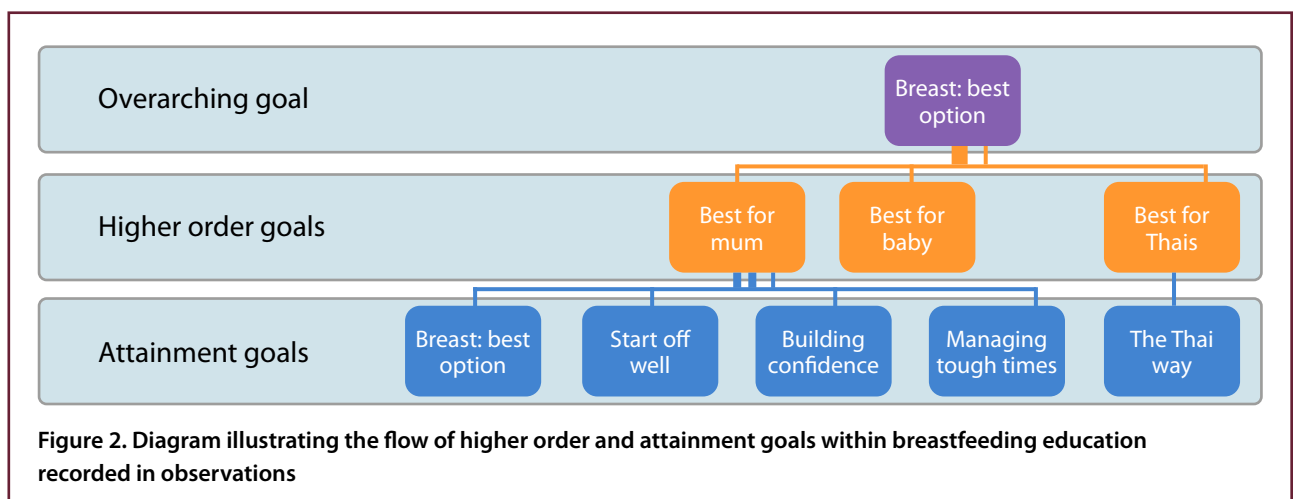


Figure 2. Diagram illustrating the flow of higher order and attainment goals within breastfeeding education recorded in observations

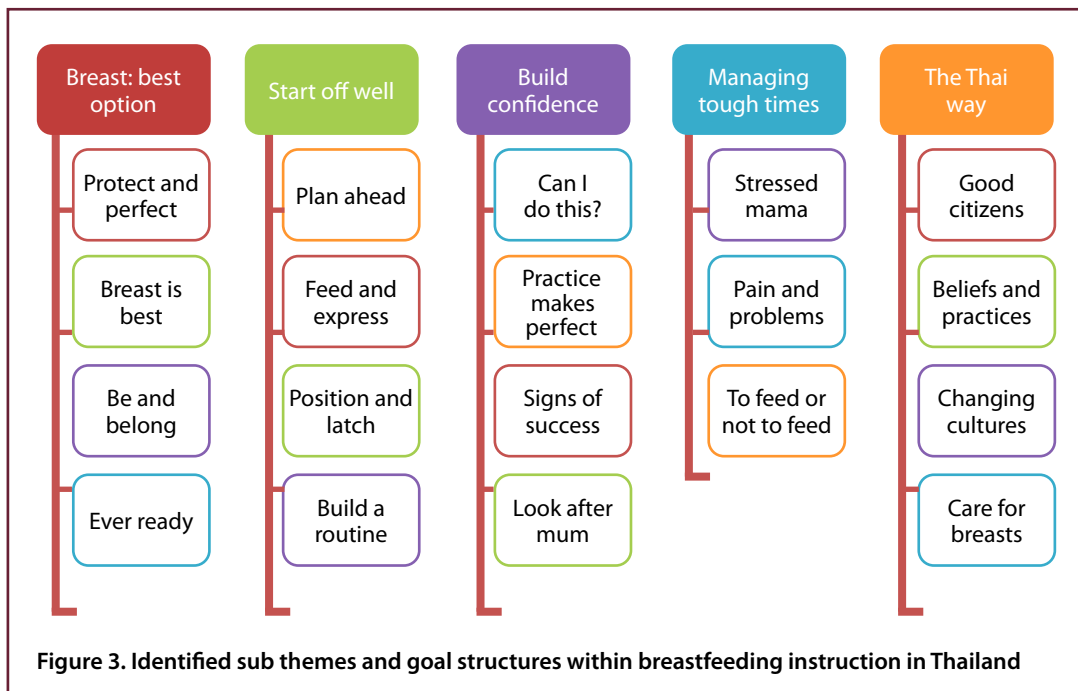


Figure 3. Identified sub themes and goal structures within breastfeeding instruction in Thailand

