SECOND EDITION

The Student's Guide to
BECOMING A MIDWIFE

Edited by
Ian Peate and Cathy Hamilton

WILEY Blackwell

The Student's Guide to Becoming a Midwife

Second edition

Edited by

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Preface to the Second Edition

In the UK, maternity services have developed significantly with an increasing recognition that midwives should take the lead role in the care of normal pregnancy and labour (DH 2007, 2010). Midwifery-led care has been seen to have good outcomes such as shared care, reports of greater satisfaction from women and a reduction in obstetric intervention rates (Devane et al. 2010).

The first edition of *Becoming a Midwife in the 21st Century* was published in 2008. Since then the world has changed and the practice of midwifery continues to evolve. This second edition reflects the changes that have occurred but maintains its central aim of helping to prepare the next generation of midwives who are fit for purpose and fit for practice.

Feedback from students and lecturers alike has been instrumental in ensuring that this edition will be as popular as the first one. There are now 20 chapters in this edition arranged around the new pre-registration midwifery standards. The five essential skills clusters have been interlinked within each of the chapters where appropriate.

The new edition builds upon the positive comments made by the reviewers and anecdotal comments concerning the current text's 'student friendliness'. Each chapter commences with an aim and a set of 4–6 objectives which will help you to pre-plan learning and understand the rationale for the discrete yet intertwined chapters.

We have reviewed the various elements of pedagogy, developing this further to make it stronger and more engaging. Readers will note that the text layout has been prepared in such a way as to make it more appealing.

Chapter order has been rearranged and we have retained the popular case studies and extended them further. Each chapter has review questions using a variety of formats with answers provided at the end of the book. The aim is to improve retention and enhance learning.

As appropriate, midwifery pearls of wisdom have been provided throughout the text, providing the reader with practical hints and tips. There is a glossary of terms at the end of the book.

Updated evidence to support discussion has been provided. Reference and referral to organisations such as National Institute for Health and a Care Excellence (NICE) and other appropriate government organisations have been retained. Throughout, referral to the *Code of Conduct* and *Guidance on Professional Conduct for Nursing and Midwifery Students* has been included.

Various White Papers that have had and will have an impact on the practice of midwifery and the care of women produced by the government have been included. An additional chapter has been included focusing upon public health and the role of the midwife.

We have sincerely enjoyed being able to provide you with an updated version of the first edition. We hope that you will enjoy reading it with the primary intention of providing safe and effective care

based upon the best available evidence to those women and their families for whom you have the privilege to care.

Ian Peate and Cathy Hamilton

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Introduction

Ian Peate and Cathy Hamilton

This text is primarily intended for midwifery students, midwifery support workers, healthcare assistants, those undertaking Scottish Vocational Qualifications/National Qualifications Framework level of study or anyone who intends to undertake a programme of study leading to registration as a midwife. Throughout the text, the terms midwife, student and midwifery are used. These terms and the principles applied to this book can be transferred to a number of healthcare workers at various levels and in various settings in order to develop their skills for caring for women and their families throughout childbirth.

The unique role and function of the midwife

Midwives provide individual care to women and their families, encouraging them to participate in their pregnancy and determine how they want it to progress. Each year, over 700,000 women in the UK will give birth, nearly all of whom will have had the majority of their care from a midwife. In women's homes, birth centres and hospitals, midwives co-ordinate a woman's journey through her pregnancy, offering her continuity with the aim of ensuring that she experiences safe, compassionate care in an appropriate environment.

Midwife means 'with woman' and this highlights the empowering/partnership role of the midwife – the midwife works with the woman rather than telling her what to do. The underpinning philosophy of midwifery care is articulated by Page and McCandlish (2006) who suggest the following:

> *The essence of being a midwife is the assistance of a woman around the time of childbirth in a way that recognises that the physical, emotional and spiritual aspects of pregnancy and birth are equally important. The midwife provides competent and safe physical care without sacrificing these other aspects.*

The support the midwife offers is established by assessing the woman's individual needs and by working in partnership with her and other healthcare workers. The midwife is usually the lead healthcare professional involved in caring for pregnant women. There will be occasions when you will need to work on your own as a midwife and times when you will be working as a member of the wider team. It is

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important that midwives work collaboratively with other healthcare professionals, including obstetricians, paediatricians, specialist community public health nurses and paramedics, in order to ensure a high quality of care for women and their families.

Medforth et al. (2011) note that the definition of a midwife was first officially formulated in 1972. This was after discussions and debates among various organisations and committees and is as follows:

> *A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.*

The midwife is the senior professional attending over 75% of births in the UK, providing total care to mother and baby from early pregnancy onwards, throughout childbirth and beyond. The role of the midwife is thus multifaceted.

The midwife's role in public health

Another important aspect of that role is within the context of public health. Public health can be defined as improving the health of the population, as opposed to treating the diseases of individuals. This is particularly appropriate in midwifery as you will be caring for healthy individuals going through the physiological process of childbirth. Public health functions (DH 2004) include:

- health surveillance, monitoring and analysis
- investigation of disease outbreaks, epidemics and risks to health
- establishing, designing and empowering communities
- creating and sustaining cross-government and intersectoral partnerships to improve health and reduce inequalities
- ensuring compliance with regulations and laws to protect and promote health
- developing and maintaining a well-educated and trained, multidisciplinary public health workforce
- ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities
- research, development, evaluation and innovation
- quality assuring the public health function.

