

Chapter 1

INTRODUCTION TO MIDWIFERY AND THE PROFESSION

Susan Way

Introduction

Starting your midwifery programme is an exciting time and a key element of your role is being 'with woman'. One of the aims of this chapter is to explore various beliefs about how care should be provided, with the aim of starting you off thinking about the kind of midwife you would like to be. It explores philosophies and models of care, including the 6C's and how, through the use of appropriate language, you always keep women at the centre of your care. The latter half of this chapter helps you understand the role of the Nursing and Midwifery Council (NMC), the regulatory body that is responsible for setting the rules and regulations that govern our practice as midwives, and how these will impact on you the moment you become a student midwife. They will shape the knowledge and skills you acquire, but more importantly the way you behave and what is expected of you by the public.

Philosophy of care

What is the practice of midwifery?

Midwifery care is practised by many different people across the globe such as qualified midwives, obstetricians, support workers, family doctors and traditional birth attendants. The quality of care will be different depending on the training or lack of training that the person has received. Who and how they were taught, their skills will accordingly shape the way they think and practise midwifery.

Introduction to philosophy

Philosophy is a way of thinking which has a common understanding and is shared by a group of people or from personal experience – forming an individual perspective. Philosophy is, therefore, a particular way of thinking. A philosophy of care in a midwifery context is how

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healthcare professionals such as midwives believe care should be provided to women, their babies and families.

A significant report in 1993 commonly referred to as 'Changing Childbirth' or Cumberlege report, named after the Chair of the Committee, Baroness Cumberlege (DoH 1993) detailed for the first time that care provided to pregnant women should be kinder, more welcoming and more supportive. Women and their families should be at the centre of maternity services, which should be planned and provided with their interests and those of their babies in mind. Other reports have continued to drive this policy forward (DoH 2007, 2009, 2010; The Maternity Services Action Group 2011). 'Changing Childbirth' (1993) offered a different way of thinking about how care should be provided, and supported a particular philosophy that many midwives were trying to practise or aspire to.

Before the 'Changing Childbirth' report was published, evidence was beginning to show that women were becoming increasingly dissatisfied with maternity services and that women wanted more continuity and individualised care (Garcia 1982). As more women birthed in hospitals (up to 98% by the end of the 1970s), care had become fragmented and women were subjected to many, often unnecessary, interventions, without any thought of individual circumstances, needs or experiences. For example, all women would have been given an enema at the beginning of labour, because it was believed that this reduced the amount of soiling, the length of labour and the risk of infection. Romney and Gordon's (1981) important piece of research

challenged whether enemas were actually needed and so eventually it was stopped, but it took some time. In the same period, care offered to women began to be task focussed with different midwives being involved with specific activities or aspects of care. This meant that women would be seen by a range of midwives during the antenatal, labour and postnatal periods; the end result was that women were unable to build a trusting relationship with 'their' midwife. Thompson (1980 cited in Bryar 1991 p49) describes this conflict with the following statement:

'we [midwives] have become assembly-line workers with each midwife doing a little bit to each woman who passes by'.

Two opposing philosophies

The 'Changing Childbirth' report and subsequent policy initiatives emphasise the need to put women at the heart of maternity care taking into account their individual social, spiritual and psychological needs and wishes. The other viewpoint puts task-orientated care and the needs of the organisation above those of the woman; progressing large numbers of women through a factory-like system to achieve efficiency and productivity.

The social or physiological model

Acknowledging the woman as a whole person is often talked about as holistic care, and the philosophy related to this is sometimes referred to as a social or physiological model or approach. Supporters of this philosophy would argue that childbirth is a normal physiological

event, where the progress of pregnancy, birth and the postnatal period is seen as normal and not defined as being at the risk of something going wrong (Royal College of Midwives 1997). Routine practices and interventions such as withholding food and drink from women in labour are not used as they are seen as unnecessary in improving the health of women and their babies. Women and midwives are viewed as partners in care, sharing knowledge to enable women to make their own choices based on accurate and unbiased information. A trusting relationship is built between midwives

and women, empowering women to be in control of their own birth experience. Women are the focus of care, with midwives listening and responding to their needs. The approach aims to increase women's independence or autonomy over the whole childbirth experience (DoH 2004, 2012). An example of a student midwife's philosophy is shared below. Mille wrote this philosophy for her caseloading module and it reflects the care she provides to women – not only those within her caseload but all women with whom Millie comes into contact.

Vignette 1.1 Philosophy of care

My philosophy of midwifery practice stems from my personal values. These are to treat all individuals, irrespective of background, with kindness, dignity and respect. To me, midwifery is about guiding each woman through a normal, but changing, stage in her life. In order to form a meaningful relationship, I think it is important to have a compassionate and empathetic approach from the first point of contact which would entail understanding any particular additional needs the woman may have. The power of a smile is underestimated; it can help relieve anxieties from the outset, showing that you are friendly and want to be there with the woman.

I believe that my care of a woman must be founded on a mutually trusting relationship wherein she feels both safe with, and confident in me at all times. I believe that a trusting bond between the woman and the midwife is most likely to develop from the midwife's competent and committed care, which is non-judgemental, and tailored to her needs regardless of culture, age, disability, or sexual orientation.

I believe the woman will be empowered to make informed choices and to feel comfortable in doing so if the midwife is honest, open minded and quietly assistive. This gives the woman control over, and confidence in her body and its ability to take her through her journey of pregnancy and childbirth. In this way, midwifery becomes a woman-centred approach, which is fundamental to good practice.

(continued)

Holistic care is very important to me. In addition to the woman's physical needs, any psychological, social and emotional needs should always be addressed to enable high-quality health care. This care might be expanded to meet public health needs, such as education about adapting to motherhood, and about weight management.

Millie Westwood

Third-year student, Bournemouth University, Dorset, UK

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Medical model

At the other end of the scale is the focus on preventing or reducing the risk of something going wrong. This requires an approach where statistics and medical intervention are considered more important and is often referred to as a medical model of care, with an understanding that pregnancy and birth is potentially risky and that childbirth can only be classed as a normal once the outcome is known (Walsh et al. 2004; van Teijlingen 2005). The body is divided up and viewed as separate systems such as the circulatory system, the reproductive system or the nervous system, resulting in care being delivered according to the system under inspection rather than the body as a whole. An example would be the differing views towards pain in labour. A physiological approach may mean that it is important for a woman to experience this, viewing it as a way of connecting with her soon to be born baby and that labour contractions are a life-giving force to enable the birth to take place. The medical model would however see this as a problem which needs to be cured; pain relief such as an epidural would therefore be offered routinely.