‘The nurse said it would take time to get used to learning to breastfeed and to learn new ways of doing things. You just have to be patient and persevere. Just take one step at a time; in the end you will be able to achieve the best for your child.’ (SECV2)

‘There are three stages to breastfeeding; stage 1 where your body just starts to get ready in pregnancy, stage 2 when just before you have your baby and your body starts to produce milk and stage 3 when your milk comes in... don’t worry you’ll be ok.’ (PNW1 MW1)

The combination of these goals helped the mother know that there will be less milk in the early days but as she keeps feeding her milk supply will increase, thus providing the goal and motivation to keep feeding longer. The value of breastfeeding was also emphasised through goals such as:

‘By helping mum and child to be able to experience their love and show love to each other they can both get the benefit from the attachment.’ (SECV)

Goals were also combined to show the mother how to breastfeed and how to know that she was doing it successfully:

Table 1. Data collection codes for observational study.

Code	Description
PNDCV	Postnatal discharge class video
PNDC HN	Postnatal discharge class head nurse
ANC5 MW2	Antenatal class 5, midwife 2
SECV/2	Self-efficacy class video /2
PNW1 MW1	Postnatal ward 1, midwife 1
ANCV	Antenatal class video
ANC1/2 MW2	Antenatal clinic 1/2, midwife 2
LW1 MW1	Labour ward 1, midwife 1
LCS HN	Lactation clinic 5, head nurse
ANL1	Antenatal leaflet 1

‘Having correct positioning will help ensure the nipple is deep in the mouth.’ (ANCV & ANC2 MW2)

There was a focus on assisting mothers to start off well in breastfeeding. This included suggestions for planning ahead, the importance of position and latch and different options related to breastfeeding:

‘After birth, hormones will be produced in your body, so it is good to have your baby start breastfeeding within an hour of being born. This will help with milk production.’ (ANCV & ANC1 MW1)

This theme also addressed the reality of mothers returning to work, which is an economic reality for many mothers in Thailand. Recommendations included:

‘When you have given birth, if mothers have to go back to work, they can pump and store milk.’ (LW1 MW1)

Within the theme ‘Managing tough times’ there was also a clear recognition and goal structure of breastfeeding challenges with both target goals and PFIs to assist mothers to know how to address and succeed in overcoming challenges:

‘Your breasts are engorged, you need to massage in circular movements like this, first on the outside then further in and around the nipple.’ (LC5 HN)

‘Make sure that the baby’s mouth is wide open and latches on well, right up to the base of the nipple. This will help produce more milk and will ensure that your nipples will not be hurt.’ (ANCV)

A key aspect of maintaining and increasing motivation is the congruence of goals which create a motivationally positive environment (Dornan et al 2017). The recognition and normalisation of

breastfeeding challenges appeared to allow for both a disclosure of difficulties and discussion towards resolution which allowed a continuation of the breastfeeding journey. This appeared to be inherent within the unit.

Culture

The concept of culture was evident throughout the midwife-led instruction. Nationally, breastfeeding continues to be an accepted part of Thai culture, although rates are decreasing as cultural shifts occur (Thepha et al 2018). However, within this unit breastfeeding was promoted as both a cultural norm and positive decision. Breastfeeding goals were frequently framed in a way that was both relevant and appropriate to Thai mothers. These included suggestions that:

'Mothers' milk helps the nation as it brings down the cost of living.' (ANL1)

'Mothers breast milk shows perfect [true] love for your child so it has more benefit than any other food.' (ANL1).

This goal is in line with a Thai Buddhist belief that is known as the 'milk debt'. Within Thai culture it is believed that parents are entitled to build up a moral credit through the process of conceiving, carrying, bearing and nurturing their baby which will then be repaid by the child later (Lancey 2108). However, there were also practical suggestions made in relation to the size and shape of women's breasts in Thailand, which is known to cause concern, for example:

'The size or shape of your breast does not reflect how well you can breastfeed – how much or how little milk you have. The size of your breasts has to do with how much fat cells have deposited there.' (ANCV)

Other practical suggestions also included cultural advice such as:

'Have wide straps on your bras.' [Thais don't have maternity bras] (ANC1 MW1 & ANC2 MW2)

One theme which seemed to be uniquely cultural was the idea of breast care. This was taught on the wards in the daily session and women were encouraged to both wash and massage their breasts regularly:

'Wash hands and breasts before feeding. Dry yourself by patting gently. Don't use soap regularly and be gentle drying yourself or else your nipples will become dry and cracked.' (ANCV)

It may be argued that while culture is present in all elements of life it may not be required during specific breastfeeding instruction. However, within this setting breastfeeding was presented in a way that was uniquely Thai, appearing to build a bond between the midwives and mothers as they begin the journey of breastfeeding.