The Department of Health (2012a) defines public health as: 'about helping people to stay healthy and avoid getting ill'. Within this definition specific areas are included such as nutrition, recreational substance use, sexual health, pregnancy, immunisation and children's health. The key concerns of public health are dual: the health of populations and the health of individuals or groups within a population. The health needs of populations are embraced within overarching measures such as food and water safety, road safety and the provision of health services which are free at point of care.

A great deal of public health activity in the UK is derived from government; the drivers are political and economical, as the burden of disease is costly to a nation in which the state subsidises health and social care. Public Health England, introduced in April 2013, has been charged with protecting public health by delivering on the objectives of the Public Health Outcomes Framework (DH 2011, 2012b). The legislation responsible for this is the Health and Social Care Act 2012. At a national level in England, Public Health England will be the executive agency that delivers the wider agenda and at local level, the move of public

health services into local authorities aims to create a multiprofessional approach to delivering local strategy and supporting better healthcare for the population.

Public health activities can take place with individuals, their families or communities, on a national or international level. The midwife is ideally placed to influence and enact public health policy when working with women and their families as well as being able to develop a population perspective within midwifery.

All the chapters in this text are concerned with midwifery practice, and as such are rooted in public health. Midwives make a substantial contribution to public health by promoting the long-term well-being of women, their babies and their families. They provide information and advice regarding screening and testing, sexual health, nutrition, exercise and healthy lifestyles. The midwife promotes breastfeeding, offering support and advice, as well as providing guidance to women and their families in relation to immunisation. Public health in midwifery is not new; midwives have always provided care that has a public health focus. Public health is at the heart of all aspects of midwifery practice.

Terminology

There are a variety of terms that can be used to describe women who use maternity services. 'Patient', 'woman', 'person' and 'client' are used throughout this text and refer to all groups and individuals who have direct or indirect contact with healthcare workers and in particular registered midwives, registered nurses and specialist community public health nurses.

'Patient' is the term commonly used within the NHS. It is acknowledged that not everyone approves of the passive concept associated with it or the way in which it can emphasise a medical focus. The term is used in this text in the knowledge that it is widely understood. The other two commonly used terms – 'woman' and 'client' – are also used to reflect changes in the way midwives and other care providers are considering their relationships with users of maternity services. The term 'client' emphasises the professional nature of the relationship that the midwife has with the women she cares for. The term 'consumer' is taken from the marketplace and highlights the concept of service users as consumers of products such as medications or care services. Client and consumer have their roots in healthcare provision during the 1980s and 1990s when, particularly in the health service, market forces and consumerism were in vogue. Another term used is 'expert'. Experts are said to be on an equal footing with expert care providers (for example, midwives and obstetricians). They are often patients who live with long-term health conditions.

There are 35,305 midwives on the midwives' part of the professional register (spring 2013) (see Table I.1). The majority of midwives in the UK are women and whilst it is acknowledged that the number of men entering the midwifery profession is increasing, for the sake of brevity this text uses the pronoun 'she'.

Table I.1 Number of midwives on the midwives' part of the professional register

	Number of midwives
Male	132
Female	35,169
Total	35,305 (four forms not filled)

Source: NMC 2008b.

4 The Nursing and Midwifery Council and Quality Assurance Agency (Education)

The primary aim of the Nursing and Midwifery Council (NMC), an organisation established by Parliament, is to protect the public by ensuring that midwives and nurses provide a high standard of care to their patients and clients.

The NMC is the regulatory body responsible for promoting best practice amongst the midwives and nurses registered with it. The key role of the NMC is to ensure that women receive the best possible care. It is the responsibility of the NMC to set and monitor standards in training (Nursing and Midwifery Order 2001). The NMC has produced a framework for quality assurance of education programmes which relates to all programmes that lead to registration or to the recording of a qualification on the professional register.

The programme you have embarked on, or are going to embark on, must meet certain standards. These include the standards set by your educational institution – for example, your university's policies and procedures relating to quality assurance and external influences. The NMC and the Quality Assurance Agency (QAA) standards must be satisfied before a programme of study can be validated and deemed fit for purpose. Other external factors that must be given due consideration are the European Directives. Two European Directives – 77/453/EEC and 89/595/EEC.

The Nursing and Midwifery Order 2001 provides the NMC with powers in relation to quality assurance and, as a result of this, the production of a framework that education providers (for example, universities) that offer, or intend to offer, NMC-approved programmes leading to registration or recording on the register have to adhere to. There are many provisions in place in the UK that ensure the quality of education programmes.

The NMC has to be satisfied that its standards for granting a licence to practise are being met as required and in association with the law. It does so by setting standards to maintain public confidence, as well as to protect the public. By appointing representatives, it can be satisfied that it is represented during the quality assurance process in relation to the approval, reapproval and annual monitoring activities associated with programmes of study.

Each programme of study for pre-registration midwifery must demonstrate explicitly and robustly that it has included the rules and standards of the NMC so that those who complete a recognised programme of study are eligible for registration. The *Standards for Pre-registration Midwifery Education* (NMC 2009) are examples of standards that must be achieved prior to registration.

Midwives' Rules and Standards

The Nursing and Midwifery Order 2001 demands that the NMC sets rules and standards for midwifery and local supervising authorities (LSAs) for the function of statutory supervision of midwives. *The Midwives' Rules and Standards* (NMC 2012) replace those produced in 2004. The current *Rules and Standards* came into force on 1 January 2013 (see Table I.2).

