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Education is a private matter: Clinical midwives' experiences of being part-time master's students in midwifery

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ABSTRACT

When the master's degree in midwifery was introduced in Norway, clinical midwives with a professional diploma soon requested the possibility to upgrade their education to a master's degree. In 2014, a part-time master's program worth 40 ECTS credits was introduced at a Norwegian university. In this study, we aimed to explore clinical midwives' experiences of how taking a part-time master's program in midwifery was received at their workplace. We employed a qualitative research design and an explorative descriptive approach. A convenience sample consisting of 47 clinical midwives with varying seniority was recruited in 2016 and 2017, and five focus group interviews were conducted at the end of the study programs. Systematic text condensation was used to analyze the data, generating three themes. The first concerns the midwives' experiences of learning new tools to advance their profession. Secondly, they expressed hope for support, but found that education was a private matter. Finally, they experienced that financial support depended on goodwill from their employers. The study demonstrates that a master's degree in midwifery can be instrumental to strengthen clinical practice, but also points towards the need to update and strengthen management and leadership to facilitate and implement new knowledge.

1. Introduction

In 2015, the World Health Organization (WHO, 2015), in its “European Strategic Directions for Strengthening Nursing and Midwifery towards Health 2020 Goals”, presented strategies to enhance nursing and midwifery in Europe, including recommendations for scaling up and transforming education and training. The action areas include standardization of nursing and midwifery education at degree level and facilitating a culture of evidence-based practice in nursing and midwifery. The document states, “It is of utmost importance that patient safety, quality of care and the ability to apply evidence-based clinical practice are central to nursing and midwifery professional education” (WHO, 2015, p. 11). The document recommends priority action areas implementing nursing and midwifery research at national level in order to inform health strategy and policy (WHO, 2015). However, to lead and take part in research, postgraduate training is necessary. Accordingly, universities are required to develop appropriate programmes, and employers are encouraged to establish structures for nurses and

midwives enabling them to participate and conduct research alongside their practice (WHO, 2015). In Norway, five universities or university colleges offer two-year full-time midwifery education at diploma or master's level. Two of these universities also offer a part-time master's degree in midwifery for clinical midwives already holding a diploma.

2. Background

Midwifery education in Norway was established in 1818, and has since undergone several radical changes. In 1952, it became a “nursing specialization”, meaning that applicants for the midwifery program had to be qualified nurses. In 1977, midwifery programs became part of university college education. Under new legislation in 2004 (National Curriculum and Regulation for Midwifery Education, 2005), midwifery became a two-year full-time program, where theory and practice were in a 50/50 ratio. The Bologna process of harmonization of higher education in Europe resulted in the implementation of a common degree structure (Davies, 2008). In 2012, the first midwifery program in

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Norway was converted from diploma to master's degree level, worth 120 ECTS credits. Midwifery students thus obtained an academic degree and the possibility of a continued academic career, in addition to a professional diploma in midwifery. Today, four of the five institutions offering midwifery education in Norway have upgraded the program to master's level and the two years of study are still equally divided between theoretical and clinical studies.

When the master's degree in midwifery was introduced, clinical midwives with a professional diploma in midwifery soon requested the possibility to upgrade their diploma level midwifery education to a master's degree. To meet this request, in 2014, a part-time supplementary master's program was developed at a Norwegian university. It is worth 40 ECTS: a 10 ECTS course in research methods and a 30 ECTS master's thesis. The program includes seven two-day seminars with obligatory participation. The curriculum focuses on research knowledge and methods, evidence-based practice and the possibility to conduct and communicate research in midwifery. In this study, we aimed to explore clinical midwives' experiences of how taking a part-time master's program in midwifery was received at their workplace.

3. Methods

3.1. Design

This study is based in an interpretive paradigm and a humanistic tradition. In this research paradigm, reality is perceived as subjective experiences, meanings and interpretations, and not as objective entities to be studied (Malterud, 2001). Qualitative methods are a set of research strategies aiming to increase our understanding of a phenomenon, in this case midwives' experiences of how taking a part-time master's program in midwifery was received at their workplace. We therefore employed a qualitative research design and an explorative/descriptive approach in the study (Schneider et al., 2013).

3.2. Participants and setting

A convenience sample (Patton, 2002) of 47 part-time master's students was recruited from two successive cohorts in 2016 and 2017. At the time of the interviews, the participants worked as clinical midwives while attending the master's program. The participants were aged 26–58 years, and lived in different parts of Norway. They worked in maternity or postnatal wards in specialist health care, in primary antenatal care or in private clinics. Their work experience varied from two to more than 30 years.

