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A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England

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ABSTRACT

Objective: to explore student midwives' experiences of caseloading to develop an understanding of how they perceive this educational strategy has impacted on their learning journey to becoming a midwife.
Design: a qualitative approach drawing upon the principles of grounded theory. Data were collected by in-depth semi-structured interviews.
Setting: a university in the South of England providing undergraduate pre-registration midwifery education across Advanced Diploma and BSc (Hons) programmes.
Participants: eight Caucasian female final-year student midwives aged 23–50 years who had completed their caseloading experience.
Findings: one core category ('making it good') and four major categories emerged: (1) 'developing and managing caseload', (2) 'learning partnerships', (3) 'feeling like a midwife' and (4) 'afterwards'. The core category was reflected in all the other categories and was dependent upon them.
Key conclusions and implications for practice: students identified caseloading as a highly beneficial learning approach, facilitating application of theory to practice and acquisition of new skills promoting confidence and competence in practice. Students articulated an overwhelming desire and concern to meet and facilitate women's expectations. Perceptions of letting the woman down evoked feelings of inadequacy and failure. Flexible working practices, on-call commitment and carrying a caseload alongside academic and home commitments was, for many, emotionally stressful. Effective preparation of students for the realities of caseloading, the development of realistic caseloads that take account of the student's individual situation, and the provision of supportive frameworks are essential.

Introduction

The new Standards for Pre-registration Midwifery Education (NMC, 2009) require all higher education institutions across the UK providing pre-registration undergraduate midwifery programmes to afford student midwives the opportunity to experience continuity of care through caseloading practice. A caseload is defined as a group of women for whom the student provides care and support from early in pregnancy throughout the childbearing continuum (NMC, 2009). This change in educational strategy will expose students to new ways of working, and impact on the way in which they experience work-based learning. A core element of midwifery education, work-based learning exposes students to experiential learning opportunities through working alongside their sign-off mentors in clinical practice (NMC, 2009).

Studies suggest that work-based learning is highly valued by students as it affords the opportunity to develop confidence and competence in professional skills within real-life contexts, promoting the development of professional attributes through the generation of knowledge of practice (Spouse, 2001; Papp et al., 2003; Morgan, 2005). This learning occurs within a complex social context requiring students to combine psychosocial, psychophysical and cognitive skills in order to plan and deliver holistic woman-centred care facilitating clinical reasoning, problem solving and interpersonal communication skill development (Freeth and Parker, 2003; Chan and Ip, 2007).

However, there is evidence that short clinical placements hinder learning as they do not facilitate the active engagement of the student in the clinical setting, or the opportunity to explore, assimilate and reflect on knowledge to develop understanding and meaning (Nolan, 1998; Morgan, 2005). In an American study exploring students' experiences of continuous versus block placements, Adams (2002) reported that students experiencing multiple placements felt they lacked depth. This is because students do not initially fully engage in new workplace environments, requiring time to settle in (Nolan, 1998), and mentors need time to get to know individual students' learning needs (Knuteson and Wielichowski, 1994), potentially limiting opportunities for independent working.

Deep learning within clinical practice takes time, requiring regular exposure to, and active participation in, client care

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(Lofmark and Wikblad, 2001; Morgan, 2005; Chan and Ip, 2007). Student caseloading practice occurs outside of block placements and facilitates close contact with a known group of women through continuous care provision throughout the woman's childbearing journey. This current study explores student midwives' experiences of caseloading practice and how they perceive it impacted on their learning journey to becoming a midwife. It was anticipated that the insight gained might support the future development of student caseloading in pre-registration midwifery programmes.