The NMC's Midwifery Committee undertook a full public consultation exercise when revising the *Midwives' Rules* (NMC 2012). As this second edition of this text goes to press the new rules are included in the content. The rules are set to have the most far-reaching changes since the establishment of the NMC. The changes ensure that the rules are streamlined, clear and relevant, and the NMC will continue to maintain a statutory framework for the practice and supervision of midwives that aims to protect the well-being of mothers and babies.

Major changes to the *Midwives' Rules and Standards* include the following:

- Some rules were simplified and clarified, and rules which are already covered by other standards or legislation have been removed.
- Local supervising authorities will be required to publish guidelines for the annual review of midwives' practice to ensure a standardised approach across the UK.

Table I.2 The 15 midwifery rules

Rule	Description
1.	Citation and commencement
2.	Interpretation
3.	Notification of intention to practise
4.	Notification by local supervising authority
5.	Scope of practice
6.	Records
7.	The local supervising authority midwifery officer
8.	Supervisor of midwives
9.	Local supervising authority's responsibilities for supervision of midwives
10.	Publication of local supervising authority procedures
11.	Visits and inspections
12.	Exercise by local supervising authority of its function
13.	Local supervising authority reports
14.	Suspension from practice by a local supervising authority
15.	Revocation

Source: NMC 2012.

- Guidance has been added to outline how best to deal with issues arising from a midwife's practice.

The rules will continue to state the requirements for practice and the accompanying standards offer extra guidance on what standard would reasonably be expected from a practising midwife.

Becoming a competent midwife

Those who wish to study to become a midwife, and then go on to register with the NMC and afterwards practise as a midwife must undertake a 3-year (or equivalent) programme of study. The number of hours to be studied by student midwives can vary. Each programme must comprise 2300 practice hours as a minimum and the programme must be at least 50% practice based (the total theory and practice combined must be a minimum of 4600 hours). The NMC, for example, allows for programmes to comprise 60% practice and 40% theory. This flexibility must be NMC approved.

The title 'registered midwife' is protected in law. This means it can only be used by a person who is registered with the NMC and her name must appear on the national register. There are three parts to the professional register:

1. Nurses
2. Midwives
3. Specialist community public health nurses

Table I.3 Summary of the standards for pre-registration midwifery education

Standard	Summary
Standard 1	Appointment of the LME
Standard 2	Development, delivery and management of midwifery education programmes
Standard 3	Signing the supporting declaration of good health and good character
Standard 4	General requirements relating to selection for and continued participation in approved programmes, and entry to the register
Standard 5	Interruptions to pre-registration midwifery education programmes
Standard 6	Admission with advanced standing
Standard 7	Transfer between approved education institutions
Standard 8	Stepping off and stepping on to pre-registration midwifery education programmes
Standard 9	Academic standard of programme
Standard 10	Length of programme
Standard 11	Student support
Standard 12	Balance between clinical practice and theory
Standard 13	Scope of practice experience
Standard 14	Supernumerary status during clinical placements
Standard 15	Assessment strategy
Standard 16	Ongoing record of achievement

Source: NMC 2009.
LME, lead midwife for education.

The student who wishes to undertake midwifery education must meet the NMC's requirements as well as any specific requirements the higher education institution may have. How these requirements are set is the prerogative of the individual educational institution; however, the NMC must agree to and permit these requirements and there must also be evidence of literacy and numeracy. Those wishing to practise in Wales must also be able to demonstrate proficiency in the Welsh language where this is required. On entry, during and on completion of their programme, all applicants must demonstrate that they have good health and good character sufficient for safe and effective practice. It is the responsibility of educational institutions to have procedures to ensure assessment of health and character. Any convictions, cautions or bind-overs related to criminal offences must be declared. There are several ways in which this can be achieved – for example, self-disclosure and/or criminal record checks conducted by accredited organisations.

Completion of the programme and achievement of the standards mean that the student will graduate with both a professional qualification (registered midwife (RM)) and an academic qualification at degree level. The good character and good health declaration is made on an approved form provided by the NMC. This must be supported by the registered midwife whose name has been notified to the NMC, who is responsible for directing the educational programme at the university, or her designated registered midwife substitute. This midwife is known as the lead midwife for education (LME).

Once registered with the NMC, the midwife is accountable for her actions or omissions and is bound by the tenets enshrined in the *Code of Professional Conduct* (NMC 2008a). Legal requirements, such as participating in continuing professional development and maintaining a personal professional portfolio, must be addressed. This text provides you with insight into how to become a competent midwife.

There are 16 standards associated with pre-registration midwifery education. These range from the appointment of the LME to standards for the structure and nature of a pre-registration midwifery programme (see Table I.3). This text will address the standards for entry to the register for midwives. Currently, no other texts describe in the same detail the levels of education required to achieve the NMC standards for pre-registration midwifery education proficiency.

Case notes and activities

Most of the chapters provide the reader with case notes to consider and activities to carry out. They are included to encourage and motivate you, as well as for you to assess your learning and progress. It is also anticipated that they will enable you to link theoretical concepts with what is occurring in the clinical setting. There are a variety of review questions provided for you to attempt so you can test your understanding and learning. You are encouraged to delve deeper and seek other sources – both human and material – to help with your responses.