3.3. Data collection

We conducted five focus group interviews (Morgan, 1997) at the end of the study program. An interview guide was developed containing a few open-ended questions concerning students' experiences of the program. Three teams consisting of university academic staff conducted the interviews, alternating as moderator and secretary. The interviews lasted for 45–60 min and were recorded and transcribed verbatim. The participants were instructed about taking turns to talk and that the moderator would interrupt the interview if necessary.

3.4. Ethical considerations

The study did not require approval from the Regional Committee for Medical and Health Research Ethics. Approval was obtained from the Norwegian Centre for Research Data (No. 918247). However, written informed consent to participate in the study was obtained from all participants. Before the interviews took place, the students were advised that participation was voluntary, and that they could refuse to participate or withdraw from the study without giving reasons.

3.5. Data analysis

Systematic text condensation was chosen because it is a suitable strategy for thematic cross-case analysis (Malterud, 2012, 2001). The analysis was conducted by two authors in collaboration and agreed upon by all authors. During the analysis, we strived to suspend our prior knowledge of the phenomenon and to withhold the assumption of the actual existence of what the participants described. The analysis process followed four steps. In the first step, we read the interviews to gain an overall impression, noting preliminary themes. In the second step, the interview texts were read line-by-line and meaning units, i.e. parts of the text representing the students' experiences, were identified, coded and organized in code groups. In the third step, we identified subgroups within the code groups, and the meaning units within each subgroup were summarized and condensed. Finally, we created an analytical text generalizing descriptions and concepts. Quotations were included to elucidate the findings.

4. Results

We generated three themes from the analysis. The first concerns the midwives' experiences of learning new tools to advance their profession. Secondly, they expressed hope for support, but found that education was a private matter. Finally, they experienced that financial support depended on goodwill from their employers.

4.1. Learning new tools to advance one's profession

For all participants, the need for advanced knowledge and competence was a highly motivating factor to attend the program. It was important for the midwives to be up to date professionally and they saw the part-time program as a key opportunity to continue their education beyond the diploma level. Many had looked forward to this opportunity and enjoyed being students again. Some had recently finished their diploma level in midwifery and viewed the program as a way of having their master's degree formalized, while others regarded the program as a door opener to a future academic career. According to one experienced midwife, it was important to have a master's degree since she supervised full-time master's students of midwifery in her clinical practice.

I supervise lots of students and I really enjoy it, but I've become more conscious about asking my students why they do this or that, or I ask them what caused this particular problem. Often the students say, "Oh, I haven't thought about that". The fact that I've become more conscious of this must count for something. (Interview # 2)

The participants stated that it was important to have research expertise, and they looked upon the master's degree as a tool to this end. Many aimed to combine clinical practice and academic work in the future, arguing that clinical midwives should conduct research and contribute to developing their profession. Some participants had already been included in various projects at their workplaces that required research competence and found it important to understand statistics and quantitative research methods. Others had experienced a lack of research competence compared to that of their physician colleagues. However, after having completed parts of the program, they found that their knowledge had increased, and they were able to understand and participate in discussions with their medical colleagues at local research meetings. This resulted in a change of attitude from the doctors, they said. They felt more like equal partners and were able to share a "common language".

One of the doctors invited me to join a project group working with hospital procedures. In the beginning, I felt "small" compared to the doctors, but now I'm starting to catch up with the group. I join research meetings regularly, and I'm able to participate in the discussions. It feels great!

(Interview # 2)

The participants held strong opinions about professional autonomy and the future development of their profession. They hoped that the program would help them feel more confident in joining the professional and public debate.

I think our language ... we have things in our hands and our fingers, but we do not know how to express ourselves. We need an academic language to describe what we are doing. (Interview # 4)

It was important for the midwives to safeguard and promote their own profession in order to avoid being overrun by other professions, and their experience was that the program offered a knowledge base that helped them argue for their insights and ask qualified questions in interaction with other professional groups. In their clinical practice, they had experienced that the midwifery profession was influenced by what they described as “sentimental feelings and perspectives” and stressed the need to change this. The midwifery profession was based on a strong tradition, they said, but it was time that midwives also started using academic language to describe and develop their profession.

