Chapter 1

To be a midwife

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Learning outcomes

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

- understand how midwifery has evolved as a profession
- examine how midwifery as a profession is regulated in the united kingdom
- identify the support processes available to student midwives undertaking a pre-registration midwifery programme
- be cognisant of the demands working within the midwifery profession
- identify factors that can facilitate successful course completion.

Introduction

Midwifery is a dynamic profession that is responsive to change. In recent years, the social, economic and technological forces have altered the context of midwifery significantly. The scale of healthcare provision has changed greatly; philosophies and values have been adjusted and the restructuring of healthcare provision has been dramatic. Public expectation regarding involvement in care and opportunities for informed choice has increased; consequently women and their babies expect more than ever before to be partners in the care process.

Midwives provide high-quality professional care to women and their families, acting autonomously, accountably and responsibly within their sphere of practice. This chapter aims to explore the development of midwifery and its professional regulation with the subsequent evolution of the role and responsibilities of a midwife. The quality of midwifery education and the supervision of midwifery will also be examined.

Fundamentals of Midwifery: A Textbook for Students, First Edition. Edited by Louise Lewis.
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Companion website: www.wileyfundamentalseries.com/midwifery

Activity 1.1

Ask yourself why you wanted to become a midwife. It will be useful to revisit this as you progress on your programme. At difficult times within your programme these statements can be very helpful.

To be a midwife is to understand the role and responsibilities of being a midwife. The midwifery profession is recognised globally and is defined by the International Confederation of Midwives (ICM) (2011) as:

> *…A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery…*

This definition is complex; therefore the professional status and regulation of midwifery nationally and internationally will now be clarified.

The professional status and regulation of midwifery

Historically the professional status of midwifery in England and Wales began with The Midwives Act 1902. This enabled the state enrolment of midwives and established the Central Midwives Board (CMB) for England and Wales. The Midwives Institute was established in the 1880s and was instrumental in the application of the Midwives Act. The Midwives Institute became known as the Royal College of Midwives (RCM) in 1941. All practising midwives were enrolled with the CMB by 1910. A Midwives Act was not passed in Scotland until 1915, which built on the experience of the CMB for England and Wales when setting up the CMB for Scotland.

The CMB produced an annual Roll of Midwives, which was a list of qualified midwives, indicating which were practising. The CMB was independent from nursing, although many midwives were nurses. In 1983 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) replaced the General Nursing Council (Nursing) and the CMB (Midwifery), which brought the nursing, and midwifery records together for the first time. The Nursing Midwifery Council (NMC) was established under the Nursing and Midwifery Order 2001 ('the order') (SI:2002/253) and came into being on 1 April 2002, abolishing the UKCC and its four National Boards.

Midwifery, as a profession is recognised globally, although there are wide variations in education and scope of practice between the different continents. Currently, in the United Kingdom, the NMC is the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands. The aims of the NMC are outlined in Box 1.1.

The NMC

The NMC are governed by legislation approved by the Houses of Parliament and this is detailed in what is known as the Statutory Instruments (SIs). SIs allow an Act of Parliament to be brought

Box 1.1 Aims of the NMC

- Exist to safeguard the health and wellbeing of the public.
- Set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.
- Ensure that nurses and midwives keep their skills and knowledge up to date and uphold the professional standards.
- Have clear and transparent processes to investigate nurses and midwives who fall short of the standards.

into force or altered. The Statutory Instrument 2002 No. 253 is The Nursing and Midwifery Order 2001, and replaced the Nurses, Midwives and Health Visitors Act 1997.

The main objective of the NMC in exercising its functions under The Order is to safeguard the health and wellbeing of persons using or needing the services of registrants. The principal functions of the Council are to establish from time to time standards of education, training, conduct and performance for nurses and midwives and to ensure the maintenance of those standards.

Part VIII of the Nursing and Midwifery Order is specific to Midwifery and is concerned with:

- The Midwifery Committee.
- Rules as to midwifery practice.
- Local supervision of midwives.

Since 1 December 2012, following the Health and Social Care Act (2012) the NMC has been regulated by the Professional Standards Authority for Health and Social Care (PSA). The PSA replaced the Council for Healthcare Regulatory Excellence (CHRE). The PSA's function is to ensure that the NMC and other healthcare regulators promote the best interests of patients and the public and ensure consistency across the professions (Yearley and Dawson-Goodey 2014).

European Union

The UK became part of the European community in 1973, and after the Maastricht Treaty was signed in 1992, the European Union (EU) was formed. As a member state of the EU, all EU legislation must be enforced and UK law must adhere to the EU framework and refer to the European Court of Justice. The NMC maintains close partnerships with colleagues and decision makers in Europe to ensure they can influence EU legislation in the interests of patients and the public in the UK.

There are three main institutions involved in EU legislation:

- The European Parliament, which represents the EU's citizens and is directly elected by them.
- The Council of the European Union, which represents the governments of the individual member countries. The Presidency of the Council is shared by the member states on a rotating basis.
- The European Commission, which represents the interests of the Union as a whole.

Together, these three institutions produce the new policies and laws that apply throughout the EU. In principle, the Commission proposes new laws, and the Parliament and Council adopt them. The Commission and the member countries then implement them, and the Commission ensures that the laws are properly applied and implemented.