The literature revealed a paucity of information around student caseloading, comprising primarily of anecdotal and reflective accounts. One recent study by Rawnson et al. (2009) explored student midwives' perceptions of their preparation and support during caseloading. In relation to their learning for midwifery practice, students identified the attitude of their community-based midwife mentor as important. Student learning was enhanced where mentors were known and trusted or conveyed a desire to develop a supportive and mutually trusting relationship. A perceived lack of mentor interest negatively impacted on student learning. Caseload practice fosters opportunities for students to work more independently, with indirect rather than direct mentor supervision. The development of reciprocal trusting student/mentor relationships in which good communication exists is therefore essential to ensure safe practice (Rawnson et al., 2009), and optimise student learning, confidence development and skill acquisition (Randle, 2001; Papp et al., 2003; Licqurish and Seibold, 2008).

Qualified midwives working in continuity of carer schemes report high levels of job satisfaction (Sandall, 1997a, b; Walsh, 1999), and there is a reluctance among midwives who have worked in this way to return to more conventional ways of working (Stevens and McCourt, 2002c). Significant factors that appear to contribute to this satisfaction include the potential to develop meaningful reciprocal relationships with women (Sandall, 1997a, b; Walsh, 1999), and having an opportunity to provide quality care to women through caseloading (Stevens and McCourt, 2002b).

It is reported that caseloading practice promotes professional autonomy, facilitates increased practitioner confidence in holistic care provision and clinical decision-making skills (Sandall, 1997a, b; Stevens and McCourt, 2002a, 2002b), has the potential to transform approaches and attitudes to midwifery practice (Page, 2003), and improves inter professional communication and collaboration (Stevens and McCourt, 2002b).

The on-call commitment integral to caseload practice is reported as a stressor for midwives, particularly where they lack occupational autonomy (Sandall, 1997b; Todd et al., 1998; Stevens and McCourt, 2002b) or childcare support (McCourt et al., 2006). Parallels can perhaps be drawn with students who caseload, raising issues for the curriculum in terms of educational preparation and initiation of supportive frameworks. However, unlike midwives who caseload, student caseloading occurs within the context of a single time limited period, where the size of caseload carried is small and individually negotiated.

Midwives were also found to over-commit themselves to the women within their caseload at times, resulting in emotional and physical exhaustion (Sandall, 1997a, b; Stevens and McCourt, 2002b). Factors that promote sustainable practice and reduce stress and emotional and physical burnout include control over the organisation and management of professional workload (Sandall, 1998), and peer and social support systems (Sandall, 1997b, 1998; McCourt et al., 1998). These are important issues to consider in examining the student experience of caseloading.

Methods

Setting

The setting was a university in the south of England providing undergraduate pre-registration midwifery education programmes. Programmes are of three years duration with each annual student cohort consisting of around 75 students. Students experience clinical practice within local National Health Service (NHS) trusts across a wide geographical spread, encompassing urban and rural areas with a variety of integrated and more traditional models of service delivery. Students commence caseloading practice during the final 18 months of their midwifery education, individually negotiating the size of caseload in consideration of personal and academic commitments. This can extend from one to a maximum of 18 women. During this experience, there is an expectation that students will commit to be on-call for the woman's labour and birth from 37 weeks of gestation (Fry et al., 2008). Allocation to traditional clinical placement areas continues with students negotiating flexible working patterns within their shift allocations to facilitate holistic midwifery care provision for the individual women within their caseload. As the caseload develops, mandatory practice hours may be accrued through caseloading practice requiring only tacit attendance to allocated placements. While university attendance continues, students may negotiate to attend women within their caseload for urgent events arising antenatally/postnatally, scans or during labour. Non-urgent attendance should be negotiated around taught time. Students are supported by a midwife tutor, who links to their clinical area, throughout their caseloading experience and are supervised by a community-based midwife sign-off mentor. This supervision is initially direct but, as the student matures in their caseloading experience, becomes increasingly indirect, enabling the student to take on greater decision making and personal responsibility (Fry et al., 2008).

Approach

A qualitative approach drew upon grounded theory. According to Glaser and Strauss (1967), grounded theory is particularly suited to areas of research which have not been explored previously, having utility for the researcher attempting to identify unknown or unclear phenomenon. This approach utilises a systematic approach to data collection and analysis, allowing exploration of participants' feelings in detail while considering the context in which the research is conducted (Charmaz, 2006).