In most chapters you will find useful snippets of midwifery knowledge, gathered and honed as a result of many years of midwifery practice, called midwifery wisdom.

The aim of this text is to encourage, inspire and stimulate you, as well as instilling in you the desire, confidence and competence to become a registered midwife. What is required from you is an interest in women and their families through all stages of pregnancy. Becoming a member of the midwifery profession places many demands on you, the key demand being the desire to care with compassion and understanding for the women and families you will have the privilege to work with.

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1

Effective Communication

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Aim

This chapter aims to relate and understand how the development of communication from infancy can influence and inform our skills as adults in order to enhance your work-based experience to meet the needs of clients in your care.

Learning outcomes

By the end of this chapter you will be able to:

1. appreciate that development of interpersonal skills is co-dependent on key concepts from parent–infant interaction
2. analyse the needs of infants which parallel the needs of adults to enhance the care of mothers and babies
3. enhance communication skills to overcome common barriers to communication and building relationships in practice
4. develop strategies in practice that meet essential skills clusters for pre-registration midwifery education.

Introduction

This chapter will highlight the unique abilities of babies to communicate from birth, and how their optimal development relies on contingent responses, which are part of the parent–infant attachment process. These qualities in interpersonal skills are fundamental to building relationships, and the lessons from

The Student's Guide to Becoming a Midwife, Second Edition. Edited by Ian Peate and Cathy Hamilton.

infancy influence our adult ability to communicate. Thus, by enhancing early relationships between parents and babies, midwives can reapply these principles in everyday communication. The common errors that inhibit midwifery communication will be outlined and skills of listening and empathy will be analysed.

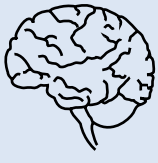
Midwives are in a unique position to observe how humans learn to communicate. When time is taken to observe infants, it can be noticed that babies are 'pre-programmed' to interact with adults (Stern 1998). This is due to their preference for the sound, sight and movement of adults to other comparable stimuli and they are especially attracted to their mother. This interaction is probably a biological instinct, as humans depend on mother and other adults to care for them to ensure survival.

The work of MacFarlane (1977) clearly highlighted the ability of babies, and dispelled many myths around infants, such as the idea that babies cannot see. Not only can they see (and focus well at about 30 cm) but they like to look at contrast and contours found in the human face. They turn to sound, particularly the mother's voice; they will turn to the smell of their own mother's breast pad in preference to another. So they develop recognition of their mother very quickly through their senses, and communicate their needs through behaviours (RCM 1999). As adults, we also communicate through voice and behaviours.

The behaviours of a human baby are social and communicative; they mimic adults, most noticeably by facial changes. So if you smile, open your mouth wide or stick out your tongue, the baby will watch carefully and then copy (Murray & Andrews 2010), which is quite remarkable when you consider how they know that they even have a mouth. Indeed, this mimicking can be observed in the first hour after birth. This response to adults demonstrates babies turn taking in their non-verbal responses and vocalisations, provided the adult is sensitive to them (Brazelton et al. 1974).

Being sensitive to interaction in this dance of communication requires that the other is responding to that baby (or indeed an adult) and does not ignore or overwhelm with intrusive responses. The critical aspects of building relationships is engagement but its absence gives the message of indifference, which indicates lack of importance, and possibly feeling unwanted by the other or even a feeling of non-existence (McFarlane 2012). This indifference can readily be recognised when a mother is suffering with postnatal depression (RCM 2012). 'Insensitive mothers' may be overintrusive in communicating with their baby, and base their responses on their own needs and wishes, or general ideas about infants' needs. The same dynamic is easily replicated by midwives when they have an agenda which differs from the client's needs, for example during a booking history.

Midwifery wisdom



You cannot feel indifferent towards clients in your care. If you find yourself feeling this way, then think 'how can I love this person?'. And 'who can help me feel cared for?'.

Care taking and our sensitivity to infants are normally based on how we were cared for as infants. If we formed a good enough attachment to our parents and they were in tune with our needs, if they were 'baby centred', then we become secure adults (Steele 2002) and naturally become 'woman centred' in midwifery care. Sensitivity also comes from our attitudes and behaviours. Thus, every time babies are changed in a loving way or sympathetically responded to when lonely, tired, hungry or frightened, they take in the experience of being loved in the quality of care received. For a baby, physical discomfort is the same as mental discomfort and vice versa (Stern 1998).

The key aspects of early parenting and building a sensitive relationship are described clearly in the RCM's *Maternal Emotional Wellbeing and Infant Development* (RCM 2012). It is the parental attunement

to the needs of the infant (which midwives have a role in fostering) that leads to loved individuals who do not become antisocial adults. Through our early relationships and communication from conception to 3 years of life, Sinclair (2007) suggests that we develop our emotional brain and our capacity for forming relationships. Fundamentally, human beings at any age respond and feel understood when an attuned warm, positive and sensitive other interacts with them. As a professional responding as a sensitive mother would, you too can communicate in this way with clients in your care, which can enhance how you build relationships and improve communication.

Sensitive responsiveness is one of the key constructs of attachment theory (Bowlby 1980, RCM 2012). The early infant–mother relationship has far-reaching consequences for the developing child's later social and mental health. It is the underpinning theory in national agendas and frameworks interventions (e.g. DfES 2006, DH 2004, 2009, RCM 2012, Sinclair 2007), recommended for effective practice in the promotion of family health and parenting skills, which are now a priority politically and professionally.