EU directives

The purpose of the EU is to facilitate the freedom of movement of people, goods and services. In the case of seven professions who have to be registered to practice (doctors, nurses, dentists, midwives, veterinarians, opticians and architects); specific sectarian directives were developed as the EU recognised that the purpose of the registration is first and foremost the protection of the public. To ensure the protection of the public throughout the EU, directives were developed so that a minimum standard of education and practice could be identified. Midwifery education and practice are determined by the Directive 2005/36/EC of the European Parliament and of the Council (2005). This Directive has just been amended on 20 November 2013 to ensure greater efficiency and transparency with the recognition of professional qualifications and has placed value on the use of a European Professional Card (Directive 2013/55/EU, 2013).

The NMC set standards for education and practice and give guidance to professionals. The latest standards for pre-registration midwifery education (NMC 2009) are guided by the international definition of a midwife and the requirements of the European Union Directive Recognition of Professional Qualifications 2005/36/EC Article 40 (training of midwives) and amendments to the EU Directive as stated above. These directives stipulate the experience that students must demonstrate before registering as a qualified midwife and are listed in Box 1.2.

All member states that adopt this directive must ensure that midwives are at least entitled to take up and pursue the following activities listed in Box 1.3.

The NMC insist that education programmes prepare students to practise safely and effectively so that, on registration, they can assume full responsibility and accountability to undertake the

Box 1.2 The European Union Article 40 (training of midwives) of Directive 2005/36/EU

- Advising of pregnant women, involving at least 100 antenatal examinations.
- Supervision and care of at least 40 women in labour. (The student should personally carry out at least 40 deliveries; where this number cannot be reached owing to the lack of available women in labour, it may be reduced to a minimum of 30, provided that the student participates actively in 20 further deliveries.)
- Active participation with breech deliveries. (Where this is not possible because of lack of breech deliveries, practice may be in a simulated situation.)
- Performance of episiotomy and initiation into suturing. Initiation shall include theoretical instruction and clinical practice. The practice of suturing includes suturing of the wound following an episiotomy and a simple perineal laceration. (This may be in a simulated situation if absolutely necessary.)
- Supervision and care of 40 women at risk in pregnancy, or labour or postnatal period.
- Supervision and care (including examination) of at least 100 postnatal women and healthy newborn infants.
- Observation and care of the newborn requiring special care including those born pre-term, post-term, underweight or ill.
- Care of women with pathological conditions in the fields of gynaecology and obstetrics.
- Initiation into care in the field of medicine and surgery. Initiation shall include theoretical instruction and clinical practice.

(NMC 2009)

Box 1.3 Article 42 of Directive 2005/36/EU

- To provide sound family planning information and advice.
- To diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies.
- To prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk.
- To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
- To care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means.
- To conduct spontaneous deliveries including where required an episiotomy and, in urgent cases, a breech delivery.
- To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus.
- To examine and care for the newborn infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation.
- To care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant.
- To carry out treatment prescribed by a doctor.
- To maintain all necessary records.

(NMC 2009)

activities of a midwife as directed by the EU Directive. To meet this in the UK, the NMC expect students, at the end of their midwifery programme to demonstrate competence in the following tasks, listed in Box 1.4:

Box 1.4 Students must demonstrate competence in:

- Sound, evidence-based knowledge of facilitating the physiology of childbirth and the newborn, and be competent in applying this in practice.
- A knowledge of psychological, social, emotional and spiritual factors that may positively or adversely influence normal physiology, and be competent in applying this in practice.
- Appropriate interpersonal skills (as identified in the Essential Skills Cluster – Communication) to support women and their families.
- Skills in managing obstetric and neonatal emergencies, underpinned by appropriate knowledge.

(*Continued*)

- Being autonomous practitioners and lead carers to women experiencing normal childbirth and being able to support women throughout their pregnancy, labour, birth and postnatal period, in all settings including midwife-led units, birthing centres and the home.
- Being able to undertake critical decision-making to support appropriate referral of either the woman or baby to other health professionals or agencies when there is recognition of normal processes being adversely affected and compromised.

(NMC 2009)

The International Confederation of Midwives

In view of the Global Midwifery agenda, the International Confederation of Midwives (ICM) is active and current. The use of global standards, competencies, tools and guidelines ensures that midwives in all countries have effective education, regulation and strong associations. The ICM has developed various interrelated ICM Core Documents, which guide Midwives Associations and their Governments to review and improve on the education and regulation of midwives and midwifery, and enable countries to review their midwifery curricula for the production and retention of a quality midwifery workforce.

The ICM supports, represents and works to strengthen professional associations of midwives throughout the world. There are currently 108 national Midwives Associations, representing 95 countries across every continent. This includes the Royal College of Midwives in the UK, which is the UK's only professional organisation and trade union led by midwives for midwives. The ICM is organised into four regions: Africa, the Americas, Asia Pacific and Europe. Together these associations represent more than 300,000 midwives globally. Its first recorded meeting was in 1919 in Belgium after World War I.

ICM Scope of Practice

…The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units…

(Revised and adopted by ICM Council June 15, 2011. Due for review 2017)

Key midwifery concepts

(See Box 1.5.)

The European Midwives Association (EMA) is a non-profit and non-governmental organisation of midwives, representing midwifery organisations and associations from the member states of the European Union (EU), members of the Council of Europe, the European Economic Area (EEA) and EU applicant countries.