Sample and recruitment

To bring the study to the attention of potential participants, an e-mail containing two attachments (an information sheet and an invitation letter) was sent to all third-year student midwives. Arguably, students although adults potentially lack autonomy as their freedom to refuse to participate in research around their teaching may be impaired by a perception that they have little choice (Clark and McCann, 2005). To ensure participation was voluntary, the initial e-mail, information sheet and invitation letter were couched in clear terms, informing students that non-participation would not incur any penalty or subsequent discrimination.

The initial purposive sample was taken from the whole third-year cohort and comprised students from both Advanced Diploma and BSc (Hons) programmes who had completed their caseloading experience, caseloaded two or three women and were not clinically placed within one local NHS trust. The exclusion of

students from one clinical area arose from a desire to uphold the principle of autonomy as, arguably, the researcher's relationship with these students through her link tutor role could impinge on their perceptions of freedom of choice to participate (Clark and McCann, 2005). Four students who had caseloaded two or three women and who responded to the introductory e-mail were contacted and interviewed.

Emerging categories from initial analysis of data directed theoretical sampling as students who had carried caseloads comprising a larger number of women were sought to confirm, refute or extend concepts. Data collection continued until no new concepts of importance to the developing constructs emerged, and saturation of the categories was felt to be achieved. The final sample comprised eight Caucasian female student midwives aged 23–50 years from five NHS trusts, six of whom were married and seven of whom had family commitments (Table 1).

Data collection

In-depth semi-structured interviews were carried out at the location most convenient to the student; either clinical site or university. Five students chose the latter and these were conducted in a classroom to provide a neutral and non-threatening environment (Kvale, 1996). Verbal information about the study was reiterated prior to the interview, and consent requested. Students were also reminded of their right to withdraw at any time. The taped interviews of 30–90 minutes were initiated by an open-ended question in which students were asked to describe how they felt about their caseloading experience. Subsequent sequencing of questions from the interview guide was guided by the student's responses. All interviews were transcribed verbatim and analysed consecutively. All students were offered a transcript of their interview, and invited to contact the interviewer if changes were required (Tobin and Begley, 2004). To explore emergent constructs, there was some deviation from the interview guide and questions evolved from the developing theory were employed as the interview process moved to theoretical sampling.

Data analysis

Each transcript was read carefully to capture the whole of the content and improve theoretical sensitivity. Data analysis began with a process of open coding, transcripts were examined line by line, and all words or segments of text carrying meaning were given codes. Through a process of focused coding, open codes were selected and grouped to form initial loose categories as those with similar traits were linked. Twenty-eight loose categories emerged through this process, revealing concepts that were subsequently integrated to form seven minor categories and ultimately refined into four major categories–'developing and managing caseload', 'learning partnerships', 'feeling like a midwife' and 'afterwards'–building towards the one core category–'making it good' (Fig. 1). Constant comparative analysis was central to this process, as sections of data were compared and developing constructs verified, refuted or modified as conceptual relationships were sought. To aid this process, theoretical memos were made, describing the researcher's interpretation of the emerging constructs, the rationale for decisions made, along with reflective accounts of the data analysis.

Through a process of selective coding in which categories were further integrated and refined (Strauss and Corbin, 1998), the core category of 'making it good' was conceptualised. This was the very essence that integrated all of the other categories and lay at the heart of the emergent theory.

Recruitment began following receipt of ethical approval from the University Research Governance Committee and gaining support from the Lead Midwife for Education.

Findings

The characteristics of the eight interviewees are presented in Table 1. To maintain their anonymity, pseudonyms have been used.