Discussion

Values have been a key concept in social sciences since their inception and play an important role in psychology, sociology and anthropology. Values have been used to help characterise cultural groups, societies and individuals, to track changes over time and to offer explanations for the motivational base of attitudes and behaviours (Schwartz 1999, Schwartz 2004, Schwartz 2012). Recognising and identifying key cultural values and implementing them into breastfeeding instruction appeared to increase both maternal attention and relevance. The underlying cultural value of breastfeeding, although changing, may offer a positive motivational force but women may still encounter breastfeeding challenges. Receiving congruent and comprehensive goals, combined with a high value for breastfeeding, may allow them the motivational energy needed to overcome the barriers they encounter on their breastfeeding journey.

The systematic approach of ARCS combined with the cultural framework offered a valuable mechanism for this cross-cultural research (Gardenswartz et al 2003, Dornan 2015). Understanding the underpinning motivational and cultural components embedded within the midwife-led instruction allowed the identification of some critical insights into the role of education and maternal behaviour in breastfeeding. The value placed upon breastfeeding within the unit was notable from the outset through the implementation of policies, practice and the inclusion of both individual and group instruction which was readily available on a daily basis. The focus on building maternal confidence and the inclusion of practices which were acceptable within the collective culture appeared to present an inbuilt peer support between mothers within the groups across the settings.

The results of the TBMMS showed a high level of skewness and kurtosis but the rate of 78% intention to breastfeed with a continuation rate of 68% post birth suggests a high value for breastfeeding. The findings from this study suggest that while breastfeeding is extremely complex, if explored from multiple angles, key motivational elements can be identified and included to overcome barriers. When breastfeeding education is designed to engage mothers, capture their attention, is relevant to their individual (or in the Thai context, group goals) and includes routine confidence-building strategies leading to a sense of satisfaction it may well lead to a continuation in breastfeeding. The role of values, individual, corporate and national, were clearly evident in this research and appeared to be an influential factor. The cultural perspective of values, particularly those of tradition, family and well-being offered an additional layer within the instruction and motivational profile of the mothers. It is recognised that a single educational or care

approach to breastfeeding is unlikely to be successful (Radyzynski & Callister 2016). Understanding the depths of cultural values and contextual influences allowed midwives to adapt their instruction into a uniquely relevant process, which crossed over from a 'one size fits all' strategy to an approach which was personalised within the context but still deliverable within group settings. Finding the cultural and contextual factors which increase motivation and relevancy is an area still to be explored with midwifery in the UK but is becoming increasingly crucial in our multicultural, resource-limited world. The RCM recognises that many factors influence women's choices and recommends that every attempt should be made to understand and address the cultural and societal barriers (Livingstone 2018). This may in turn contribute to an increase in breastfeeding initiation and duration in high, middle and low-income countries.

Recommendations in recent studies advised of the need for a deeper understanding of the facilitators and barriers to breastfeeding within Thai settings. This included a focus on the unique needs and motivating factors such as knowledge, health care support and traditional practices (Nuampa et al 2018, Thepha et al 2018). This study contributes to this knowledge through a deeper understanding of integrated motivational and cultural factors within breastfeeding education and the ownership of breastfeeding policies and practices. This led to an integrated, accessible and well-designed educational approach to breastfeeding instruction.

Conclusion and implications for practice

The complexity of the breastfeeding journey cannot be underestimated as it is, by its very nature, inter-related to internal and external influences. Maternal motivation lies at the heart of women's decisions and experiences and consistent, relevant instruction is critical (Dornan et al 2015, Dornan 2017). Midwives' ownership of breastfeeding policies including a breastfeeding champion, a high organisational value and consistent motivational goals which are culturally relevant, can all contribute to an optimal breastfeeding environment which would allow women to both set and achieve their goals. Although midwives face challenging workloads they continue to be uniquely placed and, in many global contexts, the only point of care in communities as they continue to support mothers. Identifying the underpinning positive and negative cultural values and influences will empower midwives to facilitate optimal breastfeeding achievement in mothers. At a point where the world needs nine million more midwives to achieve universal health coverage (WHO 2020) the development of motivationally and culturally relevant breastfeeding materials could make a significant impact and valuable resource within low, middle and high-income countries.

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Midwifery student practice grades: case study and discussion

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ORIGINAL

Background: Assessment of student competence is a key component of undergraduate professional programmes such as midwifery. The competencies required to be eligible for registration as a midwife in the United Kingdom (UK), are set by the regulatory body, the Nursing and Midwifery Council (NMC). The NMC (2009) *Standards for pre-registration*, introduced mandatory grading of student midwifery practice.