To me, it's about the terms used in research, to get to know what they mean. And when you read a text ... now I understand the text in a completely different way ... if I read a scientific paper, I understand the terms used in the paper. (Interview # 4)

Some of the participants mentioned the increasing number of procedures and clinical guidelines introduced in maternity wards, and they described feelings of frustration and powerlessness related to the implementation of non-evidence-based procedures. In most clinics, obstetricians were in charge of developing these guidelines, and they wanted to challenge this practice. Having encountered many situations where doctors undervalued their professional knowledge, they often avoided starting a discussion about the procedures as they felt they lacked the language to argue for their professional knowledge. However, they found that the master's program had spurred them to reflect critically, and to deviate from procedures based on personal beliefs rather than relevant research.

It's something about promoting our profession to avoid being overrun by other professions. When you start doing a master's, you start reflecting and presenting arguments more, you start asking questions and being more visible. (Interview # 2)

4.2. Hoping for support, but finding that education is ‘a private matter’

The students described attitudes from the clinical management varying from negativity and total disregard of their master's education to positivity and encouragement. Some received good support, including scheduling that enabled them to attend the seminars. Others felt discouraged when the head of their department took no interest in the program when they had hoped for some support. Many were informed that they had to take the program in their spare time and at their own expense; management considered it to be a private matter and of no interest to the clinic. This prompted them to complete the program in spite of the workload.

We do this in our own spare time, we swap shifts to get here. Nothing is organized to make it easier for us to attend the seminars. More like it's the other way round ... Our clinical leaders stated quite clearly that this is something we have to organize ourselves. Nobody is cheering us on ... (Interview # 3)

The students had to organize everything themselves to be able to attend the seminars. For some, it was difficult to get time off from work, while others found it difficult to get unpaid leave of absence or help in exchanging their shifts. However, by the end of the program, several

students experienced a change of attitude from the management. Some were invited to present their projects at hospital seminars, while others were offered project positions or were told that their competency was interesting and useful for updating the procedures and guidelines of the maternity ward. However, some students were encouraged to start a master's degree in nursing science or a course in breastfeeding counselling by their leader instead, as this was considered more useful for the ward. Others were confronted with comments about the workload involved in completing the program. One leader called one of the participants into her office when she reported sick.

“You must be very tired doing all this work,” she said. “You work nearly full-time in the ward and well ...” She continued, informing me that the master's program shouldn't affect my working capacity. (Interview # 2)

Many participants experienced that their fellow employees were interested in the program and in the subject they had chosen for their thesis, and some said it was important that experienced clinical midwives took the initiative to start on a master's program. Newly educated midwives holding a master's degree or midwives with a PhD had the most encouraging attitude, probably because they understood the value of having a master's degree. Many students experienced encouragement and support from obstetricians, who often demonstrated a genuine interest in the students' research projects. Some were invited to join research groups by the medical staff, while others were offered assistance with their research, such as access to relevant databases in the hospital. However, after a time, the participants experienced a lack of interest from their colleagues, particularly from other midwives.

My colleagues aren't interested. More and more midwives have a master's degree now, so my colleagues are tired of hearing about it. One of my colleagues asked me why I didn't work 100% in the clinic instead of being a student. (Interview # 2)

4.3. Financial support depends on goodwill from one's employer

The participants described varying attitudes from their employer regarding financial support for the program. A limited number of students had their travel and hotel expenses covered by their employer, while some were given paid leave to attend the workshops and to write up their master's thesis. This implied a moral obligation to continue working at the ward after they had completed the program, they said. Others received financial support initially but later had it withdrawn. As a result, they had to pay the remaining expenses themselves. Most students received some financial support, but their employer said they were greedy if they expected more as that would affect the educational budget of the ward.

I thought the leader would support me but I was accused of being greedy if I wanted more. They said I was stealing from the educational budget of the ward and that I couldn't have it all. (Interview # 3)

Some students received no financial support whatsoever from their employer and had to cover all expenses themselves. This felt discouraging, as they were aware that their leaders were allowed paid leave themselves for their master's degrees.

I have three leaders who are having their master's degree paid as well as time off to study and write. I was allowed one hour compensation when we had the last seminar! One hour! (Interview # 3)

An important theme for discussion among the participants was the possibility of a salary increase when they had completed their degree. Once again, the participants described a variety of experiences. Some students were told that they would receive no compensation at all since the education was a private initiative, while others were told they would be in a position to negotiate their salary once they had finished the program. One hospital informed the students that if the management considered their master's degree relevant, the hospital would

consider the possibility of a salary increase. Others found that their employers simply had decided not to offer financial compensation for a master's degree as it was considered unnecessary.