Although referred to as the medical model, it is not always or only practised by doctors but many midwives also support this view. Medical or technological interventions become important in managing any potential risk that may be harmful to the progress of pregnancy or labour and birth. The term 'risk' has more recently appeared in the midwifery literature, with concepts such as 'antenatal screening for risk of abnormality' and 'risk criteria for midwife led care' being used (Thomas 2003). Interventions in labour to manage such risks include birthing in hospital, induction of labour, rupturing membranes, episiotomy and caesarean section; these are undertaken in the belief that the health of the woman and her baby will be improved.

Comparing the models

Further differences between the two models are seen when comparing how success is defined in terms of birth outcome. With the physiological model, factors are taken into account such as given in Fig. 1.1.

Even if the woman required an operative procedure to birth her baby the above needs should still be met. The success indicators are fairly broad and



Figure 1.1 Physiological model: factors to consider.

relate very much to the experience of the woman and her family. The indicators of success for the physiological model demonstrate that social, cultural and psychological factors all have an influence on outcome that can impact on the birth experience well beyond the completion of birth. Successful outcomes of birth within the medical model are talked about in relation to illness or injury (often referred to as morbidity) as well as mortality – the death of a woman or newborn baby. Numbers or statistics are often used to demonstrate results of causes and cures for specific disorders.

The following quotes taken from a report published by the Care Quality Commission (CQC) highlight two women's contrasting experiences:

'we found out a few days before my baby was due that he was breech [bottom first rather than head]. Various options were made available to us but we chose a planned Caesarean Section. All of the staff I came into contact with were very kind and explained everything'

CQC (2013:14)

"Due to me not being listened to and being ignored when I was telling the midwives

I felt labour had started. I was left in a room with other women and not checked for 4^{1/2} hours even though I went to them 3 times to tell them I felt my baby was coming. After me struggling to their desk in the early hours and arguing, they eventually checked me and discovered the head was there. I had given them many opportunities to check earlier and asked for a private room but this was ignored leaving me alone with 2 other women sharing my room = DISGUSTING!"

CQC (2013:24)

The two opposing models of midwifery care expressed above are extreme ends of a spectrum and some midwives' practise would incorporate elements from both. Categorising the approaches to care in terms of models provides a way of understanding people's thinking and can be considered a way of simplifying aspects of a complex world (Ireland & van Teijlingen 2013). Our philosophical style to the practice of midwifery may well have been influenced by our view on life. This can impact on the way we see the world and so start to use the model in our own lives and subsequently in our practise as midwives.

Women's views of maternity care

Negative feedback reinforces the view from the Department of Health that women should be at the heart of maternity care (2004, 2005) and that midwives have an integral role in developing

woman-centred care (DoH 2010). The Chief Nurse for England, Jane Cummings refers to the 6Cs of care, compassion, competence, communication, courage and commitment and how these can improve the culture of care we give (NHS Commissioning Board 2012). Using these 6Cs, midwives can make a significant contribution to high quality, compassionate and excellent health and well-being outcomes for women across all settings.

Recently Renfrew et al. (2014: 2), in order to assess the quality of midwifery care from a global perspective, defined the practice of midwifery as:

'skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, physiological, social and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families.'

Many of the core characteristics reflect the 6Cs as well as a philosophy that respects the individual contribution that women make to their own care.

A humanising values framework has been developed to show how these principles can be incorporated into the midwifery care you will be providing

Table 1.1 Dimensions of humanisation.

Forms of humanisation	Forms of dehumanisation
Insiderness: experiencing the world through mood, feeling and emotion	Objectification: seeing women with a list of problems rather than a holistic person
Agency: having freedom to make choices	Passivity: not enabled to make true, informed choice
Uniqueness: being individual and having unique characteristics	Homogenisation: fitting people into boxes such as, the obese woman, the smoker
Togetherness: belonging within a community of care giver, family and friends	Isolation: isolated through negative relationships with the midwife(s), family and friends
Sense making: value the experience of women and support them to make sense of it	Loss of meaning: ignoring experiences because they are different, difficult to accept or do not have the time to listen
Personal journey: acknowledge the childbirth journey as part of a bigger life event	Loss of personal journey: not recognising the impact of childbirth as a life event
Sense of place: environments offer familiarity, comfort and safety	Dislocation: environments lack privacy and dignity that can sometimes be frightening and inflexible
Embodiment: recognising the woman within their psychological, social and socio-cultural context	Reductionism: stereotyping women into particular behaviours such as those who construct a birth plan being seen as 'difficult'

Adapted from the dimensions of humanisation (Todres et al. 2009).

(Todres et al. 2009). There are eight themes and the diagram given in Table 1.1 demonstrates dimensions of humanisation/dehumanisation. During your time in practice reflect on the dimensions of humanisation to help develop the care you offer into being woman-centred, compassionate and caring.

Top ten tips for what women want from their midwives/ student midwives

Luisa Cescutti-Butler

AIMS (Association for Improvements in the Maternity Services) a volunteer organisation was founded in 1960 by

Sally Willington. Her story, describing her antenatal and birth experience was published in a national newspaper, which resulted in many other women also complaining about their experiences. Thus, AIMS was 'born' and as a campaigning pressure group, its underlying premise is based on believing that change for women in childbirth comes from supporting midwives as autonomous practitioners in their own right, and who should be the lead carer for women and babies throughout the childbirth continuum (AIMS 2012; DoH 2010). Over the last 54 years, AIMS have campaigned for changes in maternity services, and as a result of these campaigns have collected a rich database of women's experiences which have all shown similar themes. These themes have enabled AIMS, and now us, to better understand what women would like from midwives as they journey through pregnancy, birth and beyond (AIMS 2012). The themes represented in Fig. 1.2 as top ten tips are primarily aimed at midwives; however, they will be equally relevant to you as a student midwife.

Watch your language

Luisa Cescutti-Butler

Communication is at the heart of everything we do as humans. As midwives we spend much of our working day sharing and communicating with pregnant women and their families, or with our colleagues. Throughout all interactions we need to consider our use of language. Inappropriate words and phrases used by healthcare professionals may undermine

a woman's confidence in herself, and more specifically in her ability to birth her baby and be a mother (Robertson 1999; Simkin et al. 2012). This section will highlight some of the common phrases you may hear midwives and others use whilst in placement, and provide you with alternative suggestions. By being mindful of the language you use when interacting with women you are well on your way to being 'with woman'.