Objective: To examine and discourse about the practice grades of student midwives, at one UK university, over a five-year time span.

Method: A case study methodology with multiple sources of data collected over five years was undertaken between 2011–2015. Data included all student practice grades (n=124), 11 group interviews with student midwives (n=51), one group interview with midwifery lecturers (n=5) and individual interviews with midwives (n=15).

Results: The majority of students received high grades for their practice (above 70%) and only a few failed in clinical practice. One interpretation of this finding is that most students were performing well and deemed competent to practice. However, the amount of time available for midwives to observe the students' performance in clinical practice was variable, students thought that social interactions with their midwife affected the grading process and therefore the grade was not always considered an objective measurement of their performance.

Implications: Assessing midwifery student competence is critical to ensuring safe care for women and babies. Over the next two years all UK midwifery curricula will be developed in response to the NMC's (2019a, 2019b) new future midwife standards and *Standards for student supervision and assessment* (NMC 2018), therefore the profession needs to consider how best to assess students' practice.

Keywords: practice assessment, competence, performance, evaluation, grading

Background

All professions publish guidelines that state what their qualified members should be competent to perform and what the public can reasonably expect from them. In the midwifery profession, there are international and national definitions and competencies. The International Confederation of Midwives' (ICM) report, *Essential competencies for midwifery practice* (2019) outlines the minimum set of knowledge, skills and behaviour required of individuals entering the profession which are seen as a benchmark for pre-service education. These are set out in four sections: general competencies, such as being autonomous, using research to inform practice, informing women of their choices and possessing effective communication skills and competencies associated with knowledge, skills and behaviour for pregnancy, labour and birth care (ICM 2019). The NMC (2019a) sets out the national standards for pre-registration midwifery education. From 2009 until present day, the competencies required for entry onto the register, are categorised under four domains: effective midwifery practice,

personal and ethical practice, professional development of the individual midwife and achieving quality care through evaluation and research (NMC 2009). The domains are complemented by five essential skills clusters (NMC 2009) which largely align with the ICM (2019) competencies. Competence can therefore be summarised as a body of specific knowledge, combined with action which encompasses attitudes and behaviours to provide safe care.

The *Global standards for midwifery education* (ICM 2010) and the NMC's (2009, 2019a) standards state that students should spend 50% of their course in clinical practice. The majority of UK students complete a three-year direct entry midwifery course. A shorter midwifery course is also available in some areas for qualified adult nurses. All students are supported to learn by a qualified midwife, utilising evidence-based practice to assess competencies. Internationally, some midwifery curricula assess students' competency with pass/fail criteria, whereas others assess performance and award a clinical grade. Performance encompasses competence; however, it comprises more than being

knowledgeable and demonstrating professional values. It is also the extent to which an individual applies scientific or ethical knowledge to practice, the critical thinking behind clinical decision making and the compassionate and kind manner in which interpersonal and communication skills are used.

Assessing students during their education and at the point of registration is necessary to ensure that each individual meets the professional standards and to protect the public (NMC 2009, ICM 2019, NMC 2019a, 2019b). The assessment can be viewed as a quality assurance measure. However, there are issues around making valid and reliable judgements about professional occupations due to the complexity of their work (Eraut 1994). Definitions regarding competence can be seen as stages on the way to proficiency and expertise (Benner 2001) or as a binary where an individual is either competent or not (Eraut 1994). Assessing practice-based programmes such as midwifery with pass or fail competencies, can be viewed as devaluing the status of practice, especially when half of the course is spent in the clinical environment. Conversely, grading practice is inherently difficult, and there are arguments against it, questioning its fairness and its limited predictive value (Eraut 1994). Fairness is related to differences in challenge and support in the various placements making equity difficult to ensure. The limited predictive value is because professional knowledge develops over time, how a student performs at the end of their third year will not be the same as after six months of practice. There is an assumption that their proficiency will increase and therefore the grade does not predict their future potential (Eraut 1994). However, as the decision to grade practice in the UK was mandatory at the time the study was undertaken, the literature review focuses on the evidence for this type of professional assessment.

Literature review

A systematic literature review was undertaken in December 2016 using academic databases to examine the evidence on grading clinical practice. Several combinations of key words were used to maximise the literature search. Truncation of the terms 'grade' or 'grading' was used to ensure that all the variants and plurals of words would be captured (Ridley 2012). 'Student' or 'undergraduate' were used as a second search string to encompass the change to an all-graduate profession, and also other professions already at graduate level, such as physiotherapists. 'Practice' or 'clinical practice' or 'professional practice' were searched with the near to proximity locator.