The concept of sensitive responsiveness includes the ability to accurately perceive and respond to infant signals, with contingent responses because the person is able to see things from the baby's point of view. These key concepts (in italics below), that mothers who are sensitively responsive seem to demonstrate, are fundamental to all our interactive relationships.

- An observer who *listens* and sees their strengths and helps them with their difficulties.
- Warm and responsive interactions with caretakers. The mother's task is to respond *empathically* – to mind read. The baby has no control or bad intent; they learn that they can self-regulate through maternal containment. They then learn to self-soothe, for example, by sucking.
- Structure and routine, flexible,and age appropriate, that give *boundaries*. Providing psychological and physical holding; holding also relieves anxiety the baby feels 'held together'.
- Maintains interest by providing things to look at and do through play and touch, but *in tune*, e.g. recognises that a yawn means 'leave me to sleep'.
- Vocalisation reinforced by response-dialogue. Hearing and *being heard* – responds to familiar parent voice, giving a sense of security. Babies need to hear talking in order to develop speech (DfES 2006, DH 2004, Paavola 2006, Ponsford 2006, RCM 2012).

Sensitive responsiveness can be facilitated, and when mothers' sensitivity and responsiveness are enhanced, this results in dramatic increases in secure attachments with fussy infants (Steele 2002).

Our infant–parent attachment patterns are largely acquired, rather than determined by genetic or biological make-up (Steele 2002), so with support we can all improve our ability to relate to others. For midwives, this means relating to clients and colleagues but also facilitating parent–infant relationships. This can be done by praising the sensitivity you observe in the parents, and helping them see and understand their baby. Using the questions in Box 1.1 with parents might enable them to realise that they can understand their baby. The RCM's *Maternal Emotional Wellbeing and Infant Development* (RCM 2012) also has many suggestions to develop your skills in this area.

Box 1.1 Helping parents to know their baby

- Ask them to tell you about their baby.
- What does he/she like?
- What does he/she like to hear, look at, feel and smell in particular?
- How does he/she get your attention?
- How does he/she tell you he/she is content?
- What does he/she like when going to sleep? What do you notice about sleep? Or crying?

The basic methods of improving relationships are those that mothers ideally use with their infants. This is primarily non-verbal so it is not surprising that over 65% of our communication is non-verbal (Pease & Pease 2006), observing bodily and facial cues, and being in touch with what the person might be feeling. This is truly listening and being with another person, and because we are listening and empathising, we provide a safe environment. Sometimes midwives demonstrate this by holding women physically, which seems to help contain the labouring women in their pain, and at birth by encouraging skin-to-skin contact, thus giving the baby safe framework after having been contained in the womb. But we also provide holding psychologically, by being with women and trying to understand what the experience is like for them; this is demonstrating empathy. When we reflect back what the client says and feels, by our actions, sometimes by touch or words, then the client feels held and heard.

Humans become socialised, and learn that they should not say this or that or that they should not upset another person or that they should not argue. We often learn to hide our feelings and not say clearly what we mean, which in turn leads to a lack of communication. Dissatisfaction in midwifery care and family life is often due to lack of communication. It is recognised that communication is one of the key elements for a compassionate workforce.

> *Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.*
>
> (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser 2012)

Our early skills in relation to communication become fixed into patterns, and the stamped foot of a temper tantrum in a toddler can still be apparent in the adult. Nichols (2009) summarises the four early stages of the development of self, described by Stern (1998), which helps inform us of how we adopt patterns of acting and reacting that become unconscious responses in adult life. This partly explains why, when we are in an anxious state, we cannot find the words to describe it because we have returned to a developmental stage which was preverbal.

Effective communication can be hard to achieve. Sometimes it seems that no matter how carefully we try to phrase the things we say, the listener either doesn't understand us or they misunderstand us. In verbal communication, we often add emphasis through body language or the intonation of our voice. We may adopt defensive or intimidating postures to reinforce the intended messages and, of course, we may raise or lower our voices. These techniques are used subconsciously, having developed through our socialisation from childhood.

Some common problems in communication

Bolton (1997) suggests that there are six common problems of human communication. These are mainly to do with understanding and listening:

1. Use of unclear meaning as words can have a different meaning.
2. Failing to understand because a message is 'coded'.
3. Failure to receive the message as another agenda clouded the issue.
4. Being distracted, and not hearing the message.
5. Not understanding because the message was distorted by perception or other filters.
6. Not handling emotions during a conversation.

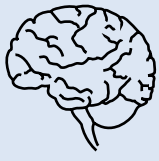
The first problem is poor understanding, which is often due to an unclear message or unclear words, because words can have different meanings for different people. As Ralston (1998) points out, terms such as 'incompetent cervix' or 'inadequate pelvis' are open to very different interpretation for the non-professional listener. But even a straightforward term, such as 'mayonnaise' when it is not differentiated into 'home made' (with raw eggs, to be avoided in pregnancy) and the commercial product, can lead to women misunderstanding the information given (Stapleton et al. 2002).

When the message is 'coded', the real meaning is masked; for example, the client asks you to put her flowers in water but she could really be asking you to keep her company. It can also often be observed that clients present with one agenda but really have a different problem; for example, they present with backache but they are really concerned that the pregnancy is normal. Midwives also miss conversational codes for more information from clients (Kirkham et al. 2002a). 'I don't know' and 'What would you do?' are both tactics women use to elicit more information, which unfortunately are generally not very successful.