I get no help from the hospital whatsoever. I work full-time as a clinical midwife and I do this on my own initiative. I've been told I won't get a salary increase (Interview # 3).

One factor that was important to many students was the possibility to use the newly acquired knowledge in their clinical practice. Some of the students who had been encouraged by their employer to start on the program chose a subject for their master's thesis that was of interest to their employer and themselves. One student was asked to conduct a project mapping midwives' experiences with screening for domestic violence, while another chose a theme for her thesis related to her hospital's global engagement. However, most students received no cooperation from their employer when making decisions about a topic for their thesis. They would have preferred such cooperation because they felt it would have been an excellent opportunity for the ward to start a research project, and were therefore disappointed when their employer demonstrated no interest.

We asked if we could do some kind of ... We'd just started a new program in our ward and the ward was supposed to conduct a user survey related to the program. We asked if we could take part in this work. They told us that would be a way of making things easy for ourselves ... (Interview # 1)

5. Discussion

In this study, we explored clinical midwives' experiences of how taking a part-time master's program in midwifery was received at their workplace. The findings demonstrate that clinical midwives and their leaders hold different opinions about the importance of and need for continual professional education in midwifery on a master's level. These differences were reflected in the practical and financial support the students received from their work place when accomplishing the program. As a result, the midwives' abilities to invest their private time and money became decisive to accomplish the education.

The findings demonstrated that midwives were concerned about having high professional standards. They described themselves as responsible and accountable professionals (*ICM International Definition of the Midwife, 2011*). Unlike ordinary (full-time) master's students in midwifery, they did not have to struggle with the transition from being a student to being a professional midwife, they already possessed advanced clinical midwifery skills (*Hermansson and Mårtensson, 2013; Lukasse et al., 2017; Hughes and Fraser, 2011; Schytt and Waldenstrom, 2013*). *O'Connell and Downe (2009)* argue that clinical midwives describe themselves as guardians of normal childbirth, and perceive performing "real midwifery" to be the authentic position of the midwifery profession. The midwives in this study argued the importance of advancing midwifery knowledge to safeguard their profession, but at the same time they described how "sentimental feelings and perspectives" sometimes influenced clinical practice and they believed this devalued their profession. This may refer to an understanding that tacit knowledge still plays an important role in midwifery. However, to develop a sound knowledge base, we argue that a profession should lean on traditions developed within different paradigms, including the use of theory to underpin and strengthen clinical practice. Combined with a reflective attitude, this reduces the risk that tacit knowledge becomes tacit lack-of-knowledge, reflecting rigidity and blind spots in professional practice rather than developing and challenging established knowledge (*Wackerhausen, 2008*). Today, the medicalization of labor units necessitates interprofessional collaboration between midwives and obstetricians. However, it is vital that midwives are conscious of their professional identity in order to make a qualified contribution to this collaboration (*Norlyk et al., 2013*). In this

regard, education is pertinent.

The midwives in our study were experienced midwives, and through formal knowledge and informal and tacit learning acquired in practice, they had developed ways of thinking, understanding and asking questions characterizing their professional conduct (*Wackerhausen, 2009*). Practiced within a familiar professional context, professional conduct is 'invisible' and confirmatory rather than transforming; it does not elucidate everyday practices. Expanding a familiar knowledge base on the other hand, requires a new set of 'tools'. The midwives described that it was important for them to reflect upon and question clinical practice and they were aware of elements in their daily practice that inhibited possible reflection, such as policies and guidelines developed by their medical colleagues. Studies have argued that hospital policies and guidelines prevent midwives from being autonomous practitioners (*Aanensen et al., 2018; Pollard, 2003*), arguing that critical thinking is vital to professional accountability and quality of care (*Wangensteen et al., 2010*). Consequently, it is important for midwives to engage in developing procedures and guidelines themselves, as current procedures often reflect the medical profession's opinion of labour and birth as a high-risk event (*Healy et al., 2016*). The midwives also argued that, in order to counteract the prevailing risk culture it was important to be able to discuss and criticize guidelines and protocols with their medical colleagues. Thus, they had to become familiar with "scientific language", and to understand research methods and conduct midwifery research in the future. *Farley and Carr (2003)* argue that in addition to providing excellent clinical care to women, midwives should acquire skills to critically analyze research, synthesize it into evidence-based practice and to plan, implement and evaluate their own research on the structure, process and outcomes of clinical care. The WHO describes similar ideas as strategic goals to enhance nursing and midwifery (2015), and the midwifery educator core competencies underline that midwifery educators should promote the use of research and use it to inform midwifery education and practice (*WHO, 2014*).