Several studies researched grading simulation, virtual patients or used portfolios to grade practice, these were excluded as evidence from authentic practice assessments rather than using a proxy. After reading the title and abstract of all potential papers, 34 research papers were included. This paper presents findings from a range of studies comprising a literature review (n=1), a large-scale action research project

(n=1), surveys (n=13), audits or analyses of practice grades (n=13) and qualitative studies (n=6). The literature focuses on how practice is assessed and on grades and relationships in clinical practice.

The weight of the evidence is limited by the size, generalisability and transferability of some of the studies. For instance, the quantitative studies tended to be small-scale local surveys, as small as one student and seven examiners (Reubenson et al 2012). Even the larger national surveys had methodological issues. Oermann et al (2009) emailed 21,719 members of a nursing network asking for full- or part-time faculty to respond. The sample of respondents who were eligible was not known, those who responded were self-selected and the numbers from each university were not stated. The representativeness of the sample was unknown therefore the generalisability of the findings is compromised. One of the most rigorous studies was the large-scale, two-phase action research project of over a thousand participants from multiple universities which developed a national grading tool for physiotherapy in New Zealand and Australia (Dalton et al 2009). However, once the grading tool was developed, there was only a limited evaluation of it by students. Thus, the evidence across the studies of how best to grade practice is not robust.

Fifteen papers stated how practice was assessed (Table 1). Many studies used more than one type of assessment of practice. The most frequently cited method across the professions was with observation. This included general observation, where a qualified professional worked alongside a student for an extended period of time and one-off assessments of specific skills, such as history-taking and physical exams. Several studies specifically included oral assessments that incorporated decision making and evidence-based practice as they felt observation alone did not capture this essential professional knowledge. Two studies concluded that this led to greater stratification of student performances (Clouder & Toms 2008, Imanipour & Jalili 2016).

There were 13 studies that stated or analysed the practice grades, with a variety of grade types (Table 2). Collectively this table demonstrates that practice grades tend to be clustered towards the higher end of the grade ranges regardless of the grading type, either letter, mean or descriptor. It is also worth acknowledging that the grades were awarded by a variety of health professionals working in university and practice settings. Several studies had large data sets with results collected over many years indicating that the strength of evidence for high practice grades is strong. This is corroborated by the comprehensive literature review published by Gray & Donaldson (2009) of 119 studies from a range of professional groups where practice was graded across the globe. Grade inflation was noted, with students typically receiving grades near the top of the scale. This was attributed to four influences: the student, the assessor, the student-assessor relationship and grading tools (Gray & Donaldson 2009).

Table 1. Methods used to assess practice.

Methods	Professions	References
Observation	Nursing, physiotherapy, midwifery, medicine	Clouder & Toms 2008, Meldrum et al 2008, Dalton et al 2009, Oermann et al 2009, Hatfield & Lovegrove 2012, Plakht et al 2013, Murphy et al 2014, Paskausky & Simonelli 2014, Imanipour & Jalili 2016, Lawson et al 2016, Fisher et al 2017
Skills testing	Nursing, medicine, midwifery	Pulito et al 2007, Oermann et al 2009, Imanipour & Jalili 2016
Physical exam	Medicine, nursing	Eggleton et al 2016, Imanipour & Jalili 2016
History taking	Medicine, nursing	Eggleton et al 2016, Imanipour & Jalili 2016
Supervised interviews	Medicine	Briscoe et al 2006
Case presentation	Medicine, nursing	Briscoe et al 2006, Imanipour & Jalili 2016
Measurement of humanistic qualities	Medicine, nursing	Eggleton et al 2016, Imanipour & Jalili 2016
Diagnostic ability	Medicine	Pulito et al 2007
Oral examinations	Physiotherapy, medicine, nursing, midwifery	Briscoe et al 2006, Pulito et al 2007, Clouder & Toms 2008, Reubenson et al 2012, Imanipour & Jalili 2016, Fisher et al 2017
Self assessment	Nursing	Oermann et al 2009, Hatfield & Lovegrove 2012, Plakht et al 2013
Final exams	Medicine, nursing	Briscoe et al 2006, Paskausky & Simonelli 2014
Written assignments	Nursing, medicine	Briscoe et al 2006, Oermann et al 2009
Portfolio	Midwifery	Fisher et al 2017
Conference presentations	Nursing	Oermann et al 2009

Table 2. Practice grades.