Box 1.5 Key midwifery concepts that define the unique role of midwives

- Partnership with women to promote self-care and the health of mothers, infants, and families.
- Respect for human dignity and for women as persons with full human rights.
- Advocacy for women so that their voices are heard.
- Cultural sensitivity, including working with women and healthcare providers to overcome those cultural practices that harm women and babies.
- A focus on health promotion and disease prevention that views pregnancy as a normal life event.

Activity 1.2

After thinking about why you wanted to become a midwife, identify how this links to the role, responsibilities and regulation of the midwife.

Interpersonal skills and attributes

Preparedness to learn, accept, and not judge, to give advice and support are key characteristics of all healthcare professionals today. Emotional maturity to facilitate trust, respect and confidence from the women and families being cared for is also crucial. Maturity does not mean age. It is now recognised that to be a midwife requires in-depth tacit knowledge, competence and confidence to undertake the activities of a midwife, which are, as evidenced laid down in statute. In recognition of this, all midwifery programmes are now at a minimum level of degree. However, midwifery, although demanding and requiring a diverse knowledge base also needs compassion, caring and commitment. These are harder to measure.

Emotional intelligence (EI) as a concept has been researched extensively within other professions, but not within midwifery. It has been a major topic of debate since its appearance in the psychological literature in 1990 (Salovey and Mayer 1990). The interest in EI seems to stem from the view that despite seemingly average intelligence, some individuals appear to do well in life, whereas others with a seemingly high intelligence quotient (IQ), struggle with life challenges (Goldenberg et al. 2006). EI is defined as:

> *…the capacity to reason about emotions to enhance thinking. It includes the ability to accurately perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions as to promote emotional and intellectual growth…*
>
> (Mayer et al. 2004, p. 197)

Patterson and Bagley (2011) believe that raising the profile of EI will increase effectiveness and capacity in midwives to manage the constant change and challenges facing the profession. To be emotionally intelligent appears to evidence higher coping strategies, successful problem solving, higher academic achievement, improved interpersonal relationships and the ability to feel less anxious and to be more resilient (Kun et al. 2012). Attributes deemed desirable within a highly emotive and challenging profession such as midwifery.

These attributes are arguably as individual as the women with whom midwives provide care. How your own emotions and those of others are managed, combined with empathy and communication skills, without provoking conflict in a practice situation that is becoming increasingly challenging, are important components that must be considered in midwifery practice. However, these are profound concepts; therefore the challenge to identify, measure and apply meaning to them, in an attempt to facilitate appropriate recruitment and retention to a profession that is currently at the height of media attention and scrutiny is one that must now be faced.

Healthcare education has evolved beyond recognition since the NHS was formed. With the move into Higher Education in the early 1990s for all midwifery education, the emphasis on academic achievement is consistently in the spotlight. With the decision for all pre-registration midwifery programmes to be at degree level by 2009 (NMC 2009) academic entry and degree classifications are now seen as key to a university's success. Academic achievement is naturally aligned with IQ; however midwifery is more naturally aligned with care and compassion. Therefore it is reasonable to assume that a successful midwife today should possess a high IQ, should aim for academic success, and have the personality to care for and cope with the demands of the nature of midwifery practice. However, as the literature disputes the association between EI and IQ (Cherniss et al, 2006; Davis 2012; Faguy 2012), recruitment and retention strategies have limited evidence on which to be based.

Performance in practice is largely observable and constitutes a minimum of 50% of the midwifery programme; it must be undertaken in clinical practice. The reliability of the practice assessments undertaken by clinical midwives has been scrutinised since their introduction by the NMC and continues to be open to criticism of subjectivity, unreliability and inequity.

Working within the NHS is a unique experience, and many studies have considered socialisation to the culture of midwifery and the NHS as both a barrier and a coping mechanism for those working within it. Even those with experience as healthcare support workers have reported experiencing a culture and reality shock (Brennan and McSherry 2007). Socialisation can lead to a loss of idealism and identification of negative aspects of care, which can decrease the ability to cope (Mackintosh 2006). Organisational socialisation, where interpersonal relationships are to be maintained, together with adaptation to the ward rules and culture, can create frustration and stress (Feng and Tsai 2012). However, resilience and mental toughness (Clough and Strycharczyk 2012), can foster clinical reasoning and critical decision-making abilities, which are vital in this profession. Midwives must have the ability to question and challenge practices and make difficult decisions based on available evidence and the preferences of women in their care (Parsons and Griffiths 2007).

There is currently a great deal in the press about the kind of skills and attitudes healthcare professionals need to have. This is related to the recent Francis Report (2010) and the Care Quality Commission (CQC) (2013) report into maternity services at Barrow in Furness. This has led to the Department of Health (DH) strategy to set out the requirement for care and compassion around those who are in the caring profession (DH 2012).

Further reading activity

Read: The vision for midwifery care within the Department of Health strategy.
[Available online] http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-midwifery.pdf

Activity 1.3

Think about how you can be caring and compassionate at all times and what aspects of the caring environment could challenge this?

Effective communication is crucial. Midwives work in a multidisciplinary environment and therefore must be able to consistently communicate accurately and clearly with women, their families and to other professionals. Being able to communicate effectively both verbally, and in writing to ensure that all care provided is safe, is essential. The NMC (2009) standards reflect this requirement and assessment aims to reduce and challenge barriers.