The way a sentence is spoken can also indicate an underlying message. Most speech has an obvious and a hidden meaning (Kagan et al. 1989). For example, 'What did you say?' has the obvious meaning of 'please say that again' but the hidden meaning could be 'you are so boring, I was not listening'. But if we said what was meant, we may hurt someone's feelings so we try to act in a professional way, thus creating barriers to communication, because we are not clear in our message. Indeed, as professionals there are times when we are acutely aware of appropriate interactions and needing to maintain a professional face. For example, it is inappropriate to look cheerful or go into a long explanation of care during life-threatening emergencies (Mapp and Hudson 2005).

Clients also do not hear or take in what we say because they are distracted, by the environment or physical symptoms. The disruption of a child needing attention during a conversation is an example of distraction, or a client may be in pain and can consequently miss the information given. However, what is tragic is that midwives often miss the non-verbal cues and often carry on with their own conversation, neglecting the woman. This could end up with the midwife thinking 'I know I have given the information', even if the client 'could not hear'. It is interesting to observe that mothers will say 'look at me when I am talking to you' when addressing their children, thus ensuring the non-verbal feedback that tells us we are being heard (Yearwood-Grazette 1978). Midwives need to ensure that they respond to non-verbal cues with their clients, particularly eye contact.

Midwifery wisdom



Reflect on your interactions with clients. If you are doing most of the talking, then you are not listening, and the client probably has switched off too!

Midwives and clients often filter information because of perception, emotions or simply hearing what they wish to hear. A midwife may say 'you can go home after the paediatrician has discharged the baby' but the client hears only the 'go home' part and so phones her partner to collect her immediately. Midwives filter information by avoiding discussion. They may emphasise physical tasks, giving the message that discussion, particularly on how women feel, is less important. Indeed, discussion if often avoided, for example by filling the time with asking for urine samples and ignoring possible anxiety,

even when the last pregnancy was a stillbirth (Kirkham et al. 2002a). In essence, filters become blocks to communication.

Another block to communication is the phrase 'don't worry', used frequently to reassure (Stapleton et al. 2002). However, it has the effect of causing anxiety. The client is denied expression of how they really feel, and as such the words 'don't worry' should be avoided (Mapp and Hudson 2005) as this blocks the client from disclosing further concerns or feelings (Stapleton et al. 2002). A smile and touch are more helpful in allowing the client to feel human and reassured (Mapp and Hudson 2005).

It is not just what we say and do; it is also how we listen. It is rare for midwives to explore topics such as what foods a client eats, to invite discussion (Stapleton et al. 2002). This would enable the client to say what they know, but the midwife then needs to listen for the relevant missing information. This is harder work, so instead there is a tendency to tell clients what to do, things they often already know, such as the advantages and disadvantages of breastfeeding, but not what the client is seeking, for example how it feels to breastfeed (Stapleton et al. 2002).

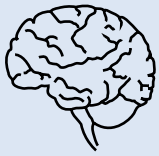
Finally, people who have difficulty with emotional issues may deny their emotions or become blinded by them (Bolton 1997). Blinded because anxiety and fear or any high levels of emotional arousal lock the brain into one-dimensional thinking (Griffin & Tyrrell 2004). Our emotions are then affecting our physiology, hijacking the brain's capacity for rational thinking. This inhibits our ability to rationalise or entertain different perspectives, because these traumatic and distressing experiences, big and small, cause imbalance in the nervous system, thus creating a block or incomplete information processing. This is why it is difficult to take in medical or other information or advice when upset, frightened, angry or in pain. This dysfunctional information is then stored in its unprocessed state both in the mind (neural networks) and in the body (cellular memory) (Pert 1999). Certainly, during emergencies poor communication can compound the stress. Careful sensitive communication that is congruent, i.e. the non-verbal matches the verbal communication, is what is required (Mapp and Hudson 2005).

Non-emergency situations can also involve high emotional states. Emotional arousal, for example, as a consequence of a power struggle, will evoke a defensive response. The thinking part of the brain becomes inhibited in emotional arousal, so it follows that learning and taking in information cannot be effective when the client feels conflict or stress (Griffin & Tyrrell 2004). When a midwife says 'I want to tell you about breastfeeding', the emotional arousal in the client may come from the unsaid 'who are you to tell me how to bring up my family?'. It would be more useful to first reduce the emotional arousal, and reframe or present the information another way: 'It's good you have decided on your method of feeding and I would like to hear more about how you are going to feed your baby'. Nichols (2009) points out that 'It isn't exuberance or any other emotion that conveys loving appreciation; it's being noticed, understood and taken seriously'.

However, midwives may perceive that the use of open questions in this way will take up too much time. When information becomes blocked, then misunderstanding is increased which leads to spending more time correcting the problem at a later date. Midwives also limit their emotional effort, and they may stereotype in order to increase control over work situations (Kirkham et al. 2002b), although if they were able to increase their sensitive responsiveness, clients would be able to find out the information they need, understand and feel understood.

Midwives need to give emotional care to their clients, particularly those in labour, and this is draining for them. Many midwives realise they do not have time for their own emotional feelings so they pull down the shutters to look calm. It is this that can give the impression of 'aloofness', whereas others are perceived as naturally friendly (John & Parsons 2005). As John and Parsons (2005) suggest, support mechanisms need to be developed and implemented in order to reduce stress in practice. According to Nichols (2009): 'If you see a parent with blunted emotions ignoring a bright-eyed baby, you're witnessing the beginning of a long, sad process by which unresponsive parents wither the enthusiasm of their children like unwatered flowers'.