Grading type	Grade/mean	Number of grading episodes	Author
Mean	93%	124	Plakht et al 2013
	82%	547	Hiller et al 2016
	84% in the older tool	184	Murphy et al 2014 (same study awarded grade two ways)
Descriptor	Excellent (41%), good (52%), adequate (7%), not adequate (0%) (Combined good and excellent=93% of students)	71	Murphy et al 2014 (same study awarded grade two ways)
Range	60–72%	1057	Roden 2016
	40–70%	7	Reubenson et al 2012
	61–89%	100	Eggleton et al 2016
	80–95%	281	Paskausky & Simonelli 2014
	82–93%	184	Walsh & Seldomridge 2005
Letter	A or B (combined = 95% of grades)	204	Seldomridge & Walsh 2006
	68% A; 32% B (combined =100% of grades)		
	90% higher than B+	585	Pulito et al 2007
	A or A+ 80% in last practicum	281	Paskausky & Simonelli 2014
		4500	Scanlan & Care 2004
Honours/pass/fail	22.6% honours, 49% strong pass, 28.4% pass, 0 fail	3369	Weaver et al 2007
Not stated but high	5% fell outside cluster but no value given meaning 95% similar	38	Edwards 2012

In Rowntree's words, assessing a person is to 'know' that person:

'Occurring whenever one person, in some kind of interaction, direct or indirect, with another, is conscious of obtaining and interpreting information about the knowledge and understanding, or abilities and attitudes of that other person.' Rowntree (1987:4)

Many studies noted the special and supportive relationship between students and assessors in clinical practice. Some midwives were aware of the relationship they developed with the student, recognising that, if the student mirrored their own way of working, this positively affected their grade (Smith 2007). Similarly, the relationship hindered delivering candid feedback,

and leniency in grading seemed to occur (Briscoe et al 2006, Seldomridge & Walsh 2006). Assigning lower grades was more difficult when the boundary between student and faculty was blurred and an emotional bond had developed (Scanlan & Care 2004).

In 2009, when grading was introduced and as a junior member of the midwifery team, the author was especially interested in how midwives would grade students' practice in addition to the potential influence of grading on the student's degree classification. In the UK the classification of an honour's degree is based on a weighted average mark of the assessed work, including practice grades (NMC 2009). The degree classifications are 1st (representing 70–100%), 2:1 (60–69%), 2:2 (50–59%) and 3rd (40–49%). The Office for Students recent report (OfS 2019) noted that a growing proportion of students are receiving first and upper second-class degrees and that reasons for this increase cannot be explained by entrance qualifications or student characteristics. The increase is suggestive of grade inflation over time which has the potential to devalue university education. In midwifery the increase in student grades was noted by many lead midwives for education, after practice grading was introduced (Fisher et al 2017).

Methodology

Case study is particularly useful when exploring descriptive questions such as What? or How? (Yin 2009). This study aimed to explore these types of questions: What were the practice grades?; How were they assigned?; What meaning did they convey? It typically combined several sources of data to consider the phenomenon holistically. This study was broadly qualitative, as participants' experiences were examined. However, practice grades were also collected, which were quantitative. That said, the grades were not seen as fixed objective measures of student practice performance but were understood to be symbolic of the interactions that had occurred between the student and midwife during the placement. To understand the phenomena and reasons for one grade or another, one had to hear the experiences of the participants involved. Therefore, the case study included the experiences of participants in one UK university and practice partners from three NHS trusts where students' practice was graded.

Ethical approval was gained to collect data between 2011 and 2015. This was relatively straightforward as the author was studying at one university and working at the second from where data was collected. However, gaining access to the hospitals was a long, complex and frustrating process. Initially one of the three NHS sites declined a request for access but eventually, ethical approval was granted for all three NHS sites.

As a lecturer in the university and partnership trusts where the study took place and as a researcher, it was important for the author to consider her position as an insider and outsider. Indeed, any interpretive approach should reflect upon the role of the researcher as the primary instrument of data collection (Merriam

1988). At all times, the author strived to reduce power differences to encourage disclosure and authenticity between herself and the participants. However, in doing so the author faced some ethical tensions and ultimately tried to uphold the ethical principle of non-maleficence.

Students had three or four placements per year, of at least four weeks but frequently longer, where they would work alongside a qualified midwife. The placements comprised community, labour suite, the birthing unit and antenatal and postnatal ward settings. On each placement the student was expected to have three meetings with their midwife; one each at the beginning, mid-point and end. Here students would receive feedback on their strengths and weaknesses and midwives would verify, if appropriate, competence of the NMC (2009) essential skills relevant for that placement. Additionally, students had a formative and summative grade each year. The formative grade, included feedback from, midwives on skills, attitudes or knowledge that the student needed to work on to improve their summative grade at the end of the year. The summative grade contributed towards the student's degree classification and is the one used for this research.

