**Evidence series**

**Understanding research**

**2 Theoretical and conceptual frameworks and their application to midwifery knowledge and research**

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Understanding research is a series of articles aimed at dispelling the myths around research theories and practices, and exploring just what is meant by the different terminologies encountered when reading and using research articles. On alternate months we explore different aspects of research to make this knowledge accessible and relevant. It forms part of the Evidence series, and aims to help midwives understand, use and engage with research, and consider how research matters to their practice.

**The big words (part 2)**

In 2009, I took over responsibility for the midwifery research modules at my university. I soon realised that I dreaded the teaching sessions on theoretical and conceptual frameworks. Initially, this dread came from a position of fear. Was my knowledge of these complex ideas sound enough? More importantly, would I be able to make this knowledge accessible to the students? Over time, as my confidence in the concepts and my teaching of them grew, I was apprehensive for another reason: the look of bewilderment on some of the students’ faces. Many questioned whether they would ever know enough, others admitted the ideas went above their heads.

As a teacher, I wondered whether or not to keep this content in the module. I knew it was important, but so is building students’ confidence in their ability, not knocking it. This research topic, more than others, seemed to confuse and unsettle many students, especially at first. This research knowledge was like learning another language, over and above the midwifery terminology with which the students were becoming conversant. Nevertheless, when students ‘got it’ they had an epiphany, and this was my reward. As midwives, they would need access to these concepts. Understanding research and its application to practice (whether it is the woman’s experience or professional dynamics in the workplace) becomes more likely, not less, with theoretical and conceptual frameworks. First, let’s make sure we understand theories and concepts.

**What does a theory do?**

In the first article we introduced theories; here we explain their place in research. They are tools for thinking about midwifery practice. A theory enables midwives to compare women’s experiences with knowledge from different disciplines and practice (Bryar and Sinclair 2011). ‘A good theory is one with explanatory power’ (Risjord 2010: 95). This means that theories are sets of interrelated constructs or concepts that help explain relationships between variables. A theory can be thought of as a big idea, or a map of why the world is the way it is. How theories are used is differentin quantitative and qualitative approaches.

In natural sciences, which tend to use a quantitative approach, research theories are often seen as guiding truths until proved false by other research. The theory is a proposed explanation for the phenomenon, stating a relationship between variables. This is called the hypothesis. If there is no relationship between the variables, the null hypothesis is proven. Medical research, for example, might theorise that one drug is better than another for a certain condition because body systems react in similar ways. However, as we said in the first article, human behaviour is less predictable. Therefore, in social sciences, theories are more open to alternative interpretations. Qualitative researchers employ theories as a broad explanation. This is especially if the research is grounded in the notion that everyone’s interpretation of reality is socially constructed or dependent on their individual experience. Qualitative research often starts with a theoretical framework and develops new or variations on the theory as its outcome (Somekh and Lewin 2011). We will explore an example of what it is that theories do in more detail later in this article, when we examine Dove and Muir-Cochrane (2014).

**Concepts explained**

Theories need their concepts clearly identified and defined, regardless of whether the research is using a quantitative or qualitative approach. Concepts enable researchers to distinguish one experience or event from another. They are the bricks from which theories are built (Risjord 2010). A concept is a word or phrase that encompasses the essential characteristics or key components of what is being studied. Let’s use a well known midwifery concept to explore this.

**The concept of continuity of care**

Can you identify and define the concept of continuity of care? Does it have a shared, relatively closed meaning within the midwifery community, or is it open to interpretation? Examining two research papers on the topic we can compare their definitions. One is the large-scale quantitative research of 17,674 women and babies (Sandall et al 2016). The other is a smaller qualitative study of the views of 17 women, eight midwives and one obstetrician (Dove and Muir-Cochrane 2014).

*Midwife-led continuity models provide care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period. These midwives also involve other care providers if they are needed* (Sandall et al 2016: 2)*.*

*For the purposes of this study continuity of care was defined as: a*[midwife](https://www-sciencedirect-com.uos.idm.oclc.org/topics/nursing-and-health-professions/midwife)*with*[*responsibility*](https://www-sciencedirect-com.uos.idm.oclc.org/topics/social-sciences/responsibility)*for providing antenatal, intrapartum and*[*postnatal care*](https://www-sciencedirect-com.uos.idm.oclc.org/topics/nursing-and-health-professions/postnatal-care)*to the women in her caseload, and sharing these responsibilities with medical colleagues for women at higher risk* (Dove and Muir-Cochrane 2014: 1063)*.*

From the definitions above, it is clear that both studies are defining the concept of continuity of care similarly. The essential characteristics are the midwife, the periods of time – antenatal, intrapartum and postnatal – and the involvement of others, if required. Therefore, we could consider this a closed concept from these two papers’ definitions.