1 Midwives are commonly heard referring to women in their care as 'my ladies' or 'my women' (Simkin et al. 2012). Mary Stewart, in a paper where a number of authors discuss concepts around 'language of birth', dislikes the use of the words 'lady' or 'ladies' to describe women. These two particular phrases represent in her opinion, the concept of a woman belonging to her husband, a possession and defined by her relationship to her husband. She also objects to the use of 'my' which implies a relationship where the balance of power lies with the healthcare professional and not with the woman (Simkin et al. 2012). Other expressions you may hear being used frequently by midwives are: "I delivered Mrs Blogs baby", "I had a C/S last night", "I had twins last week", "I had a PPH today" (Robertson 1999; Hunter 2006). These phrases suggest ownership of the birthing process, the woman is just the 'problem' and goes against the midwifery philosophy of woman-centred care (Lichtman 2013).

2 Imagine you are in the early stages of labour and experiencing a lot of discomfort during your labour contractions and are told by a midwife "You are only in early labour" or "you are still only



Figure 1.2 Top ten tips for what women want from their midwives/student midwives.

5 cm". How would you feel? Perhaps you were once 'that woman! Women are very receptive during their labour; choose your words carefully to describe their progress. 'Still' and 'only' may make them feel negative about what they have achieved so far and for what is to come (Robertson 1999).

3 'The section in bed '4', the induction in room '1', 'she's 3 cm', 'she's contracting', are terms which demote women to a

'series of body parts' (Simkin et al. 2012). This, in effect, is a reductionist approach to viewing and referring to women and reflects a biomedical model of care. It is not reflective of a holistic approach, it is patronizing and the language reflects an environment that is medicalised and technical and women are there to have 'things done to them' (Carboon 1999).

4 Consider the impression these phrases convey 'failure to progress', 'incompetent

cervix', 'trial of scar', 'inadequate contractions'. Do they inspire confidence in a woman's ability to birth? Terms such as these indicate women need to be closely observed and regularly monitored during labour and may even require 'fixing' at some point (Simkin et al. 2012; Hunter 2006; Pollard 2011).

5 What does the word 'patient' mean to you? If you are a student on the shortened midwifery programme and are a registered nurse, you will need to adjust your conceptual thinking around this term. 'Patient' is a term which suggests illness; it also suggests obedience and an acceptance that care is done to you (Hunter 2006). Let us not forget that some women do become patients because they develop complications either during their pregnancy or post birth, so it may be entirely appropriate to refer to them as patients. However for healthy women the environment of birth should not determine their status. Women who birth at home are seldom referred to as 'patients', the same respect should be accorded to women who have babies in hospital. Interestingly, the first ever national Dignity Survey of Women's Experiences of Childbirth in the United Kingdom highlighted that women who gave birth in hospitals experienced less choice and respectful care than those who gave birth in birth centres or at home (Prochaska 2013).

So is there a language of birth? We know what women want! They would like midwives and the wider team to use positive language (AIMS 2012). Choosing our words carefully and spoken at the

right time can positively enhance a woman's experience of pregnancy and childbirth. Consider replacing 'delivery' with 'birth' (Robertson 1999). Reflect on the expression 'the section in bed 4'. How would that make you feel if you were that woman? The words are degrading and impersonal – instead why not say 'the woman in bed 4 has had a baby' and also remember that she has undergone major abdominal surgery and all the issues that go alongside an operative birth (Simkin et al. 2012) (Fig. 1.3).

It is not always easy to change the words we have used over many years and this is nicely portrayed by a midwife responding to a blog on the importance of language written by Sheena Byrom. The midwife describes how she initially felt awkward saying 'attending a birth' instead of 'delivering a baby', but soon got used to it (Byrom 2013). Women birth their own babies; midwives guide and facilitate the process (Lichtman 2013). As Hunter (2006) elegantly reminds us, women give birth and pizzas are delivered!

As an educationalist, I encourage students at all levels to embrace language that is women-centred. I avoid words that are not women-friendly in my teaching resources and when discussing or debating midwifery issues with students. I try not to refer to students that I tutor as 'my students' and am also careful to avoid referring to particular students as 'the student'. This strategy I hope serves as an example of how students themselves should be mindful of the use of their own language both with women and when discussing women with



Figure 1.3 Positive language wordle.

colleagues in placement. We need to be constantly aware of the language we use and take responsibility for our words so that we can transform and enhance care for women (Simkin et al. 2012).

What is a midwife?

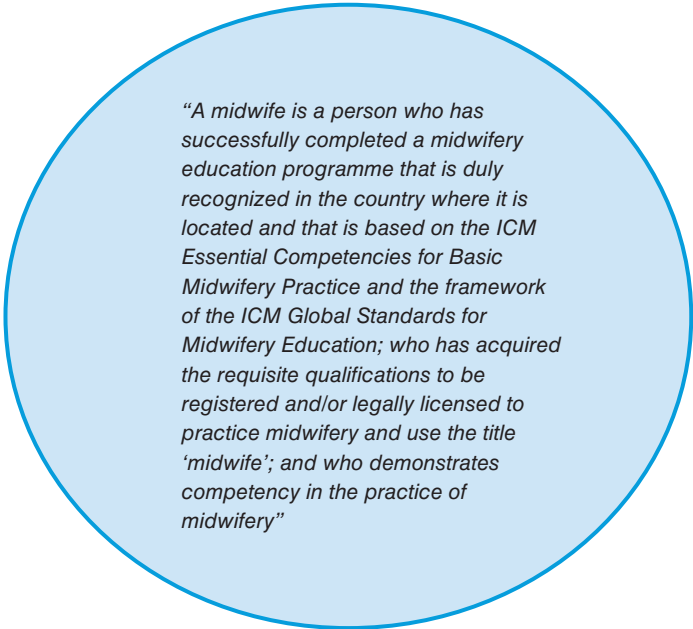
Sue Way

The International Confederation of Midwives (ICM 2011) offers the definition given in Fig. 1.4.

In the United Kingdom, the title 'midwife' is protected by law, which means it can only be used by a person who is registered on the midwives' part of the NMC register.