It is discouraging to find that, while the students describe education on a master's level important to strengthen professional development, some of the leaders considered the master's program a private matter and encouraged the students to take up courses that they considered more relevant, e.g. breastfeeding counselling. We find this attitude challenging, and ask if it demonstrates that most midwife leaders perceive the midwifery profession to be a hands-on clinical skill. If so, it is comprehensible that rethinking professional habits sometimes came at a personal and professional price for the midwives (*Wackerhausen, 2009*). They were concerned with professional identity, but still they argued the need to question habitual practices and challenge professional conduct. This may indicate that by stepping outside the accepted code of conduct, no longer attuning to and embodying the rules, beliefs and habits that represented their profession, they crossed a line that was difficult to accept for other members of their profession, including their leaders. This makes it easier to understand why they sometimes felt supported by their medical colleagues, but not by their clinical leaders and colleagues.

Being supported by their leaders was important for most midwives in order to accomplish the education. Few students were offered the possibility to perform research projects at their workplace as a part of their master's thesis and some were even told that doing this would be "making things easy for themselves", demonstrating either lack of knowledge or lack of interest in being supportive from their leaders. While some midwives were encouraged to start the education, others had to organize everything themselves, including getting time off from work or exchanging shifts to be able to attend the seminars. While some got a paid leave of absence to attend the seminars and write up their thesis, others were denied an unpaid leave. Consequently, in spite of the heavy workload many midwives carried out the master's thesis in their spare-time, and sometimes the lack of support from their leaders even seemed to spur their engagement. It is not unlikely that the possibility to provide financial support was limited by economical demands at the

various workplaces. However, the negative attitude and lack of personal support from some leaders also calls attention to limitations that deserve to be examined further, including leadership style and work place culture.

6. Strengths and limitations of the study

We used the concepts of internal validity, external validity and reflexivity as described by Malterud (2001) to discuss study limitations. To verify internal validity we asked whether the study investigated what it was intended to investigate, and whether the chosen methods had been appropriate. The advantage of our decision to use focus groups rather than individual interviews was that it enabled us to conduct the interviews while the students were attending the seminars. The interview guide included few questions, but the students were encouraged to narrate freely and reflect upon each other's comments during the interviews. Two authors conducted a systematic text analysis and condensation, and consensus about generalized meanings was achieved between all authors. However, we are aware that data analysis and synthesis are always dependent on the researcher's subjective consciousness, thus other researchers might have identified different meanings. To control for external validity it is vital to ask if the study findings can be generalized beyond the setting in which they were generated (Malterud, 2001). It is important to note that meanings in qualitative studies are not entities that exist within individuals; meanings exist in the relation between the subject and the context. Generalizations in this context refer to how far the generalized meanings transcend the context in which they were lived to encompass a range of different concrete experiences of the phenomenon. We included five focus groups consisting of 47 students of different ages and seniority from various parts of Norway and found that our sample provided sufficiently rich data to fulfil the study aim.

7. Conclusion

This study explored clinical midwives' experiences of how taking a part-time master's program in midwifery was received at their workplace, demonstrating that clinical midwives and their leaders hold different opinions about the importance of and need for continual professional education in midwifery on a master's level. The midwives enjoyed acquiring new academic skills; they learnt academic language and started questioning clinical practice. They described how the increased high-risk focus in their clinical practice restricted them from practicing good midwifery, and argued that in order to strengthen clinical practice, advance their profession and supervise future master's students in midwifery they needed knowledge that enabled them to work evidence based and to safeguard their profession. While some leaders supported the midwives' decision to carry out a master's degree in midwifery, others argued that the education was a private matter and had no clinical interest. These differences in opinion were reflected in the practical and financial support the students received at their work place while carrying out the education. Some of the priority action areas described in the European strategic directions for nursing and midwifery include the scaling up and transforming of educations to facilitate evidence-based practice and to strengthening management and leadership to meet the requirements of safe, high-quality and evidence-based care. Our study demonstrates that a master's degree in midwifery can be instrumental to strengthen clinical practice, but also points towards the need to update and strengthen management and leadership to facilitate and implement new knowledge.

Conflicts of interest

No conflict of interest has been declared by the authors.

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