Core category: making it good

'Making it good' reflected the students' overwhelming desire and concern to meet and facilitate women's expectations, and was the conceptual strand that wove through the analysis encapsulating participants' experiences, linking and bonding together all four major categories. Through the analysis, the emergent constructs grew, with the core category being represented by a flower, the 'Caseloading Bloom', and the emergent constructs as part of the flower (Fig. 1). The Caseloading Bloom illustrates the potential for students to move from burgeoning bud to full blossoming through developing meaningful learning partnerships with women through caseloading.

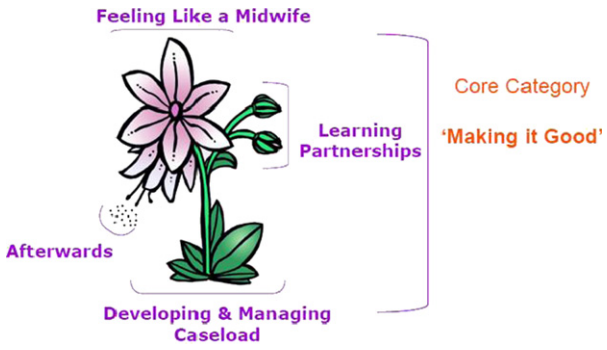

Fig. 1. Conceptual map: the caseloading bloom.

Table 1
Characteristics of participants.

Name	Age (years)	Educational programme	Number of women caseloaded	NHS trust (1–5)	Marital status	Family commitments
Abigail	23	BSC (Hons)	3	1	Single	No
Beth	34	ADM	2	2	Married	Yes
Carol	37	ADM	3	2	Married	Yes
Donna	35	ADM	3	3	Single	Yes
Eve	36	ADM	12	4	Married	Yes
Fran	48	BSC (Hons)	9	4	Married	Yes
Grace	50	BSC (Hons)	4	5	Married	Yes
Heather	36	BSC (Hons)	8	3	Married	Yes

Developing and managing caseload

This category explores participants' experiences in planning, building and managing a personal caseload. As plant leaves are the essential life-blood of the organism, the fundamental nature of this category to the student caseloading experience is symbolised by the 'leaf' image within the caseloading bloom (Fig. 1).

In the interviews, developing, managing and carrying a personal caseload alongside university, academic and social commitments was described as challenging. A primary source of anxiety for students was how to balance the competing pressures of academic assignments and caseloading:

> The impression was you know 'oh it's terribly time consuming' and um you know, 'there won't be time for you to concentrate' on your studies (Heather).

> 'I think if I hadn't had all the other assignments to do I probably would have done more [caseloading] and I would've enjoyed it, enjoyed doing more … but I didn't want to, um you know with a family life as well I didn't want to commit to, cause assignments don't come easy to me (Carol).

Preparing for examinations and assessments are known major stressors for students (Clarke and Ruffin, 1992; Jones and Johnston, 1997; Lo, 2002). Furthermore, feelings of stress are significantly increased where students combine other demands with studying, or have insufficient time to complete assignments (Snape and Cavanagh, 1997).

Choosing which women to caseload was a further dilemma, as a strong desire to build meaningful relationships with the woman and her family was articulated. It was the development of such relationships that made caseloading emotionally satisfying and rewarding for the students. While all students reported experiencing such relationships, some felt that they had failed to forge emotionally satisfying relationships with individual women in their caseload. Not being able to build such a relationship negatively impacted on students, evoking feelings of dissatisfaction and regret:

> I often thought to myself 'I wonder why she said yes to caseloading. What, what was it she thought she would get out of it, because she kept me at such a distance'. I couldn't quite, I couldn't, I couldn't give what I had to give (Fran).

Failing to build meaningful relationships with women was reported as a source of frustration and stress for caseloading midwives (Sandall, 1997b; Stevens and McCourt, 2002b). For students, being able to compare their relationships helped mitigate negative emotional feelings, creating a more balanced and rich learning experience.

The students expressed a deep sense of commitment and responsibility to the women, with a strong desire not to raise unrealistic expectations, and a need to build a mutually trusting student/woman caseloading partnership based on honesty:

> With your caseload ladies you sort of want to go out for them 110%, you really do (Eve).