The nursing and midwifery council (NMC)

Having researched your chosen career in midwifery, you will have quickly realised that between 50% and 60% of your programme will take place in clinical practice. The variety of clinical experience alongside the academic content of the programme is set by the NMC, the regulatory body for nurses and midwives in the United Kingdom (England, Northern Ireland, Scotland and Wales). The NMC is an organisation set up by Parliament, whose main aim is to safeguard the health and well-being of the public by ensuring a high standard of care to those



“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”

Figure 1.4 ICM definition of a midwife.

who need and use the services of midwives and nurses. The organisation:

- safeguards the health and well-being of the public;
- sets standards of education, training, conduct and performance so that nurses and midwives can deliver high-quality healthcare consistently throughout their careers;
- ensures that nurses and midwives keep their skills and knowledge up to date and

uphold the NMC professional standards and

- has clear and transparent processes to investigate nurses and midwives who fall short of the NMC's standards.

The NMC publishes rules, standards and guidance for nurses, midwives, employers, students and members of the public to understand how the above is achieved; however, the following are of particular interest

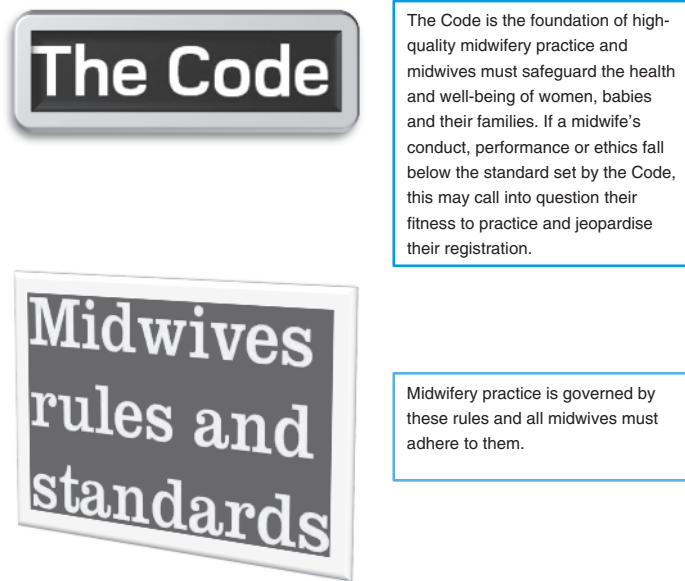


Figure 1.5 NMC publications of interest to student midwives. (Source: NMC: www.nmc-uk.org)

to midwives and you as a student in training (Fig. 1.5). Should you wish to read them in full please look at the reference list for the complete details of each publication.

A further document which may be of interest to you is Standards for pre-registration midwifery education (NMC 2009) which outlines the standards of education and training necessary for you to qualify as a midwife (Table 1.2). As this book goes to print, the NMC is undertaking a review of the pre-registration education standards, so they may look different in the near future. It is always

useful to look at the NMC website on a regular basis to find out what is happening and what is new.

The NMC holds a register of all nurses and midwives who are entitled to practise, which can be viewed by any member of the public. Registration with the NMC provides the nurse or midwife with a license to practise (more can be read about this in Chapter 9). Once you have successfully completed your midwifery programme, signed your declaration of good health and good character form and the Lead Midwife for Education has recommended to the NMC that you

Table 1.2 Standards for pre registration midwifery education (Adapted from NMC 2009).

Standards	Scope of standards
Standards for the lead midwife for education	
Standard 1	Appointment of the lead midwife for education
Standard 2	Development, delivery and management of midwifery education programmes
Standard 3	Signing the supporting declaration of good health and good character
Standards for admission to, continued participation in, pre-registration midwifery programmes	
Standard 4	General requirements related 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
Standards for the structure and nature of pre-registration midwifery 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
Standard 14	Supernumerary status during clinical practice
Standard 15	Assessment strategy
Standard 16	On-going record of achievement
Standard 17	Competencies required to achieve the NMC standards
The Essential Skills Clusters	

are eligible for registration, you will be able to apply to join the midwives' part of the NMC register. Currently, in order to be fit to practise as a midwife you must also have notified your Intention to Practise (ITP) to the Local Supervising

Authority, paid your annual registration fee and have an appropriate professional indemnity arrangement. Professional indemnity insurance means that if you in some way cause harm to a woman or her baby because of negligence then the

woman will be able to recover any compensation she is entitled to (www.nhsemployers.org). If you work within the NHS, the NHS will have an appropriate indemnity arrangement in place for you. If you are self-employed you need to have your own arrangements in place. As a self-employed midwife, sourcing professional indemnity insurance may not be easy as highlighted by Lewis (2014). In January 2015, the NMC made the decision to remove statutory supervision from its legal framework. Once the legislation is amended there will be a number of changes, one of which is likely to be that midwives will no longer have to submit an annual ItP as referred to above'.

Having registered with the NMC, you are able to practise as a midwife, but learning does not stop there. Every 3 years the NMC requires you to complete a Notification of Practice (NoP) declaration stating that you have met the Post-registration Education and Practice Requirements (PREP). Revalidation will replace the PREP requirement in 2016. Revalidation means that you will be required to declare that you have

- met the requirement for practice hours and continuing professional development (CPD);
- reflected on your practice, based on the minimum requirements of the Code, using feedback from women, relatives, colleagues and others and
- received confirmation from a third party that your evidence is acceptable, such as your manager.

The NMC and midwifery education

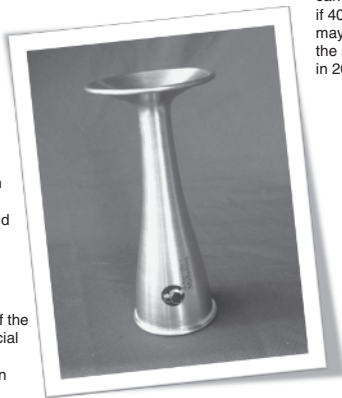
The NMC does not provide the education and training for student midwives; this is the responsibility of an approved education institution (AEI), more commonly known as a University. The University works in partnership with service partners (usually NHS Trusts) who provide clinical placements. The NMC calls this joint collaboration of the University and service partners 'programme providers'. The programme providers interpret the standards and develop a curriculum (programme of study) that meets national and local need. Often members of the public such as women who have recently given birth, or members of lay organisations such as the local Maternity Services Liaison Committee (MSLC) or breastfeeding support groups are also involved in the development of the curriculum.