Professional expectations

As soon as a person commences a professional programme that on completion will allow entry onto the NMC register, then their behaviour is under scrutiny. This behaviour is set out in NMC documents, which are periodically updated. The code of practice and the NMC guide for students sets out clearly what is classed as acceptable and unacceptable behaviour.

Further reading activity

Read: The Code (NMC 2008a) and student guidance on professional conduct (NMC 2011a) and think about what aspects of your behaviour you might need to change in order to meet these codes.

One of these aspects of behaviour may be the use of social networking sites. Practitioners and students must not put anything on these sites that they would not be happy for the entire world to see. This has implications in relation to the confidentiality of patients and other healthcare workers, as well as to appropriate language and comments (Jones and Hayter 2013). The transition to a student midwife can be a challenging one and it is useful to revisit the code and student guidance, as well as discussing this with midwifery lecturers and midwives.

Life as a student midwife

Further reading activity

Read: Lisa McTavish's article about her experiences as a student midwife and think about what lessons you can learn from her story and write your own story.

McTavish, L. (2010) 'A student midwives' experience in the 21st century' *British Journal of Midwifery* 18 (1), pp. 43–47.

Student midwives often face challenging times on their demanding midwifery programmes. This is good preparation for post-registration practice: some 'mental resilience' is needed for students and midwives alike. This is currently more challenging due to the latest changes to the NHS structure which are underway and the financial situation within the NHS. This means that

students and midwives need to develop coping strategies in order to manage the working environment, whilst still giving good quality care.

Further reading activity

For more information on the latest changes in the NHS, read: The New NHS 2013. [Available online] http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx

As midwifery education is very intimate in its delivery and practice, 'people' skills are paramount. This is where, arguably, the emotionally intelligent element plays a significant role in course progression. Generally, mentor/student relationships are acknowledged as compatible or not; adjustments can easily be made if required. The important thing is to recognise if there is a problem and address it. This requires a confident, self-compassionate and resilient individual and highlights that appropriate student recruitment is vital.

There is undisputed evidence to suggest that healthcare practitioners cope better than others with the challenge of the demands placed upon them, and there are also those who actively flourish and thrive. Resilience has been defined as:

> *…The inner strength, competence, optimism, flexibility and the ability to cope effectively when faced with adversity…*
>
> (Wagnild 2009, p. 105)

Control is crudely, a cognitive ability, which requires knowledge and skill. It is seen as important when coping within the workplace and cited as a major cause of burnout if lost. Resilience has a core philosophy, which makes individuals take responsibility for their own success or failure, and it is a measure of self-worth (self-compassion). It focuses on emotional flexibility, responsiveness, strengths and resilience. Compassion has been defined as:

> *…Being open to and moved by the suffering of others, so that one desires to ease their suffering. It also involves offering others' patience, kindness and non-judgmental understanding, recognising that all humans are imperfect and make mistakes…*
>
> (Neff 2003, p. 224)

Buddhist belief regards the self and others as interdependent; therefore to be compassionate to others is not possible without compassion for the self (Baer 2010).

University students must be adult learners who must develop and enhance their own learning skills. Student midwives therefore should identify their needs; self-assess and be able to seek help and support proactively. Seeking help retrospectively, following poor performance in assessments, indicates earlier missed opportunities. There are many people within the university and the clinical practice areas who can help and support students; it is the student's role to seek them out when necessary.

The programme

The midwifery degree is a degree of two awards: first, the professional award, Midwifery, which is regulated by the NMC, and must adhere to all the NMC documentation, standards and guidance. The second award is the academic award of a degree, which is regulated and monitored by the university where it is being studied.

With the professional recognition of becoming a midwife, having evidenced all the requirements and competences to be admitted to the professional register and achieve the University's academic standard to be awarded a degree, comes an increase in workload and commitment. Despite being forewarned of this, this creates a major struggle for some student midwives.

There are two lengths of programme. One is 156 weeks in length, or 3 years (NMC 2009); the other is where the student is already registered with the NMC as a nurse level 1 (adult). The length of this programme is not less than 78 weeks full time. Both student groups are *pre-registration* midwifery students, who will be competent to practise, at the point of registration. The theoretical content is driven by the Standards (NMC 2009); the clinical practice is driven by local provision and the EU Directive. The university processes generate the structure, assessment, teaching style and resources. All universities that provide pre-registration midwifery must appoint a Lead Midwife for Education (LME).

> *…The lead midwife for education is an expert in midwifery education and has the knowledge and skills to develop policy, as well as to advise others on all matters relating to midwifery education. She should liaise directly with commissioning and purchasing agencies for midwifery education, as well as being involved in any decisions regarding midwifery education…*
>
> (NMC 2009, p. 8)

Midwifery lecturers are practising midwives who hold a recognised teaching qualification. Universities who run pre-registration midwifery programmes employ them. Midwifery programmes usually exist within University Faculties or Departments encompassing Health, Social Care, or Medicine and Allied Health. The number of midwifery lecturers within each university was traditionally determined by student numbers and worked on a ratio of 1:10; however this is variable across the country and does impact on the quality of the teaching resource. Midwifery lecturers are all practising midwives; they must maintain their competence and confidence as a midwife, notify their intention to practise annually and remain up-to-date with mandatory training and education. Midwifery lecturers, in addition to teacher training, should hold or be working towards a higher degree or doctorate. In meeting these requirements, midwifery lecturers are able to apply contemporary practice to the classroom. This is to address the theory/practice divide which can occur if practice taught away from the clinical area is not consistent with practice that is taught/observed within the clinical area.

