

# Becoming a Midwife in the 21st Century

Edited by:

**Ian Peate**

**Cathy Hamilton**



John Wiley & Sons, Ltd



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This book is dedicated to women, their families and to midwives,  
because they matter.





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# **Introduction**

**Ian Peate and Cathy Hamilton**

This text is primarily intended for midwifery students, health care assistants, associated practitioners, those undertaking SNVQ/NVQ 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 health care workers at various levels and in various settings in order to develop their skills for caring for women and their families through childbirth.

## **The unique role and function of the midwife**

Midwives provide individual care to women and their families, encouraging them to participate in and determine how they want their pregnancy to progress. Midwives work with women during and after their pregnancy in a variety of settings, for example, in the women's own homes, midwifery-led units and hospitals. 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 support the midwife offers is determined by assessing the woman's individual needs and working in partnership with her and other health care workers. The midwife is usually the lead health care 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 important that midwives work collaboratively with other health

care 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.

According to Medforth et al. (2006) the definition of a midwife was first officially formulated in 1972. This followed 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 per cent of births in the UK; she provides total care to mother and baby from early pregnancy onwards, throughout childbirth and until the baby is 28 days old (Medforth et al. 2006). 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 risk to health
- Establishing, designing and empowering communities
- Creating and sustaining cross-government and inter-sectoral 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

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 (RCM 2001). 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 number of terms that can be used to describe women who use maternity services. 'Patient', 'woman' and 'client' are used throughout this text and refer to all groups and individuals who have direct or indirect contact with health care workers and in particular registered midwives, 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. However, 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 health care 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.

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

Number of midwives	
Male	163
Female	42 718
Total	42 881

Source: NMC 2006

There are 42 881 midwives on the midwives' section of the professional register (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.

## **The Nursing and Midwifery Council and Quality Assurance (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 them. The key role of the NMC is central to ensuring 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. This framework 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 (Quality Assurance Agency for Higher Education 2000). Other external factors that must be given due consideration are the European Directives. Two European Directives – 77/453/EEC and 89/595/EEC – and their implications are discussed.

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. They do so by setting standards to maintain public confidence, as well as to protect the public. By appointing representatives they can be satisfied that they are represented during the quality assurance process in relation to the approval, re-approval 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 of Proficiency for Pre-registration Midwifery Education (NMC 2004a) 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 2004c) replace those produced in 1998. The current *Rules and Standards* came into force on 1 August 2004 (see Table I.2).

## **Becoming a proficient 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 three-year (or equivalent) programme of study. The programme must by law comprise 2300 hours of practice and another 2300 hours of theory.

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:

**Table 1.2**    The 16 midwifery rules

Rule	Description
<b>1</b>	Citation and commencement
<b>2</b>	Interpretation
<b>3</b>	Notification of intention to practise
<b>4</b>	Notification by LSA
<b>5</b>	Suspension from practice by LSA
<b>6</b>	Responsibility and sphere of practice
<b>7</b>	Administration of medicines
<b>8</b>	Clinical trials
<b>9</b>	Records
<b>10</b>	Inspection of premises and equipment
<b>11</b>	Eligibility for appointment as a Supervisor of Midwives
<b>12</b>	The supervision of midwives
<b>13</b>	The local supervising authority midwifery officer
<b>14</b>	Exercise local supervising authority of its function
<b>15</b>	Publication of local supervising authority procedures
<b>16</b>	Annual report

Source: NMC 2004c

- Nurses
- Midwives
- Specialist community public health nurses

The student who wishes to undertake midwifery education must meet the NMC's requirements for age of entry. Those entering a programme of pre-registration midwifery education must be no less than 17 years and 6 months of age on the first day of the commencement of the programme. However, in certain exceptional circumstances and related to specific programmes the NMC may agree to an earlier age, but this will never be less than 17 years. Currently this requirement is index review.

As well as satisfying the NMC's age requirement, general entry requirements must also be met. Educational requirements are set by each educational institution; and there must also be evidence of literacy and numeracy. How these requirements are set is the prerogative of the educational institution; however, the NMC must agree to and permit these requirements. Those wishing to practise in Wales must also be able to demonstrate proficiency in the use of 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 in place to ensure assessment of health and character. Any convictions or cautions related to criminal offences that the applicant has 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 proficiencies mean that the student will graduate with both a professional qualification (Registered Midwife (RM)) and an academic qualification at degree or enhanced diploma 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 his/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 2004b). Legal requirements, such as participating in continuing professional development and the maintaining a personal professional portfolio, must be addressed. This text provides you with insight into how to become a proficient midwife.