The standards set by the NMC for pre-registration midwifery education have to meet the requirements of the European Union Directive 2013/35/EU of the European Parliament and of the Council (2013) on the recognition of professional qualifications. This ensures that all members of the EU provide a training programme of a similar standard. An example of some key practice skills can be found in Table 1.3. This enables midwives across Europe to freely move from one-member states to another without further training.

Although the standards set by the NMC are national standards – they are required to be met by all universities

Table 1.3 The European Directive 2013/35/EU: key practise skills.

Advising of pregnant women, involving at least 100 prenatal examinations	Supervision and care of at least 40 women in labour
Initiation into care in the field of medicine & surgery, initiation includes theory & clinical practice	Students should personally carry out at least 40 deliveries, if 40 cannot be achieved it may be reduced to 30 provided the student participates actively in 20 further deliveries
Care of women with pathological conditions in the field of gynaecology and obstetrics	Active participation with breech deliveries. If not possible practice may be simulated
Observation and care of the newborn, requiring special care, including preterm, postterm and ill newborn babies	Performance of episiotomy and initiation into suturing through theory & clinical practice
Supervision, care and examination of at least 100 women and healthy newborn infants	Supervision and care of 40 women at risk in pregnancy, labour or postnatal period



across the United Kingdom offering a pre-registration programme – there will be individual variation to meet the needs of the local population. For example, the practice environment that students link to from a particular University may have a large number of women who are immigrants with specific cultural and health needs which may not be as evident in another University's area. This does not mean the latter University excludes the teaching of cultural diversity, but its application to practice may be different.

Before a pre-registration midwifery programme can be provided by a University, it must gain approval from the

NMC. Approval means that the University programme complies with the standards set by the NMC in the document 'Standards for pre-registration midwifery education' (NMC 2009). The NMC approves the programme through an evaluation event where an expert midwife, who has been trained by the NMC to work on their behalf, scrutinises the documentation and talks to midwife academics about its content as well as current students and midwives in clinical practice. The expert midwife will then make a judgement about the suitability of the programme to support student midwives to be appropriately educated in

order to take on the role as a registered midwife.

As well as the NMC requirements, midwifery education programmes must meet a variety of University standards including academic entry, assessment criteria and academic progression. The Quality Assurance Agency, a UK-wide body, also sets standards that enable an organisation to be called a University as well as more specific standards related to the academic level of programmes such as BSc (Hons), for example (QAAHE 2001). These requirements will also be confirmed at the same evaluation event that the NMC attends.

On-going monitoring of the quality of the programme in both practice and the University is undertaken annually by the NMC to ensure that the standards remain rooted in the programme and that they are maintained at a high level. Quality monitoring is also undertaken by the commissioners (the organisation(s) who pay the University to run the programme) such as the Department of Health (DH) in England, and equivalent in Northern Ireland, Scotland and Wales. The commissioners have organisations which work on their behalf and have a more hands-on approach to reviewing the programmes. Feedback is then reported upwards to give a national picture of what is happening.

The standards set by the NMC not only cover requirements during your programme but also before gaining a place to study midwifery. Your journey through the recruitment and selection progress would have been influenced by the University regulations and the standards set by the NMC. For example:

- Midwifery clinicians should be directly involved in the interview process.
- Applicants must provide evidence of literacy and numeracy of a satisfactory level to achieve the programme outcomes.
- Applicants must demonstrate they have good health and good character sufficient for safe and effective practice.

Good health and good character are fundamental to the fitness to practice of a midwife (NMC 2010). Good character is based on an

“Individual’s conduct, behaviour and attitude. It takes into account any convictions, cautions and impending charges that are likely to be unsuitable with professional registration”

(NMC 2010:8).

Good health in this context

“Does not mean the absence of any disability or health condition. Many disabled people and those with health conditions are able to practise with or without adjustments to support their practice”

NMC (2010:8).

It is strongly advised to declare any disability you may have on your application. This means that an early meeting with the University and relevant practice partners will be able to be arranged with you. The purpose of this is to discuss the requirements of the programme in an open and transparent way and determine whether reasonable adjustments may be required for either your practice placements or academic learning. Best practice indicates that the earlier this

discussion takes place the easier reasonable adjustments can be implemented. (See Chapter 2 – section referred to as ‘Support for you while in placement’).

The NMC standards for midwifery education also outlines a number of guiding principles relating to professional competence and fitness for practice as well as the promotion and facilitation of the normal physiological process of childbirth. Competence is the ability to practise safely and effectively without the need for direct supervision. Students must demonstrate competence in a range of settings and many different scenarios during the antenatal, intrapartum and postnatal periods, as well as assessment and care of the newborn baby. Demonstration of competence

must be supported by appropriate knowledge. The NMC states six key areas that you must demonstrate competence in at the point of registration (See Box 1.1) (NMC 2009:4):

The NMC and practice requirements

The NMC require a minimum of 50% of the programme to take place in practice, providing direct care to women, babies and their families. While in clinical practice you will be under the direct or indirect supervision of a midwife. Direct supervision means you will be working

Box 1.1 Six key areas of competence at point of registration

- Sound, evidence-based knowledge of facilitating the physiology of childbirth and the newborn, and be competent in applying this in practice
- Is knowledgeable of psychological, social, emotional and spiritual factors that may positively or adversely influence normal physiology, and be competent in applying this to practice
- Appropriate interpersonal skills to support women and their families
- Skills in managing obstetric and neonatal emergencies, underpinned by appropriate knowledge
- 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 home
- Being able to undertake critical decision making to support appropriate referral of either the woman or baby to other health professionals or agencies where there is recognition of normal processes being adversely affected or compromised

closely with a practising midwife, so they can directly observe what you are doing. As you become more skilled, independent and confident in your practise, the midwife may feel it more appropriate to supervise you indirectly. On these occasions, care has been delegated to you in a safe and responsible manner. Indirect supervision is more likely when you are in the later stages of your programme. The midwife, however, must be easily contactable and provide a level of support that is safe for both the women and yourself.

Standard 17 in the NMC 'Standards for pre registration midwifery education' (2009:21) gives examples of how the six key areas identified above can be achieved in practice using the following headings:

- Effective midwifery practice
- Professional and ethical practice
- Developing the individual midwife and other
- Achieving quality care through evaluation and research

Supporting each of the above are the Essential Skills Clusters (ESCs) given in Fig. 1.6.