The students' theory elements are assessed generally in the university by the midwifery lecturers employed by that university. Midwives in the clinical areas who are employed by the local Trusts assess midwifery practice. Assessment of practice must be graded and must contribute to the award of the degree as per the Standards (NMC 2009). Therefore, as it is the university who awards the degree, it is exceptional if university staff are not solely responsible for the assessment of that award. This has and does cause difficulties when seeking university approval, which must be granted by the university to offer and support pre-registration midwifery programmes. To address this anomaly, the university seeks reassurance that equity and parity of all assessments are assured.

Midwives who assess student midwives must be sign-off mentors. The role of the sign-off mentor is to make judgments about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register. The LME confirms to the approved education institution assessment board that both the theoretical and practice elements have been achieved on completion of the programme (NMC 2008b).

The midwife with whom the student will be working mainly provides placement support. The NMC stipulate that a minimum of 40% of the time is spent working with a sign-off midwifery

mentor, who is an experienced midwife and has undergone additional training to be able to assess the students' practice. Additional support is available by a Supervisor of Midwives who is available 24 hours every day, and a Practice Learning Facilitator (PLF). A PLF is a person who is generally jointly employed by the Trust and the university where students undertake their programme. The PLFs are visible within the clinical areas, and are a point of contact should issues arise; they work alongside a link lecturer. The link lecturer is usually a member of the midwifery teaching team at the university; along with the PLFs they provide ongoing education and training to clinical staff on curriculum issues and student assessment.

A minimum of 50% of the programme must be spent in the clinical area: clinical systems of care will vary between Trusts and some students find that they prefer one system to another. The advantage of the team approach is consistency of mentor and continuity of carer for those accessing that service. The advantage of the non-integrated approach is working with different mentors and adjusting to different placement areas. All midwives, despite the same common goal and mission as depicted in the Midwives Rules and Standards (NMC 2012) work slightly differently. This is the autonomous element of the midwives' role. All students have different learning styles and all educators and mentors have different teaching styles. Therefore some students and mentors/teachers work better together than others. However experiences can be unpredictable and there are times of stress in all systems.

Different students have different learning styles whether in academic or clinical learning; therefore some teaching methods will appeal to some and not others. All curricula should evidence different styles in an attempt to meet the needs of all. All learners can be helped by knowing their own learning styles.

Activity 1.4 Learning styles

The websites below will assist you in identifying your learning style and also examine the learning situations which suite you best. If you have done one of these assessments before, it can still be worth doing this again as these can change over time.

[Available online] http://www.brainboxx.co.uk/A2_LEARNSTYLES/pages/learningstyles.htm and http://www.vark-learn.com/english/page.asp?p=questionnaire

The statutory supervision of midwives

Supervision of midwives was introduced over 110 years ago as a purely inspectorial function to lower maternal mortality rates and to protect mothers and babies from unsafe midwifery practice. It is enshrined in law and has evolved to support the protection of mothers and babies by promoting excellence in midwifery care, through the leadership roles of Supervisors of Midwives. This is achieved by every midwife in the UK having a named Supervisor of Midwives, whether they practise clinically, or in education, or in a research post or whether they practise in the NHS, or are privately employed. Supervisors of Midwives work within a framework of supervision outlined by their Local Supervising Authority (LSA) Midwifery Officer who appoints them to practise within that LSA area. They have a caseload of midwife 'supervisees' and have a responsibility to ensure their supervisees' eligibility to practise by undertaking an annual supervisory review to identify and discuss how best to address any developmental needs. On the basis of that review and on any other relevant information, the supervisor then submits the midwife's annual Intention to Practise (ITP) to the NMC which is displayed to the public on the NMC register.

Clinical consideration

Intrapartum stillbirths are a central indicator of patient safety and quality of care, but despite this stillbirth rates have changed little in the English National Health Service over the past two decades. Increasing evidence indicates that fetal growth restriction is currently missed in most pregnancies in the NHS, and that better antenatal detection needs to become a cornerstone and key indicator of safety and effectiveness in maternity care. This has, therefore, been an LSA priority over recent years with the LSA and supervisors disseminating best practice evidence to midwives within local conferences, presentations, newsletters and during annual supervisory reviews. Preventing poor practice has occurred by the LSA producing a best practice competency assessment tool for fundal height measurement, which supervisors have worked through with midwives to ensure that midwives consistently and competently measure and respond to fetal growth in the same way. Intervening in unacceptable practice has occurred by LSA reviews where clusters of stillbirths have been noted. Reviews have led to some changes to generic practice within Trusts, e.g. the implementation of customised growth charts. Other reviews have led to additional supervisory input to aid the development of individual midwives' practice where required.

All maternity services are required to ensure the availability of 24-hour access to support and advice from a Supervisor of Midwives for midwives and service users. Supervisors practise in a team within maternity services; hold regular supervisors' meetings to determine their local work priorities; are involved in the maternity services' clinical governance systems, for example, audit meetings and risk management meetings; and ensure that their supervisory framework encompasses involvement with their local universities in the recruitment to and progress of student midwives through their midwifery education programmes. Evidence from the diaries of newly qualified midwives (MINT research commissioned by the NMC 2010) indicates that where the role of a Supervisor of Midwives for student midwives occurs it enhances students' understanding of supervision.