There are 15 standards associated with pre-registration midwifery. These range from the appointment of the LME to standards of proficiency (see Table I.3). This text will address the standards of proficiency for entry to the register for midwives.

Currently, no texts are available that describe in the same detail as this text does the standards of education required to achieve the NMC standards of proficiency (standard 15) as demanded by the NMC.

## The proficiencies

The format of the text draws upon that used by the NMC in their publication *Standards of Proficiency for Pre-Registration Midwifery Education* (NMC 2004a). Standard 15 concerns the standards of education and is divided into four domains.

Domain I	Effective Midwifery Practice
Domain II	Professional and Ethical Practice
Domain III	Developing the Individual Midwife and Others
Domain IV	Achieving Quality Care through Evaluation and Research

**Table 1.3** Summary of the standards for pre-registration midwifery

Standard 1	Appointment of the LME
Standard 2	Development, delivery and management of midwifery programmes of education
Standard 3	Signing the supporting declaration for good health and good character
Standard 4	Age of entry
Standard 5	General requirements for admission to approved pre-registration of education and entry to the register: 5.1. Literacy and numeracy 5.2. Good health and good character
Standard 6	Interruption in pre-registration midwifery programmes of education
Standard 7	Admission with advanced standing
Standard 8	Transfer between approved education institutions
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	Supernumerary status
Standard 14	Assessment strategy
Standard 15	Standards of education to achieve NMC standards of proficiency

Source: NMC 2004a

## Case notes and activities

Most of the chapters provides 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. You are encouraged to delve deeper and seek other sources – both human and material – to help with your responses.

In Chapters 2 and 3 you will find useful snippets of midwifery knowledge, gathered and honed as a result of many years 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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# Effective Communication

**Tandy Deane-Gray**

## **Introduction**

The purpose of this chapter is to relate and understand how the development of communication from infancy can influence and inform your skills as adults in order to enhance your work-based experience to meet needs of the clients in your care. The chapter encourages you to draw from the lessons of optimal parent–infant relationships, including sensitive responsiveness, which underpins effective communication, as well as providing an outline of communication issues for practice. This is a condensed chapter on communication skills for midwives, and is designed to stimulate the reader to seek the original sources for expansion of the concepts.

Midwives are in a unique position to observe how humans learn to communicate. When time is taken to observe infants it is apparent that babies are ‘pre-programmed’ to interact with adults (Stern 1985). This is due to their preference for the sound, sight and movement of adults rather than other comparable stimuli. They are especially attracted to their mother. This is probably a biological instinct, as humans depend on their mother and other adults to care for them to ensure survival.

MacFarlane (1977) highlighted the ability of babies and dispelled many myths about infants, such as the belief that they cannot see. Not only can they see – and focus well at about 30 cm – but they like to look at the contrast and contours found in the human face. They turn to sound, particularly their mother’s voice; and will turn to the

smell of their mother's breast pad in preference to another woman's. So they develop recognition of their mother very quickly through their senses, and communicate their needs through behaviours (RCM 1999).

Babies also mimic the behaviours of adults, most noticeably by facial expression. If you smile, open your mouth wide or stick out your tongue, the baby will watch carefully and then copy. This is quite remarkable – how do they know that they even have a mouth? This can be observed in the first hour after birth and it is this response to adults that makes the baby a social and communicative being, as they will demonstrate taking turns in their non-verbal responses and vocalisations (Murray and Andrews 2000), provided the adult is sensitive to them.

It is not surprising that adults are attracted to baby features. We find certain attributes of the human infant 'cuddly': a relatively large head with big eyes, a receding chin and large forehead, round body outline and relatively short limbs, small size and high-pitch vocalisation (Eibl-Eibesfeldt 1996). These features normally stimulate care-taking responses and are perceived as loveable.

Care-taking and our sensitivity to infants is 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). 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 1985).