The NMC views the ESCs as essential to your learning in practice and this is why they are specific requirements for you to achieve by the end of your programme.

The variety and length of practice placements may differ between universities. Often this depends on what placements are available in the local community and NHS Trusts as well

and how many students are on the programme. For example some universities place student midwives in general medical and surgical wards where traditionally student nurses are placed (see Chapter 7 on 'Wider Experiences'). However, other universities prefer to demonstrate that the knowledge and skills gained in these placements can be met entirely in a midwifery setting. Despite the variety of environments there is still the need for student midwives to meet all the NMC requirements by the end of their programme.

The NMC and assessment of practice

Chapter 3 'Assessment of Practice' goes into depth about this important aspect of your practice placements. A brief explanation only is therefore included here. Since 2008 pre-registration midwifery programmes have needed to ensure that the assessment of direct hands-on practice is graded. This means that rather than just receiving a pass or fail judgement about your level of competence in practice, a system recognised by the University such as a percentage grade (50%, 60%, and 70%), or letter (A, B, C, and D) will be used to distinguish more clearly your level of practice. The grades awarded must contribute to the final outcome of the award. Universities use a variety of different practice assessment tools as the NMC does not stipulate one particular method that should be used (Fisher et al. 2015). Whatever

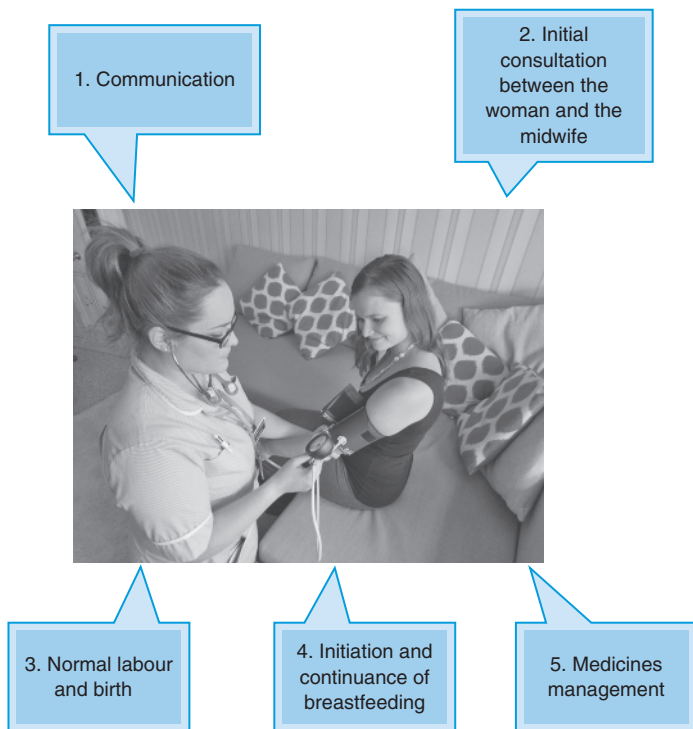


Figure 1.6 Essential skills clusters.

method is used in your University will have been agreed by the NMC at the curriculum approval event previously described. Some areas within the United Kingdom are seeking a similar practice assessment tool; in London for example a number of universities are in the process of agreeing a common tool in order to provide some consistency in how

students are assessed in practice. This is particularly relevant as clinical areas may be shared by more than one University.

A range of people will be involved in assessing your practice. The NMC sets the standards for those midwives who support learning and make judgements about your ability to practise

(NMC 2008), who are known as sign-off mentors. Chapter 3 goes into more detail about their role. Others such as a member of the midwifery teaching team and the women you care for may also be asked to contribute in various ways. The NMC advises that midwife teachers should spend approximately 20% of the normal teaching hours assisting in the support of learning in practice. Each University will have a particular way that this is achieved and how you can make contact with them when they are in the clinical area.

Raising concerns

The new NMC Code published in March 2015, has meant the NMC Document 'Guidance on professional conduct for nursing and midwifery students' (2011) has been withdrawn. This is because the content within the 2011 publication for student nurses and midwives has now been incorporated within the Code (2015). The Code is therefore central to your practice as a student midwife and will continue to be during your midwifery career. The pre-registration programme you will be following will enable you to use these standards demonstrating your commitment to upholding them. The Code (2015) is based on four themes that nurses and midwives are expected to adhere to

- prioritise people,
- practise effectively,
- preserve safety and
- promote professionalism and trust.

Poor standards of care in the NHS and other health care organisations often attracts media attention such as that at Mid Staffordshire which culminated in the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry', chaired by Robert Francis QC (Francis 2013). Although this has been mostly related to nursing and medical care, reports of care in midwifery that has fallen below an acceptable standard have also been published (Care Quality Commission – CQC 2013; NMC 2014). You may be in the unfortunate position to witness poor care and are unsure what to do about it. You have a duty to put the interests of people in your care first and act to protect them if you consider they may be at risk. The NMC provides guidance for all nurses, midwives and pre-registration nursing and midwifery students about how to do this (NMC 2013).

It might not be easy for you to raise a concern but there are people you can go to for advice and support. All Universities should have a policy available to students about how to raise concerns and it is important you know where to find the document and what it says. Generally the advice would be to inform your mentor or academic tutor as soon as you believe that you, a colleague or anyone else may be putting someone at risk. If you believe that harm has already been suffered, then you must let a qualified health professional know immediately. If someone tells you they are not happy with their care, then you should seek help from your mentor or academic advisor/personal tutor. A hypothetical example is provided by the

NMC on raising concerns: <http://www.nmc-uk.org/Nurses-and-midwives/Raising-and-escalating-concerns/Toolkit/case-studies/>. After reading the case study read page 4 of the NMC document, Raising concerns: guidance for nurses and midwives (NMC 2013). Referring to the section 'Your role in raising concerns' make notes about whether you think the student acted appropriately and why. Next, read the 4 themes that the Code is based on. Which themes do you think the case study is referring to and why?