To understand how the grades were attributed and the meaning derived from them, qualitative data were collected from participants. This included 51 students who participated in 11 self-selected group interviews and all five of the lecturers at the university who discussed their collective experiences. Midwives (n=15) from three NHS hospital trusts providing practice education were interviewed individually to discuss how they graded students' practice.

Quantitative findings

Over the five years of the case study, 124 students commenced the two midwifery courses between February 2009 and February 2013. The three-year direct entry course comprised 93 students and the shorter course for qualified nurses, 31 students. The first-year grades of the three-year course did not count towards their degree classification, so these were not analysed. Twenty-four students left the course early in their studies. Two students transferred in from other universities, and a further six students left before they qualified (some received a second-year grade, others did not). With the resubmissions this study examined a total of 208 grades which contributed to the students' degree classifications.

Table 3 shows that the majority of student grades were 70% or above. This accounts for 75% of all midwifery student grades (157/208). A smaller proportion (25/208) 12%, were awarded 60–69%. Meaning 87% were awarded high practice grades. Only 2% of students were awarded grades of 50–60% and no student was awarded a borderline pass on their first attempt for practice.

The 13 grades which were classified as a fail represent ten students. During the five-year case study two

students, one from each course, were failed and withdrawn at the end of their studies (1.6% of the 124 students who commenced midwifery). The other eight students (80% of those referred) passed with a capped grade on their second practice placement. The six students who left the course prior to qualification had concerns raised by their midwives about their practice. This is not to say they would have failed or that they did not have the potential to succeed but the outcome of their grade is unknown and potentially masks the statistics.

These findings concur with a retrospective survey of 27 UK universities (52% response rate) which compared referral rates for student nurses (Hunt et al 2012). The fail withdraw range for practice was 4.25% in nursing (Hunt et al 2012) compared to 1.6% in this study. In nursing 79.5% of students passed on subsequent attempts (Hunt et al 2012) which was similar for midwifery students in this study. However, in nursing, students were more likely to be failed in practice in their second year (Hunt et al 2012). Whereas most of the midwifery students failed in this study were in their final year.

There was minimal stratification of practice grades as the majority were clustered at the top of the scale, as is the case with other research presented in the literature review. For example, Scanlan & Care (2004) studied 4500 student nurses' grades over a 25-year period and found 90% of grades were a B+ or higher, and 80% received an A or A+ in their last practicum in the United States (US). More recently in midwifery, Edwards (2012) noted 95% of the 38 grades were clustered towards the top, although she does not state the grade.

Qualitative findings

As expected, there were many differences in the meaning derived from the assessment of practice and grades. Students understood their practice was observed by the midwife, however, there were perceived variations in the amount of time available for observation of practice between community and hospital environments and different midwives.

'I think mentors in the community ... see more of your practice and your communication everything like that because they are with you all the time, whereas in the hospital the midwives tend to leave you with the women on your own for periods of ... they don't actually see what you're doing.' (Student (S) 24)

Some students knew of strategies to ensure midwives were aware of their practice if they had not been present during the interaction.

'If you've given a woman a piece of advice that you

know is the right piece of advice, you just want, like if your mentor goes out of the room, and she comes back in the room oh I'll say we were just discussing and reiterate the whole conversation.' (S20)

For some students being observed was an uncomfortable experience.

'Every time, someone standing there and watching me then I just go to pot and I'm nervous and then they go out the room and I'm chatting away and it's fine and they come back in the room and I'm like silent again.' (S17)

Observation was not the only tool midwives used to assess students' practice.

'I've been asked questions about things before they've [midwives] asked why are you doing this? Um what's your rationale? What are you going to do? What equipment do you need? and things like that.' (S19)

No student doubted their midwives' ability to assess their practice, but several students thought midwives were not familiar with the grading process.

'They don't understand how it works; they have to have it explained to them all the time.' (S20)

However, some midwives disputed this:

'You can look at the criteria and give them [the student] examples.' (Midwife (M)1 and M5)

Some students recognised it was easier to receive higher grades in practice than theory.

'Say you got 85% in an essay then you'd be like, wow, that's crazy publishable ... it's easier to get higher marks in [practice].' (S19)

Others thought based on feedback that they deserved high grades.

'I'd have been very disappointed if I hadn't got a first, over 70% on that [practice]. Because I felt from the feedback that I'd had and the interviews that I'd had and from everything that happened in the three years nothing had even been pulled up that I needed to improve or change apart from developing my skills and knowledge.' (S44)

Others thought the relaxed relationship between students and midwives was detrimental to grading objectively.

'If they like you as a person ... and want to be your friend they're 100% more likely to give you fantastic grades.' (S20)

Several students thought their practice grades were placement-specific and one grade per year was insufficient as it did not reflect all their practice

Table 3. Practice grades.