The example in Box 1.6 demonstrates how supervisors work to promote excellence in midwifery care, prevent poor midwifery practice and intervene in unacceptable practice.

A Supervisor of Midwives is now commonly assigned to every student midwife undergoing a pre-registration midwifery programme. The student midwife can contact the Supervisor of Midwives, in confidence, at any time to voice concerns or to debrief following an upsetting or difficult situation in the clinical area.

Raising and escalating concerns

Raising and escalating concerns is a fundamental responsibility of all healthcare workers, and the NMC have published guidance on this (NMC 2013). If students or practitioners are worried generally about an issue, wrongdoing or risk which may affect or is affecting others in the workplace or in their care, they should raise a point of concern. This is not an easy thing to do, which is why students are advised where to access support at the start of the programme. These include their personal supervisors, university lecturers, midwifery mentors and Supervisor of Midwives.

Quality assurance

The quality measure of midwife lecturer to student ratio at the university demonstrates the resource commitment from the university to that provision, where 1:10 is seen as best practice.

Clinically, the birth rate to midwife ratio should also be considered, with the additional quality measures of Care Quality Commission reports, Professional Standards for Health and Social Care, Maternity Liaison Committee, LSA audits, all of which are readily available to the public. Evidence suggests that if the team of teachers includes a Supervisor of Midwives, it can enhance communication between the universities and their clinical placement areas and provide an additional level of support to newly qualified midwives during their transition period from that of student midwife.

Midwifery educationalists are often invited members of LSA working groups and receive routine communication, for example newsletters from the LSA, which are disseminated to student midwives. This ensures close links between education and supervision, with resultant benefits to education, supervision and to the LSA. Any forums that bring education, practice, Supervisors of Midwives and the LSA together are in line with Maternity Matters (Department of Health 2007) and research advocating closing the theory–practice gap.

Universities value student evaluations and seek student representation on committees at programme, departmental, faculty and university levels. Student evaluations of modules, placements, programmes and the university are sought and acted upon. The National Student Survey is undertaken annually; all students are invited to complete this in their final year of study. The results are available to the public, and are valued as a serious quality measure of student satisfaction.

Student support

Personal supervision is an element found in all pre-registration midwifery education programmes, and is generally undertaken by a member of the midwifery teaching team. University processes tend to determine the format this takes. The personal supervisor role can play a significant part in a student's progress whilst on the midwifery programme. It allows a relationship to be developed between the personal supervisor and the student, with mutual respect, honesty and confidentiality being crucial components. Ideally the student and personal supervisor meet early after the programme commences agreeing the subsequent frequency and format for further contact. As with the mentor–student relationship, a rapport between the two parties must be established in order to maximize the benefit; therefore the option of changing should always be available. Changing mentors clinically, or personal supervisors in the university, is not a failure, but merely recognition of different learning styles and personality traits.

Student support services are also a feature of Higher Education Institutions, but these vary. The student union is an example. Student midwives/nurses may find it more challenging to participate in student unions and campus life for various reasons (see Figure 1.1). They are still eligible to receive student union support and to participate in any student ballots. It is important to also access various study support services available to all students, including library services, study skills advice and information and communication technologies (ICT). These are all essential to learning and continuing education post-registration. Additionally, most universities will have confidential counselling services, which can be accessed by students; at times these may help to cope with the conflicting demands and stresses which may accompany student life.

Health screening

Health screening has consistently been a feature of all healthcare programmes, with all student midwives requiring health clearance prior to the course commencement and to declare annually their good health and good character (NMC 2009), whilst on the programme and prior to

Campus life
Academic study
Clubs and societies
Social life
Student/campus politics

Conflicting commitments
Older age profile than non-vocational students →
↑Family commitments
Accommodation off campus
Placement working hours/ shift work

Figure 1.1 Conflicting commitments faced by midwifery students.

their admittance to the NMC professional registers. Students with long-term health issues must be passed as fit to undertake the programme from the occupational health department. Students whilst on clinical placement can also access the Trust occupational health department should the need arise. Students and midwives must take responsibility for their own health, and are required to have all vaccinations recommended by the Department of Health to protect themselves and the people in their care. These include rubella, measles and seasonal influenza. All midwifery students prior to commencing the programme are tested for blood-borne viruses due to the risk of exposure prone procedures.

Criminal record

All students and midwives upon appointment have to undergo a Disclosure and Barring Service (DBS) investigation. Should this return with a positive record, a meeting would be convened between the applicant, an admissions representative and a Trust representative to discuss this in more depth. This meeting would be to determine the gravity of the record, and to determine whether this would preclude the applicant from being successful with this application. Generally, decisions are dependent upon the nature of the offence, circumstances surrounding the offence and the time elapsed since it was committed. All applicants are routinely asked at interview if they have anything to declare; therefore the opportunity is afforded to discuss this frankly and honestly. Should any offence, subsequently disclosed on the DBS not be declared at this point, it is generally viewed unfavourably. It is worthy of note that all offences will be disclosed with an enhanced DBS enquiry, even speeding offences and offences committed as a juvenile. Any subsequent offence, warning, reprimand or caution received whilst on the programme, or as a midwife must be notified to the university (if applicable) or the NMC and may initiate a Fitness to Practise investigation (NMC 2011a).