Guidance on using social media and social networking as a student

Luisa Cescutti-Butler

The rise in the use of social media has soared over the last 10 years, with Facebook and Twitter being the most popular. The NMC in its document "Facebook trials and tribulations: Social networking sites and their joys and dangers" says of the 25, 789, 200 users of Facebook that 77, 580 listed their occupation as nurse, midwife or health visitor (Facebook, 2011a cited in Jaeger 2011). Chances are that you yourself use one or more of the numerous social media applications which are easily accessible via your personal smart phone or tablet to connect with friends and family. Many midwives and student midwives are doing likewise, enabling them to link professionally with colleagues to share

ideas and resources or to network through an online community (Byrom & Byrom 2014). One of the advantages of social media is everybody has a voice and you can communicate with people who would otherwise be inaccessible to you (Byrom & Byrom 2014). Examples include linking up with student midwives from other universities, connecting with key midwifery professionals and joining in with health and social care discussions on Twitter. Jane Cummings (NHS England Chief Nursing Officer) and Cathy Warwick (Chief Executive of the RCM) are two of the senior leaders who see the benefits of social media and regularly use it as an opportunity to reach as many people as possible (Chinn & Foord 2014). In addition service-users of maternity care (mothers/fathers/partners) are using platforms such as Facebook and Twitter to share their experiences, connect with healthcare professionals and importantly, campaign for change (Byrom & Byrom 2014).

It appears, however, that many student midwives are wary of using social media in case they do something 'wrong', but if you follow the guidelines as set out by your professional 'Code' (NMC 2015) and your University, you should keep yourself safe. The NMC supports the use of social media, as do many senior leaders within the NHS (Chinn & Foord 2014). Don't be afraid of using it providing you follow the 'guidelines'. Find out what your University's policy is on using social media – read and absorb its contents. While bearing these in mind, the following 6 Ps should also help you consider what is appropriate or not.

1 Professional.

As a student midwife you must act professionally at all times. What happens on your social media pages in a personal capacity can still reflect upon you as a student.

2 Positive.

Be positive when posting on social media. Don't complain about your busy shift or the lazy midwife you may have worked with. Don't re-post any posts which may be deemed offensive; you will still be linked to them. If you are tagged in any inappropriate messages etc, remove the links, un-tag yourself and if applicable report the content to the relevant authorities.

3 Person/woman, patient free.

You must keep posts person/women & patient free. Do not discuss on any site how you facilitated a wonderful birth. Never accept a 'friend request' from a woman whose birth you have facilitated. Do not post any pictures of women who are service users.

4 Protect yourself.

Protect your professionalism, your reputation and yourself. It may be difficult to have separate accounts; one for you as a professional and one for your personal life. To make life simple, have one account and use it wisely but remember to uphold your profession.

5 Privacy.

Check your privacy settings & respect the privacy of others. Use robust passwords and change them regularly. Avoid using the same password for all your online interactions. Avoid the common

passwords, for example your date of birth (DOB), or your child's name and DOB etc.

6 Pause before you post.

Always THINK before you post anything. Once it's on, it's there for the whole world to see. THINK: would you want your post to be seen by your family, your personal tutor, your mentors or the Head of Midwifery? If in doubt, do not post. Also, don't post in anger or quickly.

(Nursing and Midwifery Board of Ireland 2013)

#Wecomunities available on <http://www.wenurses.co.uk/> has a variety of resources (articles and presentations) on how to use social media safely. Much of the information has been written for nurses (students and qualified), but is equally applicable to you as a student midwife. Chinn & Foord (2014) have written a short article busting the myths around Twitter usage which is a useful read.

Social media can also help midwifery tutors to effectively connect with students. In most universities, traditional methods of communication are used with students, the most popular being email. Often, if a response is required, it can take several days especially if the student is busy in placement. The solution was to try Facebook. I created a group page which is only open to midwifery students who are clinically based in the NHS Trust to which I link. First-year students are added as soon as they are officially enrolled at University, and third-year students are taken off once they have qualified. Guidelines have been set which have been respected by all the students using it. As a medium

Extract 1



Luisa Cescutti-Butler

1 July · Edited

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for communication, it works very well with students responding to requests much quicker than the traditional email. An extract presented above highlights how the page is used to communicate with students.

The students, however, find value in the Facebook group themselves. Many of their postings relate to shift patterns and whether the off-duty is out. Students are free to post any interesting articles/links that others may find interesting. See below for examples of how students use the page.

When students were asked whether they felt the Facebook group page served their needs the following quotes demonstrate some of their views:

"I like this group as it does make communicating easier especially with other years as I wouldn't really know them otherwise and it's nice to be able to ask questions and get a response from people who have been through the same things"

First-year student.

"I love all your articles along with being able to communicate with peeps as necessary"

Third-year student.

"I agree. It's great to be able to keep in touch and it's really nice when it's across all three years too as we might not have been able to communicate as much being on placement at different times etc"

Second-year student.

"Hi Luisa, I've found it really helpful and good to have for communication with you and other years when needed, it's almost guaranteed to get a quick response which is great. And love the articles x"

Second-year student.

As can be seen, students seem to value the Facebook group page. From my perspective I usually get a response to a query fairly quickly. Most of all the students really like being able to get to know each other – especially those from different years – and to ask questions or for advice about their practice area in a safe environment.

Extract 1

Hey all, Just asked my community midwife to confirm what drugs we carry for home births and she said:

- 2 Ampoules Syntometrine
- 2 Ampoules Ergometrine
- 2 Ampoules Lignocaine
- Paracetamol
- 2 Ampoules of Vitamin K
- Cylinder of Entonox

Hopefully this can help you with emergency skills and anything else and hopefully its correct, let me know if you think it anything different 😊 xx

Extract 2

Hi guys! lovely to see u all today. I thought I would compile a list of things that would be useful for (future) first years to know how to do. As many students may not have been in a hospital or care environment. These are some of my thoughts as they are things that can be shown to them prior to commencing placement:

1. How to wash a woman and provide personal care.
 2. How to thoroughly clean a labour room or postnatal bed space using the correct stuff.
 3. Catheter care, How to empty one without spilling 😊, where it goes etc.
 4. How to af feed babies (may sound silly) but those that have never done it may find it difficult. ie when to wind, best position to hold them in. And it may be something you have to do early on in practice.
- I cant think of anything else right now. What do u guys think? 😊

Extract 3

Are the shifts for week beginning 21 Jul up? Thanks in advance 😊

Like · Comment

✓ Seen by 24

To conclude, using social media has many benefits providing you understand the boundaries. Try it and see. There are many advantages and as a medium it can

help enhance your learning and connect you with people far and wide. #WeMidwives at @WeMidwives (part of the @WeNurses community) on Twitter,

supports and connects the tweeting Midwives Community. It is a great forum to link up with midwifery students and key midwifery professionals (and others, such as obstetricians) both in the United Kingdom and internationally.