> Make them aware of what you are able to offer them. Don't give anything that you can't, can't deliver at the end of it, and be honest with them (Carol).

Students often reported working outside their usual shifts, using a flexible way of working, to 'make it good', by providing individualised woman-centred care. Students who enjoyed having this level of control over their work successfully integrated caseloading with family life. For many, trying to juggle home and family lives around such flexible working practices was often stressful. Being on-call was a further challenge, and events at home and the pressure of achieving academic commitments further compounded issues, placing students under additional stress:

> Obviously you can be called-out any time of day or night and you think 'oh great, got to get the kids somewhere to be looked after or get your husband home'. So I think that was quite a big challenge (Beth).

> I had some silly things went on at home and I felt very torn. You have to realise that things are going to happen beyond your sort of power, you know, in your own life that's suddenly going to take away what you are going to give to your caseload, especially if you've got family (Eve).

These experiences of using, and adapting to, flexible working practices are strikingly resonant to those found by McCourt et al. (2006).

Learning partnerships

This category explores participants' experiences in developing learning partnerships with mentors and the women caseloaded, and how these impact on their learning. The potential for student growth and development through these relationships is symbolised by the flower bud image within the caseloading bloom (Fig. 1).

Interviewees described the importance of developing learning partnerships with their mentors and the women they caseloaded. Feedback was integral to this, and a factor crucial to 'making it good'. Getting the woman's feedback appeared to be immensely important to students, and a deep-seated need that they craved. It was often with emotion that students reported receiving small gifts, letters and cards as these were viewed as manifestations of this appreciation. Woman's verbal cues further reinforced this sense of feeling valued. The students' desire for this feedback resonates with McCrea (1993), who reported that being 'needed' or being 'important' to women is vital to being valued as a midwife.

Perceived as the linchpin within the caseloading experience, the mentor's attitude significantly impacted on the students' learning and enjoyment of caseloading. All students formed positive supportive relationships with their responsible supervising community-based mentor, engendering feelings of confidence to work without direct supervision:

> I really enjoyed it because I had a good mentor that was very supportive of me. If I had a question or a problem or whatever, it was always 'no problem we'll go through it, we'll sort it out, we'll find out' … So I never worried about going to see somebody [by her-self]. So the mentor support was really, really important (Beth).

Students' perceptions of the community setting as the most effective clinical learning environment have been reported by others; it is within these areas that students feel accepted within the team and form better relationships with mentors (Currie, 1999; Davies, 2001). These factors enhance the quality of clinical placements, and promote student learning and confidence development (Gray and Smith, 2000; Randle, 2001; Papp et al., 2003).

Mentor allocation at the time of the woman's labour was often on an ad-hoc basis, either the on-call midwife or someone already

on shift. For students, the spectre of the 'unknown' mentor was a source of anxiety:

> The only thing I found challenging was being on-call and not knowing who was going to be supporting me (Donna).

Not having the support of a 'known' mentor at this time was invariably inhibiting and disempowering, undermining students' confidence in care giving. It was within this context that role conflict and negative mentoring experiences often occurred, as Donna and Eve indicate (bold type indicates stressed words):

> The mentor support was really, really important which I think why in that one particular labour I found it so **inwardly** stressful to try and provide what I wanted to, to provide with somebody who was being obtrusive (Donna).

> I wanted them to feel comfortable with **me** and for me to support them with this homebirth, and I didn't feel I could do it, I really didn't. I think if it had been my midwife that I knew, but that's because she knew the way I worked (Eve).