Life as a midwife

Upon successful course completion, the LME has to be satisfied of the student's good health and character, and that they have completed all the required statutory elements. The LME then notifies the NMC of the student's successful completion and that he/she is satisfied that all requirements have been fulfilled. The successful student is allocated an NMC Personal Identification Number (PIN) and her/his name appears on Part 2 of the professional register. At this point the candidate has become a registered midwife and is licensed to practise midwifery in the UK and other regions of the world, where this is recognised.

Midwives practising in the UK utilise statutory supervision for support and professional development. Annual LSA audit visits to maternity services indicate the substantial psychological, clinical and professional support that Supervisors of Midwives provide to midwives during their careers. Midwives undertake Post-Registration ongoing Education and Practice (PREP) (NMC 2011b) requirements and mandatory training, which is to be superseded by the Revalidation process in 2015. Additionally there are different career routes to consider.

Activity 1.5 What kind of midwife do you want to be?

Think about a midwife you admire and that you feel is a good role model. Undertake a SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats) to identify challenges and support frameworks for you to achieve your goals.

Career routes

To remain firmly rooted in clinical practice is the most popular career choice, with many opportunities to advance experience and scope of practice. These include: intravenous cannulation skills; examination of the newborn; ultrasound techniques; labour ward co-ordinator; Supervisor of Midwives and sign-off midwifery mentor. Some midwives become advanced practitioners and/or consultant midwives by specialising in certain areas, for example, ultrasound, family planning, teenage pregnancy, domestic violence and healthy lifestyles. There is the option of undertaking further academic study by undertaking a master's degree, or a doctorate. These provide the opportunity to undertake research positions. Midwifery management is a vital element to any maternity provision, which again can be a career choice. Some midwives become midwife educators, working within higher education or in a statutory capacity. This list is not exhaustive, but indicative of the pathways available upon qualification as a registered midwife.

Key points

- Midwifery regulation is extensive and rigorous.
- Essential characteristics for student midwives and midwives are deemed paramount to cope with the demands of the profession.
- Clinical practice, supervision of midwifery and education are closely aligned.
- Student support is varied and readily available.

Conclusion

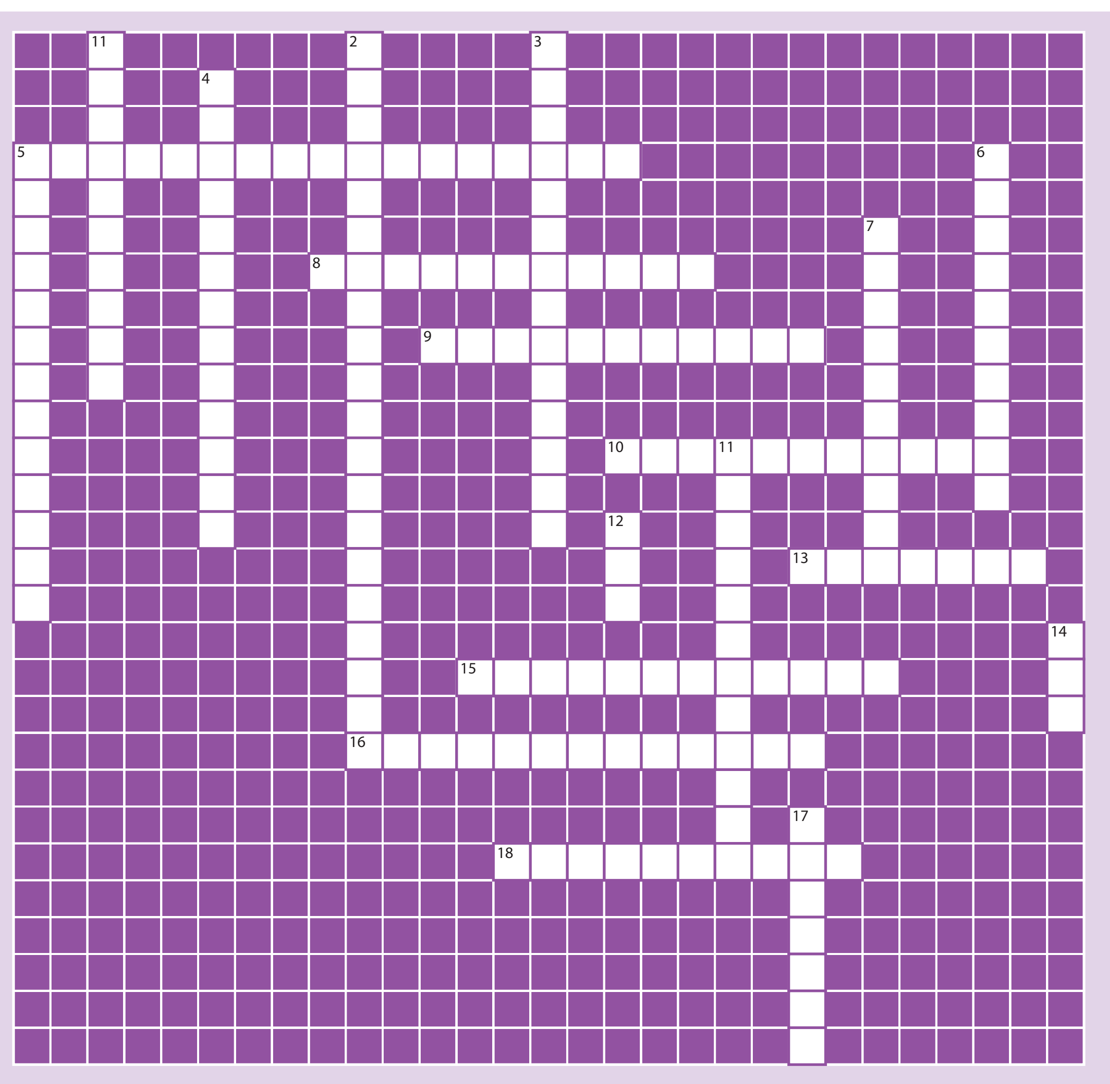
What it means to be a midwife, how you become a midwife and how to remain a midwife is entrenched in EU legislation, and professional standards. The professional status of a midwife is protected, the regulation complex and internationally compliant, the quality and academic rigour of pre-registration midwifery programmes is assured and career choices diverse. Statutory