Number of grading episodes	Number of refer/fail grades	Number of 40–49% classifications	Number of 50–59% classifications	Number of 60–69% classifications	Number of 70–100% classifications
208	13	8 (all second attempts)	5	25	157

experiences. Although there was no discernible difference between the grades awarded in each placement area, there was a perception that what students were awarded in one area was not transferrable to the next placement.

'You might be competent in community, but you might fall to bits on labour suite.' (S36)

Discussion

The findings suggest that most midwifery students are performing very well and that only a few are not at the highest level. However, students recognised that midwifery-specific knowledge was not always assessed sufficiently, especially when the midwife did not witness the student's performance. This left students questioning the reliability and fairness of a graded performance. Leaving students to care for women on their own happened more frequently in the hospital than in the community. Some students knew of strategies to ensure their performance was visible to their midwives if they were not physically present in the rooms, such as, reiterating conversations with women back to them. Despite these differences, most students were awarded high practice grades.

According to Bernstein (2000), an eminent British educational sociologist, a graded performance should demonstrate differences between students. It is an assessment for stratifying how well the student has met the criteria. With limited stratification, it could be argued that the criteria are not explicit enough, and the grading tools are, as Gray & Donaldson (2009) suggest, not reliable or valid, yet they need to be according to Bernstein (2000) for a graded performance. In a performance model the grade awarded is not transferrable to another area, so the grade has no value in the next area of practice (Bernstein 2000). The students in my study thought they should be assessed in each area of practice too, since their performance in the community did not relate to their practice in the hospital, despite similarly high grades in each area. Competence assessment, alternatively, crosses the boundaries (Bernstein 2000).

The author's understanding of the grades is that the midwife is authorising the student to progress as expected rather than grading their practice, so the assessment is a competence model rather than a performance model. This deviates from the official UK standard (NMC 2009). As the *Global standards for midwifery education* (ICM 2010) focus on competency assessment, one could question whether grading in practice is necessary, especially when it potentially leads to inflated degree classifications which has the potential to devalue their currency for student midwives. Registration is the beginning of a lifelong learning experience, and the midwifery profession needs to consider whether grading of practice has a place in this process. As Eraut (1994) states the predictive value of the grade post registration is limited.

The evidence is strong that practice grades in nursing, medicine, physiotherapy and occupational therapy tend to be clustered towards the higher end of the grade ranges regardless of the grading type; letter, mean or descriptor (Table 2). In common with the literature presented above, students in this study thought the social interactions between themselves and their midwives affected the grading practices. It may be that practice is harder to assess, that the assessment needs to combine multiple parts to be reliable and fair. That the assessment, often based on observation, is not capable of stratifying students or the relationship between students and assessors, affects the grades.

One way to potentially increase the reliability and validity of the practice assessment is to separate out the relationship that develops over several weeks in clinical practice between the student and midwife. This fits with the new NMC (2018) model of supervision and assessment. However, research from a US faculty that graded students after working occasionally with them, still tended to award high practice grades in nursing and medicine (Scanlan & Care 2004, Weaver et al 2007, Amicucci 2012, Paskausky & Simonelli 2014).

Recommendations

The introduction of an oral examination as well as observation of practice seemed to be beneficial in midwifery, physiotherapy, medicine and nursing (Briscoe et al 2006, Clouder & Toms 2008, Imanipour & Jalili 2016). Oral examinations are used in some UK midwifery assessments (Fisher et al 2017). In the former studies, student performances were stratified, and students were required to articulate their decision-making processes and the application of these to care. This enabled students to foreground knowledge rather than relationships with midwives in clinical practice. If the profession values grading of practice, an oral examination may be helpful to stratify midwifery student performances.

A Council of Deans for Health (CoDH 2017) discussion paper, suggests that the NMC revisits the rationale for grading of practice or a pass/fail assessment informed by the evidence base. The evidence base includes variations across the UK of grading practice which have led to challenges in achieving consistency (Fisher et al 2017) and high practice grades despite a range of student performances. The draft standards have been published (NMC 2019a, 2019b) and there is no requirement for grading of practice so those involved in developing new midwifery curricula have the opportunity to revisit this. A practice assessment toolkit has been developed by midwifery academics that may assist in this process (Fisher et al 2019).

The global standards for midwifery based on competency assessment may also have something to offer the profession (ICM 2010). As all midwifery care requires excellent communication skills, an oral examination of choices, care options and decision making may be beneficial for the profession. The

underlying issue is that the midwifery profession needs to ensure that students are competent to practice and pass/fail seems to be the best way forward.

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