Midwifery wisdom



Blunted emotions can be seen in overstressed midwives. These midwives need support, and a discussion with their supervisor could be helpful here. Some units have staff counsellors in highly stressful areas.

Thus far, the problems and the way midwives communicate have been discussed. To be more effective in communication, our sensitive responsiveness, as defined earlier, needs to be developed. This chapter can only scratch the surface in this respect as communication skills need to be developed experientially as our patterns of communicating are often ingrained from childhood. Having said that, there are things individuals can practise every day which will improve professional practice, particularly listening and empathy. Some pointers will be outlined here but learning these skills needs to take place through experience in order for long-term change in practice to occur.

Listening

Listening skills are essential for a midwife; listening is an active process requiring the full attention of an individual as one needs to listen and fully hear what is actually being communicated, not just what is said. Listening involves the mind, senses and emotions, to pick up what is not said. This is bound up with the development of self-awareness, the awareness of when we fail to listen and attend, which, if addressed, is likely to have a positive effect on future communication. Good communication minimises misunderstanding, poor communication can lead to complaints (Sidgewick 2006).

Part of the process of communication is receiving messages. Obviously, verbal messages are heard but the receiver does need to be actively listening. Passive listening includes encouraging phrases such as 'umm', 'uh huh' as well as non-verbal nodding of the head and eye contact (Balzer-Riley 2012). Passive listening implies understanding but active listening removes the guesswork as it ensures messages are received properly (Balzer-Riley 2012).

Listening skills will differ depending on what we are doing. On some occasions, passive attentive listening will be sufficient. However, if we require more information from clients, or perhaps they are giving an emotional account, then a more active approach is helpful (Kagan et al. 1989). Attending is listening to what is really being said by the speaker, which may also require the skill of appropriate questioning (questioning skills are addressed later). If we focus on our questions then we go back and forth between what is being said and our reply, so we may not really hear what is being said (Rowan 1998). It cannot be emphasised enough that listening is one of the most important communication skills.

Guidelines for listening

- Listen, without interruption as far as possible, and minimise questions.
- Remember what is being said, as if you might be tested on it. Listen to what is not being said, particularly feelings.
- Observe the client's body language as well as your own; are there any clues being given?
- Have an empathic stance; what would it be like if you were in the client's situation?

- Try not to immediately rush in with explanations and answers. The client generally has the answer.
- Look like you have time, or make it clear how much time you have and give your full attention. (Adapted from Jacobs 2000).

Unfortunately, because much of midwifery requires information from the client, we focus on questions and not listening. Questions are so much part of conversation that they seem to have almost replaced the ability to listen or respond in any other way, because we are forming the next question. In order to enable clients to talk and midwives to listen and talk less, it is generally useful to begin with open questions. Open questions usually begin with words such as; would, could, tell me, seem to be, I think, I feel or I wonder. Questions that begin; how, what, where, and particularly *why*, can leave the client feeling they are at the Spanish Inquisition, whereas an open question allows them to explain their experience.

Activity 1.1

One of our jobs is to ask questions which are of a personal nature. Some of us find these easier to ask than others. However, you still need to ask them. So think about asking the following; could they be rephrased into more open questions?

- When was the first day of your last menstrual period?
- Have you had your bowels open?
- When did you last have sex?
- Can I see your sanitary towel?
- How are your breasts?

The following are some of the activities for daily living which may be used on admission forms. How would you phrase the questioning order to gain the information you need? How could you broach the question on issues such as:

- expressing sexuality?
- death?
- safer sex?
- termination of pregnancy?
- use of alcohol?
- domestic violence?
- mental health?

When trying to establish legal responsibility for a child, how will you ask this when the child has a different surname from the mother and the 'next of kin' who is the 'father'?

Further reading: England C, Morgan R (2012) *Communication Skills for Midwives: challenges in everyday practice*. Buckingham: Open University Press.

Listening to what is not being said

In ordinary listening, we are often interested in the content or subject. We generally try to relate this to our own experience (this is sympathy), thinking of interesting replies to carry the conversation on. In contrast, in a therapeutic relationship we are listening to the content but also the message under

the message. This may be about the client's emotions and if our own thoughts, experiences and emotions arise, we try to put them aside because it is the client's experience that is the focus (Rowan 1998).

Jacobs (2000) suggests we listen to the 'bass line' in conversations, as if it were a piece of music. Under a melody there is a bass line. This invites us to listen to what is not being openly said but possibly being felt by the client.

Case study 1.1

Tom's Story

'My partner Amy and I arrived early this morning to get things started. Our baby was due last week. It's been awful having people phone constantly asking what is happening. So we really want this induction thing. Amy is scared and disappointed as she wanted a 'natural birth', but I think it's for the best and it's great to know we will have a baby today.

Well, we were kept waiting for an hour before we were seen, then the midwife checked us in, examined Amy, while I had a coffee. But I returned to be told the labour ward is busy and the birth could not be started!

We were sent for breakfast, then lunch. I feel confused and worried as Amy is getting more anxious and nothing is being done. They said the induction was because it's dangerous to go overdue. If that is so then why are we not a priority? The staff all seem rushed and say they will be with us later.'