Conclusion

This chapter has highlighted the processes you need to go through to qualify as a midwife including outlining the rules and regulations that govern your practice. First you are expected to successfully complete an approved midwifery education programme, following which you are then required to register with the NMC which provides you with a license to practise. This license, including an annual fee, requires renewing each year and you will have to prove to the NMC that you remain competent to

practise as a midwife, have submitted your annual Intention to Practise form (required at the time of writing) and remain updated in order to provide safe and effective care. In addition, the chapter has explored aspects of midwifery care including the use of language, the 6Cs, and humanisation of care. By considering how you can incorporate these elements into your daily midwifery practice will ensure you truly provide woman and family centred care and be the midwife that is 'with woman!' Finally the chapter concludes around a discussion on the advantages of social media and how you as a student can safely use it to enhance your learning, make useful connections and contribute to midwifery care and practice.

Text box 1: Please see vignette 1.2 'Meeting Suzy where student midwife Millie has incorporated aspects of the 6Cs and humanisation of care into her practice.

Vignette 1.2 A reflection on meeting Suzy

Suzy was the first mother I met in my student midwifery training, on placement in the community. Her story was compelling and it stirred up a lot of emotion for me. This reflection uses Borton's (1970) reflective model to explore the psychology behind Suzy's situation, and the impact her situation had on me. All names have been changed in accordance with the NMC code of conduct (2008).

On my first shift, my mentor and I visited Suzy and her new baby Esme for their day 5 postnatal check. My mentor gave me Suzy's background beforehand: that she was a 17-year-old woman who had conceived her child with her stepfather, whom she had known since she was 6 years old. Social services (Child Protection) were involved regarding Esme's welfare, including the possibility of her being groomed by Suzy's stepfather. I was shocked – the first woman I was going to meet was in such a vulnerable, difficult situation, and I immediately visualised a dysfunctional and inadequate teenager. Not only would I have to observe and digest the entire postnatal check, but also in what I thought would be rather difficult circumstances [...] and it made me feel incredibly nervous and worried.

We arrived at Suzy's foster accommodation where my mentor and I were met at the door by a shy- and sweet-looking woman, holding Esme close to her chest. We chatted to her first about her situation. I was amazed at how besotted with love she was for her baby, and realised that I had earlier prejudged her. We learnt that she felt very lonely, because her mother did not visit, and her foster family were out working most of the time. She was not allowed contact with her stepfather, and she planned to move north to live with her biological father. Before Social Services became involved she had hoped to go to France to live with her stepfather, and her mother (who was apparently happy with the situation).

My mentor performed the postnatal check whilst I observed. Suzy picked up Esme afterwards to breastfeed her. Suzy was so young, and I saw her as needing nurturing and support herself, but now she was comfortable and competent, performing the most natural act as if it was the best thing in the world for her.

[. . .] As the week progressed I felt that a trusting relationship formed between Suzy, my mentor and me. Suzy expressed her anger at being restricted from seeing her stepfather, seemingly unaware of the potential dangers to her baby. When the legalities around safeguarding Esme were explained again Suzy became angry as she was desperate for her partner to meet his new daughter. I felt saddened by how naïve she seemed, then I remembered how vulnerable I had felt at that age, how everything could be so confusing; how on earth could she manage to nurture a newborn without anyone there for her? But Suzy seemed to be coping, and to be strongly bonded to her baby. We [. . .] explained everything again clearly and calmly. She was aware that if she made contact with her stepfather, Esme would be removed by Social Services. This brought tears to her eyes and I truly felt, at the time, that there was nothing on this earth that would risk her losing her daughter.

I learnt the following week from my mentor that Suzy had visited her stepfather and that the police had been called by a neighbour. [. . .] I felt shattered by this, and confused. How could Suzy? She had appeared to love Esme with all her heart. I could not bear to think of her without her baby.

I was initially shocked by Suzy's fluctuating behaviour between anger, infatuation for Esme, confusion, and impulsive decision making. On later reflection, emotional isolation for any new mother with responsibility for a new life, even without Suzy's additional problems, would be unbearable. Suzy needed love and support herself and the only person she saw who could give it was her stepfather. She was also under the influence of hormonal changes associated with the postnatal period, such as progesterone withdrawal and prolactin release, which activate nurturing behaviour towards the newborn, but can alter the mother's emotional state, which may lead to depressive disorders (Brunton & Russell 2008).

Suzy's age was a major influence as well. Being an adolescent, she was experiencing an already difficult period of vulnerability, adjustment and brain development (Steinberg 2005). She was subject to heightened emotional

(continued)

reactivity resulting from social interactions with the people that she knew (Casey et al. 2008). Although she was probably aware that the rational decision would be to cut off contact with her stepfather, her age may have caused her limbic system – her emotional powers – to take control, therefore relying less on intellectual capability, resulting in taking a huge risk when deciding to visit her stepfather (Casey et al. 2008). It is also possible that Suzy's need for nurturing and support for herself from the man she loved and who was the father of her baby, outweighed the risk of losing the baby.

I have learnt that it is of the utmost importance to gain extra professional support when dealing with adolescents; women who themselves still need mothering, and are experiencing the self-definition process (Raphael-Leff 2005). Whether we are aware of them or not, we all make classifications and judgements about people based on experience, stereotyping and word of mouth (Paradice 2002). A judgemental attitude by healthcare professionals can have negative consequences and influence a woman's behaviour, and it is important to practise both self and inter-personal awareness (Paradice 2002).

I feel that I learnt one of the most valuable lessons in my first week from meeting Suzy; that is, to treat every woman as an individual. Our preconceived ideas can often be proved wrong, as when I initially prejudged Suzy by stereotype. Additionally, when I was shocked by Suzy being 'naive' and then 'willing' to take the risk of losing the baby she appeared to love and want, I was not truly empathising with her particular – and tragically conflictual circumstances. Best practice is to be open minded and non-judgemental, which I believe to be fundamental qualities to pursue a career in midwifery.

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Millie Westwood

Third-year midwifery student, Bournemouth University, Dorset, UK

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Further resources

- Feminist Midwife Blog: Room seven delivered, no complications. <http://www.feministmidwife.com/2014/07/10/room-seven-delivered-no-complications/>.
- Natalie Boxall discusses how the use of social media can benefit midwives by making connections and sharing experiences. Available: <https://www.rcm.org.uk/content/social-awareness>.