How do mothers respond sensitively to the specific emotional needs of their infant? Sadly not all of them do. 'Insensitive mothers' base their responses on their own needs and wishes, or general ideas about infants' needs. What is sensitive from an adult's point of view may not be perceived as such by the infant.

As the WAVE (Worldwide Alternatives to Violence) report (Wave Trust 2005, section 3) summarises, it is the parental attunement to the needs of infants, which midwives have a role in fostering, that leads to loved individuals who do not become anti-social. Sinclair (2007) suggests that through our early relationships and communication from conception to 3 years of age, we develop our emotional brain and our capacity for forming relationships occurs. Fundamentally, human beings at any age respond and feel understood when an attuned sensitive other interacts with them. As a professional, if you respond to the client in your care as a sensitive parent would, your communication with her can be improved.

Sensitive responsiveness is one of the key constructs of attachment theory (Bowlby 1973). 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. DH 2004; Wave Trust 2005; DfES 2006; Sinclair 2007), and 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 of parents to perceive and respond to infants’ signals accurately, because they are able to see things from the baby’s point of view (Paavola 2006). This has been refined by many researchers.

Mothers who are sensitively responsive demonstrate the following (the key concept is in *italics*):

- They are observers who *listen* and see their strengths and help them with their difficulties
- They have warm and responsive interactions with caretakers. The mother’s task is to respond *empathically* – to mind read. Babies have no control or bad intent, but they learn they can self-regulate through maternal containment. They then learn to self-soothe, for example, by sucking
- They offer structure and routine, which is flexible and age-appropriate, and set *boundaries*. They provide psychological and physical holding. Holding also relieves anxiety – they feel held together
- They maintain interest by providing things to look at and do through play and touch, but *in tune*, e.g. they recognise a yawn means ‘leave me to sleep’
- Vocalisation is reinforced by response-dialogue. Hearing and *being heard* – respond to parent’s voice, familiarity gives sense of security; and babies need to hear talking to develop speech

(Paavola 2006, drawn from DH 2004; Wave Trust 2005; DfES 2006; Ponsford 2006).

Sensitive responsiveness can be facilitated, and when mothers’ sensitivity and responsiveness are enhanced, this results in a dramatic increase 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 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 parents and helping them see and

**Table 1.1** Helping parents 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 they are content?
- What does he/she like when going to sleep? What do you notice about their sleep or their crying?

understand their baby. Using the questions in Table 1.1 might enable parents to realise that they can understand their baby.

The basic method of improving our relationships are those that mothers ideally use with their infants. This is primarily non-verbal, which is not surprising as over 65 per cent of our communication is non-verbal (Pease 1987). Observe bodily and facial cues, and be in touch with what that 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. This is something midwives demonstrate by holding women physically, which seems to help contain the labouring women in their pain, and at birth by encouraging skin-to-skin contact giving the baby a safe framework after being 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, whether by touch or words, the client feels held and heard.

Humans become socialised and learn that they should not do certain things: they should not upset others; they should stop arguing. We learn to hide our feelings and disguise what we really mean, which in turn leads to a lack of communication.

Dissatisfaction with midwifery care and in family life is often due to lack of communication. Our early skills in relation to communication become set in patterns, and the stamped foot of a toddler's temper tantrum can still be apparent in the adult. Nichols (1995) summarises the four early stages of development of self described by Stern (1985), which helps inform us of how we adopt patterns of acting and reacting which become unconscious responses in adult life. Interesting as these stages are between the ages of 0 and 18 months, this partly explains why, when we are anxious, we become inarticulate because we have reverted to a pre-verbal developmental stage.

Effective communication can be hard to achieve. Sometimes it seems that no matter how carefully we phrase what we say, the

listener either does not understand or misunderstands us. In verbal communication we often add emphasis through body language or intonation. We may adopt a defensive or threatening posture to reinforce our message and, of course, we may raise or lower our voice. These techniques are used spontaneously, having developed through our socialisation in childhood.

## **Some common problems in communication**

Bolton (1979) suggests there are six peculiarities or common problems in human communication. These are mainly to do with understanding and listening:

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

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

When the message is 'coded' the real meaning is masked; for example, when the client asks you to put her flowers in water, it could be a message 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 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, tactics which unfortunately are not very successful.

The way a message is spoken can also conceal a message within the message. Most speech has both an obvious and a hidden meaning