Central to 'making it good' was facilitating care provision that met the women's expectations. Key within this was being an advocate for the woman and using evidence to support her choices. Working with a mentor whose practice did not embrace this ideal was a source of frustration for students that was often compounded by a feeling of powerlessness and an inability to support the woman in her wishes. 'Making it good' became virtually impossible in this situation, evoking feelings of inadequacy and remorse, yet students often co-operated with directions from the supervising midwife, rather than intervening, to avoid confrontation:

> As soon as the baby was born, she [the midwife] literally stood there with her hands on her hips at the bedside and she was like 'okay! Lets have this placenta then [physiological third stage]'… She made her get up out of bed, stand up with the baby, you know try this try that. I was just like 'oh my god this is **not** what I!' I felt so responsible for protecting her space, and here was this midwife who'd just taken over and I felt that I couldn't do anything about it…So yeah, I kind of went along with it, thinking 'oh this is totally wrong, bonding, space! Oh you know **ahh!**' (Fran).

Complying with assertive mentors' directives was found to be a coping strategy often used by students in situations where they felt vulnerable (Currie, 1999). As reported by others, negative mentoring experiences evoked high levels of stress among the students (Cavanagh and Snape, 1997), diminishing confidence and self-esteem (Randle, 2001; Licqurish and Seibold, 2008). Working with mentors who are poor role models, and who lack expertise and knowledge further inhibits learning (Gray and Smith, 2000; Morgan, 2005; Licqurish and Seibold, 2008), diminishing the caseloading experience.

Feeling like a midwife

This category explores participants' experiences of being the woman's primary care-giver and their perceptions of how this impacted on their learning journey to becoming a midwife. The open flower image within the caseloading bloom (Fig. 1) symbolises the potential for professional growth and maturity through the experiential nature of caseloading.

For students, being recognised as the primary care provider by the woman and her family was a new experience. Undertaking this role, albeit with supervision, was initially a source of anxiety for some, particularly in regard to how they might be received and accepted. All students reported that their fears were unfounded, boosting their confidence and belief-in-self as a practitioner:

> It was lovely if I did ever go on a visit with the midwife, who she knows as well because she's had five children. Um but she talked directly to me, because I was her main carer (Abigail).

> Being accepted by them, you know even as a student they're confident in you, and you know, they're happy that you're caseloading them (Beth).

> She invited me into her family, I felt kind of like part of the whole family thing as you go in, you know, you meet all the kids, the dogs (Abigail).

Being in the role of the trusted primary carer evoked strong feelings of accountability, commitment and responsibility among students. This caused a blurring of boundaries for some, making it difficult for them to truly 'let go' and entrust care provision to others:

> So it was basically me keeping on going to her ward, um and she was never there, she was always on xxx [particular neonatal unit] or I'd miss her. So I was coming in on my days off … my midwife and she actually said, 'well actually you don't need to give her that level of support'. But I felt that, I felt that I had to (Carol).

When asked to reflect on why she felt she 'had to' continue to provide care, Carol reported:

> I s'pose cause I'd given her so much care all the way through, to actually not give any care um was really tough, and she was in there for a week … I suppose the staff they were, kept on going in and she never there. So a couple of days she didn't have any checks, so I'd be then doing the checks on her. So yeah, and it was just sitting there and discussing things with her and um debriefing her (Carol).

Carol's response indicates she felt the woman's quality of care provision was in some way inadequate. This desire to protect and enhance the woman's childbearing experience was a recurring theme. Feeling needed by the woman boosted students' confidence and belief-in-self as a practitioner. However, this 'potential to meet one's own need to be needed through such work' (Stevens, 2003, cited in McCourt et al., 2006, p. 155) can lead to a blurring of professional boundaries and the development of mutually dependent relationships that are counterproductive for both women and students (Leap, 1997; McCourt et al., 2006).

Caseloading practice was a huge awakening for students, opening their eyes to the lived reality of being a midwife, generating a new awareness of the magnitude of the weight of responsibility the midwife carries in everyday practice:

> Sometimes you'd go to the house and you'd be confronted with something that you suddenly thought, 'oh I'm not sure if I know that', and you think 'oh no, you know'. And the time I went and couldn't pick up the fetal heart, and I found that quite, quite distressing…the couple were absolutely lovely, even kept saying 'oh don't worry, I'm sure its there'. And I'm thinking I can't hear it, and I, I was really quite panicky…I did go home after that episode and sort of think, 'oh my god', you know **this** is a huge responsibility, and thinking, 'am I ready for this, and am I prepared?' (Eve).