Tom and his frustrations will be examined below and the interactions with the midwife analysed.

Activity 1.2

A young father-to-be, Tom, is talking about his discontent with his partner's maternity care. Whether or not he is justified in thinking this, what can Tom's bass line tell you? Imagine how you might feel in his position.

What is the bass line saying? He is young, so possibly has less experience of the world, and the transition to parenthood is not without stress, partly due to the unknown. So possibly he is unsure of himself, so any threat might elicit a defensive/attacking response from him. He may be feeling helpless and powerless as he feels he can do little for his new family. He may be concerned for his partner or baby. These are all possibilities, so what are the feelings he could be expressing – anxiety, anger, frustration?

Activity 1.3

A young father-to-be, Tom, is talking about his discontent with his partner's maternity care.

Tom: 'Excuse me, you said you would give my wife some of those tablets to get her started in labour, we have been waiting for hours.'

Think how you would answer. The labour ward has been busy and you were told not to induce her. You also have been frantically trying to discharge clients in order to give beds to the women waiting to clear the delivery ward. The paediatrician has not discharged the babies and the consultant wants to do a round with you.

Midwife: 'I am sorry, we are busy, and have not had time.'
Tom: 'You seem to be making time for everyone else who has babies already.'
Midwife: 'Well, the delivery ward does not have space for you anyway.'
Tom: 'Then why were we dragged in here at 7 am?'
Midwife: 'Well, it's one of those things – we do not know what the workload will be like.'

Now think again about how you could answer differently.

In Activity 1.3, the midwife is polite but defensive, and it sounds like excuses to Tom. The midwife is stressed and is having trouble coping with the workload; her factual response is not demonstrating any understanding or concern for Tom and his wife. Concern and understanding are demonstrated by letting Tom know you have heard him. Giving full attention is difficult in this case; I am sure you have seen this type of conversation occurring while the midwife is on the phone and writing up some notes. Pushing the silent button on the phone, putting the pen down and giving good eye contact may have been the midwife's first reaction, and would go a long way to contributing to Tom's perception that the midwife was listening. Furthermore, reflecting back or summarising what was said might also ensure the midwife understands and Tom would feel heard.

Here are some possible alternative replies that are more likely to help Tom feel heard and understood.

Tom: 'Excuse me, you said you would give my wife some of those tablets to get her started in labour, we have been waiting for hours.'
Midwife: 'Yes I did, you have been waiting a long time' (reflecting back what he said so he knows you heard him).
Midwife: 'Yes I did, I am sorry you have been waiting so long, it must be very frustrating for you' (empathy).
Midwife: 'You have been waiting a long time, and it's disappointing when you expected the induction to have begun by now' (empathy).

Not only are some of Tom's words being used to help him feel heard, but also the midwife has listened to the 'bass line' and tentatively is reflecting possible feelings. The midwife may be stressed and she might have started the conversation by using factual replies as that is an old habit, but she could recover or repair the communication by demonstrating empathy.

Activity 1.4

Tom: 'Excuse me, you said you would give my wife some of those tablets to get her started in labour, we have been waiting for hours'.
Midwife: 'I am sorry, we are busy, and have not had time.'
Tom: 'You seem to be making time for everyone else who has babies already.'
Midwife: 'You seem concerned that there is no time for you and your wife. You feel anxious because it seems like the induction is never going to happen.'

Empathy

Jacobs (2000) suggests that if you listen to yourself and think how you might feel in a given situation, this might be the first step towards empathy. Empathy involves the capacity to recognise the bodily feelings of another and is related to our imitative capacities. We associate the bodily movements and facial expressions we see in another with the feelings and corresponding movements or expressions in ourselves (Balzer-Riley 2012).

Mothers help babies to regulate their emotions in this way. You may have observed the distressed baby who is cuddled gently by a mother whose facial expression is as pained as that of her infant, her tone of voice and touch mirroring the infant's state, 'Oh dear! There there', gradually soothing into a calmer state with soft voice and holding: 'I know, mummy is here, you can cope' (Gerhardt 2004). Humans also seem to make the same immediate connection between the tone of voice and other vocal expressions and inner emotion. Thus, empathy is a synonym for communicated understanding. It is mentally putting yourself into the shoes of another, so that you can understand how they are feeling without judgement or evaluation, just acceptance (Figure 1.1).

A midwife needs to be empathic and has to understand the woman and provide the care and support needed while watching the process of labour and any deviations from it that might cause concern (Ralston 1998). The midwife who gets this right is truly 'with woman'; by being empathic, she is unlikely to have a different perception from the parents. Midwives also convey compassion, understanding and empathy through touch. Not being touched is related to emotional deprivation; midwives have been observed to touch the fetal heart monitor and not the woman in labour, thus distancing themselves from the intimacy of the relationship (Yearwood-Grazette 1978). Sensitive touch can help relax a person in pain but the midwife also needs to recognise when this becomes intrusive (Ralston 1998), like a mother who is sensitive and does not ignore or overstimulate her baby (RCM 1999).

To be empathic first requires you to listen and identify the emotion. Like the mother–infant relationship, we tune in non-verbally, noticing behaviours. Sometimes we pick up the feeling in our own body, e.g. the stomach is knotted. If these factors are taken into account along with what we imagine it must be like, then we can identify the emotion; however, we also need to communicate this to our client.

Figure 1.1 Example of empathy.