Findings or theories generated from the studies are about the same concept, even if the phenomenon is studied from a different standpoint, as these studies are.

Standpoints is another big word, that means position or perspective. The standpoint is the position the researcher adopts to research the topic. If the phenomenon has clearly measurable or observable outcomes, a quantitative approach is appropriate. If there are multiple possible interpretations of the phenomena, a qualitative design will be more suitable. When studying possible interpretations about why the world is the way it is, researchers might use, for instance, a feminist standpoint to shed new light on previous assumptions. Feminist researchers would argue that the way women experience the world is not the same as men and therefore the way the research needs to be constructed needs to acknowledge this standpoint, recognising of course, that all women are unique and there is no common shared feminist perspective.

**Conceptual and theoretical frameworks**

Having examined the role of theories and concepts in research, we now need to think about the terms theoretical and conceptual frameworks. These are often used interchangeably; however, strictly speaking they mean different things.

***Conceptual frameworks***

A conceptual framework can be described as a map of the existing literature or ideas (Collins and Stockton 2018). One of the first steps of any research project is to work with the existing literature on the topic. The literature comprises a field or fields of what is known, and gaps in knowledge (Somekh and Lewin 2011). Conceptual frameworks are often used in quantitative research to provide an overall description of the field, so that data can be collected that cover all of those aspects (Somekh and Lewin 2011).

We can see that, in their introduction, Sandall et al (2016) have used the existing literature on continuity of care as a map or conceptual framework. The concepts were not based on the authors’ pre-conceived ideas but rooted in previous research. They explain that, despite the previous research, there was no one study that compared continuity models with other types of midwifery care, to reach solid conclusions as to whether or not it was safer for mothers and babies. Therefore, their study intended to fill this gap in knowledge. The seven primary outcomes that the study measured were: pre-term birth, stillbirth and neonatal death, three modes of birth (spontaneous vaginal, instrumental or caesarean), intact perineum and use of epidural (Sandall et al 2016). Data on all seven outcomes were collected and compared with models of midwifery care. You will probably be conversant with the findings of this study, but they are so important to midwifery practice that they are worth repeating here. The benefits of continuity of care models are that women were less likely to have a pre-term birth, stillbirth or neonatal death (Sandall et al 2016). Women had a greater chance of spontaneous vaginal birth, and fewer episiotomies, epidurals and instrumental births (Sandall et al 2016).

***Theoretical frameworks***

‘Theoretical framework’ is the term used to describe the body of theory which shapes research designs. The theoretical underpinnings of the knowledge base of the phenomenon under study are linked to the literature in the field, to logically show the reader how the research needed to be conducted. In qualitative research, a theory conveys the values of the researcher and provides a signpost for the reader to see how the new ideas have been generated (Collins and Stockton 2018).

If we revisit Dove and Muir-Cochrane (2014), we can see they used the concept of continuity of care and combined this with existing theories to develop a new theory. Their smaller, qualitative study found that the relationship between mothers and midwives in a continuity model, was based on mutual trust. The women felt safe and the midwives were able to negotiate safer birthing practices for them. The authors draw on other theories within their findings that relate to identity work, risk and culture. Their interpretation of the role of continuity of care is that it can protect and prepare women and prevent medicalisation of childbirth (Dove and Muir-Cochrane 2014). The authors’ values are conveyed within the article: we can see that they believe in continuity of care, and their findings act as a signpost or lens for the reader. Therefore, we suggest that the way that they used the existing literature on continuity of care and linked this to other theories, is an example of a theoretical framework.

Both articles used the concept of continuity of care as the basis for their research. However, how they used previous literature and whether this was linked to explicit theories differed. For simplicity, we have suggested that Sandall et al (2016) used a conceptual framework to research one of the seven pre-determined outcomes, whereas Dove and Muir-Cochrane (2014) used a theoretical framework to explore complex interactions, between individuals, that had multiple potential interpretations. However, as you will know, with research everything can and should be questioned. On reading the research again, you may have different ideas, and this adds to the initial confusion that students have and why the terms are often used interchangeably.

**Why this matters**

Research on midwife-led continuity models are fundamentally changing the way midwifery care is offered in the UK and in other countries. The evidence is strong that this model of care is beneficial for women and babies. Theoretical and conceptual frameworks can help clarify what it is about this model of care that accounts for the benefits. Hopefully, this article and the series are helping you understand the power of research and its application to your profession, in supporting women and their families positively.

What the midwifery profession does not yet know about continuity of care is the mechanism behind the reduction in fetal loss and neonatal death by 16 per cent – and pre-term births by 24 per cent (Sandall et al 2016). To study this important gap in midwifery knowledge one would no doubt use a conceptual or theoretical framework to map the literature and theories in the field. Perhaps you are now inspired and have an idea as to how you could study this. **TPM**

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**Further resources**

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