Many students expressed gratitude at having this opportunity to experience caseloading prior to qualification. Developing knowledge for future practice and organisational roles is a key aim of practice-based learning (Boud, 2001). It is further recommended that midwifery educational programmes provide

learning opportunities that enable students to experience the realities of midwifery practice (RCM, 2003).

The students reflected that providing care to the woman throughout each stage of her childbearing experience greatly enhanced their learning and practice development, consolidating skill acquisition and affording valuable insight into areas where they had not previously linked theory-to-practice. It also enabled them to see service provision from the woman's perspective, opening their eyes to flaws in the system, and many reported that they had become more questioning of previously accepted routines and rituals. Student learning was further enhanced by seeing the effects of their practice on the woman, developing increased self-awareness and insight into personal traits. McCourt et al. (2006) assert that caseloading practice facilitates clinical confidence development, as midwives are required to fully use all of their skills. For the students, this new confidence was multi-faceted, relating to knowledge, skills and professional practice, with many stating that due to their caseloading experiences, they had changed the way in which they practised. The changes expressed revealed an inner confidence in personal practice, signifying a move from role modelling mentors to self-sufficiency and autonomous practice:

> I think confidence in going and doing visits on my own and knowing what I'm doing, and actually believing in myself and believing that actually I can do this (Abigail).

> I know now that I am competent to practise on my own … um so yes, if you can be autonomous as a student, it's increased my autonomy as a practitioner without a doubt (Grace).

Afterwards

This category explores participants' feelings on concluding caseloading, emerging as a phase of loss and new horizons as participants moved back into traditional clinical placements and ways of caring. The seed group image within the caseloading bloom (Fig. 1) symbolises the significance of this category to the caseloading experience, for as new life is generated and released, the bloom begins to fade, wither and die.

Concluding caseloading and moving back into traditional working patterns and ways of caring emerged as a difficult time of transition for nearly all students, accompanied with a strong sense of loss. The finality of 'saying goodbye' was central within this, and many students talked of continuing to visit the woman to almost the full 28 days post partum, lingering over the last few visits, delaying conclusion. Although students acknowledged the transitory nature of the midwife's role within the woman's life journey, for some, the feelings of separation experienced in terminating the student/woman relationship was emotionally difficult and many found it difficult to truly let go:

> It's, it is a bit like losing a limb! Cause you've seen them for so long and you think 'ooh, ooh bye then'! (Donna).

> You know it is only a temporary thing, you're there you do your work, and then at the end you say goodbye, and everything's lovely and you let them move on to the next phase. It's funny cause they're all coming round to just about their first birthdays…and I was sort of thinking is it appropriate, I don't know, does one send a first birthday card or not? I don't know you see, because it has ended hasn't it? (Heather).

Moving back into traditional models of working presented challenges to students' values and work ethics in care delivery, and some students reported 'missing' caseloading. The mitigation or aggravation of this sense of loss appeared dependent on the initial clinical placement following caseloading. Community placements seemed to cushion transition to traditional care routines as students felt supported to practice the holistic approach to care utilised during caseloading. However, working in the hospital environment, particularly the labour ward, often contrasted strongly with the caseloading experience. Hunter (2004) reported how the differing values in work ethic underpinning care delivery within these settings impacted emotionally on students and midwives. Community midwifery care was supported by a 'with woman' philosophy, engendering a more 'emotionally rewarding' work experience (p. 268).