supervision is a major strength of the midwifery profession. The pre-registration midwifery programme is challenging, as is the current climate of maternity service provision. The support systems in place are robust, and are there to be accessed. Completion of the programme and successful retention of high calibre recruits to the profession is pivotal to maintaining the high quality provision women and their families deserve.

This chapter has aimed to provide clarity to the evolvement of midwifery, and how student midwives are recruited and supported to become a confident, competent, compassionate, accountable and autonomous practitioner in the world of midwifery. The following chapters outline the roles and responsibilities of a midwife.

End of chapter activities

Crossword



Across

5. Midwives must have the ability to do this.
8. What all care should be.
9. What a midwife and student midwife should have with a woman and her partner.
10. What a midwife needs to be as described by the ICM.
13. A key midwifery concept.
15. What a midwife must be able to do.
16. It can be a barrier and a coping mechanism.
18. Being open to and moved by the suffering of others, so that one desires to ease their suffering.

Down

1. Inner strength, competence, optimism and flexibility.
2. What a midwife or student midwife must have 24 hour access to.
3. An essential characteristic of a midwife.
4. An essential skill which a mentor will demonstrate and teach to a student midwife.
5. Students need to demonstrate competence in this.
6. The number of postnatal women which students must supervise and care for during their programme.
7. A minimum standard for the education and practice of midwives.
11. Something which is paramount in midwifery education.
12. An expert in midwifery education.
14. Exist to safeguard the health and wellbeing of the public.
17. A key characteristic of all health professionals.

Find out more

1. For more information on the history of midwifery read:
   - Cowell, B., Wainwright, D. (1981) *'Behind the Blue Door: The History of the Royal College of Midwives 1881–1981'.* London: Balliere Tindall.
   - Leap, N., Hunter, B. (1993) *The Midwife's Tale: An oral history from handywoman to professional midwife*. London: Scarlet Press.
2. Read the article below and consider how you can prepare yourself and maximise the many invaluable learning experiences you will encounter during your programme and indeed as a midwife.
   - Healey, J., Spence, M. (2007) *Surviving Your Placement in Health and Social Care A Student Handbook*. Open University Press.
3. Read the article below and think if you can see yourself in any of the student midwives comments? Does this give any advice around how to keep your motivation in the real world of maternity care?
   - Carolan, M., Kruger, G. (2011) Understanding midwifery studies: Commencing students' views. *Midwifery* 27, pp. 642–647.
4. Read the article
   - Snow, S. (2010) Mutual newness mothers experiences of student midwives. *British Journal of Midwifery* 18(1), pp. 38–41
     a. Think about how you can and do foster an effective relationship with the woman.
     b. How can you ensure that you reflect this in your assessment documents?

5. For more information visit:
http://www.europeanmidwives.eu/eu
http://www.internationalmidwives.org/
http://www.nmc-uk.org/
http://www.rcm.org.uk/
https://www.rcn.org.uk/
http://www.6cs.england.nhs.uk/pg/dashboard
http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx
http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-midwifery.pdf
http://www.legislation.gov.uk/uksi/2008/1485/pdfs/uksi_20081485_en.pdf
http://www.brainboxx.co.uk/A2_LEARNSTYLES/pages/learningstyles.htm
http://www.vark-learn.com/english/page.asp?p=questionnaire

Glossary of terms

CHRE Centre for Healthcare Regulatory Excellence

CMB Central Midwives Board

CQC Care Quality Commission

DBS Disclosure and Barring Service

DH Department of Health

EEA European Economic Area

EI Emotional intelligence

EMA European Midwives Association

EU European Union

ICM International Confederation of Midwives

ITP Intention to practise

IQ Intelligence Quotient

LME Lead Midwife for Education

LSA Local Supervising Authority

MINT Midwives in Teaching

NHS National Health Service

NMC Nursing and Midwifery Council

PLF Practice Learning Facilitator

PIN Personal Identification Number

PREP Post-registration ongoing education and practice

PSA Professional Standards Authority

RCM Royal College of Midwives

SOM Supervisor of Midwives

UK United Kingdom

UKCC United Kingdom Central Council

VLE Visual learning environment

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