Conclusion

This qualitative study has explored student midwives' experiences of caseloading to develop an understanding of how it has impacted on their learning journey to becoming a midwife. Student caseloading could be considered a linear teaching and learning experience as it has clear start and end points, symbolised by the caseloading bloom stem (Fig. 1). Findings reveal that students' perceptions of caseloading move far beyond such narrow confines and boundaries, generating a knowledge and confidence that transgresses caseloading parameters, enhancing future practice. Caseloading exposed students to experiential learning opportunities through working in real-life contexts with a known group of women throughout their childbearing journey. Journeying with the woman, and feeling trusted as her primary care-giver, facilitated the application of theory-to-practice, acquisition of new skills, and reflective insight into personal attributes and qualities changing attitudes and promoting confidence and competence in practice.

While the number of women that students chose to caseload was not explored as part of this study, anecdotal reports suggest that small numbers are related to student concerns around the demands of the programme, their ability to meet women's needs if the caseload is too large, and anxiety about protecting their personal time and family life. Where caseloads are larger, this is usually the result of a student's prior experience of maternity care or the ongoing value they have found in the caseloading approach. In this study, many students described their experiences of trying to balance the competing pressures of being on-call, flexible working, and developing and carrying a caseload alongside academic and home commitments as emotionally stressful. These insights into the caseloading experiences of students can help educationalists identify areas of support that could be accessed or initiated and develop strategies to effectively prepare students for caseloading practice. Imperative within this is the creation of opportunities within educational provision that encourage student reflection on the building of appropriate and realistic caseloads that are commensurate with individual personal circumstances. Inviting students currently undertaking caseload practice to share their experiences with those preparing for this experience might be an effective strategy to assist students in this.

The students developed emotional bonds and trusting relationships with the women in their caseload, evoking a strong sense of commitment and responsibility. Key within this was 'being there' for the woman and her family, championing care choices and providing quality care provision that met her expectations. Perceptions of letting the woman down were experienced as emotionally stressful, evoking feelings of inadequacy and failure. For some students, this feeling of accountability led to a tendency to over-commit and a blurring of professional relationships. The finality of concluding caseloading and saying goodbye to the women caseloaded was also a difficult time of transition for students, and many found it difficult to truly let go. Effective preparation of students for the 'lived realities' of caseloading and

the potential emotional toll it may make upon them is therefore essential. Critical to this is the creation of curricula opportunities that facilitate peer reflection and peer support development. Student 'buddy' systems, where more experienced students are directly linked with junior students, encourage effective peer support network formation (Hart and Rotem, 1994; Aston and Molassiotis, 2003) and could be a valuable innovation during caseload practice. Educationalists must actively promote student awareness of the role of existing university and practice support networks, e.g. link/personal tutor, personal supervisor of midwives, and the importance of accessing these in conjunction with personal social support mechanisms, e.g. family and friends. Effective liaison with practice partners in monitoring student progress and well-being during student caseloading is a further imperative, along with inclusion of curricula provision around mitigating relationships and professional boundary setting.

The students identified having a constructive and supportive learning environment in which to caseload as important in terms of their learning, enjoyment of caseloading, confidence and competence development. Key within this was mentor attitude. While many student comments proved heartening, others revealed poor mentoring experiences where differences in priorities were evident. These experiences commonly occurred within the context of the 'unknown' mentor, when mentor allocation was on an ad-hoc basis. Good communication and close liaison between students, mentors and educationalists is therefore important and it is essential that all mentors are cognisant with the philosophy of caseloading, its framework and guidance regarding the mentor role. Further work is needed to elicit mentors' perceived needs to inform future mentor preparation programmes and develop appropriate mentor support systems.

The limitations of this study include the small group of student midwives sampled from one university and the voluntary nature of student participation. It is recognised that the study may reflect a unique situation within one academic institution, and no claims are made as to the wider generalisability of findings. Further research is needed to explore the issues raised. It is hoped that the audit trail helps to establish credibility and trustworthiness of the findings. Despite these limitations, the study findings offer valuable insight into the lived reality of the student caseloading experience and revealed students' perceptions of how this teaching and learning approach impacts on their learning journey to becoming a midwife. Given the limited body of information around student caseloading, study findings have the potential to be of value to other educators in light of the recent NMC (2009) educational standards.

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